Pathways to Innovation and Development in Education

A Collection Of Invited Essays

Rose Dolan (Ed.)

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Chapter 16

Experiential Learning as a vehicle for thinking critically on the assessment process; reflections of an educational psychologist in training.

Maeve Daly

The ways in which the experience of conducting a cognitive assessment accelerated my thinking on principles and assumptions of the assessment process will be highlighted. This will be done through examination of the informed consent process, limits of confidentiality and the feedback session of the first-ever assessment I carried out as a trainee educational psychologist in a psychological service. The extent to which the experience of assessing a client pushed me to think critically on this practice will be outlined. A discussion with reference to various psychological and reflective frameworks that guided my practice will permeate the process of resolving cognitive conflicts that arose for me during this particular assessment process.

The Process of Informed Consent

For my first case on psychological placement, I was charged with the task of carrying out a full cognitive assessment with a twenty year old girl studying at a college of further education. After recently learning how to follow a model for obtaining informed consent, I felt well-equipped for my first session with the client. After working through informed consent, my client signed the consent form and was amenable to the assessment process. As I progressed through her background history, I was lead to an unwanted surprise. In response to a question about her confidence levels, my client revealed that she had cheated to get a place on her current course as her friend with the same colour hair had sat the interview for her. As she expanded on how she had never told anyone else, I found myself thrown into a state of cognitive conflict. On the one side, my client had been referred by the college because she was struggling to keep up with coursework, while on the other side she had not earned her own place on the course in the first instance. Desperately pushing panic aside, I continued with the interview while surreptitiously recalling the parameters of confidentiality we had set out during informed consent (that information provided to me during the assessment was fully confidential except in three circumstances, where she reveals harm to herself, where she is harming others or damaging property). As I left that day, I grappled with whether I had, with

just one question, uncovered a reasonable explanation for why my client was struggling to keep up on her current course or was this merely corroborating evidence that my client is in need of extra support? I arrived home, in a state of utter confusion, battling with the rationale for proceeding with the assessment and with my own limits of confidentiality.

Reaching for the Code of Professional Ethics of The Psychological Society of Ireland (PSI, 2008), I identified all relevant clauses relating to limits of confidentiality. I needed to measure my personal constructs (my client had committed a serious offence but it was not grounds for breach of confidentiality) against those of the profession. I trawled the guidelines of my service, which stated "disclosure of information to an appropriate third party should be made where it is deemed necessary: to protect the interests of the student, to protect the interests of society and to safeguard the welfare of another individual or student" (Ethical Practice Guidelines, 2003, clause 4.2). I weighed the situation up against principles of duty of care over the client where "duty of care to the client requires initiating actions designed to protect the health and welfare of the client or others" (Ethical Practice Guidelines, 2003, clause 5.1) and noted the guideline that stated "every effort must be made to ensure that a proposed disclosure is in the best interests of the client", (Ethical Practice Guidelines, clause 10.2). I considered how she was currently in her second year of study and that this event occurred over eighteen months ago. She had since achieved her own grades last summer and passed her own interview, earning a place in year two on her own merit. Nevertheless, advice from our Professional Ethics lectures was ringing in my ears, "if in doubt, consult your supervisor and refer to your code of ethics" (G. Ni Dhomhnaill, personal communication, February, 2011). With that, I sought the guidance of my supervisor, who also concluded confidentiality need not be breached and theorised that my client's offence was committed as an act of desperation. When he added that this revelation was testimony to the rapid rapport I had established with the client, my thinking grew. This consultation was crucial in enabling me to move on with the assessment process.

During that first informed consent meeting, my attention was wholly occupied on following each step of the structured format in a logical sequence to ensure I imparted all the relevant information to the client. In this regard, I was merely fulfilling the rights of my client and my duty as a practitioner. Once stimulated by surprise, however, I was caused to reflect on the ethical and legal considerations that underpin the informed consent process, particularly in relation to the principles encompassed by limits to client confidentiality. From the informed consent process, the principles of autonomy and self-determination guide my practice and in this way, the client and the client's concerns are placed at the centre of a collaborative relationship. Secondary benefits of informed consent also became clear to me in my practice later in the assessment process. The Ethical Practice Guidelines (2003) state that "the challenge of fulfilling the spirit of informed consent...is to strike a balance between giving the client too much information (thereby, perhaps confusing or frightening the client) and too little information (thereby, leaving the client unclear about what is involved)" (p.11). From my

supervisor's comments during consultation, I realised I had gained a privileged understanding of the challenges faced by my client but also thought about the level of skill required for the balancing act of building good rapport with avoiding a compromising position for you or the client. Appropriate supervision as a structure for discussion that allows practitioners to think about anxieties and feelings stirred up by their work struck me as an important strategy for all professional practice. Roberts (as cited in Dennison, McBay & Shaldon, 2006) states that "support teams can help contain the anxieties stirred up by the work, restoring the capacity to face reality, without which effective work is impossible" (p. 88). I internalised the legal aspect of informed consent where "codes of ethics and standards of practice are guidelines that have been developed to ensure that clients' rights are protected and serve to protect the legal liability of healthcare providers" (Wilson, 2006). In line with Piaget's assertion that 'knowledge cannot be transmitted', despite training and preparation with tools (a structured model of informed consent and a knowledge of our professional codes of ethics), real meaning of the process of informed consent and client confidentiality was only constructed through personal experience. Such practical experience where I am given an opportunity to merge theory with my practice, allows "knowledge and experience stand in a relation of mutual adaptation, of mutual questioning and mutual illumination", (Bettencourt, as cited in, Mc Elwee, personal communication, 3rd February, 2011).

The Feedback Session

After the cognitive assessment, results indicated that my client to be functioning within the Low-Average range of intellectual ability that spans into the Borderline range. It also revealed her to be presenting with an inconsistent psychological profile, as her scores traverse three categories of ability from the Average to the Borderline range, which may leave it difficult for her to perform consistently across the different areas of her college course. After assessing attainments, her overall reading levels came out within the Borderline category while after technical analysis of her scores, enough evidence had emerged to suggest that she is presenting with a Specific Learning Difficulty (SLD) in Reading Comprehension. As this has major implications for her ability to access new material from her course notes and textbooks, it was clear that she would require considerable support to cope with the demands of her course. Throughout the assessment process, my client engaged in general discussion about college life and spoke openly about her difficulties at school over the years and indicated expectations of dyslexia or dyspraxia as an outcome of this assessment. As the process unfolded, I became increasingly apprehensive about how the outcome might affect my client. This concern, coupled with behavioural observations during assessment and details of her case history, prompted me to recommend a referral to the site psychologist for counselling sessions and support. Her total cooperation and sustained motivation showed an admirable determination to get to the bottom of her struggles with academic work. At various intervals, she discussed her future ambition to pursue social studies in National University of Ireland (NUI) in Maynooth and her drive to become a social worker in the future. In addition to this,

reports from college indicate that she is well respected for her high levels of motivation and her excellent attendance. In light of her expectations and hopes, finding an approach to explain the meaning of a Full-Scale IQ of 80, the implications of an SLD in Reading Comprehension and the rationale behind a referral to the site psychologist presented a considerable challenge to me. On the approach to the feedback session, I found myself in a state of perplexity about how to support my client in coming to terms with her own limitations on one side, and empower her and reassure her that her future is bright, on the other. In order to maintain my duty of care and respect for my client and stay true to my role as an agent of empowerment, the onus lay with me to equip myself with the necessary tools to embrace this challenge.

During feedback, my goal was to open my client's mind to what she can do, rather than creating the illusion of helping by offering complex explanations for why she cannot do it (Hughesman, as cited in, Cameron, 2006). To deliver this, I drew on my counselling skills to take a strengths-based approach to my explanation of the meaning behind her Full-Scale IQ and the implications of an SLD in Reading Comprehension. I drew on counselling frameworks characteristics of a helping relationship to foster my professional-client relationship (such as unconditional positive regard, warmth and respect, clear and recognition of potential proposed by Rogers, 1958). Also drawing on Hornby's (2000) partnership model, I drew up a set of student recommendations to engage my client as a direct collaborator in the interventions set out. The process of dual-signing (as we both had to sign off on them) at the session handed autonomy to the client. Research has shown that if people commit to goals and ideas orally or in writing, they are more likely to honour that commitment (Cialdini, 2001). In line with this thinking, the client was supplied with writing frames and graphic organisers for immediate use and the feedback session was followed up with a summary letter on the outcomes of the assessment process posted to the client's home address. Research has shown that when clients experience themselves to be true partners in the therapeutic process, the likelihood of a beneficial outcome increases (Behnke, 2004). In relation to the referral for counselling, *The Ethical Practice Guidelines*, (2003, clause 3.9) of my service state that "guidance, counselling and psychological interventions in general can be effective only if the client is...willing to cooperate with the practitioner in working towards mutually acceptable goals". Lazarus' Multimodal Therapy model (Lazarus, 1997) is adapted for use during the informed consent process and when I asked the client to recall the seven different interrelated areas in which a psychologist can offer support, which we had outlined during informed consent, the secondary benefit of this process became clear to me. During this process we had highlighted areas of need for potential intervention, other than the area identified as the referral issue and this empowered the client to collaborate on my rationale for the referral to the site psychologist. Taking a cognitive approach to framing my referral, that paying attention to physical condition such as getting enough sleep and exercise and psychological well-being aids study skills and memory improvement (Herrmann, Raybeck & Gruneberg, 2002), aimed to foster these "mutually acceptable goals" (p.12).

In preparation for the feedback session, I was caused to reflect on my use of language and communication skills for delivering feedback to the client and on my rationale behind each recommendation made, reflecting at a technical level (Van Manen, as cited in, Mc Elwee, personal communication, November, 2010). This reflection helped unravel the cause of my cognitive conflict about delivering feedback to this student. On one hand, we are operating within the medical model which dictates a process of identifying, assessing, classifying and remedying students into "a realm of separateness, specialness and dualism" (Kinsella and Senior, 2008, p. 657). Such practices are symptomatic of what Foucault (1979) terms dividing practices, resulting from disciplinary power where professionals have embraced the prescriptive model which operates from a within-child pathology of disability. On the other hand, however, the role of the educational psychologist is to advance concepts of empowerment (Cameron, 2006) and "promote learning, attainment and healthy emotional development of children and young people" (DfES, 2005, p1). As the social constructionist approach proposes that reality is only constructed through the language that people use, I realised that awareness of ways discourse and language can construct and determine thought, actions and decisions, will be important for effective practice. In acknowledging that problems can be reframed with a shift in language, a referral for counselling was proposed in terms of 'the development of relaxation techniques' as opposed to 'the management of her anxiety' for example. This shift of language from a 'within-child deficit discourse' may serve to encourage the client to try out the option of counselling. Furthermore, drawing on different psychological perspectives to enhance our practice may help us navigate through our system that is so 'entrenched' in the 'psycho-medical model of disability' (McDonnell, 2003, p262), enabling us to remain true to fundamental aims of healthy attainment in educational psychology.

CONCLUSION

Working through a full assessment procedure, from informed consent, to the technical analysis through to the delivery of feedback, enabled me to 'assimilate new information' at each stage of the process and 'accommodate' a new perspective that questions the principles underpinning each phase for the 'formation of new schema' on the assessment cycle. For example, that the informed consent meeting was particularly useful in laying the groundwork for the feedback session was unbeknownst to me at the beginning of this assessment but became clear to me by the end. Through the development of this mental map I gained an understanding of the principles that underpin each stage of the assessment process, allowing me to gain a critical overview of not just the assessment procedure itself, but also of the limitations of the model that operates with in our national education system at the macro-level.

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