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Tommy MacKay

Abstract

This paper considers the historical place of therapy in the early development of educational psychology. It then discusses reasons for its decline in terms of the reconstruction of the profession, increasingly demarcated professional boundaries, a predominant focus on education and the impact of special educational needs legislation on professional practice. It argues, however, that it is time for therapy to be rehabilitated in educational psychology, proposing this as a historical inevitability that is now supported by the rising profile of mental health issues in children and young people, the new evidence base for therapy and changing perspectives on the nature of applied psychology. It concludes by outlining the signs of a rising commitment to therapy within the profession and asserts the role of educational psychologists as a key therapeutic resource for children and young people.

'IN EDUCATIONAL PSYCHOLOGY the term "therapy" is seldom heard.' Thus Indoe (1995) sought to rehabilitate the concept of therapy into an arena that had in large measure abandoned it – the arena of educational psychology in the mid-1990s. It was the latter days of a period in which such abandonment would hold centre stage in that arena – a period marked by a number of mantras, such as 'educational psychology is not a therapeutic service'. It was a period indeed in which not only therapeutic work but any direct work with the individual child or young person was almost viewed in some quarters as being undesirable or, at best, second rate. That such mantras might be historically, psychologically and conceptually bankrupt did not seem to be considered, and so for a time the question of their legitimacy or validity was largely unchallenged. Thus the expert skills in direct individual work of a profession founded on the study and application of individual psychology were devalued and marginalised.

It was not that individual work, including therapeutic work, had ceased to exist (Hayes, 1996; MacKay & Vassie, 1998), or that the supporters of individual therapy questioned the necessity and value of systemic interventions in schools, albeit recognising the relative lack of a robust evidence base to validate such interventions. Nor indeed did the new mantras pass completely unchallenged. For example, MacKay (1990), in a paper entitled 'Individuals or systems: Have educational psychologists sold their birthright?', feared that 'a whole generation of psychologists may become deskilled in the methods of individual assessment and the techniques of therapeutic intervention'. He argued that the pioneers of the profession were individual psychologists, systems psychologists and academic psychologists, and that this threefold foundation represented the inalienable birthright of professional educational psychology. The importance of direct individual work in relation to mental health was also the focus of a DECP Working Party from 1993 to 1995 on reappraising the role of educational psychologists in working with child and adolescent psychological and mental health needs (Indoe *et al.*, 1996).

Historical foundations of therapy in educational psychology

The formal development of educational psychology as an applied discipline in the UK had its origins in the early decades of the

twentieth century. In 1913 Cyril Burt became the first educational psychologist in the UK on his appointment to London County Council, and his contribution shaped the structure for professional practice for the next half century, especially in relation to assessment and intervention for individual children. Parallel events took place in Scotland, where in 1923 the first post of a child psychologist was established when Kennedy Fraser was appointed by Glasgow Education Committee as a psychological adviser. Later in the same decade educational psychology clinics were set up at the Universities of Glasgow and of Edinburgh (McKnight, 1978).

The context in which these developments in educational settings took place was governed by the parent discipline of child psychology, which had become an established subject in the universities by the end of the 19th century. In 1884 Francis Galton had opened in London his anthropometric laboratory for the study of individual differences, and had advocated the scientific study of children. A psychological laboratory was opened in 1896 by James Sully, a founder member of the British Psychological Society and convener of its first meeting in 1901. In his classic *Studies of childhood* (Sully, 1896) he outlined the importance of 'the careful, methodic study of the individual child', and teachers and parents were invited to take difficult children to his laboratory for examination and advice on treatment. Sully paved the way for a new kind of specialist to work with children in the educational sphere.

Two quite different but very major influences shaped the way in which educational psychology would develop and their impact is still apparent in the emphases of services today. The first was the mental testing movement, with its focus on the assessment of individual differences in children. The second was the child guidance movement, with its focus on treatment of children with emotional and behavioural difficulties. It was the latter influence that led to the early emphasis on psychological therapies designed to support children and young people who were experiencing difficulties in their emotional and behavioural adjustment.

The way in which the joint influence of mental testing and child guidance shaped service development was somewhat different in England and Wales and in Scotland. In England and Wales a school psychological service was funded through education services, while educational psychologists also worked in child guidance clinics as members of a medically directed team of psychiatrist, social worker and psychologist. Scottish child guidance clinics, also frequently operating on a multidisciplinary basis, were directed by educational psychologists and were funded by education.

In Scotland, education authorities were empowered from 1946 to establish their child guidance clinics on a broad statutory foundation (MacKay, 1996). This became mandatory on all authorities in 1969 and it continues to govern Scottish education authority psychological services today. The remit related to children, and later young people until they reached age 19, who were described in the statutes as 'handicapped, backward and difficult' (since 2004 as having 'additional support needs'). The official guidance supporting the statutes made it clear that this covered a very wide range of educational, developmental and other difficulties, including those who suffered from 'emotional instability or psychological disturbance'. Thus a broad foundation was established not only for work of an educational nature but also for therapeutic interventions in relation to children's mental health.

It was against this background of early developments in relation to children with mental health difficulties that the routine therapeutic involvement of educational psychologists developed. In some services, the records kept for annual statistics were divided between 'educational' and 'clinical' cases and it was these latter cases, covering all forms of difficulties in development and adjustment, that were the recipients of therapeutic interventions.

The fall of therapy

There were several reasons for the changes by which educational psychologists over a period of time largely ceased to identify themselves as psychological therapists. Four are outlined here: the reconstruction of educational psychology, increasingly demarcated professional boundaries, the focus on education and the impact of legislation.

The reconstruction of educational psychology

The reconstruction of the profession through the 1980s was an essential process in the transformation of educational psychology into a robust, highly accountable and evidence-based profession. Undoubtedly the main catalyst was the work of Gillham and his colleagues with the publication of *Reconstructing educational psychology* (Gillham, 1978). The concept of professional 'reconstruction' paralleled developments in other disciplines from the beginning of the 1970s onwards. Shulman (1970) was reconstructing educational research, followed by Armistead (1974) who was reconstructing social psychology.

The essential element of reconstruction was a move away from the psychologist as individual caseworker to being an agent for systemic change in schools and other systems, using models drawn from organisational psychology and other disciplines. The arguments for change were compelling and were eloquently expressed and exemplified. A robust critique was offered of reactive, individual methods of working in terms of efficiency, efficacy and equity. For the next 20 years and more the educational psychology literature was to be dominated by the agenda for change (Acklaw, 1990; Jensen *et al.*, 2002; Stobie, 2002a, 2002b).

Change driven by arguments based on efficiency and efficacy was for all practical purposes unanswerable. There could be no justification for an accountable profession to work at individual level with a tiny proportion of the population requiring its services. What could be the possible impact of any profession that was concerned with the individual alone? The entire system was marked by a large number of children and young people who had significant problems in their learning, behaviour and development. However, the number in question far exceeded anything within the reasonable compass of individual assessment and intervention. The application of the knowledge base of educational psychology at systemic level was crucial. Although it was apparent in the systemic work of pioneers like Burt, whose contribution influenced entire systems right to the level of national policy formulation by government committees (Hearnshaw, 1979), it was not a feature of the work of educational psychology services immediately prior to the reconstruction movement.

In terms of equity of service provision, the model of offering individual assessment and treatment was also open to challenge. It was not just that some received a service while others did not, but that questions could be raised as to who were the recipients of the services offered. Many years ago it was shown that while the mental health issues and other problems with which the caring professions are concerned are overrepresented in the lower socio-economic groups, these groups are often underrepresented in the distribution of resources and in the extent to which they can gain access to them (Hollingshead & Redlich, 1958). Tudor Hart (1971) described this as the 'inverse care law', whereby resources are distributed in inverse proportion to need. More recently this has been demonstrated in an educational context (MacKay, 2000c; Sacker *et al.*, 2001).

One of the many advantages of reconstruction was that it presented an opportunity for the profession to stand back and challenge every dogma by which it had ever been guided. While this process was not without its risks and indeed its mistakes, it was crucial to professional renewal and regeneration. Thus, the entire foundation of practice was challenged, and the old models were weighed in the balance and found wanting. Significantly, it was recognised that applied

psychology in general, and educational psychology in particular, was still operating on a 'medical model'. Assessment and intervention were governed by a medical analogy based on 'within-child' deficits. The whole language and structure of the profession echoed the model in its practice, its remit and its vocabulary. Educational psychologists offered 'treatment' to children with impairments and disabilities in settings that were often described as (and in an interesting anachronism of Scottish legislation are still defined as including) 'clinics'.

The rejection of the medical model resulted in a 'paradigm shift' (Kirkaldy, 1997) towards what was essentially a psychological or even educational model in which the psychologist became a consultative colleague working alongside parents, teachers and other key adults with primary responsibility for assessment and intervention in the child's normal context. The new perspective was interactionist and ecological, with the educational psychologist as a collaborative colleague working with others for effective change in the social ecology of children and young people. The emphasis was fundamentally different from the model of the psychologist as an expert providing therapy to remedy the problems of the individual.

Increasingly demarcated professional boundaries

The increasing demarcation of professional boundaries was a historically inevitable process in the development of applied psychology from being a largely generic professional discipline to a highly specialised one. It is a process that has been incisively delineated by Bender (1976) in his seminal work on community psychology. First there are the 'pioneers', those who break new ground, forming a profession in its embryonic stages and demonstrating its utility to society. Next come the 'consolidators', those who generally do not match the exceptional work of the pioneers, but who establish the profession by setting up training courses and a careers structure, by defining and restricting the role and by making the profession a monopoly.

This is precisely the process that has taken place in applied psychology. Those of us who have worked in the field for a lengthy period of time remember days in which distinctions between 'educational' and 'clinical' child psychology were largely an artefact of employment arrangements, and when psychologists moved easily between these (and other) psychological specialisms by a process that later came to be called 'lateral transfer' – that is, an applied psychologist moved between one specialist description and another according to the employment context that obtained at the time. With the passage of time these arrangements became increasingly demarcated, but the process has been of such recent origin that most of the 'divisions' within professional psychology have only in the past few years moved out of 'grandparenting' arrangements into highly formalised qualifications and entry requirements.

This is not to say that the process of specialisation and formal qualifications lacks validity and utility. The development of new arrangements has reflected a vastly increased knowledge base where higher levels of study, skill and expertise are a fundamental requirement for practice at a satisfactory level. It is impossible as the academic evidence base advances to maintain a position of being a 'generic' psychologist without extensive study of a number of specialist areas. This is the rationale that underlies the current demarcation within the British Psychological Society, with many 'Divisions' each of which has its own qualifications and entry requirements – educational, clinical, forensic, occupational, clinical neuropsychological, counselling and sports and exercise psychology, with further routes for 'teaching' and 'research' in psychology. The potential for yet further subdivision is considerable, the next obvious 'Division' perhaps being 'traffic and transport psychology'.

However, while these divisions of the subject matter of the core discipline have rightly reflected a developing and distinctive evidence base, one outcome has been to imply

limitations to previously established professional practice. The case of 'therapy' is an obvious one. What are educational psychologists doing with 'clinical' cases? Is therapy for mental health issues an 'educational' concern? Furthermore, is there not now a Division of Counselling Psychology, and also a register of 'psychologists specialising in psychotherapy', so are educational psychologists acting with propriety if they view their core functions as falling within these domains?

This is a fundamental dilemma for applied psychology, not only in how its various domains relate within psychology itself, but also in the interrelationships it has with other disciplines. Are assessment and intervention in speech and language difficulties less of a psychological specialism because of the expansion of the old established therapeutic discipline of 'speech therapy' into the wider language and communication arena? Will psychologists eventually opt out of the field of sensory assessment and intervention – the absolute heartland of psychology – because the discipline of occupational therapy has found new ground there?

Clearly psychology must retain its foundations in all of these areas. Equally, each discipline within psychology is not expected to cease operations in its old established territory because of the development of new specialisms. The British Psychological Society has appropriately dealt with this issue by stressing that professional applications of psychology are based on 'competence' and not on the specific nature of the activity being carried out. Can we really imagine a vibrant and competent educational psychology profession demarcating its activities to avoid the work that arises in clinical psychology, health psychology, clinical neuropsychology and other fields? Examples of the invalidity of such an approach are developed in MacKay (2005) in considering the relationship between educational psychology and clinical neuropsychology.

Nevertheless, the impact of increased demarcation and specialisation remains, and it has had its influence on educational psychology. 'Clinical' work is increasingly viewed as the domain of the clinical psychologist, while 'therapy' sounds like a specialist term that only certain people are qualified to carry out. These may be some other species of psychologist, such as a 'counselling psychologist', or someone who is not a psychologist at all, but who has done a one-year course to become some description of 'therapist'. Meanwhile the whole field of therapy itself has become more formalised and regulated, with many different therapeutic applications now having their own pathways to accreditation.

The combination of factors becomes self-fulfilling. Educational psychologists find themselves with ever decreasing resources to provide therapeutic services. As a result, they spend ever decreasing time engaged in therapy. Therefore, their competence in therapeutic interventions becomes less and less. The old skills wither, confidence declines and it becomes increasingly obvious that we are not, and indeed could no longer reasonably claim to be, a 'therapeutic service'.

The focus on education

It is proposed here that over a period of time educational psychology has undergone a systematic transformation from being a broad 'child psychology' specialism into being a narrow 'educational' specialism. Unlike some parts of the world where 'educational psychology' has had no real existence as a discipline but only 'school psychology', the traditions of educational psychology in the UK, as outlined above, are rooted in the broad application of child psychology both in schools and in other settings. Increasingly, however, the profession has become defined as a 'school psychological service', and even within the strictures of that definition the emphasis has been very much on a narrow understanding of education in curricular terms rather than a wider interest that incorporates mental health.

A principal reason for this narrower educational emphasis was the increasing rigidity

of departmental boundaries through the 1980s and 1990s. The well-being of children and young people is addressed within public services through a variety of departments of which the most significant are health, education and social services. Through a long period in which successive governments were speaking about 'joined up working' in these services the actual arrangements by which they were funded and administered was becoming more rigid and inflexible. Examples continued to abound of meetings and reviews involving professionals working with young people from a variety of disciplines, but real professional collaborations on a multidisciplinary basis were not in abundance (MacKay, 2006). Meanwhile, collaborative enterprises for addressing the mental health needs of children and young people, such as the child guidance clinics, were being disbanded or cut back throughout the country (Mittler, 1990), and educational psychology links with those that remained were becoming 'residual' (Day & Fleming, 1996).

In addition there was – and continues to be – a major political imperative for schools to increase their focus on promoting basic educational competence in the core subjects of the curriculum. Basic literacy became the key emphasis, with a level of governmental prescription and inspection that was unprecedented. This emphasis extended across every age range. From the nursery through to school leaving age the pressure mounted on educational establishments to produce measurable results. The new focus was on audits, targets, standards and statistics.

Certainly, there was no denying the crucial importance of attaining these core competences and of placing them at the heart of the educational curriculum. Also, the basic issues surrounding literacy and the wider aspects of learning were key territory for the educational psychologist to make an effective contribution at the level both of the system and of the individual child. Nevertheless, educational psychologists as accountable professionals supporting the key objectives of the education system were increasingly expected to have a central focus on these curricular areas, and on supporting pupils who were experiencing difficulties in school learning. In a pressurised and competitive world of league tables, the educational environment was hardly one in which therapeutic needs were going to be at the forefront.

The impact of legislation

From the beginning of the 1980s educational legislation for children and young people with additional support needs vastly increased both in extent and in complexity. This gave educational psychologists in England and Wales their one statutory duty in relation to the Statement of Needs, and it laid additional statutory requirements on Scottish psychologists in relation to the Record of Needs (discontinued since 2004). The impact of this legislation on the profession of educational psychology is widely documented (Boxer *et al.*, 1998; Farrell *et al.*, 2006; MacKay, 2000b; Woods, 1994). In summary, it depleted the profession's resources and it narrowed and distorted the contribution that psychologists might have made.

As to depletion of resources, the servicing of the requirements of the legislation was time consuming, not only in carrying out large numbers of statutory assessments but also in dealing with any appeals. Bennett (1998) reported that a tribunal hearing involved an average of around 10 hours in prior preparation alone, with over 20 per cent of psychologists spending more than 20 hours. Boxer *et al.* (1998) expressed concerns that an increasing workload and short time scales threatened the quality and impact of the work undertaken. In Scotland, services indicated that this area of work was consuming such a disproportionate amount of time that resources had to be deflected from other functions (MacKay, 2003). Surveys of practice indicated that educational psychologists were spending an average of 15 hours collating reports and writing the draft Record of Needs for each recorded child

(Thomson *et al.*, 1995).

As to narrowing and distorting the contribution made by psychologists, the balance of work shifted inexorably towards statutory assessment and report writing at the expense of other areas (Boxer *et al.*, 1998), and innovative practice was frequently squeezed out (Thomson, 1996). Woods (1994) warned of the dangers to the future of the profession in having priorities distorted towards the demands of the legislation, and pictured 'a world without statementing' in which psychologists used the skills and evidence base of psychology itself to deliver a wide range of effective services.

It is hardly surprising that in a profession where one activity – carrying out work related to statutory assessment – gained such excessive prominence, the focus was turned away from other areas of potentially fruitful and effective psychological interventions. It was not a context in which therapy stood any reasonable chance of being seen as a priority in terms of allocation of resources. MacKay (2002) saw educational psychologists 'caught up in the Statement of Needs, while their old, established clinical and therapeutic skills atrophy'.

The rise of therapy

Indoe's (1995) remark that the term 'therapy' is seldom heard in educational psychology continued to be applicable to the profession through the remaining years of the 20th century. More recently, however, the context has begun to change and the place of therapy has been revisited. Just as there were clear reasons for its fall, so there are clear reasons for its rise. These may be summarised under the headings of: a historically inevitable process, the rise in mental health problems in childhood, the establishment of an evidence base for psychological therapies and a re-examination of roles and boundaries in applied psychology.

First, the historical inevitability of something so central and so long established as therapy rising again is part of a recurrent process in professional reconstruction. Structures and roles are first established in a new profession and for a period they remain essentially unchallenged. Then the process of reconstruction begins, and the old ways are questioned, found to be flawed and therefore rejected. Sweeping reform establishes new structures and roles, also untested and unchallenged. Then in due course, a fresh perspective leads to some of the old ways being re-examined. Their enduring value is recognised and they become rehabilitated but on a more robust footing than they were previously. This necessity of 'diversion from diversion' (Rappaport & Stewart, 1997) is paradigmatic and is not unique to reconstruction in educational psychology.

It is proposed that in relation to therapy the time for it to re-establish its place in educational psychology practice has come. The new paradigms that have emphasised systemic and strategic roles in schools are now embedded in routine practice. Their value is recognised not only within the profession but also by service users. For example, there is evidence that in the last 10 years the perceived value of the contribution of educational psychologists to schools has increased significantly, and that a central, strategic role in schools is the single best predictor of the perceived value of the contribution made (Boyle & MacKay, in press).

The same study, however, provided strong evidence that schools continue to view individual casework as being of crucial importance in the role of the educational psychologist. The review of educational psychology in England and Wales also reported that most respondent groups highly valued their contact with psychologists, but 'would have welcomed more, particularly in the area of therapy and intervention' (Farrell *et al.*, 2006). Service users are ready to receive therapeutic services, and the profession is well placed to provide them.

Second, the rise in the prevalence of mental health problems in children and young people over a considerable period of time is well documented (Rutter & Smith, 1995). It includes depression, suicide rates,

anorexia nervosa and other serious eating disorders, alcohol problems, drug abuse and emotional and behavioural difficulties in general, with the evidence pointing to a continuing rise in these difficulties. Epidemiological studies suggest overall population prevalence rates for child and adolescent mental health disorders ranging upwards from a minimum of 12 per cent (Davis *et al.* 2000). Meltzer *et al.* (2000) in their survey of the mental health of children and adolescents in Great Britain reported that 20 per cent may be described as having a mental health problem.

These disorders lead to high levels of personal distress for the young people and families involved and they show continuity into adulthood (Robins & Rutter, 1990; Rutter *et al.*, 2006). However, only a small proportion of these children and young people receive any form of specialist help. Estimates of the numbers with disorders who do receive help have ranged from 10 per cent to 21 per cent (Davis *et al.*, 2000). Reasons for this include the inaccessibility or unavailability of appropriate services and the perceived stigma of attendance at specialist health services. It is recognised that resources are inadequate and that it is 'impractical to expect current specialist child and adolescent mental health services to cope with significantly increased demand' (Davis *et al.*, 2000).

It is clear in any event that mental health issues on this scale are not going to be tackled on a reactive basis through individual interventions either by psychologists or by other specialist professionals, and that systemic and preventative initiatives are required (Albee & Gullotta, 1997). The case for prevention and for tackling the system at the macro-level rather than the individual at the micro-level has been convincingly argued by Prilleltensky and Nelson (2000) in their critical agenda for priorities in promoting child and family wellness. Their view is that specialist services spend almost all their resources fire fighting, and they point to the futility of continuing to 'focus on counselling, therapy or person-centred prevention as the main vehicles for the promotion of wellness'.

The need for prevention, however, does not detract from the need for therapeutic services. No matter how important the role of fire prevention, we still must have people to put out the fires. There will always be a need for expert individual work in the field of child mental health. It must also be recognised that not all needs can be addressed by a focus on the child's social ecology. There are also 'within-child' variables – disorders, impairments, disabilities – that need to be identified, assessed and treated (MacKay, 2000a).

Addressing the mental health issues of children and young people has become a central political imperative to which public agencies in health, education and social services are expected to respond. This emphasis on mental health, together with an increased focus on integrated children's services, with agencies across health, education and social services working in collaboration, provides a key opportunity for educational psychologists to make a significant contribution to this area and to include therapy in the range of services they routinely offer.

Third, a robust evidence base has now been established for psychological therapies (see Greig in this issue). At a former time when therapeutic work was very much more prevalent in educational psychology services the evidence base for its efficacy was scant. Now, when there is an established evidence base, therapeutic work is relatively scant. Earlier approaches to examining the efficacy of therapy were generally inadequate. With the exception of a large body of evidence for behaviour therapy to address highly focused problems, approaches to assessing evidence did not sufficiently differentiate between different therapeutic approaches or different disorders. Also, the terms 'therapy' and 'psychotherapy' were usually associated with psychodynamic approaches. These tended to be long-term therapies that either had no discernible outcomes or that did not readily lend themselves to outcome appraisal (see, for example, Eysenck, 1952).

In recent years therapy has become much more focused in terms both of its methodology and of the particular difficulties it addresses. This has facilitated the development of a very substantial evidence base covering many areas, such as cognitive behaviour therapy for mood disorders and EMDR (eye movement desensitisation and reprocessing) for post-traumatic stress disorder. Educational psychology in seeking to be an evidence-based profession can therefore appropriately embrace therapeutic interventions and apply them where they have known effectiveness.

Finally, it is clear that roles and boundaries within applied psychology are being re-examined. It is not sustainable for a discipline that has such a common foundation in its knowledge base and methods to continue with ever increasing levels of demarcation, supported by very long and completely separate training routes. Alternatives are now being proposed in comprehensive terms. For example, Kinderman (2005) has called for an 'applied psychology revolution' with a single three-year doctoral training, with specialisation into the current branches of applied psychology in the third year.

The reviews of educational psychology services both in Scotland and in England and Wales have recognised the need for more shared practice, cooperative working and integration across the disciplines of applied psychology. The Scottish review (Scottish Executive, 2002) recommended that steps should be taken towards educational and clinical child psychology services developing more integrated training and working arrangements. The English review went so far as to recommend that 'professional organisations representing EPs should begin discussions about the possible eventual merger of the two professions, child clinical and educational psychologists' (Farrell *et al.*, 2006, p.12). Viewing therapy and mental health issues as the province of another branch of psychology will not be helpful as applied psychology moves towards more integrated approaches.

Therapy rehabilitated: Evidence from the profession

There is evidence from the profession that therapy is being rehabilitated within educational psychology, and that new trends may reverse the force of Indoe's earlier observation that the term is seldom heard. This is reflected in official reports, in data gathered from the field and in a number of wider developments within the profession.

In terms of official reports, a significant change may be discerned in the six years that elapsed between the Working Group report on educational psychology services in England (Department for Education and Employment, 2000; Kelly & Gray, 2000) and the recent review of the functions and contribution of educational psychologists in England and Wales (Farrell *et al.*, 2006). The Working Group report contains no reference to therapy, although it does refer to counselling services to support children's emotional development. The new review report contains a large number of direct references to therapy, including a recommendation that with the trend towards reduction of statutory work educational psychologists should expand into areas 'where their skills and knowledge can be used to greater effect, e.g. in group and individual therapy' (Farrell *et al.*, 2006, p.106).

The Scottish review also pointed to the rehabilitation of therapy and its place in holistic psychological interventions across home, school and community. In addition, it provided the strongest confirmation from the field of the readiness of the profession to expand its therapeutic work. About 60 per cent of Scotland's educational psychologists responded to a survey regarding core psychological activities that had been compromised by the pressures of non-psychological work. Of these, 155 respondents provided specific and unprompted examples of work they believed required more prominence. The most recurrent theme, raised by over 100 respondents, related to therapeutic interventions with children and families.

In terms of wider developments in the

profession there are many signs of a revived interest in therapy and mental health issues. This has been reflected in recent literature locating these issues firmly within the context of educational psychology practice (for example, Greig, 2004a, 2004b; Greig & MacKay, 2005; and this current issue devoted to therapeutic interventions). Educational psychologists have been very much to the fore in the practice of specific therapies such as EMDR and solution-focused brief therapy, and in a few cases full accreditation in areas such as cognitive and behavioural psychotherapy has been attained.

Conclusions

This paper has argued for the rehabilitation of therapy in educational psychology practice. It has outlined the reasons why therapeutic interventions declined from their former prominence within the profession, but it has also examined the basis on which these skills and approaches are again required. Reference has been made to the high prevalence of mental health issues in children and young people, to the value placed on therapeutic work by service users and to the fact that the profession has identified therapy as an area that should be expanded.

It has been estimated that in a secondary school of 1,000 pupils, around 50 will be seriously depressed and 100 will be suffering significant distress (Young Minds, 2000). Where educational psychologists have responded to these contexts by providing carefully targeted therapeutic services where they are most needed (such as the services provided by the editors of this issue in Argyll and Bute), these services have not only been effective but in many cases have been of crucial significance to individual children and young people. In some cases, such as mood disorders in Asperger's syndrome, they have made the key differences that have made mainstream placements sustainable; in others, such as obsessive-compulsive disorder, they have been the essential ingredient in enabling children to attend school at all and improving their future life prospects; in others, such as depression and attempted suicide, they may have been the difference between life and death.

Educational psychologists are a key therapeutic resource for young people, especially in educational contexts such as schools. They are the professionals most thoroughly embedded in educational systems; they have the widest training in child and adolescent psychology and are therefore best poised to be generic child psychologists (MacKay, 2006); and, despite lack of resources, they are in fact the most plentiful group of child psychologists employed in public services. If mental health issues in educational settings are not addressed by educational psychologists through a fresh commitment to therapeutic work then they will be bought in from other sources.

The effective development of therapeutic services has implications for postgraduate training courses, for continuing professional development and for service organisation. Such services, in combination with a wide range of other psychological initiatives including preventative and systemic interventions, could represent a key contribution to evidence-based educational psychology practice.

Note: The author is an educational psychologist and an accredited cognitive behavioural psychotherapist.

Address for correspondence
Dr Tommy MacKay, Psychology Consultancy Services, Ardoch House, Cardross, Dumbartonshire G82 5EW.
E-mail: Tommy@ardoch.fsnet.co.uk

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