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# Developmental Coordination Disorder: A Contextualised Perspective

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Submitted in the fulfilment of the requirements for the degree of:

Doctor of Psychology

Department of Psychology

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This project is also dedicated to the memory of George Lawson, someone born at a time when 'clumsy' children were little understood.

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SECTION A

PREFACE

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## **PREFACE**

The preface will introduce to the components of the Doctoral Thesis portfolio. The thematic pattern in this work is quite clear as each part of the thesis is about Developmental Coordination Disorder (DCD) in different contexts. The work is presented in a specific order to try to tell a story about DCD and so it may help the reader to follow the pattern in the portfolio as the thesis follows the journey of DCD from childhood to young adulthood. The first part of the thesis is a Critical Literature Review covering the psycho-social impact of DCD in children. The second part of the thesis is the research project which seeks to find out about the lived experience of DCD in the transition to young adulthood at university or college. The final part of the thesis is about DCD in the therapeutic context and is the client study of a young woman who has been assessed as having DCD. Linked to each piece of work has been my development as a Trainee Counselling Psychologist in a specific context and its contribution to the Counselling Psychologist I hope to become.

### **Section B: The Critical Literature Review**

The critical literature review focuses on the psychosocial aspect of DCD, however first the topic of DCD is introduced. The background of DCD in terms of definition, diagnosis, theoretical influences and intervention are all addressed while major debates in the literature, are surfaced. It is clear from the balance of the research literature that while the psycho-social component of DCD is recognised, interventions are focused predominantly on motor skills development. Of the literature that does exist on the psychosocial aspect of DCD, key studies are reviewed and implications for Counselling Psychology highlighted. At the time that I first completed this piece of work I also had a placement in a school which very much brought home to me the level of anxiety that some very young children experience. In this placement I developed child centred and psychodynamic skills in working with children and together with this piece of work developed an appreciation for the importance of the developmental perspective in psychological distress which has also influenced my work with adults.

### **Section C: The research project**

While there is at least some literature on the psychosocial aspect of DCD in children, there is very little research on young adults with DCD. I also have a personal interest in DCD which has been a key driver for the research project as I am the parent of a young person who has DCD. The aim of the research project was therefore to explore the lived experience of young adults with DCD and particularly to hear from the young adults. It is noticeable in the

research literature that it is often the parents or teachers who are asked to comment on young people with DCD, rarely the young person themselves. The defining feature of DCD is a difficulty in control of bodily movement so it seemed natural to use a phenomenological methodology to engage with the 'body-self' and therefore Interpretative Phenomenological Analysis (IPA) was chosen. Eight young adult students were interviewed using semi-structured interviews to explore their lifeworld at university or college. From the analysis of the data, the resulting thematic structure is discussed in relation to major topics such as transition to adulthood and the development of identity. This project also has significance for my transition to becoming a Counselling Psychologist because I would like to continue to do this type of research post-qualification and to work with this client group. During the research project I have therefore been attending professional development events on DCD and have begun making contacts with others involved in this area.

### **Section D: The Client Study**

The portfolio is therefore viewing DCD in different contexts and having reviewed the literature academically in children and explored the lived experience of DCD contextually in young adults, the client study turns to the acute intra-personal world of a young woman with DCD. The client study follows the progress of therapy with this young woman with anxiety and depression using Cognitive Behaviour Therapy (CBT) which has been my chosen specialist therapeutic model. However, the discovery of DCD challenged me to work in a flexible and inclusive way and to bring a range of skills and adapt my CBT practice to meet this young woman's needs. In this context I also came up against structural barriers in working holistically to support this young woman but my research knowledge on DCD prompted me to persevere in being resourceful and my developmental perspective helped me build a warm and reparative relationship with her.

As each piece of work is about DCD, there is some overlap of the DCD literature but it has been kept to a minimum. The completion of this portfolio also follows my development as a Trainee Counselling Psychologist and demonstrates how the strands of my development from different contexts have become integrated in the therapist I have become. However, in this process, I have also discovered my community agenda and my desire to facilitate change in support of young people with specific learning needs. Completion of the portfolio has therefore helped me prepare for my next step which is to work with young adults with specific learning needs in a therapeutic context, e.g., training scheme, employment or university setting and to pursue my research interest in this area.

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## SECTION B

Developmental Coordination Disorder – is there a role for  
Counselling Psychology to contribute?

A Critical Literature Review

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## CRITICAL LITERATURE REVIEW

### Developmental Coordination Disorder in children and adolescents – Is there a role for Counselling Psychology to contribute?

#### INTRODUCTION AND RATIONALE

Developmental Coordination Disorder<sup>2</sup> (DCD) presents as a motor skills deficit in children and affects around 6 % of school age children (APA, 2000), representing approximately a third of children in receipt of occupational therapy in the UK (Dunford & Richards, 2003). DCD often only becomes apparent when the demands of the environment challenge the child's abilities, for example, when the child starts school, and affects a child's ability to perform daily tasks such as play, self care and academic work (Cermak, Gubbay, & Larkin, 2002). The prevailing paradigm of DCD is predominantly that of a motor skills deficit (Wilson, 2005) but DCD is, however, a complex condition and often co-occurs with other learning, developmental and psychosocial problems (Dewey, Kaplan, Crawford, & Wilson, 2002; Schoemaker & Kalverboer, 1994). Current interventions for DCD focus on motor skills training with minimal attention paid to integrating psychosocial interventions (Wilson, 2005), arguably limiting the overall effectiveness of support for children.

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<sup>2</sup> Developmental Coordination Disorder (DSM-IV-TR, American Psychiatric Association (APA), 2000).

- A. Performance in daily activities that require motor coordination is substantially below that expected given the person's chronological age and measured intelligence. This may be manifested by marked delays in achieving motor milestones (e.g., walking, crawling, sitting) dropping things, "clumsiness," poor performance in sports, or poor handwriting.
- B. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living.
- C. The disturbance is not due to a general medical condition (e.g., cerebral palsy, hemiplegia or muscular dystrophy) and does not meet the criteria for a Pervasive Developmental Disorder.
- D. If mental retardation is present the motor difficulties are in excess of those usually associated with it.

DCD is an extensive subject which this review cannot adequately cover, rather, the intention is to identify some limitations in the prevailing paradigm and highlight the psychosocial area of the literature. A review of a few key selected papers on the psychosocial impact of DCD in children is presented with conclusions on how counselling psychology could effectively support children with DCD.

#### DCD DEFINITION AND CRITERIA

The current DSM-IV-TR (APA, 2000) definition of DCD leaves room for interpretation as Geuze, Jongmans, Schoemaker, and Smits-Engelsman (2001) concluded in an extensive review of clinical and research criteria in DCD in children. The terminology Developmental Coordination Disorder (DCD) was first agreed at the 1994 Consensus Meeting in London, Ontario (Polatajko, Fox, & Missiuna, 1995). A related definition is that of 'Specific developmental disorder of motor function' (SDDMF) in the ICD – 10 (World Health Organization (WHO), 1992) though the ICD-10 classification is rarely used (Geuze et al., 2001) () and this report will therefore focus on the DSM-IV-TR (APA, 2000) criteria for DCD.

Geuze et al. (2001) found that a range of terminology was used alongside DCD (26%), including clumsiness (41%), developmental sensorimotor dysfunction (26%), developmental dyspraxia (6%) and minor neurological dysfunction (MND) (10%). In their recommendations to improve consistency in research and practice Geuze et al. (2001) made the following suggestions: First, they propose that the qualitative criteria of DCD be clearly described as is provided for Attention Deficit Hyperactivity Disorder (ADHD) (APA, 2000). Second, they advocated the use of a standardised motor test based on age appropriate norms, e.g., the Movement ABC Test (previously TOMI) (Henderson & Sugden, 1992) with a cut off point of the fifth percentile for research studies and fifteenth percentile in treatment settings. Third, they suggest that it is reasonable to accept inclusion at a mainstream primary school and satisfactory school performance as evidence of normal intelligence (Criterion D, APA, 2000) without the need for an IQ test.

The Leeds Consensus Statement (Sugden, 2006; Sugden, Kirby, & Dunford, 2008) has also refined the definition and diagnosis of DCD including: 1) acceptance of the detrimental impact of DCD on daily living though not full theoretical or empirical support for the impact on academic performance, 2) that while DCD can improve with development and intervention, this is by no means assured and many individuals retain problems across the lifespan, 3) that while DCD is viewed as a discrete neuro-developmental disorder, a dual diagnosis can be given with attention deficit hyperactivity disorder (ADHD), autistic spectrum disorder (ASD), and dyslexia but not a diagnosis of atypical brain disorder (ABD) (Gilger &

Kaplan, 2001), 4) that a norm referenced motor skills test with a cut-off at the 5<sup>th</sup> percentile to support diagnosis of DCD is appropriate in research and practice, and 6) that a child with an IQ below 70 should not be given a diagnosis of DCD.

While Geuze et al. (2001) and the Leeds Consensus Statement (Sugden, 2006) clarify the criteria for DCD, it seems that DCD can be difficult to differentiate from other developmental disorders.

#### DCD – COMORBIDITY AND CO-OCCURRENCE

While Geuze et al. (2001) and the Leeds Statement (Sugden, 2006) recognise that DCD has comorbidity with ADHD, Dyslexia, and developmental language disorder, Gilger and Kaplan (2001) go even further and argue for a broad based individual neuropsychological classification of Atypical Brain Disorder (ABD). They argue that comorbidity of DCD with other disorders such as ADHD and language disorders is more common than not and that within each child there is variability of learning difficulties. Gilger and Kaplan (2001) therefore suggest that assessments and treatment plans should include a comprehensive evaluation of a child's neuropsychological strengths and weaknesses.

In support of Gilger and Kaplan's (2001) conceptualisation of ABD, Kaplan, Crawford, Mantell, Kooistra, and Dewey (2006) suggest that comorbidity as a terminology is misleading and prefer the term 'co-occurrence'. Based on their investigations of school age children they found an overlap of DCD and ADHD, and DCD with ADHD and Reading Disorder (RD); with decreasing of levels attention and increased reading problems in groups defined as 'non-DCD', 'suspect DCD' and 'DCD'.

Kadesjo and Gillberg (1999b) also identify the relationship of DCD with ADHD or Deficits in Attention, Motor Control and Perception or 'DAMP' (Rasmussen & Gillberg, 2000), and highlight long term psychological and behavioural problems in these children including depression, conduct disorder and autistic type behaviour. In Kadesjo and Gillberg's (1999b) study, 47% of those children assigned as ADHD (DSM-III-TR, APA, 1987) also met the criteria for DCD. Both these groups had significantly increased problems of school adjustment, reading comprehension and Asperger symptoms than the ADHD or DCD only groups. 'Pure' ADHD was shown to be the exception, occurring in only 13% of the clinical sample.

Motor skills problems have long been highlighted in Asperger Syndrome (AS) (Wing, 1981). Gillberg, Gillberg, and Groth (1989) identified motor difficulties in 83% of an AS group, while Gumley (2005) reported a similar extent of motor problems in AS, though Manjiovani and Prior

(1995) did not find this level of occurrence. Green, Baird, Henderson, Huber, and Henderson (2002) also concluded that motor impairment in AS and DCD could not be differentially diagnosed and that children with overlapping motor problems and AS have an elevated risk of attention and reading problems.

Kirby and Davies (2006) also highlight another overlapping condition, Joint Hypermobility Syndrome (JHS), originally described by Kirk, Ansell, and Bywaters (1967) which potentially identifies children, particularly girls, with DCD. Girls with JHS tend to outnumber boys while DCD is more readily identified in boys (Adib, Davies Grahame, Woo, & Murray, 2005; Missiuna, 1994) with girls motor skills needing to be worse before being identified (Revie & Larkin, 1993).

#### DCD – AETIOLOGY AND MODELS

Issues of comorbidity or co-occurrence with other developmental disorders underpin a major area of debate in developmental disorders generally which are reflected in key theoretical approaches to DCD.

Msall (2000) highlights the pre-natal and genetic influence in developmental disorders, particularly in boys, while Vaivre-Douret and colleagues (2011) quote a diverse range of biological and environmental factors implicated in the aetiology of DCD including premature birth, oxygen deprivation at birth, neurological damage in the cerebellum or basal ganglia (Lundy-Ekman, Ivry, Keele, & Woollacott, 1991) and parietal dysfunction (Lesny, 1980). Other potential factors include foetal drug and alcohol effects (Henderson & Barnett, 1998) and socio-economic class (Hadders-Algra & Lindahl, 1999). However, no definitive explanation has yet been found and, as in other developmental disorders, DCD is most likely to result from a combination of factors (Pennington, 2006).

Morton (2004) outlines a generic causal modelling system for specific developmental disorders which would enable modelling DCD as a specific disorder reflecting the current stance in the Leeds Statement (Sugden, 2006). In contrast, Pennington (2006) outlines a multiple deficit model of developmental disorders which accommodates comorbidity arguing that complex behavioural disorders, such as dyslexia, ADHD and autism, have common interacting biological or environmental causal risk factors which change the normal development of cognition resulting in the range of symptoms that are observed in the co-occurrence of these disorders (Willcutt, et al., 2002).

While Morton's (2004) and Pennington's (2006) causal models of developmental disorders are helpful in furthering a functional understanding of DCD, they are perhaps less helpful in

considering the longitudinal psycho-social impact of DCD. Morton, in light of this alternative goal, proposes Rutter's (1989) psychosocial pathways approach which represents trends over time through 'chains of circumstance' to identify risk factors that correlate with future outcomes (Kraemer et al., 1997).

## DCD - APPROACHES AND INTERVENTIONS

DCD has a significant impact on the ability of children to feed, dress and play in their daily lives. Academically, DCD has an impact on writing, drawing, cutting, playing musical instruments and physical education. Physical mastery is seen as helping children with DCD to cope with these daily tasks so considerable attention has been paid to motor skills development. Wilson (2005) in his evaluative review of interventions in DCD encapsulates five current approaches: 1) Normative Skills Approach, 2) General Abilities Approach, 3) Neurodevelopmental Theory (medical model), 4) Dynamical Systems, and 5) Cognitive Neuroscience. A deficit of Wilson's (2005) taxonomy is that few references are made to psychosocial interventions though he acknowledges the social and emotional problems associated with DCD in children. An overview of Wilson's (2005) taxonomy is provided with evaluative comments.

### **Normative Skills Approach**

The Normative Skills Approach to DCD is based on maturational theories (Piaget, 1952) with motor proficiency progressing along developmental milestones. Assessments are the most common in use, e.g., M-ABC (Henderson & Sugden, 1992) but a limitation of the assessments, are that they use norm referenced groups between age four – twelve/fourteen with no specific motor tests for the under fours and older adolescents, and no comprehensive assessment across all motor skill types. Counselling Psychologists should be aware of the Motor Competence Checklist (MCC) for teachers (Gentile, 2000) which identifies behaviour problems and has good psychometrics (Schoemaker & Smits-Engelsman, 2003) and the emergence of the 'cognitive approach' which integrates the child's personally generated motor and self regulation goals, e.g., the Cognitive Orientation to Daily Occupational Performance (CO-OP; Missiuna, Mandich, Polatjko, Malloy, & Miller, 2001).

While Counselling Psychologists whose training includes the Cognitive Behaviour approach (Riha, 2010) could contribute to this type of cognitive intervention in DCD, the breadth of our training, which also includes person-centred and psychodynamic training, would enable us to validate and conceptualise the child in the context of relationships, providing a more holistic understanding of the child for others, including teachers. Armstrong and Hallett

(2012) argue that teachers often lack the psychological skills to support children with social and emotional behavioural difficulties (SEBD) and have particular concerns with specific learning difficulties including DCD. As Counselling Psychologists, there is an opportunity to build understanding and challenge some of the positioning of these children within a psychopathologising narrative (Graham, 2008) and take account of the embedded nature of the child in educational and other systems.

### **General Abilities Approach (Sensory Integration Theory)**

In Sensory Integration Theory (SI), difficulties in perceptual-motor behaviour are thought to indicate an underlying problem in organising sensorimotor input which disrupts the organisation and planning of motor actions. Sensory Integration Training (SIT) (Ayes, 1989) is thought to develop a proprioceptive schema, or sense of the body in space, to assist in the cortical integration of sensory data but evidence is contradictory about its effectiveness (Smits-Engelsman et al., 2012).

However, higher level cognitive functions, including the organization of visual and muscular memory as Ayres (2005) suggested, may be implicated in DCD, ADHD and Dyslexia as Jeffries and Everatt (2004) report in their study on the role of Working Memory (WM) and Central Executive functions (CE) (Baddeley, 1996). Jeffries and Everatt (2004) found evidence that Phonological Loop (PL) working memory deficits are implicated in dyslexia and Visio Spatial Sketch Pad (VSSP) working memory deficits are implicated in dyspraxia (DCD) but they found all of the children with learning difficulties had deficits in the CE with no particular pattern discerned. This study demonstrates the complexity of DCD and the need for broad based cognitive assessments that takes account of individual differences.

### **Neurodevelopmental Theory (Medical Model)**

This approach is based on neurodevelopmental norms and abnormal motor development with 'hard signs' assessed by medical examination, e.g., muscular dystrophy. Wilson (2005) emphasises the lack of empirical data underpinning this approach though neuroimaging processes can now substantiate hard neurological symptoms. In the past, 'soft signs' were used to differentiate children with motor difficulties without a medical condition as having Minimal Brain Damage (MBD), a term mainly discontinued.

## **Dynamical Systems Theory**

The Dynamical Systems approach assumes that motor development is based on interacting systems between the child, the task and the real world. Interventions are child and task specific with observational assessment made by trained physical education professionals against proficiency norms, e.g., over arm throwing (Gallehue & Ozman, 2002).

Training is task specific, e.g., Unigym (Revie & Larkin, 1993) utilising the child's self talk, but Smits-Engelsman et al. (2013) comment that children with superior language skills improve more. Although simple tasks can be learned quite quickly, e.g., hopping, it seems that practice does not make perfect (Fitts, 1954) on complex tasks as some tasks, e.g., hockey shooting, are difficult to train (Marchiori, Wall, & Bedingfield, 1987). It is also unclear that verbal guidance and labelling strategies assist motor coordination. In a multiple case study investigation, Myahara, Leeder, Francis, and Inghelbrecht (2008) found no effect using a verbal labelling strategy on sequential movements in a study in which children consistently failed to improve in motor skills which is potentially unhelpful to the child's perception of self-worth (Harter, 1978). Careful consideration should therefore be given to research design and follow up of children with DCD.

## **Cognitive Neuroscience Approach**

The Cognitive Neuroscience Approach is a process oriented approach to improve motor functionality through new techniques in neuro imagery. Children with DCD seem to have a deficit in imagining themselves doing a particular motor activity, e.g., a mental hand rotation (Wilson, Maruff, Ives, & Currie, 2001). However, using 'action replay' imaginal interventions of role models Wilson, Thomas, and Maruff (2002) were able to demonstrate some training effects ascribed to modifications in the parietal lobe in mapping and transmitting motor movements to the pre-motor cortex (Wolbers, Weiller, & Buchel, 2003).

A number of key points are made by Sugden et al. (2008) in relation to effective interventions in DCD in children. These authors acknowledge that most interventions focus on motor skills development and recommend that attention should also be paid to academic, daily living and task oriented approaches. The key points they advocate for helpful intervention in DCD are modelled by the national and local strategy of Forsyth, McIver, Howden, Owen, and Shepherd (2008) including: 1) the child and the child's family should be the focus of support and both child and parent views should be taken into account, 2) researchers, practitioners and educators should work collaboratively to develop resources and support the transfer of knowledge to non-specialists, 3) interventions be function and task focused wherever possible as the evidence base is most supportive of this type of intervention (Smits-Engelsman

et al., 2012) 4) wherever possible interventions take place in everyday settings with imaginative approaches to encourage participation (Magalhaes, Cardoso, & Missiuna, 2011), 5) interventions are generalizable can be transferred to a variety of everyday contexts, and 6) that emotional and social resilience be developed for the longer term benefit of children with DCD.

The taxonomy of models and interventions of DCD offered by Wilson (2005) typically focuses on motor skills deficits and treatments with little discussion or evidence of the psychosocial impact. To complement Wilson's (2005) review and the recognition of Sugden et al. (2008) that the social and emotional aspect of DCD is a key issue, a review of studies on the social and emotional impact of DCD on the healthy psychological development of children is presented.

#### LITERATURE REVIEW - PSYCHOSOCIAL IMPLICATIONS OF DCD

While physical mastery is seen as important to the child's psychological and social well being (Cermak et al., 2002) as proficiency in motor skills is often culturally important there is increasing recognition that 'real life' research should reflect not only impairment but contextual and environmental limitations (Magalhaes et al., 2011). However, Magalhaes et al. (2011) demonstrate that most of the research papers on DCD reflect the dominant paradigm of quantitative psychology. This trend is repeated the psychosocial literature on DCD in children so that most of the representative papers outlined are quantitative studies.

#### **Schoemaker and Kalverboer (1994)**

In an original study of its time, Schoemaker and Kalverboer (1994) investigated the social and emotional problems of 'clumsy' children in comparison to their non clumsy peers with younger children than had previously been investigated (6 – 8 year olds). Eighteen children (15 boys and 3 girls) were assigned as clumsy and compared to a control group matched on age and sex with no clumsiness. Motor skills were assessed by a school doctor and tested on the Henderson revision of the Test of Motor Impairment (TOMI) (Stott, Moyes, & Henderson, 1984) at a 5% cut off. Psychosocial attributes measured included state and trait anxiety using the State-Trait Anxiety Inventory for children (STAIC) (Spielberger, Edwards, Lushene, Montuori, and Platzek, 1973) and the child's view of their physical competence and social acceptance using the Pictorial Scale for Perceived Competence for Young Children (PCSAS) (Harter & Pike, 1983). Additionally teachers and parents were asked to complete the Groningen Behaviour checklist for school (GBC-S) and family (GBC-F) (Schaefer,

Droppleman, & Kalverboer, 1965) providing information on introversion/extraversion; positive task orientation/negative task orientation and socially negative behaviour.

The results indicated that clumsy children were judged by parents and teachers to be more introverted, insecure and isolated than their peers with more socially negative behaviour (like to tease, rigid, hostile). These young children reported lower self esteem and fewer friends than controls with heightened anxiety in motor performance and concerns in how others perceived them. No relationships were found between the seriousness of motor problems and social and emotional effects. Schoemaker and Kalverboer (1994) emphasised that all clumsy children had one or more social or emotional problems regardless of how bad their motor skills were.

Although this landmark study did obtain views from the children and identified that very young children experience the psychological impact of clumsiness, the sample was small with few girls which limits generalization. Social behaviour particularly overactivity and distractability could be explained by the children also having co-occurring ADHD, and rigidity and hostility may alternatively be explained by elements of autism (Gumley, 2005). The presence of state and trait anxiety in the clumsy children was a key result but some school environments (Ames, 1984) may make the situation more anxiety provoking than others, e.g., competitive environment vs. a cooperative or individualistic environment but no contextualising information about the prevailing school culture is provided. A claim of the study was that the clumsy children were more introverted and withdrew from social situations but perhaps the children were tired as children with motor problems use considerable effort to manage their bodies (Ayres, 2005).

Lastly, the study mentions that the clumsy children felt "terrified and troubled" prior to the motor skills test which may have impacted on their performance and raises questions about the ethics of this procedure in terms of the child's ability to withdraw. Very little information is provided on any type of de-briefing or safeguarding of the welfare of these very young children in a research project (BPS 2004, 2006) which may reflect the age of the study. While the language used to describe the children as 'clumsy' has been superseded by DCD terminology, one could argue that 'clumsy', while a globally negative evaluation of the child, is broadly understood whereas DCD is potentially jargon and not well understood, raising the need for description of children with motor skills issues that is both meaningful and non-discriminatory.

### **Skinner and Piek (2001)**

In a study designed to investigate perceptions of self-worth, social support and anxiety of children and adolescents with DCD based on Harter's (1978) model of self-worth, Skinner and Piek (2001) attempted to replicate Schoemaker and Kalverboer's earlier findings on anxiety and extend the study to include adolescents. Skinner and Piek (2001) hypothesised that as DCD's motor and psychosocial effects persist into adolescence (Losse, Henderson, Elliman, Hall, Knight, & Jongmans, 1991), that continuing lack of mastery and increasing self awareness in adolescence would mean a worsening picture of psychosocial outcomes for adolescents.

218 pupils from primary and high schools in two age groups of aged 8-10 years and 12-14 years were selected. 58 children with DCD were compared to 58 children without DCD in the younger age group and 51 adolescents with DCD were compared to 51 adolescents without DCD. There were 40 girls and 18 boys in both the DCD and non DCD groups in the younger group and 29 boys and 22 girls in the both the adolescent groups. Participants completed the M-ABC test of motor skills (Henderson & Sugden, 1992) and the Weschler IQ test (WISC-III; Weschler 1992). Unusually in this study there were more girls than boys which is against the trend (Adib et al., 2005). Participants in both DCD and control groups completed the STAI (Spielberger, 1983) to measure state and trait anxiety and the self-perception profile (Harter, 1985a; Harter, 1985b) to assess a range of self-perceptions including scholastic competence, athletic competence, physical appearance, social acceptance and global self-worth. Both groups of children and adolescents completed the social support scale for children and adolescents (Harter & Robinson, 1988) to measure source (parents, teachers and classmates) and type of social support (approval, instrumental and emotional).

The study concluded that children and adolescents with DCD had lower self-perceptions of athletic competence. Younger children with DCD had lower perceived academic competence and adolescents in the DCD group had lower perceptions of social acceptance than controls. Both DCD groups had lower perceptions of physical appearance than their peers without DCD and both groups reported higher levels of anxiety in line with the Schoemaker and Kalverboer (1994) study. Global self-worth was found to be lower in the adolescent group than in the younger group and in both DCD groups self-worth was lower than in the control groups. DCD participants in both the younger and the adolescent group perceived themselves to have lower support than peers and the adolescents overall felt they had less social support than the younger children.

It is difficult to find many flaws in this study except that the motor ability criteria for selection to the DCD group were less rigorous than may be expected in a research project, i.e., 15<sup>th</sup> percentile (Geuze et al., 2001) and the sample was biased towards girls, restricting generalization. The procedure was perhaps more taxing on children with DCD as the assessment sessions were lengthy (>40 minutes) and children with DCD tire quickly (Ayres, 2005). As DCD can co-occur with ADHD (Dewey et al., 2002; Kaplan et al., 2006) problems of inattentiveness may have had an impact here and it is recommended that children with DCD be given longer to complete tests (Johnstone & Garcia, 1994).

Given these limitations the study lends weight to the argument that children with DCD experience higher levels of anxiety (Schoemaker & Kalverboer, 1994) than their peers, that their cognitive perceptions of competence and self-worth are poorer than their peers (Harter, 1978) and that they think they have less social support (Harter, 1978), though the evidence is not conclusive as other researchers have not found differences in global self-worth in children with DCD (Cantell, Smith, & Ahonen, 1994). The study also reinforces the evidence that DCD persists physically and emotionally into adolescence (Losse et al., 1991).

### **Dewey, Kaplan, Crawford and Wilson (2002)**

This study by Dewey and her colleagues investigated the relationship between the severity of motor skills deficits and attention, learning and psychosocial adjustment as no previous studies had addressed this issue though Kadjesko and Gillberg (1999) had found that children with DCD had more problems in attention deficit, Asperger's syndrome and school performance than non DCD children. In line with Kadjesko and Gillberg (1999), Dewey et al. (2002) hypothesised that children with DCD (severe) and suspect DCD (moderate) would differ from non DCD children on difficulties in attention, reading and psychosocial adjustment but there would be no difference between DCD and suspect DCD. This discussion focuses on the psychosocial findings of the study.

Participants were selected from a large sample (430 children) from public and private schools and categorised as DCD, suspect DCD and non DCD by: 1) excluding children with general medical problems, 2) by a battery of motor skills assessments including BOTMP (Bruininks, 1978) or M-ABC (Henderson & Sugden, 1992), and 3) completion of Development Coordination Disorder questionnaire (DCDQ) (Wilson, Kaplan, Crawford, Campbell, & Dewey, 2000). 45 children were classified as DCD (26 boys and 19 girls of average age 11.8) and 51 suspect DCD (33 boys and 18 girls of average age 11.2) and 78 non DCD (59 boys and 19 girls of average age 11.4). IQ was estimated from the short form of the WISC III (vocabulary and block design) (Weschler, 1992) with children excluded < 75. Psychosocial adjustment

was measured with the parent form of the Child Behaviour Checklist (CBCL) (Achenbach, 1991) with acceptable reliability.

Group differences were analysed and showed that the children in the DCD and suspect DCD groups both scored significantly higher than the control group on all Internalizing Problems (Withdrawn, Somatic complaints, Anxious/Depressed) while on Externalizing Problems significant differences were found between both DCD groups (DCD/suspect DCD) and the non DCD group on the subscale for Aggressive Behaviour and a trend toward significance on the Delinquent Behaviour subscale. As expected and in line with Kadesjo & Gillberg (1999) there was no difference between the DCD and suspect DCD levels on psychosocial adjustment, which confirms the findings of Schoemaker and Kalverboer (1994), that at all levels of seriousness, DCD presents a risk for psychosocial problems.

In this study with a large sample and strict inclusion criteria using a parental questionnaire with good psychometric properties, the findings seem acceptable. Parents can be used to elicit concerns predictive of developmental difficulties at a level that can detect 70 – 80% of disability problems (Glascoe, 2000) but this still leaves some room for some children to be missed. In this case the parental sample was predominantly white middle class and well educated (Dewey et al., 2002) so that it may be difficult to generalize the findings of this report to other socioeconomic groups though Glascoe (2000) suggests that parents are able to raise predictive developmental concerns irrespective of their socioeconomic status or education. It is worth noting that for children with DCD, somatic complaints such as dizziness, tiredness and nausea may be explained by vestibular problems (Ayres, 2005) and general aches and pains may be associated with co-occurring JHS (Kirby & Davies, 2006) and should be acknowledged in the research design.

### **Kanioglou, Tsorbatzoudis and Barkoukis (2005)**

Kanioglou and colleagues (2005) examined two areas of socialization behaviour in the classroom in children with DCD, namely social status and deviant behaviour (hyperactivity, inattention, and tension-anxiety and conduct problems). A sample of 154 children (82 boys and 72 girls) of average age 10.9 years old were tested on motor skills using the M-ABC (Henderson & Sugden, 1992). Ten children were categorised with serious DCD (< 5<sup>th</sup> percentile) and 16 with moderate DCD (6<sup>th</sup> – 15<sup>th</sup> percentile) and the rest of the children as non DCD, forming three groups. Sociometric assessment was evaluated using the peer nomination method (Cole, Dodge, & Coppertelli, 1982) based on the nomination of three children a child 'likes the least' and 'likes the most' resulting in categories of popular, controversial, neglected and rejected. Deviant behaviour was assessed using Conners'

Teacher Questionnaire (Conners, 1985) indicating hyperactivity (fidgeting), inattentive-passive (easily distracted), conduct problems (disturbing other children) and tension-anxiety (overly anxious to please).

A high percentage of children with either severe or moderate DCD were in the 'rejected group' though some children with moderate DCD were represented in the popular group. Children with moderate DCD had significantly lower assessments on social acceptance and social preference and significantly higher scores on social rejection than their non DCD peers. On the range of deviant behaviours, there were significant differences between both the moderate and severe DCD groups and children in the non DCD category with children in the severe DCD category having the least favourable outcomes. The authors comment that the deviant behaviours may reflect the co-occurrence of a hyperactivity disorder (Dewey et al., 2002; Kaplan et al., 2006) rather than intentionally poor behaviour. Based on the results of the Conner's Teacher questionnaire, children categorised as severe DCD experienced the highest levels of anxiety.

While the groups were drawn from a non clinical sample, the DCD groups were small so it is difficult to generalize the results. The results follow the pattern of higher anxiety levels and social acceptance problems in children with DCD in line with Schoemaker and Kalverboer (1994) and Skinner and Piek (2001). Caution is required on the use of teachers' perceptions of children as accurate, as teachers seem predisposed to noticing disruptive behaviour particularly in boys, ignoring withdrawn behaviour and noticing motor skills problems less in girls (Rivard, Missiuna, Hanna, & Wishart, 2007). Ethically this study raises some questions as the methodology seems to have encouraged pejorative labelling of young children by their peers. Crabtree and Rutland (2001) highlight that adolescents with learning difficulties use strategies based on social comparison to maintain their self-esteem (Crocker & Major, 1989) and when their differences were highlighted in comparison to those without a learning difficulty their self-esteem dropped. Careful consideration should therefore be given to inclusive practice in research with children with DCD.

### **Dunford, Missiuna, Street and Sibert (2005)**

There is recognition that research into daily living with DCD is in the minority of research studies in comparison to motor skills research and that further studies which combine the perspective of the child in context will provide a richer picture of DCD (Magalhaes et al., 2011). Dunford and her colleagues (2005) used a novel way to help younger children express their views of living with DCD and also compared the children's views of living with DCD to those of their parents and teachers. These researchers argued that understanding childrens'

goals is important to collaboration and motivation in therapeutic interventions (Harter, 1978) in which parents and teachers may play a part (Sugden & Chambers, 2003).

In this study 35 children aged 5 – 10 years old, referred for coordination difficulties, were assessed for inclusion in line with DSM-IV-TR (APA, 2000) criteria. Participants with a general medical condition (Criterion C, DSM-IV-TR, APA 2000) and children with cognitive ability test information of <85 were excluded (WISC: Weschler, 1992). Children were categorised as either 'definite DCD' – < 5<sup>th</sup> percentile and borderline if in the 6<sup>th</sup> to 15<sup>th</sup> percentile (M-ABC, Henderson & Sugden, 1992). The children meeting the criteria for DCD completed the Perceived Efficacy and Goal Setting System (PEGS) (Missiuna, Pollock, and Law, 2006) to report their perceived level of competence on a range of daily activities in school, self care and leisure based on whether 24 picture cards are 'a lot' like or 'a little' like themselves on a four point scale. Parents and teachers completed a questionnaire designed by occupational therapists and physiotherapists.

This innovative study on young children's self-perceptions suggests that the children were predominantly concerned with leisure activities and self care goals in contrast to parents' and teachers' concerns about academic abilities. The teachers seemed to have a particular concern about writing and given the difficulty children with DCD have in handwriting (Ayres, 2005), teachers' expectations may need to be addressed and alternative resources offered, e.g., a computer (Johnstone & Garcia, 1994). The children were aware of the impact of DCD on their daily lives and were able to set personal goals on improvements outwith those described in the PEGS (Missiuna et al., 2006).

Unfortunately, the limitations of the design of this study make it difficult to draw firm conclusions. First, the children were selected from a clinical population with no controls. Statistical significance of results was not reported and generalization cannot be made. No data on the reliability and validity of the parent and teacher questionnaire was provided. A significant issue in the procedure of the children completing the PEGS was that the parents were in the room and the parents could disagree afterwards with the child's perception to the therapist. Young children tend to rely on external sources of their competence (Harter, 1978) and in this design it is possible that the children were influenced by their parents' expectations.

As an innovative methodology in working with young children this study offers promise. The design and analysis may have benefitted from a qualitative approach in which the meaning of DCD to the child could have been illustrated through a phenomenological approach as the children were competent to talk about their own goals (Magalhaes et al., 2011). While

Sinitsky (2010) outlines that, as Counselling Psychologists, our emphasis on the individual child's subjective values and on the contextual and systemic setting can help the child create their story, few Counselling Psychologists may have had the opportunity to work with children due to the limitations of our training and the requirement to work within our level of competence (BPS, 2009; HPC, 2008).

### **Rasmussen and Gillberg (2000)**

This study is the latest in a series of influential longitudinal studies (Gillberg & Gillberg 1983, 1988; Hellgren, Gillberg & Gillberg, 1994a;) in which the neuropsychiatric status of a cohort of 6 and 7 year olds with ADHD, DCD or DAMP (ADHD plus DCD) have been followed by Rasmussen, Gillberg and colleagues to provide a controlled developmental study of the outcome problems of these children. In the present investigation 101 of the original 6 year olds now aged 22 years old were categorised in index groups as follows: ADHD + DCD = 39, ADHD = 11, DCD = 5 and a COMP - control group = 46. In the index groups there were 42 males and 13 females. All participants had been checked at age six for learning disability and had been screened using a pre-school teacher questionnaire (PSQ) (Gillberg, 1982) and had diagnostic examinations by psychiatrists, physiotherapists, neurologists and psychologists to determine diagnoses of ADHD +DCD, ADHD and DCD only. At age six the children were also tested on IQ (WISC-R) and the Southern California Sensory Integration Test (SCSIT) (Ayres, 1972). In this follow up study individuals had undergone a similar assessment process which included a blind neuropsychiatric interview (DSM-III-R, APA 1987), a modified version of the Asperger Syndrome Diagnostic Interview (ASDI) (Ehlers & Gillberg, 1983) and the current ADHD Symptoms Interview (CASI). Outcome measures assessed were: permanent sick pension, conviction of a criminal offence, diagnosis of a DSM-III-R alcohol or substance abuse disorder (excluding depressive disorders), DSM-III-R Personality Disorder, or autism spectrum disorder (ASD).

Results were not encouraging for the index groups with particularly poor outcomes for the ADHD+DCD and DCD only groups with a tendency for poorer outcomes for males. 58% of the index group had poor outcomes but this rose to 69% for the ADHD+DCD and 80% for the DCD only group. 11% of index groups were in receipt of a sick pension compared to 0% for the control group; only 2% had gone on to higher education compared with 30% of the control group; six individuals had indications of autism spectrum disorder; 24% of the index group had alcohol abuse problems compared to 4% of the control group; 33% of the index group had a fulfilled criteria for a Personality Disorder diagnosis as opposed to 7% of the control group and 49 % of the index group demonstrated symptoms of ADHD in comparison

to 9% of the control group. Also, 19% of the index group had a criminal record and none of the control group had.

There is a danger in a longitudinal study that cohort effects are present in that the findings are particular to this group and therefore problematic to generalize, however, the index group was originally drawn from a large general population sample with a rigorous selection process. Another issue is that the groups have small numbers, particularly the DCD group and females are under-represented so that again it is difficult to generalize the results for these groups. This study does at least distinguish among the effects of the permutations of ADHD and DCD and highlights the need for longitudinal research into DCD.

### **Pratt and Hill (2011)**

This study aimed to investigate the level and type of anxiety in children with and without DCD. Pratt and Hill (2011) were also interested in the divergence in the anxiety profiles of children with DCD and the factors which increased risk or developed resilience in this group of children. In particular they hypothesised that panic anxiety, social phobia and fear of physical injury would be the most common types of anxiety in the children with DCD.

Participants in the study were 27 parents (25 mothers and 2 fathers) of children of average age 10 years old with DCD, and 35 parents (34 mothers and 1 father) of typically developing children of similar age. The children in the DCD group included 20 males and 7 females while the typically developing group included 18 males and 17 females. Children in the DCD group had a clinical diagnosis of DCD which had included an M-ABC2 score below the 5<sup>th</sup> percentile for motor skills (Henderson & Sugden, 2007). Parents also completed the DCD-Q (Wilson, Kaplan, Crawford, Campbell & Dewey, 2000) to ensure that no participants in the typically developing group had undetected motor skill problems. The parents of both groups completed the Spence Children's Anxiety Scale parent checklist (SCAS-P; Spence, 1998) to measure overall anxiety and the following types of anxiety: panic/agoraphobia; generalised anxiety disorder; social phobia; separation anxiety disorder; obsessive compulsive disorder and physical injury fears. This checklist has excellent validity and reliability.

An ANOVA demonstrated that there was a significant overall difference in anxiety levels between the DCD and non-DCD group and three of the sub-scales also demonstrated significant differences including: panic/agoraphobia, social phobia and obsessive compulsive anxiety. Over 25% of the DCD group were reported to show clinical levels of anxiety but patterns of anxiety within the DCD group were heterogenous. However, half the DCD group were reported to show panic anxiety and a third of the DCD group were

reported to show social phobia. The authors conclude further research is required on whether co-morbid panic anxiety and social phobia are indicative of self-image differences in children with DCD and while they suggest that mental health interventions may alleviate the anxiety they do not provide specific interventions.

While this study has taken an important step in differentiating types of anxiety in children with DCD, the main drawback to the study was that it was based only on parents' self reports without any perspective from the children to balance parental bias. This is a particular concern as the children were of an age to provide competent feedback about themselves. While Carr (2009) suggests that the best evidence for an anxiety reduction intervention in children is the Coping Cat cognitive behaviour therapy (CBT) programme (Kendall, Hudson, Choudhury, Webb, & Pimentahl, 2005), the authors allude to self-image issues underlying the children's problems. However, Counselling Psychologists, with a range of therapeutic approaches at our disposal across person-centred, CBT and psychodynamic paradigms (Riha, 2010) may be able to utilise an integrated approach such as the Sequentially Planned Integrative Counselling for Children model (SPICC) (Geldard & Geldard, 2008) with children. This integrative therapeutic model incorporates client centred therapy which builds a relationship with the child and enables them to tell their story, utilising play and narrative to help a child express strong emotions before working with negative beliefs and behaviours in a cognitive behavioural phase.

## SUMMARY

From the selective appraisal of the literature it can be illustrated that DCD is a complex developmental condition with pervasive motor, psychological and social effects. Social, affective and cognitive factors appear at a young age including anxiety, negative appraisals of self-worth and perceived social rejection. Children with DCD are attributed by teachers and parents as being more introverted, hyperactive, disruptive, and aggressive and are said to report more somatic problems than their peers. The long term outcome for children with DCD is potentially disadvantaged with negative health, educational, alcohol addiction and criminal implications. This rather negative picture should be tempered by the fact that the studies reviewed have in many cases been based on small and gender biased samples though the replication of findings internationally using a range of research methodologies tends to suggest that there is a basis for concluding that DCD is a significant developmental problem with negative psychological consequences which needs to be addressed more comprehensively. Most of the literature reviewed used quantitative approaches with minimal attempts to address the child's experience of daily living with DCD. This gap in the research literature is one that Counselling Psychologists could address with

more qualitative studies including phenomenological approaches that describe the lived experience of DCD (Smith, Flowers, & Larkin, 2009) (please see Appendix 1 for a reflexive account).

## CONCLUSIONS

The lack of an integrated theoretical framework to explain DCD and the predominance of motor skills interventions means that while part of the problem is being addressed further support is needed in the psychological impact of DCD. While mastery in the physical domain is seen as improving self-perceptions of competence with emotional benefits to the child (Harter, 1978), it is the contention here that children with DCD need to be supported from a complementary psychological perspective as the evidence reviewed suggests that complex motor skills problems often persist even with training (Marchiori et al., 1987; Mayahara et al., 2008; Wilson 2005), that DCD often co-exists with other developmental, emotional and social problems and there is a need to mitigate longer term poor outcomes (NICE, 2008). Children with DCD need help to develop more positive perceptions of self-worth, to reduce their anxiety and improve their social skills broadly by addressing all of the child's neurocognitive strengths and weaknesses (Gilger & Kaplan 2001; Johnstone & Garcia, 1994; Levine 2003). This could be achieved through comprehensive assessment of the child's abilities and treatments that meets the needs and goals of children by involving them (Dunford et al., 2005). Counselling Psychology methodologies may help children access feelings, give meaning to their experience and help them reframe their negative beliefs (Geldard & Geldard, 2008).

## IMPLICATIONS FOR RESEARCH AND PRACTICE

Further research is needed on teachers' perceptions and expectations of children with DCD perhaps in conjunction with investigation of classroom culture (Ames, 1984) to establish the environmental factors in social inclusion for children with DCD. A qualitative approach such as Interpretative Phenomenological Analysis (IPA) (Smith et al., 2009) may provide rich data in this research area. In addition Counselling Psychologists could support teacher training by providing education on the psycho-social impact of DCD and collaborate with teachers to create inclusive learning environments.

Not all children with DCD have poor outcomes (Kanioglou et al., 2005; Rasmussen & Gillberg, 2000) and further research is needed to identify the differentiating factors of children with DCD who do succeed despite their disadvantages which may give clues to intervention

strategies. Case study material or qualitative methodologies as described may be a first step in highlighting this information.

Counselling Psychologists must ethically ensure that any research strategy or intervention that they are involved with does not pejoratively label a child, set a child up to consistently fail without appropriate debriefing and acknowledge that children with DCD, who look physically healthy, may experience physical and emotional distress in research and treatment settings.

Counselling Psychology potentially has a valuable role to play in the research and intervention of DCD by taking a child centred perspective, by raising the profile of the daily lived experience of DCD through the use of qualitative research methodologies and by finding routes to collaborate with other professionals in working with children with DCD. While Pattison's (2010) findings suggest that Counselling Psychology core humanistic values and person centred approach are inclusive, we may also, as Counselling Psychologists, need to be proactive in challenging the 'covert rules of the game' or political and cultural barriers that exclude, marginalise and label children with DCD.

## REFERENCES

- Achenbach, T.M. (1991). *Manual for the child behaviour checklist/4-18 and 1991 profile*. Burlington: University of Vermont.
- Adib, N., Davies, K., Grahame, R., Woo, P., & Murray, K.J. (2005). Joint hypermobility syndrome in childhood. A not so benign multisystem disorder? *Rheumatology*, 44 (744-750).
- Ames, C. (1984). Competitive, cooperative and individualistic goal structures: A motivational analysis. In R.E. Ames & C. Ames (Eds.), *Research on motivation in education. Vol 1: Student motivation* (pp. 177-207). New York: Academic Press.
- APA (1987). *Diagnostic and statistical manual of mental disorders*. (3rd ed.). Washington, DC: American Psychiatric Association.
- APA (2000). *Diagnostic and statistical manual of mental disorders*. (4<sup>th</sup> ed.). Washington, DC: American Psychiatric Association.
- Armstrong, D., & Hallett, F. (2012). Private knowledge, public face: Conceptions of children with SEBD by teachers in the UK – a case study. *Educational & Child Psychology*, 29(4), 77-87.
- Ayres, A.J. (1971). The challenge of the brain. Perceptual Motor Conference. Sparks Nugget Conventions Center, Sparks, Nevada August 26-28.
- Ayres, A.J. (1989). *Sensory integration and praxis tests*. Los Angeles: Western Psychological Services.
- Ayres, A.J. (2005). *Sensory integration and the child: Understanding hidden sensory challenges*. Los Angeles: Western Psychological Services.
- Baddeley, A.D. (1996). *Working Memory*. Oxford: Oxford University Press.
- British Psychological Society. (2004). *Guidelines for minimum standards of ethical approval in psychological research*. Leicester: BPS.

- British Psychological Society. (2006). *The British Psychological Society position paper (October, 2006) Autistic Spectrum Disorders: Guidance for chartered psychologists working with children and young people*. Leicester: BPS.
- British Psychological Society. (2009). *Code of ethics and conduct: Guidance published by the ethics committee of the British Psychological Society*. Leicester: BPS.
- Bruininks, R.H. (1978). *Bruininks-Osteretski test of motor proficiency*. Circle Pines, MN: American Guidance Service.
- Cantell, M.H., Smyth, M.M., & Ahonen, T.P. (1994). Clumsiness in adolescence: Educational, motor, and social outcomes of motor delay detected at 5 years. *Adapted Physical Activity Quarterly, 11*, 115-129.
- Carr, A. (2009). *What works with children, adolescents and adults?: A review of research and effectiveness of psychotherapy*. New York: Routledge.
- Cermak, S.A., Gubbay, S.S., & Larkin, D. (2002). What is Developmental Coordination Disorder? In Cermak, S.A. & Larkin, D. (Eds.), *Developmental Coordination Disorder* (pp. 2-22). New York: Delmar.
- Cole, J.F., Dodge, K.A., & Coppertelli, H. (1982). Dimensions and types of social status: a cross-age perspective. *Developmental Psychology, 18*, 557-570.
- Conners, C.K. (1985). Teacher questionnaire. *Psychopharmacology Bulletin, 21*, 823-828.
- Crabtree, J., & Rutland, A. (2001). Self-evaluation and social comparison amongst adolescents with learning difficulties. *Journal of Community & Applied Social Psychology, 11*, 347-359.
- Crocker, J., & Major, B. (1989). Social stigma and self esteem: The self protective strategies of stigma. *Psychological Review, 96*, 608-630.
- Dewey, D., Kaplan, B.J., Crawford, S.G., & Wilson, B.N. (2002). Developmental coordination disorder: Associated problems in attention, learning and psychosocial adjustment. *Human Movement Science, 21*(5-6), 905-918.

- Donaldson, M. (1978). *Children's Minds*. London: Croom Helm Ltd.
- Dunford, C., Missiuna C., Street E., & Sibert, J. (2005). Children's perceptions of the impact of Developmental coordination disorder. *British Journal of Occupational Therapy*, 68(5), 202-214.
- Dunford, C., & Richards, S. (2003). *'Doubly Disadvantaged': Report of a survey on waiting lists and waiting times for occupational therapy services for children with developmental coordination disorder*. London : College of Occupational Therapists.
- Ehlers, S., Gillberg, C., & Wing, L. (1999). A screening questionnaire for Asperger syndrome and other high-functioning autism spectrum disorders in school age children. *Journal of Autism and Developmental Disorders*, 29(2), 129-141.
- Fitts, P.M. (1954). The informed capacity of the human motor system in controlling the amplitude of movements. *Journal of Experimental Psychology*, 47, 381-391.
- Forsyth, K., MacIver, D., Howden, S., Owen, C., & Shepherd, C. (2008). Developmental Coordination Disorder: A synthesis of evidence to underpin an allied health professions' framework. *International Journal of Disability, Development and Education*, 55(2), 153-172.
- Gallehue, D.L., & Ozmun, J.C. (2002). *Understanding motor development: Infants, children, adolescents and adults* (5<sup>th</sup> ed.). Boston: McGraw-Hill.
- Geldard, K., & Geldard, D. (2008). *Counselling children: A practical introduction*. (3<sup>rd</sup> Ed.). London: Sage.
- Gentile, A.M. (2000). Skill Acquisition: Action, movement and neuromotor processes. In J.H. Carr & R.B. Shepherd (Eds.), *Movement Science: Foundations for Physical Therapy* (2<sup>nd</sup> ed., pp. 111-187). Rockville: Aspen.
- Geuze, R.H., Jongmans, M.J., Schoemaker, M.M., & Smits-Engelsman, B.C.M. (2001). Clinical and research diagnostic criteria for developmental coordination disorder: a review and discussion. *Human Movement Science*, 20, 7-47.

- Gillberg, I.C., & Gillberg, C. (1983). Three-year follow-up at age 10 of children with minor neurological disorders. I: Behavioural problems. *Developmental Medicine and Child Neurology*, 25, 438-449.
- Gillberg, I.C., & Gillberg, C. (1988). Children with deficits in attention, motor control and perception (DAMP): need for specialist treatment. *Acta Paediatrica Scandinavica*, 77, 450-451.
- Gillberg, I.C., Gillberg, C., & Groth, J. (1989). Children with preschool minor neurodevelopmental disorders V: Neurodevelopmental profiles at age 13. *Developmental Medicine and Child Neurology*, 31, 14-24.
- Gilger, J.W., & Kaplan, B.J. (2001). Atypical Brain Development: a conceptual framework for understanding developmental learning disabilities. *Developmental Neuropsychology*, 20(2), 465-481.
- Glascocoe, F.P. (2000). Evidence based approach to developmental and behavioural surveillance using parents' concerns. *Child: Care, Health and Development*, 26(2), 137-149.
- Graham, J.J. (2008). From ABCs to ADHD: The role of schooling in the construction of behaviour disorder and production of disorderly objects. *International Journal of Inclusive Education*, 12(1), 7-33.
- Green, D., Baird G., Barnett, A.L., Henderson, L., Huber J., & Henderson S.E. (2002). The severity and nature of motor impairment in Asperger's syndrome: a comparison with specific developmental disorder of motor function. *Journal of Child Psychology and Psychiatry*, 43(5), 655-668.
- Gubbay, S.S. (1975a). *The clumsy child*. Saunders: Philadelphia.
- Gumley, D. (2005). *Behaviour and social functioning in children with developmental coordination disorder*. Unpublished doctoral thesis, City University, London, United Kingdom.
- Hadders-Algra, M., & Lindahl, E. (1999). Quality of general movements in infancy is related to neurological dysfunction, ADHD and aggressive behaviour. *Developmental Medicine and Child Neurology*, 41, 381-391.

- Hakim, A.J., & Grahame, R. (2003). A simple questionnaire to detect hypermobility: an adjunct to the assessment of patients with diffuse musculoskeletal pain. *International Journal of Clinical Practice*, 57, 163-166.
- Harter, S. (1978). Effectance motivation reconsidered: Toward a developmental model. *Human Development*, 21, 34-64.
- Harter, S. (1985a). *Manual for self-perceptions profile for children: Revision of the perceived competence scale for children*. Denver: University of Denver.
- Harter, S. (1985b). *Manual for self-perceptions profile for adolescents*. Denver: University of Denver.
- Harter, S., & Pike, R. (1983). *The Pictorial Scale of Perceived Competence and Social Acceptance for Young Children*. Denver, CO: University of Denver.
- Harter, S., & Robinson, N. (1988). *The social support scale for older children and adolescents (Revised): Approval, emotional and instrumental support*. Denver: University of Denver.
- Health Professions Council. (2009). *Standards of proficiency: Practitioner psychologists*. London: HPC.
- Hellgren, L., Gillberg, C., & Gillberg, I.C. (1994a). Children with deficits in attention, motor control and perception (DAMP) almost grown up: The contribution of various background factors to outcome at the age of 16 years. *European Child and Adolescent Psychiatry*, 3, 1-15.
- Henderson, S.E., & Sugden, D.A. (1992). *Movement assessment battery for children*. Sidcup: The Psychological Corporation.
- Henderson, S.E., & Sugden, D.A. (2007). *Movement assessment battery for children 2*. Sidcup: The Psychological Corporation.

- Jeffries, S., & Everatt, J. (2004). Working memory: Its role in dyslexia and other specific learning difficulties. *Dyslexia*, 10, 196-214.
- Johnstone, B., & Garcia, L. (1994). Neuropsychological evaluation and academic implications for developmental coordination disorder: a case study. *Developmental Neuropsychology*, 10(4), 369-375.
- Kadesjo, B., & Gillberg, C. (1999b). Developmental coordination disorder in Swedish 7-year-old children. *Journal of the American Academy of Child & Adolescent Psychiatry*, 38, 820-828.
- Kanioglou, K., Tsorbatzoudis, H., & Barkoukis, V. (2005). Socialization and behavioural problems of elementary school pupils with developmental coordination disorder. *Perceptual and Motor Skills*, 101, 163-173.
- Kaplan, B., Crawford, S., Cantell, M., Kooistra, L., & Dewey (2006). Comorbidity, co-occurrence. continuum: what's in a name? *Child: Care Health and Development*, 32(6), 723-731.
- Kendall, P., Hudson, J., Choudhury, M., Webb, A., & Pimental, S. (2005). Cognitive behavioural treatment for childhood anxiety disorders. In H.E. Hibbs & P. Jensen (Eds.), *Psychosocial treatments for child and adolescent disorders: Empirically based strategies for clinical practice* (2<sup>nd</sup> ed., pp. 47-74). Washington: American Psychological Association.
- Kirby, A., & Davies, R. (2006). Developmental coordination disorder and joint hypermobility syndrome – overlapping disorders? Implications for research and clinical practice. *Child: Care Health and Development*, 32(5), 513-519.
- Kirk J.A., Ansell, B.M., & Bywaters, E.G.L. (1967). The hypermobility syndrome: musculoskeletal complaints associated with generalized joint hypermobility. *Annals of the Rheumatic Diseases*, 26, 419.
- Kraemer, H.C., Kazdin, A.E., Offord, D.R., Kessler, R.C., Jensen, P.S., & Kupfer, D.J. (1997). Coming to terms with the terms of risk. *Archives of General Psychiatry*, 54, 337-343.
- Levine, M. (2003). *The Myth of Laziness*. NY: Simon & Schuster.

- Lesny, I.A. (1980). Developmental dyspraxia-dysgnosia as a cause of congenital clumsiness. *Brain and Development*, 2, 69-71.
- Losse, A., Henderson, S.E., Elliman, D., Hall, D., Knight, E., & Jongmans, M. (1991). Clumsiness in children - do they grow out of it? A 10-year follow-up study. *Developmental Medicine and Child Neurology*, 33, 55-68.
- Lundy-Ekman, L., Ivry, R.B., Keele, S., & Woollacott, M. (1991). Timing and force control deficits in clumsy children. *Journal of Cognitive Neuroscience*, 3, 367 – 376.
- Magalhaes, L.C., Cardoso, A.A., & Missiuna, C. (2011). Activities and participation in children with developmental coordination disorder: A systemic review. *Research in Developmental Disabilities*, 32, 1309-1316.
- Marchiori, G.E., Wall, A.E., & Bedingfield, E.W. (1987). Kinematic analysis of skill acquisition in physically awkward boys. *Adapted Physical Activity Quarterly*, 4, 305-315.
- Missiuna, C (1994). Motor skill acquisition in children with developmental coordination disorder. *Adapted Physical Activity Quarterly*, 11, 214-235.
- Missiuna, C., Mandich, A.D., Polatajko, H.J., & Malloy-Miller, T. (2001). Cognitive orientation to daily occupational performance (CO-OP): Part 1 – Theoretical foundations. *Physical & Occupational Therapy in Pediatrics*, 20(2&3), 69-81.
- Missiuna, C., Pollock, N., Law, M., Walter, S., & Cavey, N. (2006). Examination of the Perceived Efficacy and Goal Setting System (PEGS) with children with disabilities, their parents and teachers. *American Journal of Occupational Therapy*, 60(2), 204-214.
- Morton, J. (2004). *Understanding developmental disorders: a causal modelling approach*. Oxford: Blackwell Publishing.
- Msall, M.E. (2000). Genes, brain and development: Linking preschool developmental disorders to medical science and care. *The Journal of Pediatrics*, 137(5), 600 – 602.
- Myahara, M., Leeder, T., Francis, G., & Inghelbrecht. (2008). Does an instruction of a verbal labelling strategy for hand movements improve general motor coordination as well as

gestural performance? A test of the relationship between developmental coordination disorder and dyspraxia. *Sage Clinical Case Studies*, 7(3), 191-207.

National Institute for Health and Clinical Excellence. (2008). *Promoting children's social and emotional wellbeing in primary education*. London: NICE.

Pattison, S. (2010). Reaching out: a proactive process to include young people with learning disabilities in counselling in secondary schools in the UK. *British Journal of Guidance & Counselling*, 38(3), 301-311.

Pennington, B.F. (2006). From single to multiple deficit models of developmental disorders. *Cognition*, 101, 385-413.

Piaget, J. (1952). *The origins of intelligence*. New York: International Universities Press.

Pless, M. & Carlsson, M. (2000). Effects of motor skill intervention on developmental coordination disorder: a meta analysis. *Adapted Physical Activity Quarterly* 17, 381-401.

Polatajko, H., Fox, M., & Missiuna, C. (1995). An international consensus on children with developmental coordination disorder. *Canadian Journal of Occupational Therapy*, 62, 3-6.

Pratt, M.L., & Hill, E.L. (2011). Anxiety profiles in children with and without developmental coordination disorder. *Research in Developmental Disabilities*, 32, 1253-1259.

Rasmussen, P. & Gillberg, C. (2000). Natural outcome of ADHD with developmental coordination disorder at age 22 years: A controlled, longitudinal community based study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(11), 1424-1431.

Revie, G., & Larkin, D. (1993). Task-specific intervention with children reduces movement problems. *Adapted Physical Activity Quarterly*, 10, 29-41.

Riha, A. (2010). Counselling psychology for children? - The questions of training and career paths in an emerging profession. *Counselling Psychology Review*, 25(1), 49-51.

- Rivard, L., Missiuna, C., Hanna, S., & Wishart, L. (2007). Understanding teachers' perceptions of the motor difficulties of children with DCD. *British Journal of Educational Psychology*, 77(3), 633-648.
- Rutter, M. (1989). Pathways from childhood to adult life. *Journal of Child Psychology and Psychiatry*, 30, 23-51.
- Schaefer, M.M., Droppleman, A.F., & Kalverboer, A.F. (1965). Development of a classroom behaviour checklist and factor analysis of children's school behaviour in the United States and the Netherlands. In *Mongraphs of the Society for Research in Child Development*. Chicago: University of Chicago Press.
- Schoemaker, M.M., & Kalverboer, A.F. (1994). Social and affective problems of children who are clumsy: How early do they begin? *Adapted Physical Activity Quarterly*, 11(2), 130-140.
- Schoemaker, M.M., & Smits-Engelsman, B.C.M. (2003). Psychometric properties of the Movement Assessment Battery for Children-Checklist as a screening instrument for children with developmental coordination disorder. *British Journal of Educational Psychology*, 73(3), 425-441.
- Sinitsky, G. (2010). A trainee's experience of counselling psychology's contribution to therapeutic work with children and adolescents. *Counselling Psychology Review*, 25(1), 52-56.
- Skinner, R.A., & Piek, J.P. (2001). Psychosocial implications of poor motor coordination in children and adolescents. *Human Movement Science*, 20 (1-2), 73-94.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Smits-Engelsman, B.C.M., Blank, R., Van der Kaay, A., Van der Meijs, R.M., Van den Brand, E. V., Polatajko, H.J., & Wilson, P. (2013). Efficacy of interventions to improve performance in children with developmental coordination disorder: a combined systematic review and meta-analysis. *Developmental Medicine & Child Neurology*, 55, 229-237.

- Spence, S.H. (1998). A measure of anxiety symptoms among children. *Behaviour Research and Therapy*, 36, 545-566.
- Spielberger, C.D., Edwards, C.D., Lushene, R.E., Montuori, J. & Platzek. (1973). *Preliminary test manual for the State-Trait Anxiety Inventory for Children*. Palo Alto: Consulting Psychologists Press.
- Stott, D.H., Moyes, F.A., & Henderson, S.E. (1984). *The test of motor impairment – Henderson revision*. San Antonio: The Psychological Corporation.
- Sugden, D.A. (2006). *Developmental Coordination Disorder as Specific Learning Difficulty. Leeds Consensus Statement. ERSC Seminar Series, 2004-2005*. Cardiff: Dyscovery Trust.
- Sugden, D.A., & Chambers, M.E. (1998). Intervention approaches and children with developmental coordination disorder. *Pediatric Rehabilitation*, 2, 139-147.
- Sugden, D., Kirby, A., & Dunford, C. (2008). Issues surrounding children with Developmental Coordination Disorder. *International Journal of Disability, Development and Education*, 55(2), 173-187.
- Vaivre-Douret, L., Lalanne, C., Ingster-Moati, I., Boddart, N., Cabrol, K., Dufier, J., Golse, B., & Falissard, B. (2011). *Developmental Neuropsychology*, 36(5), 614 – 643.
- Weschler D. (1992). *Weschler Intelligence Scale for Children-Revised*. New York: The Psychological Corporation.
- Willcutt, E.G., Pennington, B.F., Smith, S.D., Cardon, L.R., Guyan, J, Knopik, V.S., et al. (2002). Quantitative trait locus for reading disability on chromosome 6p is pleiotropic for attention-deficit/hyperactivity disorder. *American Journal of Medical Genetics*, 11(3), 260 – 268.
- Wilson, P.H., (2005). Practitioner review: Approaches to assessment and treatment of children with DCD: an evaluative review. *Journal of Child Psychology and Psychiatry*, 46(8), 806-823.

Wilson, B.N., Kaplan, B.J., Crawford, S.G., Campbell, A., & Dewey, D. (2000). Reliability and validity of a parent questionnaire on childhood motor skills. *American Journal of Occupational Therapy* 54, 484-493.

Wilson, P.H., Maruff, P., Ives, S., & Currie, J. (2001). Abnormalities of motor and praxis imagery children with developmental coordination disorder. *Human Movement Science* 20, 135-159.

Wilson, P.H., Thomas, P.R., & Maruff, P. (2002). Motor imagery training ameliorates motor clumsiness in children. *Journal of Child Neurology*, 17, 491-498.

Wing, L. (1981). Asperger syndrome: A clinical account. *Psychological Medicine*, 11, 115-129.

Wolbers, T., Weiller, C., & Buchel, C. (2003). Contralateral coding of imagined body parts in the superior parietal lobe. *Cerebral Cortex*, 13, 392-331.

WHO (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: World Health Organization.

## REFLEXIVITY

As the author of this paper and a Trainee Counselling Psychologist advocating qualitative research based on the child's experience, I am bound to reflect on my reasons for choosing this subject. I am the mother of an adult student diagnosed with Dyspraxia at four years old with a motor test score on the 6<sup>th</sup> percentile but with good cognitive abilities. I have been struck as I have read through the research how my personal observations of my child's development are reflected in the literature. At age four the pre-school teacher told me she had only seen "one other child like this in ten years of teaching" (Sugden & Chambers, 2003) as they constantly fell off chairs, had difficulty navigating a very small classroom and found transitions between tasks difficult. Following the teacher's comments my child was seen by the GP who proclaimed them perfectly healthy, but following a motor skills assessment by an Occupational Therapist (Normative Skills Approach) and a Neurological Paediatrician (Neuro-developmental/Medical Model) we were told that they had a mild motor delay and flexible joints. I have always known the latter but had not heard of JHS (Kirby & Davies, 2006) until I did the reading for the literature review. It makes sense of their somatic complaints (Dewey et al. 2002). Following this diagnosis we went to weekly Occupational Therapy for Sensory Integration Therapy (Ayres, 1989) for twelve months and did exercises at home. By age six an assessment by an Educational Psychologist concluded they were a bright curious child but was still stopped from progressing with the rest of the peer group for six months with implications for social exclusion (Kanioglou, 2005) emphasising the normative expectations of the school environment (Ames, 1984). Although my child did have an Individual Education Plan they were always on the first stage and always performed averagely so never had any additional resources in school. Finally, at the risk of further educational problems in the local state school in the UK at age ten, we sent our child to a small private school with very small classes and an ethos of valuing every child where they did well (Ames, 1984). At a large state High School in the USA (5000 pupils), my now adolescent child struggled with organisation skills and again was prevented from progressing onto a course not because of their ability, but because they could not always produce the required written work consistently (DCD+ADHD, Kaplan et al., 2006). Throughout school they have had problems with production of written work and despite excellent vocabulary and comprehension skills, have problems moving from one task to another and time management and distractibility (DCD + ADHD). Through a very supportive state school system in the US, at age 15, they received a full psychological assessment with school counsellors and psychologists on hand. This assessment revealed a variety of neurocognitive strengths and weaknesses (Gilger & Kaplan, 2001) and helped us understand the issues more fully. My child is very independent and does not want to ask for help and although very sociable, has been bullied on occasion

by other children. Now, an adult, they still have motor skills problems, bump into things, drop things, hate trains and small buttons and zips defeat them despite earlier motor skills training and they still struggle with time management and organisation.

I provide this brief case history as an illustration of the implications of DCD at the individual level which is what, as a Trainee Counselling Psychologist, I am interested in. I was lucky enough to discover my child's problem when they were very young and had interventions early. I also tried very hard to encourage them and build self esteem as they grew up dealing with the reality of school and daily tasks and was also lucky enough to have the resources I needed to help them while, as an adolescent, they attended a school in the US with an excellent pastoral support system. Still, it has been a challenge to navigate the educational system with a child who has dyspraxia when what teachers and others see is a healthy young person with no physically obvious problems yet one who cannot sit still, looks as though they are falling asleep in class and regularly loses possessions to name but a few issues, though none of this is intentional bad behaviour (Kanioglou et al., 2005). To me DCD or dyspraxia is more than a motor skills issue and, in fact, just reappears in different disguises at different stages of development. As a Trainee Counselling Psychologist, I would like to help children, adolescents and young adults make sense of this perplexing condition and provide parents and teachers with the tools to help the child grow up with a healthy self concept.

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SECTION C

Self Reported Developmental Coordination Disorder – Young  
adults' experience of Developmental Coordination Disorder in  
their daily lives as a student

An Interpretative Phenomenological Analysis

Doctoral Research Study

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## **Abstract**

This research project investigated the lived experience of DCD in the daily lives of young adult students. The participants were eight students aged between 19 and 22 years of age who self-reported DCD. Semi-structured interviews were utilised to capture the students' accounts of their daily lives and the data analysed using Interpretative Phenomenological Analysis (IPA). Six master themes emerged that illustrated the lived experience of DCD: DCD in Transition, DCD in Functional Context, DCD in Social Context, DCD in Psychological Context, DCD and Support, and finally DCD and Young Adult – Dynamic Self. Relationships among these structural, functional, interpersonal and personal themes highlighted the embedded nature of DCD in the students' lives. Evocative accounts of the students' lifeworld are presented which portray the impact of DCD on the students' academic, social and emotional lives. A particular feature that emerged of the students' lifeworld was the impact of DCD on the students' developing identity. It is argued that this contextualised account of DCD provides a complex and rich understanding of the impact of DCD in the students' lives.

## INTRODUCTION

### RATIONALE

Developmental Coordination Disorder<sup>3</sup> (DCD) has been shown to be a poorly recognised problem in mental health. Kirby, Salmon, and Edwards (2007) demonstrated that two thirds of psychiatrists had an incomplete understanding of DCD and nearly half did not know what 'DCD' stood for. This lack of awareness is of concern as DCD has been shown to have long term psychological and social implications for young adults (Rasmussen & Gillberg, 2000).

Bell and Lee (2008) highlight that one of the highest stress inducing life changes is becoming a student in Higher Education with 29% of students experiencing psychological distress (Bewick, Gill, & Mulhern, 2008), while college students at risk of social isolation are more susceptible to psychological problems (Hefner & Eisenberg, 2009). Students with DCD, it could be argued, are therefore potentially psychologically vulnerable on multiple counts. Social support has been found to improve psychological coping and a key component of social support is having someone to talk to (Hefner & Eisenberg, 2009) while the Dyspraxia Foundation (Dyspraxia Foundation, 2009) reported that young adults with DCD were seeking emotional support in achieving their life goals. As Counselling Psychologists, being able to provide psychological support is fundamental to our role and we could potentially meet this need in young people with DCD.

A problem in meeting the psychosocial needs of young adults with DCD is the lack of research in this area, as Geuze, Jongmans, Schoemaker, and Smits-Engelsman (2001) comment, "Research with adult subjects is virtually lacking", while Cantell, Smith, and

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<sup>3</sup> Criteria for Developmental Coordination Disorder (DSM-IV-TR, American Psychiatric Association (APA), 2004):

- E. Performance in daily activities that require motor coordination is substantially below that expected given the person's chronological age and measured intelligence. This may be manifested by marked delays in achieving motor milestones (e.g., walking, crawling, sitting) dropping things, "clumsiness", poor performance in sports, or poor handwriting.
- F. The disturbance in Criterion A significantly interferes with academic achievement or activities of daily living.
- G. The disturbance is not due to a general medical condition (e.g. cerebral palsy, hemiplegia or muscular dystrophy) and does not meet the criteria for a Pervasive Developmental Disorder.
- H. If mental retardation is present the motor difficulties are in excess of those usually associated with it.

Ahonen (2003) remark on the lack of qualitative research in this area. The current research study aims to jointly contribute to the research gap in DCD in young adults within the qualitative paradigm.

Due to the paucity of research literature in DCD in young adults, this Introduction therefore draws on associated literature on the transition to young adulthood, identity development and the psychological well being of young adults. These topics cover large bodies of work and the selected literature in the Introduction therefore provides an overview of the influences that impact students with DCD. Much of the literature is from the prevailing quantitative paradigm in psychological research but, where possible, qualitative research is included to illustrate the complexity of the lives of young adults.

The definition and background of DCD in children was introduced in the Critical Literature Review (please see Section A of the DPsych portfolio) while the status of DCD in adults is briefly reviewed.

## DEVELOPMENTAL COORDINATION DISORDER

DCD (APA, 2000) has also been known as Developmental Dyspraxia (Cermak, 1985) but Hill (2005) makes the distinction that DCD is a more accurate description of the broad spectrum of motor problems that occur, while dyspraxia relates to a specific aspect of purposeful movement. A recent estimate of the U.K. prevalence of DCD in children is between 1.7% and 3.2% (Lingam, Hunt, Golding, Jongmans, & Emond, 2009) while Cousins and Smyth (2003) report that motor skill problems in DCD persist from childhood into adulthood.

Developmental motor problems are defined by both DSM-IV-TR (APA, 2000) and the International Classification of mental and behavioural disorders (ICD-10, World Health Organisation (WHO), 1992) however, Sugden, Kirby, and Dunford (2008) acknowledge that that DSM-IV-TR criteria (APA, 1994, 2000) are predominantly used. The 1994 Consensus Meeting in London, Ontario (Polatajko, Fox, & Missiuna, 1995) and the Leeds 2006 Consensus Statement (Sugden, 2006) clarified issues of definition, diagnosis and assessment of DCD.

### **DCD status for young adults**

The Leeds Consensus statement (Sugden, 2006) highlights DCD as a 'lifespan' phenomenon with negative outcomes for motor, social, health, educational and psychiatric functioning bolstering DSM-IV-TR (APA, 2000) recognition that DCD may continue into adolescence and

adulthood and highlighting the universal nature of DCD 'across culture, race, socio-economic status and gender'.

Although assessment of motor skills in DCD is recommended using a standardised motor test based on age appropriate norms (Sugden, 2006), Cousins and Smyth (2003) note the lack of standardised motor tests for adults. Cousins and Smyth (2003) improvised assessment of motor skills in 21 adults up to age of 65 who self reported DCD, in comparison to pair-wise controls. These authors found that motor skills in participants with DCD were significantly worse across all tests. While the daily living activities in children with DCD include 'self-care, play, leisure, and some schoolwork, such as handwriting and PE' (Criterion B, APA 2000), Geuze (2005) comments that these activities are not relevant to independent living in adulthood. However, Drew (2005) outlines daily living activities in DCD for adults covering: 1) social skills, e.g., making friends, 2) community living, e.g., shopping, and 3) survival skills, e.g., health care. Additionally, Cousins and Smyth (2003) highlight that adults with DCD often cannot learn to drive.

In summary, DCD appears to be an under specified disorder in adults where appropriate definitions, descriptions and assessments are needed.

### **Co-occurrence of DCD**

Co-occurrence of DCD with other developmental disorders has been found to be more usual than not. Two major sets of studies have empirically demonstrated the co-occurrence of DCD with other developmental disorders. The overlap of DCD, ADHD and reading disability (RD) has been highlighted in a group of Canadian studies (Dewey, Kaplan, Crawford, & Wilson, 2002; Kaplan, Wilson, Dewey, & Crawford, 1998) while the co-occurrence of DCD, ADHD and Asperger Syndrome is outlined in a Swedish longitudinal series (Gillberg & Gillberg, 1983; 1988; Hellgren, Gillberg, & Gillberg, 1994a; Rasmussen & Gillberg, 2000).

### **DCD Psycho-social Issues – Child to Adult**

While DCD often co-occurs with other developmental disorders, it is also evident that there is a psychological and social impact of DCD from an early age<sup>4</sup> (Wilson, 2005). Children as young as six years old with motor difficulties experience anxiety about their how they are perceived, (Dewey et al., 2002; Schoemaker & Kalverboer, 1994) with childhood anxiety and

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<sup>4</sup> For a fuller review of the psychosocial literature on DCD in children please see Section A of this portfolio.

concerns about social perception persisting into adolescence (Skinner & Piek, 2001). Rasmussen and Gillberg's (2000) longitudinal study of the psycho-social consequences of DCD into young adulthood is relatively rare though there is a small but growing research interest in this area.

Before continuing to review recent studies of DCD in young adults, selected literature on the transition to adulthood, identity development and psychological well being in young adults and students is discussed.

#### TRANSITION TO YOUNG ADULTHOOD – THEORETICAL INFLUENCES

According to Dannefer (1984), adult development theories tend to be either stage or lifespan progression theories. Stage theories are underpinned by a series of defined steps which imply normative age based patterns of development in the life course (Erikson, 1950, 1968; Levinson, 1978). Particular psychological tasks are associated with each life stage which gives each phase its unique place in the change process of the person. Lifespan progression theories, in contrast to stage theories, move away from maturational unfolding to emphasise the continuing process of change across the lifespan (Baltes, 1979). Some lifespan theorists emphasise a 'dialectical' approach (Gergen, 1977) where the autonomy of the individual is seen as a defining feature of the developmental course.

Adatto (1991) outlines the transition phase from adolescence to young adult from a psycho-analytical perspective using Erikson's (1950, 1968) developmental model of psycho-social stages. Erikson's (1950, 1968) model identifies the psycho-social tasks of the adolescent stage as identity vs. role confusion, and in the young adult stage, as intimacy vs. isolation. Adatto (1991) recognises these stages encompassing 18 – 25 years of age, as the period when the young person tries to establish identity and separate from the parents exemplified by the struggle between the super-ego, or historical identification with the parents, to developing the ego ideal or adapting to reality (Blos, 1967). Ritvo (1971) also outlines the development of intimacy at this time, from narcissistic relationships in adolescence to mutually rewarding adult love in adulthood.

Arnett (2000) compares his contemporary theoretical concept of 'emerging adulthood' with Erikson's (1950, 1968) 'moratorium' or period of identity exploration (please see Table 1). However, Arnett (2000) does not favour Keniston's (1971) conceptualisation of 'youth', reasoning that 'youth' is an artefact of the 1970's dissenting social milieu. In Tanner and Arnett's (2009) view, 'emerging adulthood' also occurs between the age of 18 and 25 years

of age, and is a distinct developmental phase during which psychological and personal experiences are critical to the emergence of identity. In emerging adulthood 'recentering' is the key task in developing equality in power in relationships, experimenting with roles and accepting the responsibilities of adulthood, i.e., career, marriage and family.

Adatto (1991); Erikson (1950, 1968)	Arnett (2000); Tanner & Arnett (2009)
Generally not specified though Adatto (1991) suggests 18 - 25	Age 18 - 25
Transition from adolescent to young adult encompassing Puberty and Adolescence and Young Adulthood	'Emerging adult'
Identity vs. role confusion	Identity exploration / feeling in between / possibilities
Intimacy vs. Isolation / Concern for relationship	Intimate relationships
Narcissistic object relations / Resolving immature identifications	Self focus
Super-ego vs. ego - ideal	Reframing relationship with parent from dependence to one based on reciprocity and power equivalence

Table 1: A Comparison of Transition to Adulthood approaches

Arnett (2000) suggests that the increasing age of marriage, later parenthood and increased participation in higher education indicates personal choice as a key attribute in emerging adulthood, but he may be confounding individual choice with social pressures (Dannefer, 1984) as the college attendance patterns that Arnett (2000) ascribes to emerging adult choice may instead reflect the structural demands of the U.S. college system (Arnett, 2004; Pollard & O Hare, 1999). Arnett (2000) argues that his theory is generally applicable in Europe, though it is difficult to comprehend the choices of emerging adults in socio-economically deprived areas in the UK where only 9% of the adult population enters higher education (The Scottish Government, 2012).

Heinz (2009), in his life-course framework approach to transition, rejects 'emerging adulthood' (Arnett, 2000) as a particular age-bound construction of a post-industrial society advocating that young people claim a place in society through their engagement with 'pathways' in the life course. Engagement in pathways is achieved through the young

person's agency to shape their life story or 'self-socialization', which is impacted by socio-economic background, education and inequality of life opportunities. Heinz (2009) criticizes 'emerging adulthood' as normalising independence at a time when many young people have not yet claimed a place for themselves in society.

### **Transition to Young Adulthood and Disability**

While some contemporary adult development theorists emphasise choice (Tanner & Arnett, 2009) and agency (Heinz 2009) in the transition to adulthood, other theorists discuss disability in the context of becoming an adult.

Riddell (2009) compares mainstream understandings of transition to adulthood with those in the context of disability. Riddell (2009) reflects the post-modern view of disability based on a social model that draws the distinction between disability and impairment, where disability is the social and structural impediment to living with an impairment. Levitas (1998) argues that disabled young people are at risk of social exclusion in three ways: economically, politically and occupationally, while Riddell (2009) suggests that a key factor in advancing inclusion for disabled young people is the role of education in increasing employment and independence. Riddell (2009) distinguishes between the inherent risks for young people with global learning difficulties from those with specific learning difficulties such as dyslexia. The latter group are well represented in Higher Education though Riddell, Tinklin, and Wilson, (2005) conclude that these students congregate in Arts topics, find the transition to university demanding, build fewer social relationships and are stressed by unreceptive learning systems. These students' risks are increased by poorer exam outcomes and lower employment prospects (Riddell et al., 2005).

Irwin (2001) supports giving a voice to disabled young people and argues that a life course perspective provides a way to appreciate the embedded nature of personal experience in social frameworks rather than viewing transition from an age bound approach (Tanner & Arnett, 2009). Hockney and James (1993) identify that the value assigned to independent adulthood in contemporary society where pre-requisites are individuality (Tanner & Arnett, 2009) and gainful employment (Riddell, 2009) are dominant exclusionary social pressures. Disabled young people unable to meet independent adult criteria, argues Irwin (2001), are marginalised by powerful sectors of society who accept independence and employment as 'givens'. This marginalising perspective can be challenged from an alternative 'claiming' perspective by investigating its social and historical construction (Honneth, 1995). As Wendell (1996) suggests, it is more relevant to challenge the value system that privileges independence over dependence, as for some disabled young people, independence may

not be achievable. Counselling Psychologists working with disabled young people should perhaps be alert to the 'givens' in which they too operate.

Tisdall (2001) also rejects the notion of independence corresponding with paid employment (Riddell, 2009) preferring independence to mean having control over one's life, though she recognises that approaches to transition which advocate personal agency (Heinz, 2009) could undermine holding discriminatory social practices to account. However, Tisdall (2001) argues that linking the young person's experience with an investigation of localised social structures can be helpful in breaking down barriers to opportunities to give disabled young people some say in their lives. Although Evans and Furlong (1997) suggest that the scales are still in favour of structural factors over agency, Riddell (1998) calls for qualitative methodologies to investigate the meaning of agency in disabled young peoples' lives.

### **Transition to Young Adulthood and Psychological Health**

Schulenberg, Sameroff, and Cicchetti (2004) address psychological function in the transition to adulthood and argue that this 'turning point' (Elder, 1998; Rutter, 1996) is critical to mental health as the young person may 'flounder' in trying to manage difficult emotions in new environments and relationships. Schulenberg et al. (2004) posit that the loss of established structures, e.g., moving away from home, may dislocate the young person's emotional stability and call for a pattern or person centred approach to research on transition to adulthood to identify specific sub-groups of young adults at risk of psychological distress.

O'Connor et al. (2012) utilised a pattern/person-centred approach to test the relationship between positive development and psychopathology to identify sub-groups of young adults at risk of poor psychological coping (Schulenberg et al., 2004). 1158 young adults (647 – female) from a community cohort of infants were followed up at age 19 – 20 years. Positive development in the life course was based on self reports in social competence, life satisfaction, trust, tolerance and civic engagement (Smart & Sanson, 2003; Stone & Hughes 2002). Psychopathology was rated as internalising (depression, anxiety and stress) (Depression Anxiety Scale (DASS; Lovibond & Lovibond, 1995) or externalising (anti-social behaviour and misuse of alcohol and drugs)( Elliott and Ageton (1980). In addition, the authors used socioeconomic status, adolescent assessments of emotional regulation, peer and parent relationships and community orientation to assess whether these antecedents had an impact on outcomes.

O'Connor et al. (2012) were able to develop a taxonomy of six different sub-groups of young people based on their results: 1) thriving (high positive development and low

psychopathology), 2) well adjusted (average levels of positive development and psychopathology), 3) idling (average psychopathology and low positive development), 4) internalising (high levels of internalising and low life satisfaction), 5) moderate externalising (moderately high levels of psychopathology and low positive development), and 6) severe externalising (high levels of externalising behaviour and low positive development).

Antecedents that had a significant relationship with thriving or well adjusted outcomes were high socioeconomic status, better self control and greater community connectedness. Females were significantly better represented in the thriving and well adjusted groups and males were more likely to be in the moderate and severe externalising groups.

O'Connor and colleagues' findings demonstrated that positive development and psychopathology are not part of a continuum (Keyes, 2007); that while an inverse relationship was demonstrated of higher positive development/lower psychopathology and higher psychopathology/lower positive development, the idling group had average psychopathology but low levels of positive development. The implications for Counselling Psychology practice are that individual differences in psychological wellbeing in young adults should be identified and better emotional regulation (Shonkoff & Phillips, 2000) and multiple social networks may be factors in thriving.

While this long term study benefits from having a large community sample and a longitudinal design, the attrition of participants with low socioeconomic status under-represents this group. The poor internal consistency of some of the self report measures linking emotional regulation and community involvement to healthy psychological functioning may also undermine the findings.

However, Tuulio-Henriksson, Poikolainen, Aalto-Setälä, and Lonnqvist (2000) did not find evidence that recent life events in emerging adulthood were associated with immature defense styles and hence psychological problems. Rather, Tuulio-Henriksson et al. (2000) argue that historical factors and primitive coping styles may offer a better explanation in psychological distress in young adults. Tuulio-Henriksson et al. (2000) point out that immature defences tend to resolve in the normal developmental process in the transition to adulthood and deterioration of immature defences is associated with poor psychological coping (Tuulio-Henriksson, Poikolainen, Aalto-Setälä, & Lonnqvist, 1997).

In this study, 636 high school students (females – 408) were followed from 1991 at 15 – 19 years old to 5 years later at 20 – 24 years old. A revised version of the Defense Style questionnaire (DSQ) (Andrews, Pollock, & Stewart, 1989) measured three defense styles: 1) mature (humour, sublimation, suppression, and anticipation), 2) neurotic (idealization,

reaction formation and undoing) and, 3) immature (acting out, denial, devaluation, displacement, dissociation, isolation, passive-aggression, projection and rationalisation). Life events were assessed using an adapted age appropriate version of the Life Events Checklist (Johnson & McCutcheon, 1980).

Changes in defense style over the period 1991 – 1995 were calculated by the difference between the DSQ follow up score and the initial DSQ score (Rosner, 1997), identifying 25% of participants as having an increased immature defense style and at risk of psychological problems (Tuulio-Henriksson et al., 1997). The only recent event significantly related to an increase in immature defense style was the death or illness of a close family member for females. The authors concluded that recent life events in the transition to adulthood were not associated with immature defense style but potentially associated with chronic, traumatic or childhood events (Romans, Martin, Morris, & Herbison, 1999; Rutter & Sandberg, 1992) though, by their own admission, the authors did not investigate these issues.

While the original sample of Tuulio-Henriksson et al. (2000) reflected a cross section of schools in terms of socioeconomic status and educational attainment, the sample was top heavy in the higher socioeconomic classes and imbalanced towards females restricting generalizability.

While O'Connor et al. (2012) identified factors that may make a difference in the psychological coping of young people in the transition to adulthood and Tuulio-Henriksson et al. (2000) suggest that immature defense styles are implicated in poor psychological coping in young adults, Riggs and Han (2009) investigated the association of recent stressful life events with attachment patterns and anxiety and depression in young adults.

A sample of 317 (66% female) college students with a mean age of 21.01 years of age completed six questionnaires on adult attachment style (Ainsworth, 1991; Carlson & Sroufe 1995), self-esteem, traumatic life event exposure, irrational beliefs, anxiety and depression from which a multi-factorial structural model was developed (Byrne, 1994). The Traumatic Life Events Questionnaire (TLEQ; Kubany et al., 2000) was modified to reflect the DSM-IV-TR (APA, 2000) criteria for Post Traumatic Stress Disorder (PTSD).

Riggs and Han's (2004) final optimal model (MacCallum, Wegener, Uchino, & Fabrigar, 1993) demonstrated the following relationships: 1) a direct relationship between recent traumatic experiences and depression, 2) a direct relationship between attachment avoidance and depression, 3) a direct relationship between attachment anxiety and chronic anxiety, 4) an indirect relationship of attachment anxiety mediated by low self-esteem and irrational beliefs

with chronic anxiety and depression, 5) an indirect relationship of attachment avoidance mediated by low self-esteem with chronic anxiety and depression, and 6) trauma and attachment style were not found not to be related.

While Riggs and Han (2009) highlighted that young adults may be susceptible to the typical challenges of the transition to adulthood period (Schulenberg et al., 2004), they also identify key issues for Counselling Psychology in replicating findings on the role of chronic anxiety as a pre-cursor to depression (Dozois & Westra, 2004) and the mediating role of irrational beliefs (Williams & Riskind, 2004) and self-esteem (Roberts, Gotlib, & Kassel, 1996) in anxiety and depression. Some caution should be exercised in generalizing the findings as the sample was biased towards females and was predominantly white. The authors advocate Cognitive Behaviour Therapy (CBT) for PTSD (APA, 2000) (Rothbaum & Foa, 1996), but it should be noted that some individuals do not respond as expected to CBT for PTSD (Smucker, Grunert, & Weis, 2003).

In summary, Counselling Psychologists should therefore be aware that the transition to young adulthood is potentially a time when the events of transition may challenge the coping capacity of some young people though childhood factors including attachment patterns may also play a role.

## IDENTITY

### **Theoretical Background**

While Erikson (1950; 1968) and Arnett (2000) emphasise identity exploration in adolescent to adult transition, identity theorists outline the processes in identity formation that may impact the young adult's developing identity.

The symbolic interactionist approach to identity is based on self, language and interaction with the self developed through social interaction and the ability of an individual to be reflexive (Cooley, 1902; Hegel, 1807; Mead, 1934). Mind, according to Mead (1934), is developed when meaning between oneself and others occurs through the use of the symbolic representation of language. Blumer (1969), building on Mead's (1934) concepts, in developing traditional 'symbolic interactionism', focused on the meaning of actions with the individual open to interpret a given situation without recourse to social order.

However, Identity Theory, based on structural symbolic interaction (Burke & Stets, 2009), does take account of the social structures within which one can occupy different selves, e.g., the

groups, associations and institutions in which individuals live out social roles. However, structural symbolic interaction theorists differ on the level of impact of structural influence on identity. Stryker (1980) places most emphasis on societal or conventional roles and proposes individuals share the same expectations based on the societal structuring of named roles, e.g., husband/wife, and they organise these multiple identities in a hierarchy as part of the self. In Stryker's model (1980), enduring roles activated across a range of situations are usually at the top of a 'salience hierarchy'.

McCall and Simmons (1978) take into consideration, like Stryker (1980), the social expectations in role identity but prefer to highlight the idiosyncratic aspect of identity or distinctive meaning at the interpersonal level. McCall and Simmons (1978) suggest a 'prominence' hierarchy of identity of the 'ideal self', where the position of a role in the hierarchy is a function of the support one gains for the role either from oneself or others, the level of commitment to the role and the intrinsic or extrinsic rewards of the role. However, McCall and Simmons (1978) also suggest a 'salience' hierarchy of the 'situational' self which is transient and activated by the expectations of the social situation.

Burke (1980), also from the structural symbolic interactionist approach, focuses on the intrapsychic meaning of identity and argues that each identity has its own set of attributes which develop in interaction with other individuals to produce self and shared meanings. Individuals seek to verify an internal standard of identity with identity in a given situation with distress occurring when the social role fails to match the internal ideal role.

In contrast to the symbolic interactionist perspective, Social Identity Theory (SIT) (Tajfel & Turner, 1979) emphasises social identity or self-concept through being a member of a social category or group. In the group context, individuals compare and evaluate their own group (in-group) in comparison with other groups (out-group) (Festinger, 1954). According to SIT (Tajfel & Turner, 1979) the self concept operates on a continuum from emphasising individual distinctiveness to one in which social identity is salient (Hornsey, 2008). An individual's self esteem is boosted by the reflected positive value of the in-group compared to out-groups (Brown, 1996).

Turner, Hogg, Oakes, Reicher, and Wetherell (1987), building on SIT and taking account of inter-group and intra-group processes developed Self Categorization Theory (SCT), in which, a 'preference' hierarchy based on three levels of influence impact identity: top comes 'human identity', next comes 'social identity' based on group membership, and bottom comes 'personal identity' based on comparison with other individuals. This hierarchy is in

direct contrast to Burke's (2004a) hierarchical ranking of person, role and social identity in which person identity is above role or social identity as the controlling or 'master' identity.

By their own admission Burke and Stets (2009) acknowledge that Identity Theory has focused on interpersonal or role identities to the neglect of social or person identities and accept that their theory would be enhanced by a more integrative model. Breakwell (1986), however, provides an integrated model of identity which incorporates both personal and social aspects of identity. Breakwell (1986) makes the distinction that personal identity includes values, attitudes and cognitive style while social identity reflects both group social categories and interpersonal and social roles. However, Breakwell (1986) questions whether the boundary between personal and social identity is well defined and suggests that individuals only notice the distinction when there is conflict between the public and the private self.

Breakwell (1986) also suggests that personal identity progressively incorporates social identity through the dynamic process of assimilation (incorporating new aspects of identity) and accommodation (re-arranging the current structure to make room for new aspects of identity) and that the development of identity is a function of life experience rather than maturation. The individual, according to Breakwell (1986), ascribes meaning to the content of identity through positive or negative evaluation, which, in interaction with the principles of continuity, distinctiveness and self esteem (Gordon & Gergen, 1968) underpins the construction of identity: continuity meaning maintaining identity temporally and situationally, distinctiveness being similar to McCall and Simmon's (1978) idiosyncratic personal identity, while self esteem evokes high personal or social regard. In determining which of these three principles take precedence when incompatible, Breakwell (1986) refers to SIT principles or 'in-group' pressures as being more influential (Turner & Tajfel, 1979) while acknowledging that self reflection (Cooley, 1902; Hegel, 1807; Mead, 1934) and practical learning (Markova, 1984) contribute to resolving identity dilemmas. However, Breakwell (1986) adds another level of social influence to identity based on Leonard's (1984) materialist principles of class, gender and ethnicity, which in turn, are governed by economic, familial and state structures. Within these potentially oppressive mechanisms, identity is formed through 'contradiction' or exerting freedom of choice (Hegel 1807; Leonard, 1984).

### **Student Identity**

Change in the social context may produce a threat to identity and evoke negative or adaptive coping strategies as individuals assimilate and accommodate new material, and try to achieve continuity, distinctiveness and self esteem (Breakwell, 1986).

Mann (2001) discusses the specific social structural factors which may create an experience of alienation with consequences for a student's identity from a range of theoretical perspectives. From the postmodern perspective, Mann (2001) argues that alienation is inevitable as Higher Education institutionalises a student leaving little room to meaningfully explore identity. From the perspective of discursive practice (Foucault, 1972; Lacan, 1977a) the student is positioned in specific ways by 'gender, race, class, ethnicity, and other marks of difference' (Usher, 1998) by those in powerful positions which potentially bewilders and suppresses the student. Landing as an 'outsider' in Higher Education (Lynch & O'Riordan, 1998; Wilson, 1963) alienation may also occur because the student's perspective of reality is inhibited by the predominant culture. From a Marxist perspective, Mann (2001) suggests alienation occurs as the student has to produce work in relationships where power is unequally distributed, restricting personal individuality (Lukes, 1967). Finally, the student, in trying to survive constructs a false self (Lacan, 1977a) from which alienation is to be expected as it is only a mirage.

Given the potential structural pressures on students (Mann, 2001) and reports that students feel lonely (Cutrona, 1982), depressed (Furr, Westfield, McConnell, & Jenkins, 2001), homesick (Fisher & Hood, 1987) and experience academic problems (Levitz & Noel, 1989), Ribeiro, Feixas, Maia, Senra, and Dada (2012) reviewed the development of identity in college freshmen. Taking a constructivist approach, Ribeiro et al. (2012) suggest that the transition to university facilitates the students' construction of themselves in new and meaningful ways, which may challenge their existing core personal identity with the potential for emotional distress (Gardener, Mancini, & Semerari, 1988). The student experiences an 'implicative dilemma' (ID) (Feixas, Saul, & Avila-Espada, 2009) or tries to maintain their identity in the face of challenges to their personal construct (Kelly, 1955) and the greater the number of IDs, the higher the incidence of psychological distress (Feixas et al., 2009; Fernandes 2007).

Ribeiro et al. (2012) assessed 28 first year undergraduates (females – 24) with a mean age 19.18 years of age for psychological symptoms (Global Severity Index (GSI); Derogatis, 1977), problem solving ability (Problem-Solving Inventory (PSI); Vaz-Serra, 1989) and personal construct system (repertory grid technique (RGT); Fransella, Bell, & Banister, 2004; Kelly, 1955) at the beginning and end of first year at university. Fifteen personal constructs were developed of self before entering university, ideal self and self now. The authors measured Self-Ideal discrepancy (SID), which reflected congruence between actual and ideal self as an indicator of self esteem and the number of IDs.

Over half the students (Ribeiro et al., 2012) had more than one ID at the beginning of the first year which had reduced to a third of students by the end of the first year. Along with the decreasing number of IDs, self esteem (SID) and problem solving (PSI) had significantly increased by the end of the first year while psychological symptoms (GSI) had significantly decreased. The authors suggest that a natural resolution of identity dilemmas occurs in first year at university. Of those who resolved IDs, problem solving ability and a congruent sense of self are suggested by the authors as supportive of healthy psychological functioning. However, the study has some drawbacks as the sample is predominantly female limiting generalization and, as acknowledged by the authors, the GSI was too broad a measure of distress.

In using a quantitative approach, Ribeiro et al. (2012) identify relationships between pre-determined criteria in identity dilemmas in students, while Bufton (2003) taking a phenomenological approach inspired by Merleau-Ponty (2002) and Casey (1998) to understand the life-world of students illustrated the complexity and meaning of threats to identity. Acknowledging the sense of alienation that Mann (2001) argues may be experienced in the context of an academic setting, particularly the feeling of being an 'outsider' (Lynch & O'Riordan, 1998), Bufton (2003) suggested that the experience of Higher Education may induce a rupture in personal or social identity or 'disjunction' as key aspects of the self are threatened (Breakwell, 1986). Selfhood was viewed by Bufton as being meaningfully constructed by the individual where personal and social history 'collides' with societal structures and incorporates the concept that the body, in 'bodily hexis' (Bordieu, 1977) or 'habit-body' (Merleau-Ponty, 2002), possesses social meaning in posture, voice, expression and gesture. Bufton conducted semi-structured interviews with 27 mature adult students (19 females) aged 34 – 44 years old and transcriptions were analysed thematically (Ashworth, 1987; Miles & Huberman, 1994).

Bufton illuminates clashes in identity for the 'working class' mature students as they encounter the new university environment and found they did not 'fit' and felt imposters in their new academic role. Threatened by the change in their social context the students were ambivalent about assimilating new aspects of their identity and were embarrassed by their embodied working class speech (Bordieu, 1977; Merleau-Ponty, 2002). The rupture in the continuity of their identity seemed to create role conflict between home and university (Breakwell, 1986; McCall & Simmons, 1978) producing a split in identity, variously experienced as 'Jekyll and Hyde' or 'a different person'. Fearing loss and estrangement in close relationships the students worried that they could maintain their new academic identity (McCall and Simmons, 1978).

While Buffon (2001) creates detailed and meaningful insight into the felt sense, cognitions, emotions and behaviour of the mature students, she does not, as one might expect in a qualitative study (Finlay, 2003), provide any reflexive material from which her personal position could be assessed in relation to the data.

Harrist (2006), like Buffon, comments on ambivalence in students' identity and psychological and social development. Needham (1968) argues that being unable to resolve ambivalent experiences can indicate psychological difficulties and immaturity in making adult choices while, those who think in black and white terms as in 'splitting' or avoid the experience of ambivalence, may be more psychologically vulnerable (Akhtar & Byrne, 1983; Braverman, 1987). Harrist (2006) also chose a qualitative phenomenological approach and interviewed eight under-graduate students to capture the students' emotional experience of ambivalence (Kvale, 1996). Transcripts were analysed using a hermeneutic process of interpretation (Gadamer, 1989) to produce a thematic structure.

Ambivalence was experienced by the students when normal daily life was disrupted producing disorientation, exploration and resolution (Harrist, 2006). Disorientation encompassed feeling lost, confused, disconcerted and even 'crazy'. Exploration included finding ways to make decisions and judgements while resolution produced relief and a sense of freedom and power when decisions were made.

Harrist's (2006) findings may be relevant to Counselling Psychology in tentatively shedding light on the development of therapy for students (Smith, Flowers, & Larkin, 2009). On the one hand Harrist (2006) suggests that ambivalence experienced through the dialectical process of therapy, though potentially uncomfortable, is a healthy process for some students and should not be hurried, which may dovetail with the acceptance in the therapeutic relationship and a person-centred approach (Rogers, 1957, 1967). On the other hand, those who may be stuck in repetitive exploration or 'moratorium' (Erikson, 1950, 1968) or rumination (Morrison & O'Connor, 2005) may benefit from a more active directive therapy such as Rational-Emotive Behaviour Therapy (Dryden & Neenan, 2003).

### **Student Identity and Disability**

For people with disabilities, having one's identity culturally positioned may result in efforts to 'pass' as non-disabled to avoid shame and stigma (Goffman, 1963). However, Olney and Brockelman (2003) suggest that people with disabilities are not always ashamed and have both positive and negative perceptions of themselves which they actively manage in disclosing their impairment. In a study utilising personal interview and focus groups, Olney

and Brockelman (2003) discussed the personal meaning and social perception of disability with 25 students (15 – female) with a median age of 25 years who had a range of visible and invisible impairments. The students' self-perceptions involved a careful balance between valuing their capabilities while acknowledging their need for support in which ranking disability played a part. Students ranked physical disability as the most 'acceptable' warranting most support, while developmental and psychological disability ranked lowest leading to student concerns about needing support.

While Olney and Brockelman (2003) suggest that the students strategically disclosed their impairments to others, they also acknowledge that social stereotyping constrained the students' sense of themselves, e.g., as 'liars', 'malingerers', 'cowards', and 'complainers'. This study illuminated the complexity of self-perception of disability in students, but it perhaps under-estimated the impact of social evaluation on identity formation.

Baines (2012), in a similar vein to Olney and Brockelman (2003), set out to find out the individual, institutional and social narratives impacting on students' identity and how students positioned themselves in relation to the 'autistic' label. Taking a stance that 'autism' is socially constructed, Baines (2012) used an ethnographic methodology and positioning theory (Harre, 2003) to contextualize the experiences of two adolescent males with high functioning autism.

Harre and Moghaddam (2003) contend that a dynamic triangulation of 'position', 'performances' and 'storyline' by others or by oneself, regulates ones position in social contexts. Position is seen a function of 'rights and duties' which can enable or be a barrier to fully taking part in significant and meaningful local acts. Performances are speech and other acts that underpin a position, while 'storyline' is the context, history and developmental pattern in which events are played out. For the two students in Baines' (2012) study, being able to make the most of high school was a dynamic mixture of how they were positioned in terms of being 'smart' or 'successful', and how they enacted storylines about their future.

Baines (2012) observed two male students from a Californian High School in a case study approach over two years, to find out how the students' social relationships influenced how they saw themselves. A range of video, interview and observational data was collected about Anthony<sup>5</sup>, an 11<sup>th</sup> grader<sup>6</sup> and Mark<sup>7</sup>, a 12<sup>th</sup> grader<sup>8</sup>, across home and school contexts. The data was analyzed using a positioning triangle (Harre & Moghaddam, 2003).

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<sup>5</sup> pseudonym

<sup>6</sup> Approximately 17 years old

<sup>7</sup> pseudonym

Baines (2012) found that both students made considerable efforts to 'pass' as 'normal' and distance themselves from the 'autism' label. Mark's storyline was that of a 'recovering autistic' in which his ambivalence about being autistic was apparent from his rejection of special education classes and positioning himself as a 'leader' in debating club. Anthony's storyline was that there was 'something wrong with him', and while he experienced himself as intelligent in debating club, he sometimes positioned himself as 'entertainer' to control how others laughed at him. Both Anthony and Mark were aware of their motivation in controlling others' perceptions or as Mark described it, 'strategizing' in a bid to 'fit in or else'.

Both Mark and Anthony had future ambitions in which the identities they were creating had considerable value and in which 'autism' did not feature, e.g., Anthony wanted to be a Marine but concealed his autism from the recruiters. Both students' storylines and acts, as Harre (2003) might argue, reflected how the students actively positioned themselves personally and interpersonally to fit in with or reject prevailing cultural storylines about being 'smart', 'autistic', or 'normal'.

Drawing on a variety of sources as Taylor (1994) suggests in ethnographic work, Baines (2012) portrays Mark and Anthony evocatively, but she fails to address her own role and subjective stance (Gold, 1988) in relation to how involved she was in the young students' lives.

## COUNSELLING PSYCHOLOGY AND DISABILITY

Issues relevant to Counselling Psychology have been highlighted including the philosophy of Counselling Psychology and awareness of the context in which Counselling Psychologists work. Kanellakis (2010) adds that as Counselling Psychologists our awareness should also include our legal obligations under the Disability Discrimination Act (Department of Work and Pensions (DWP), 1995) including the Special Educational Needs and Disability Act (SENDA) (Department of Employment and Education (DfEE), 2001) and personal and family disability. In this way, Kanellakis argues, we can be influential at the organizational level by promoting inclusion and respect while, in the therapeutic encounter, we can bring the use of self as a resource.

In relation to specific learning difficulties, Stamp and Loewenthal (2008) suggest that our helpfulness as Counselling Psychologists is based on a safe and trusting relationship that opens up the 'closed-ness' that individuals with specific learning difficulties have developed

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<sup>8</sup> Approximately 18 years old

to cope in their daily life. These authors suggest that a therapeutic relationship that offers a containing structure and therapist engagement and acceptance offers a new experience as clients with specific learning difficulties have often struggled with expressing themselves and being heard. Stamp and Lowenthal (2008) argue that the learning that takes place in this reparative relationship is replicated in academic learning and extends beyond the duration of therapy.

## TRANSITION TO YOUNG ADULTHOOD AS A STUDENT WITH DCD - POSITIONING THE CURRENT STUDY

A small but developing area of research on DCD in emerging adulthood considers the functional and psychological wellbeing of young adults with DCD.

Kirby, Edwards, and Sugden (2011) reviewed the functional and daily living aspects of DCD in a group of emerging adults. Kirby et al. (2011) incorporated the opinions of both young people and their parents in their study to obtain a deeper understanding of the daily life of young adults with DCD (Denzin, 1988). 19 (7 female) young adults aged between 17 and 25 years of age (average age 20.5) completed the Adult DCD/Dyspraxia checklist which has good reliability and validity (ADC) (Kirby, Edwards, Sugden, & Rosenblum, 2010). The ADC covers: 1) frequency of difficulties, 2) motor/independent living skills (ISL), 3) executive functioning and, 4) social and communication pursuits. Parents (16 female; 3 joint male and female) completed a semi-structured questionnaire to provide qualitative data about the young adult which was analysed using interpretative thematic qualitative analysis (Boyzatis, 1998; Flick, 2006).

Of the young adults surveyed, Kirby and colleagues (2011) found that they all reported persistent motor skill difficulties in adulthood while new problems that had arisen in adulthood were driving and managing money. Over half the young adults reported attention problems, while socially, they avoided team games preferring to spend free time alone.

Parents' responses produced emergent themes covering: 1) functioning at home, school, work and college, 2) remaining co-ordination and independent living skills including motor/IDL, executive functioning skills, social skills, and emotional and psychological state, 3) general concerns in education and work, and 4) positive and negative changes. Over two thirds of parents were concerned with motor/IDL and executive functioning problems, 40% mentioned social /communication issues and one third raised emotional and psychological issues. Over 80% of parents mentioned support was provided to their children, e.g., tutors.

While over half of the parents noted negative changes, e.g., 'gets sacked', over two thirds of parents mentioned positive developments for their child, e.g., 'he has grown hugely in confidence and self belief'.

Kirby and colleagues (2011) illustrated that the difficulties experienced by young adults with DCD are not limited to motor difficulties and, that for some, positive developments in daily life are possible but for others difficulties continue or new ones emerge. The findings on EF are of note for Counselling Psychology as Knouse, Barkley, and Murphy (2012) have demonstrated the relationship between EF problems in ADHD with current and lifetime depression, though others query this link (Larochette, Harrison, Rosenblum, & Bowie, 2011).

Kirby et al. (2011) attempted to supplement the self-perception bias of the self report measure with parental observation data (Meltzoff, 1998), however, the meaningful descriptions were the parents' perspectives. The current research project aims to complement the work of Kirby et al. (2011) by enabling the young adults themselves to be heard (Irwin, 2001; Larkin, Watts, & Clifton, 2011).

In also attempting to highlight daily living issues in young adults with DCD, Hill, Brown, and Sorgardt (2011) comment on the lack of research on quality of life in this area. Using the Quality of Life Satisfaction Questionnaire (Q-LES-Q; Endicott, Nee, Harrison, & Blumenthal, 1993), Hill and colleagues (2011) assessed the responses of 51 young adults in the age range 18 – 27 years old. Of these participants 20 were young adults with DCD (9 female) and 31 were control participants (20 female). The Q-LES-Q (Endicott et al., 1993) surveys the pleasure experienced in a range of daily living activities including physical health, subjective feelings, leisure, social interactions, work, household, education and in general over the preceding week. Hill et al. (2011) found that overall, and on every measure in the survey, the group of young adults with DCD were significantly less satisfied with life than those without DCD, though some individuals with DCD were not. Hill and colleagues (2011) concluded that further research should consider issues of risk and resilience as young adults with DCD encounter challenging new situations.

Though Hill and colleagues (2008) provided a clear finding using a reliable and valid questionnaire, the sample size is small limiting generalizability (Meltzoff, 1998). The current research study aims to deepen the work of Hill and colleagues by investigating the lived experience of young adults with DCD in the specific context of college or university.

Missiuna, Moll, King, Stewart, and Macdonald (2011) utilised a phenomenological approach in this preliminary study of the lived experience of adolescence in young people with DCD.

Nine college and university students were recruited between the age of 19 and 26 years of age who self reported coordination problems and who completed a screening process using an adapted form of the DCD-Q parent questionnaire (Wilson, Kaplan, Crawford, Campbell, & Dewey, 2000). Each student took part in two in depth interviews about their recollections of adolescence which were transcribed verbatim. Though it appears that a systematic process of analysis was carried out, Missiuna et al. (2011) do not provide an epistemological stance in relation to their approach.

Analysis produced a thematic structure of: 1) understanding context-specific differences in performance, 2) strategies to manage difference, and 3) how differences evolved over time. Contexts in which DCD became apparent related to sports, new situations particularly driving and the workplace. These experiences were often described with self judgmental language by the young person, e.g., 'just kind of stupid clumsiness', with implications for the students' self concept. Strategies adopted by the students to manage their differences included avoiding activities where their difficulties would be noticed or taking up activities where they could demonstrate efficacy. Additionally the young people used self-deprecating humour, e.g., 'if you laugh at yourself then other people will laugh with you', and they took on adapted roles in contexts that they would normally avoid, e.g., score keeper in gym. The students also reported persistence in trying to achieve outcomes and as adolescence progressed, they reported positive changes as choice opened up, e.g., subject studied, and noticed that as their peers matured they were taunted less, e.g., 'when you get older people learn to keep things to themselves'.

Missiuna et al. (2008) bring to life issues that impacted upon the adolescence of students with DCD. Some of the young people felt their difficulties clearly distinguished them from their peers but others minimised any difference to maintain their self-esteem and self-concept (Crocker & Major, 1989) and adopted a range of resilient coping strategies, e.g., humour (Luthar, 2006) and endurance (King, Cathers, Brown, & Mackinnon, 2003). While the authors accept that a small situated sample cannot be used to generalize their findings, they suggest that cautious comparison may be made to similar contexts (Smith et al., 2009). Perhaps the main drawback to their study is that they relied on the students' salient memories which potentially missed the impact of less obvious but instrumental repeated events on the students' development (Willig, 2008). This research project aims to build on Missiuna and colleagues' (2008) study by investigating the current life experiences of students with DCD.

## **METHODOLOGY**

### **Research Aims**

This research investigates the lived experience of young adults who self report DCD in the specific context of life as a student. A qualitative methodology, which is novel in investigating this topic, has been used to engage with the complexity of human experience with the aim that it will be useful to young adults with DCD and to Counselling Psychology by contextualising the young adult's experience of DCD.

### **Research Topic and Question**

This research topic addresses what it is like to have DCD as a young adult. The specific research question is:

"How do young adults experience Developmental Coordination Disorder in their daily lives as a student?"

### **Rationale for adopting a Qualitative Approach**

This research project aims to explore the relatively uncharted territory of the lived experience of DCD from the individual perspective of a young adult. The quantitative paradigm is viewed as problematic because, as Willig (2008) explains, this perspective accepts the positivist principle of the correspondence theory of truth, a truth that can be objectively measured and tested through the hypothetico-deductive model against a priori theories to produce generalizable laws. Much of the existing knowledge in DCD is produced from the quantitative domain of human movement science (Geuze et al., 2001; Wilson, 2005) but this perspective neglects the context and complexity of the meaning of DCD to the individual.

This research project therefore rejects the logical positivist notion that there is one truth about DCD and takes a pragmatic approach which Cornish and Gillespie (2009) note does not privilege one reality over another and accepts a contextualised personal reality. In this way rather than a nomothetic outcome which values generalization, an idiographic approach can be taken which allows the voice of the individual to be expressed. Willig (2008) comments that the Quantitative paradigm can perpetuate a narrow perspective, while Kuhn (1962) points out that the Qualitative paradigm provides an alternative research community from which to create new knowledge. In a small way, this research project aims to transform our knowledge of DCD from an individual psychological perspective.

Additionally, the quantitative paradigm provides an objective role for the researcher which does not address the influence of the researcher (Langridge & Hagger-Johnson, 2009) whereas the qualitative approach makes the researcher's role accountable through the process of reflexivity (Griffin, 1995), essential in this project given this researcher's personal relationship to DCD (Lincoln & Guba, 1985).

### **Rationale for Interpretative Phenomenological Analysis (IPA)**

IPA is the choice of research methodology from the qualitative paradigm because it meets the aims of the research question in this project. As Smith (2011) outlines, IPA is a phenomenological approach which offers a way to develop a rich description that brings to life a subtle, textured representation of 'being in the world'. IPA is idiographic being based on the individual voice which allows the researcher to engage with personal testimonies through the hermeneutic process of interpretation to capture and make sense of experience. Other approaches from the qualitative paradigm were considered but did not meet the needs of contextualising individual embodied 'reality' with the social and cultural issues embedded in the experience of DCD to helpfully develop knowledge in DCD.

A critical social constructionist perspective would have lent itself to a political debate about the social discourse and power relations around DCD, and while relevant, it is not considered appropriate to the pragmatist approach of the research to foreground these issues at this exploratory stage of this research. Taking an overtly political emancipatory stance, such as feminist standpoint research would advocate (Griffin, 1995), may also be more of a reflection of the researcher's bias (please see Reflexivity section).

Grounded Theory and Phenomenological Methods, as Willig (2008) suggests, are the main contenders in meaning based qualitative methods. However, IPA, as an interpretative phenomenological method, is deemed more suitable to begin to engage with the depth and complexity of living with DCD. Both Grounded Theory and IPA offer options in realist ontology but the realist version of Grounded Theory, as Charmaz (2008) acknowledges, is influenced by positivism and is not compatible with the subjective 'reality' which is the IPA perspective. Grounded Theory has also been described as explaining social processes (Willig, 2008) whereas IPA is interested in producing individual meaning and psychological insight. This research project is interested in how a young adult with DCD feels, thinks and interacts and while theory about engagement with social processes may emerge (Charmaz, 2008) it is not given the prominence it would be in a Grounded Theory approach. Grounded Theory is therefore more likely to ask how you 'do' something, whereas IPA is more likely to ask how it is to 'be' and engage with the internal psychological experience and meaning of

DCD for the individual. IPA also has an integrated reflexive role for the researcher whereas the naive realist version of Grounded Theory may view the researcher as a witness only which seems incompatible with this researcher's role in this research (please see Personal and Epistemological Reflexivity).

### **IPA Overview and Philosophy**

William James (1907) and John Dewey (1951) argued that we are 'social and historical beings'. As Kloppenborg (1996) points out, James and Dewey were 'old' pragmatists who valued experience as the intersection of the conscious self and the world in which we are embedded and which we relate to in a meaningful way. Ashworth adds (2008) that Husserl in developing Phenomenology echoed James's notion of 'fringe' by developing his concept of 'horizon'; that our awareness of something is imbued with meaning. More recently Smith et al. (2009), in developing IPA, hark back to James by calling for the experiential approach alongside the experimental one in Psychology. IPA as an interpretative phenomenological approach therefore seems compatible with a pragmatist stance.

A brief review of the philosophical background of Phenomenology is needed because although Langridge (2007) contends there are 'no hard and fast' boundaries in phenomenological research, fundamental concepts are debated. Langridge (2007) comments that all of phenomenology is concerned with human experience underpinned by Husserl's concept of 'intentionality', that we are always 'conscious of something' in the relationship between what is experienced (Noema) and how it is experienced (Noesis). How we access experience of 'the thing itself' is contested and Giorgi (1997), influenced by Husserl (1931), favours a transcendental reduction in which self conscious reflection of the essential qualities of 'the thing itself' or 'epoche' can be elucidated by 'bracketing' off other influences.

Smith et al. (2009), in IPA, influenced by Heidegger and Gadamer, take the hermeneutic view in that 'being-in –the –world' we are embedded in a cultural, social and historical context which we interpret through language. IPA (Eatough & Smith, 2006; Smith & Osborn 2003) favours an idiographic analysis which accesses the essence of experience through the individual story and how to make sense of it or 'convergence and divergence'. This research project favours the IPA approach because each individual's experience is at the heart of the project.

Evocative description of first person accounts of lived experience in everyday language underpin all phenomenological approaches but the extent to which the researcher goes

beyond description and surfaces what Braun & Clarke (2006) refer to as 'latent meaning' varies. Giorgi (1992) would advocate not going beyond the data and focusing on pure description, whereas Smith et al. (2009) suggest that IPA provides the scope to examine individual description in the context of the participant's own and broader social and cultural meanings reflecting Heidegger's 'person-in-context' or Dasein in our relatedness to the world of objects, language, culture, time and space.

Kloppenbergh (1996) notes that while James (1907) and Dewey (1951) accept that language cannot always convey meaning aesthetically or spiritually, Dewey particularly recognised the 'direct give and take' in dialogue in developing shared meaning which does not 'emerge all at once or completely'. Neo-pragmatists such as Bernstein (1983) see hermeneutics and phenomenology as a way create a 'conversation' and a process of reflection critical in transforming experience. Smith (2007) incorporates many of these ideas in IPA by recalling the hermeneutics of Schleiermacher (1998) and using the grammatical text and the individual voice of the speaker to 'understand the utterer better than he understands himself', formed by the writer 'holistically' taking account of social discourse and individual meaning as they develop their analysis. The researcher as Smith (2007) argues is trying to understand 'the words and the speaker of the words' through 'the hermeneutic circle'; an iterative process in which the phenomenon is examined in detail and depth through the researcher's dialogue and relationship with the text on a number of levels between part and whole.

The researcher, in this hermeneutic process, takes a 'phenomenological psychological attitude' (Finlay, 2009) and rather than bracketing their pre-understandings, debates back and forth in 'critical self awareness' (Halling, Leifer, & Rowe, 2006) in a process of reflexivity. Shaw (2010) comments, that the process of reflexivity accepts an interpretist or contextualist ontology in which, as individuals in relationship, we co-construct multiple versions of reality and meaning. Shaw encourages us as reflexive researchers to be aware of our own context and the context of the research highlighting Gadamer's (1989) notion of subjectivity, that we cannot escape our own 'horizons', and should investigate our own beliefs and stereotypes. In the dialectical process in IPA, Shaw suggests we make our 'fore-understanding' transparent to avoid 'fusion' (Finlay, 2003) with our preconceptions to develop new understanding, while Smith (2007) reminds us that our pre-suppositions are not always apparent and may be challenged and changed at once as we encounter the text. Shaw also cautions that as an IPA researcher, though trying to gain an insider perspective (Conrad, 1988), we cannot achieve this but should pay attention when our own history and narrative break down (Shaw, 2010). However, Gough (2003) reminds researchers that our work is

about the participants, lest we become too focused on ourselves or, as Giorgi and Giorgi (2003) warn, that we change the initial experience out of all recognition.

### **IPA and Counselling Psychology**

Counselling Psychology is influenced by a phenomenological ethos and humanistic values in which there is acceptance of diversity (Wolfe, Dryden, & Strawbridge, 2004). While van Deurzen (2006) has argued since the inception of Counselling Psychology for qualitative research methods that explore human meaning, Strawbridge (2006) reminds us 'it is vital to remember that the best science depends on the careful framing of questions that it is important to answer ..... and to devise methods adequate to research these questions'. Kasket (2011) argues that as Counselling Psychologists we should adopt a pluralist attitude to research methodologies as divergent methods have utility.

The choice of IPA as the research methodology matches the values of Counselling Psychology but is also a pragmatic choice in relation its usefulness at this exploratory stage of the research. IPA fits with the values of Counselling Psychology outlined by Cooper (2009) to actively pursue human experience, subjective meaning and appreciation of the individual as unique, while Kasket (2011) suggests we can reflect these values in our research practice through transparency, reflexivity and the value of our research to the participants and the wider community. Kasket (2011) also suggests that as Counselling Psychologists, we should be democratic and empowering with our participants and the test of this is in the processes demonstrated by the researcher's research practice and ethics and the helpfulness of the outcomes of the research to Counselling Psychology practice.

### **Epistemological Position**

My epistemological stance about the kind of knowledge I am trying to create (Willig, 2008) has been influenced by pragmatist and contextualist positions.

Cornish and Gillespie (2009) in their pragmatist approach to the problem of knowledge in health psychology argue that competing knowledge, e.g., biomedical, educational and psychological can clash. There is an often an assumption that researchers have to choose between forms of knowledge, e.g., between the knowledge of the 'realist' in alleviating symptoms or the narrative of the 'social constructionist' in surfacing political debate. The pragmatist position argues that we do not need to choose between realism and relativism (social constructionist) as we can have a pluralist position that is not relativist (Cornish & Gillespie, 2009). Relativism has been criticised as not providing a way to judge knowledge

leading to disintegration and inaction while pragmatism moves beyond the seesaw of realism and relativism to developing and evaluating knowledge on the basis of its usefulness in a particular context for action. This helps the researcher choose the appropriate research methodology by asking of the research, 'what is its purpose in terms of its usefulness'? (Cornish and Gillespie, 2009) and 'will it make a difference to our lives'? (Kloppenber, 1996). Larkin and Griffiths (2004) suggest that a research methodology with an initial experiential focus based in phenomenology fits with pragmatic theory and IPA dovetails with this strategy.

IPA has two aims in its interpretative phenomenological analysis according to Larkin et al. (2006): to 'give voice' to issues relevant to the participant and to 'make sense' of these issues psychologically. These joint phenomenological and interpretative aims mean that as IPA researchers we have to balance 'representation with interpretation and contextualization' (Larkin et al. 2006). These aims are underpinned by an ontological and epistemological position described by Madill, Jordan, and Shirley (2000) as 'contextualism'. Contextualism posits that knowledge is 'local, provisional and dependent on setting' (Jaeger & Rosnow, 1988). In this framework all testimonies are seen as subjective and diversity is valued (Wallat & Piazza, 1988) aiming to produce fresh perspectives through grounding results in participant's descriptions. Of relevance to Counselling Psychology, a contextualist stance facilitates the researcher's personal and cultural history to utilise empathy and humanity as an analytic tool.

Rennie (1999) points out, the contextualist position is based on Heidegger's (1993, 2010) practical realism, in which, the individual is always part of reality where there is no room for the Cartesian divide of subject and object because as a 'person-in context', we are always part of a meaningful world. This position does not deny that real things exist outside of human experience but our encounter with them in context is what determines the nature of 'reality'. From this perspective we can only claim that the knowledge we produce in accounts tells us about a person and their relationship to their current context. However, such an account can also uncover and contribute to the 'reality' of the 'object' we are investigating in its 'appearing'.

Contextualism encompasses a critical realist philosophy (Bhasker, 1997) that objects and structures can exist independent of our knowing of them. These hidden structures influence what is experienced in social, historical and cultural contexts. As Parker (1998) puts it, 'such that discursive accounts are grounded in social practices whose underlying logic and structure can, in principle, be discovered'. Critical realist approaches do not seek to

condense or moderate complexity (Sayer, 2000) and accept the shortcomings of the research process and accounts as not establishing reality.

In 'making sense' of accounts psychologically, Eatough and Smith (2006) agree that individuals do so in the 'very particular context of their unfolding lives' and these authors are concerned that emotional reactions are not restricted to internal cognitive interpretations. Eatough and Smith (2006) argue that 'emotional performances' are dynamically embedded in social and cultural discourses which are enacted and constructed through language in much the same way as Foucauldian Discourse Analysis suggests (Johnson, Burrows, & Williamson, 2004). The difference, as Smith (2011) comments, is that IPA connects embodied experience with conversation to make sense of experience rather than to focus only on conversational features and how an individual constructs accounts of their experience. As Eatough and Smith (2006) argue this 'light' constructionist perspective is only part of the way in which individuals tell their story and they give centre ground to the existential phenomenological 'life-world' of subjective experience.

My epistemological position could be described as a pragmatic contextualist with scaffolding in critical realism and 'light' social constructionism as they are expressed in the lifeworld of the individual to usefully transform our psychological understanding of DCD.

### **Personal Reflexivity**

Given my espoused epistemological position as a pragmatic contextualist, in making the research accountable (Gomm & Davies, 2000) and useful, my personal reflexivity should parallel the 'scaffolding' of my lived experience including embodied functional 'realities', introspective elements, relationships and discourses which impact on the research project. Murphy argues (2002) that 'naval gazing' could suffocate the research but making my influence visible (Henwood, 2008) and showing my fore-understandings provides an active dialogue throughout the research process. I am also asking of myself what I have asked of the research participants; to be vulnerable in the production of the research knowledge and to show how my identity is linked to theirs (Fine, Weiss, Wesen, & Wong, 2000).

I chose DCD as my research topic as an issue in which I hoped I could make a difference based on the experience of DCD in my family. I explain this aspect of my individuality (Shaw, 2010) to reflect on how I construct my identity as I embark on the research which had some initial sway in my consideration of research methodologies in that I was attracted to feminist standpoint research to give voice to an 'invisible' disability and, in contemplating action research, to evoke practical change. My personal agenda for the research was

brought home to me in an IPA research meeting where I noticed my visceral embodied response (Doane, 2003) to creating political change in relation to DCD. I was confronted by my own fore-understanding of a personal agenda which could have been anathema to communicating what the participants had to say. In the end the latter was the value that was most important to me so I chose a phenomenological methodology suited to describing the participants' lived experience.

I need to explain a bit more about my relationship to DCD. I am the mother of a young adult student with DCD. My role as a mother has changed from active participation in my child's life to one where I have stepped back. I became interested in young adults with DCD because there seemed to be a 'cliff edge' at adulthood for young people with DCD as structures of support fell away. This experience reflected my separation anxiety and it took some effort gained through insight in personal therapy to break a cycle of helping out while still being available to support my child. In choosing to research this topic, I also confronted difficult notions that I had contributed to the 'secondary disability' (Sinason, 1992) of my child in evoking emotionally protective behaviour on their part. As a Trainee Counselling Psychologist the corollary is to enable emotional health in young people with DCD.

As a mother of a young person with DCD I have developed implicit knowledge about DCD (West, 2011) some of which converges with the literature, but I remind myself to remain open and respect the uniqueness of the person. Respecting the individual has influenced my choice of methodology and reflects a personal motivation to resist the language of negative categorical labelling to encourage a more detailed and complex narrative of individual difference.

I am also a mature student without DCD, I am highly organised, manage daily living easily, have no difficulties reading or writing and can communicate relatively clearly. However, there are days in relation to being a menopausal woman when my sense of my body in space is distorted and I cannot concentrate. On days like this, I find academic work virtually impossible and I wonder what it must be like to feel like this all the time while I find it difficult to communicate this personal embodied 'reality' to others who don't experience it. This experience is one small way that helps me to relate to what it might be like to have DCD.

Historically, I have also developed beliefs about some educators and educational processes as my child's educational progress was blocked. At times, in the face of others' doubts, I even wondered if I had made it up, though I and a range of specialists could observe my child's difficulties and I now believe I probably underestimated the impact of DCD in my child's case.

## **Epistemological Reflexivity**

The methodology chosen based on my epistemological position attempts to take the perspective of the 'other' in an 'emic' research strategy (Henwood, 2008). While a contextualist position based in phenomenology puts the experience of the participant at the heart of the research strategy there is a risk that power dynamics in the research process marginalises the participant through 'social otherness' based on social and political constructions of disability. Inter-connected with social otherness is 'research otherness' (Fawcett & Hearn, 2004) which enquires how the participant is different to me, the researcher, specifically in terms of power and social location and it is to how the participant is positioned in the research that I want to turn.

Although I am attempting an 'emic' position by paying close attention to generating detailed participant accounts (Henwood, 2008), I could have taken an overtly emancipatory stance such as feminist standpoint research (Fawcett & Hearn, 2004). However, this seems to be disingenuous, possibly even arrogant, because I don't believe I could represent this experience authentically from this standpoint as, although intimately connected to the boundary of the individual experience of DCD, I have never been 'in' this corporeal 'reality'. I also have difficulties with the 'false universal' that Wendell (1996) suggests can emanate from such a standpoint; that complexity within marginalised categories can be masked and can even paradoxically produce 'otherness'. However, by not taking an emancipatory standpoint I am accepting some discomfort in positioning the participants within an IPA methodology where, in the end, the analysis is mine. From an emancipatory standpoint I could have engaged the participants collaboratively in the research process (Shakespeare, 1997) but my strategy is more aligned to 'local otherness' in that, in the specific social context in which I met the participants, I tried to develop a relational conversation in which the participant could be there 'just as they are' (Doane, 2003). While, in this context, I recognise my power to engage openness of emotional topics, my complicity in the construction of the participant's story can be assessed (Villenas, 1996). Through referential reflexivity (May, 1998), we, the participant and I, can be reflexive together about their lived experience in the research encounter.

## **Quality and Validity**

As qualitative researchers we need to understand what constitutes quality and validity so that our research can be evaluated. In this section, quality issues relevant to this study are outlined and will inform methodological and procedural reflexivity.

Madill et al. (2000) refer to well established quality measures in quantitative psychology based in the positivist positions of naive or scientific realism versions of 'truth', i.e., reliability, representativeness, generalizability and objectivity. However as Koro-Ljungberg (2002), indicates, in the Qualitative arena it is not as simple to assess quality because of the varied epistemological stances taken in making knowledge claims. In the qualitative paradigm where the positivist correspondence notion of truth is mainly rejected, Madill et al. (2000) note that the concept of objectivity, i.e., that the person observing an event does not manipulate it and hence it can be repeated by someone else (Ashworth, 2003), is problematic, and instead reflexivity or the researcher's subjective engagement in the research process becomes a more appropriate feature of quality. Similarly, the concept of statistical generalizability, or representing the general population through a representative sample, becomes redundant in research aligned to develop meaning and depth from small samples. Qualitative researchers, according to Johnson (1997), are more interested in theoretical, vertical or logical generalizability and do not expect their findings to be repeatable but by illustrating and analysing a specific context they can cautiously contribute to understanding situations with similar features.

Elliott, Fischer and Rennie (1999) and Yardley (2000, 2008), have sought to establish generic criteria for evaluating qualitative research suggesting that there is some consensus on measures of quality and validity in this area. Henwood and Pidgeon (1992) set the foundations of evaluative benchmarks in qualitative research by advocating systematic process, clear presentation of analysis grounded in data and attention to reflexivity. Elliot et al. (1999) argue that producing guidelines for qualitative research legitimizes the qualitative domain through developing diligent methodology, producing helpful scientific review processes, controlling substandard research and encouraging developments in qualitative research practice. Though 'validity' is a term more often heard in the positivist domain, Yardley (2000, 2008) suggests that in qualitative research this means "sound, legitimate, authoritative research that is well conducted, trustworthy and useful to stakeholders".

Yardley (2000, 2008) underpins her approach to validity by reference to a range of criteria such as triangulation, comparison of researcher's coding, participant feedback, disconfirming case analysis and maintaining an audit trail. However, Willig (2008), argues, that to enable others to evaluate a qualitative study, the researcher has to be clear about the type of knowledge she was trying to generate from her epistemological position. This has implications about how I interpret Yardley's (2000, 2008) criteria and their applicability to my methodological approach, because, as Reicher (2000) cautions, some universal quality criteria are unsuited to our philosophical position. The epistemological and ontological position of this project needs to be addressed by relevant quality standards so that, as Madill

et al. (2000) argue, the research method, procedures and analysis can be appraised in alignment with the researcher's epistemological stance.

The epistemological stance in this project has been described as pragmatic contextualist broadly aligned to the 'contextual constructionist' position of Madill et al. (2000). If we accept Yardley's (2008) criteria of triangulation from a positivist realist frame it would be aimed at producing convergence and consistency (Madill et al., 2000) whereas from this study's perspective triangulation is more akin to Wallatt and Piazza's (1988) goal of maintaining diversity and producing completeness. IPA addresses the latter through honouring both convergence and divergence so that uniqueness is retained. Additionally, disconfirming case analysis (Yardley 2000, 2008) is taken into account in IPA by adherence to convergence and divergence, researcher reflexivity and the hermeneutic process of analysis which always refers back to the data. Yardley's (2000, 2008) criteria 'comparing coding' would achieve consistency and reliability from a scientific realist position, but is not suitable for an IPA study where the researcher's relationship in the research process is fore-grounded as a subjective endeavour and instead reflexivity is required. Finally, a systematic retraceable audit trail of analysis may be verified in this project through worked examples and records of the analytic process (Yardley, 2000, 2008).

Yardley (2000, 2008) also outlines validity as sensitivity to context, commitment and rigour on behalf of the researcher, coherence and transparency and, finally, impact and importance. Smith (2003) suggests that sensitivity to context can be established by awareness of the substantive literature and understanding of the key theoretical concepts of the chosen approach. In this project that means demonstrating familiarity with DCD, life transition, counselling young adults and related literature as well as an understanding of the Phenomenological approach. Additionally, in showing sensitivity to context, Smith (2003) suggests paying attention to the socio-cultural background of the participant in how you position yourself as a researcher, the construction of your interview schedule and the setting and process of the interview itself. In demonstrating commitment and rigour, commitment is shown by the researcher's methodological skills, theoretical depth and how considerately the researcher works with participants while rigour is achieved through the appropriateness of the sample and completeness of the analysis (Smith, 2003). Finally, impact and importance is based on making a contribution to your research constituency (Smith, 2003; Yardley, 2000, 2008).

From a pragmatic stance, Cornish and Gillespie (2009) contend that, like impact and importance (Yardley, 2000, 2008), a fundamental test of research knowledge should be its usefulness e.g. designing a helpful intervention. As a Trainee Counselling Psychologist, this

pragmatic position fits with Wolf's (1978) principle of 'social validity' in Counselling Psychology as we aim to help individuals improve their emotional and psychological wellbeing. Aligned to these values, Patton's (2002) notion of 'praxis' or integrating theory and practice is exemplified by paying attention to achieving deep understanding (Ponteretto, 2005) and development of meaning (Morrow, 2005) in the research relationship which requires the ability to empathically develop an emotional bond with the participant without overstepping the mark into a therapeutic relationship (Haverkamp, 2005) and requires the researcher to familiarise herself with the context and culture of the participant (Morrow, 2005).

Smith (2011) also discusses his quality criteria for an IPA study in which 'acceptable' IPA research adheres to the theoretical basis of IPA in phenomenology, hermeneutics and an idiographic focus, is transparent in showing its working, and produces an articulate and appealing analysis that makes sense and shows density of themes using enough quotes. A 'good' IPA study should also produce a powerful, informative and stimulating analysis based in 'thick descriptions' (Geertz, 1973) of sensitive, human topics with subtle, perceptive and multi-faceted interpretations.

Based on these considerations of quality and validity, I have tentatively developed quality considerations for this project (please see Appendix 1) and, while not exhaustive, guide my methodological and procedural reflexivity.

## **METHODOLOGICAL DESIGN AND PROCEDURES**

### **Sampling**

The participants were eight young adults between the ages of 19 and 22 years old, currently in or entering Higher Education who described themselves as having been diagnosed with DCD. In this purposeful and homogenous sample, the research question as Smith et al. (2009) suggest should chime with the participants' experience.

According to Silverman (2010) qualitative researchers should have thoughtful and specific reasons for selecting their sample base. In this study participants have been selected at a transition point as young adult students in Higher Education where social, cultural and academic life are intertwined (Hefner & Eisenberg, 2009) in a 'community' conducive to the idiographic focus of an IPA study (Smith & Osborn, 2003) .

By adhering to a small sample size, attention can be paid to developing a detailed, complex and local picture of the particular case approaching the 'essence' of Husserl (Giorgi & Giorgi, 2008) to shed light on the research question (Smith and Osborne, 2003). Smith et al. (2009) suggest between four and ten interviews are acceptable in an IPA study for a professional Doctorate, while the focus on obtaining depth also highlights what is common (Warnock, 1987) and though Smith et al. (2009) accept that no claims can be made of the representativeness of the results from this sample, they cautiously suggest comparisons can be made to other similar situations.

## **Recruitment**

Higher Education Institutions' Disability and Student Counselling Services were contacted in London and Glasgow, to advertise the research project (please see Appendix 2).

Additionally, the Dyspraxia Foundation, a national charity in England and Wales, was approached (please see Appendix 3) and the project advertised on their website. A professionally designed poster and flyer taking into account the special needs of the target population (please see Appendix 4) was distributed to the Higher Education Institutions and the Dyspraxia Society. A website was also professionally developed as a recruitment and resource tool for the study (dcdresearchproject, 2011).

Ethically in a study of this kind, it is essential to produce information about the project in a suitable format for individuals with DCD as DCD often co-exists with undiagnosed Dyslexia in students (Jeffries & Everatt, 2004; Nichols, McLeod, Holder, & McLeod, 2008). The poster, flyer and website were produced in accordance with the guidelines of the British Dyslexia Association (BDA, 2011). A gift voucher of £20.00 was offered as reciprocity to the participant (Zafirovski, 2004) based on a fair deal (Guth, Schmittberger, & Swarze, 1982) and in valuing the participant's contribution (Kumar, Scheer, & Steenkamp, 1995).

Interested participants were provided with information for an initial phone contact and their suitability for inclusion was discussed in a subsequent phone conversation (please see Telephone Interview Schedule, Appendix 5) which took place in a private home office in the interests of confidentiality. The purpose of the study was discussed (please see Information for Participants, Appendix 6) and written information on ethical and consent issues (please see Consent Form, Appendix 7) as well as support information (please see Resource List, Appendix 8) were provided.

A supportive conversation took place with potential participants who did not match the inclusion criteria and resources provided (please see Appendix 8). A week later a

subsequent phone call was made to inquire about any potential distress though none was reported.

### **Inclusion Criteria**

Inclusion criteria were initially that the participant should be between the ages of 19 and 22 years of age, be in Higher Education and have a diagnosis of DCD or an individual learning plan from school stating DCD (please see Appendix 4). However as Smith et al. (2009) outlines difficulty in recruiting may lead to review of criteria to obtain balance between practicality and obtaining homogeneity. As Drew (2005) relates there is not a clear cut way to assess for DCD in young adults and it is also apparent that co-occurrence with other developmental disorders is the rule rather than the exception in DCD (Gilger & Kaplan, 2001; Gumley, 2005; Rasmussen & Gillberg, 2000).

On entering Higher Education a 'top up' assessment is required (Department for Education and Skills (DfES), 2005) of any diagnosis of a learning difficulty completed before the age of sixteen and is usually carried out by an Educational Psychologist or suitably qualified teacher working within the SpLD Working Group Guidelines (DfES, 2005; SASC, 2011). This assessment is completed mainly to obtain study support and the Disabled Student's Allowance (DSA).

In order to refine my inclusion criteria when there did not seem to be a clear cut way to identify DCD or separate DCD out from other learning difficulties, I made the following judgements on inclusion to the study:

1. I accepted that co-occurrence is typical based on the literature and argue that an individual with DCD as part of their individual learning difficulty profile be included, e.g., Dyslexia may also be present, thereby not unnecessarily excluding participants (Kirby, Sugden, Beveridge, Edwards, & Edwards, 2008) while still adhering to the DSM-IV-TR criteria for DCD (APA, 2000). This meant that potential participants who had a general medical condition such as cerebral palsy were excluded from the study.
2. Participants were in the age range of 19 to 22 years of age to reflect the legal demarcation of being an adult in the Children Act (Department of Health, 2004) and the lower age range in the literature on transition to adulthood (Tanner & Arnett, 2009).

3. I accepted verbal report evidence from participants of their childhood 'diagnosis' of DCD and that a University or College assessment had been completed including that the participant was in receipt of, or in the process of applying for, the DSA.
4. The participant is in Higher Education or in progression to Higher Education.

### **Participant Summary**

The participants were asked to complete a short demographic questionnaire (please see Demographic Form, Appendix 9) designed with guidance on gender, diversity and ethnicity (University of Lancaster, 2011) and the demography of 18 to 24-year-olds (Grundy & Jamieson, 2007). A descriptive summary illustrates homogeneity and protects anonymity of the participants. All of the young adults included in the study stated that they had been formally assessed at university or college as having DCD, were in the age range of early young adulthood of 19 to 22 years of age and were currently studying at university or college.

There were three male and five female participants. Three participants were aged 22, two were aged 21, one was aged 20 and two were age 19. Seven of the participants were completing their undergraduate degree, and another was in an Access to Higher Education programme. None of the participants had caring responsibilities. Seven of the participants described themselves as single and one participant was co-habiting. Six participants lived in either student accommodation or a privately rented flat and two lived at home with their parents. Six participants described themselves as White British, one described themselves as White Other and one described themselves as Other Asian. The participants came from across Great Britain. Five of the participants described their employment status as not employed and three as employed part-time.

All the participants described themselves as having DCD; three described co-occurring Dyslexia; one described co-occurring Dyslexia and Dyscalculia and another described co-occurring Autism Spectrum Disorder. Four of the participants had been formally assessed as having DCD in childhood, two had been assessed as having DCD in adolescence and two were assessed as having DCD as young adults. All the participants had undergone an assessment at college or university indicating DCD (SASC, 2011) with four participants already in receipt of the DSA, while the other four participants had applied for the DSA.

## **Pilot Study**

Two young adults were recruited from an opportunity sample for a pilot interview to assist in reviewing the interview process (Spradley, 1979). These young adults did not fully meet the inclusion criteria in that they were just outside the upper age range of the study having completed university. They were also supported ethically in the same manner as the other participants in that the research project was discussed, they were provided with written information before the interview and gave their written consent to take part in the pilot interview and their anonymity was protected (please see Appendices 6 & 7). In addition, a de-briefing session was conducted with written resources provided (please see Appendix 8) with a follow-up phone call one week later.

## **Interviews**

According to Rorty (1979) and neo-pragmatist philosophy, conversation is a 'basic mode of knowing' where the knowledge derived from conversation is seen as useful. Van Manen (1990) contends that a conversational interview can elicit lived experience to build meaning between an interviewer and participant in pursuit of the human experience of a phenomenon. The research interview is an empirical method enabling the interviewer and interviewee to understand and create knowledge about what Kvale (1996) describes as 'the human reality of being in the world'. Merleau Ponty (1964) sees this reality as an embodied reality experienced in the material world in which Wittgenstein (1972) concludes language and self concepts are immersed. The research conversation can also be described as social action (Holstein & Gubrium, 1995) in which the researcher and participant construct meaning in the interview process through the hermeneutical dynamic of making sense together. The hope for the research conversation was that it inspired emancipation (Habermas, 1971) and generated insight. Burr (1999) though discusses the challenge that the often silenced 'extra-discursive' properties of a different embodied experience, which phenomenology seeks to express, is not 'lost for words' or marginalised by prevailing discourses. IPA, as Reid, Flowers and Larkin (2005) contend, offers a one-to-one interview process which connects with the personal reality of the participant and can question the dominant rhetoric by 'hearing the voice' of the participant.

Producing a useful, insightful research interview in which the participant's lifeworld can be described in everyday language and in which the participant is valued and heard sensitively is challenging (Kvale, 1996). As the research interview and subsequent transcript are the subject of the researcher's further conversation in the hermeneutical analytic process of going 'back and to' the text, nuance, curiosity, and reflexivity are tools in the interview which

Kvale (1996) suggests produces rich meaningful data. The validity of this data starts with a systematic interview process that is guided by the stated research assumptions, but flexible enough to elicit and explore the subjective reality of the participant. A semi-structured format using an interview schedule (please see Interview Schedule, Appendix 10) was designed to frame the interview broadly based on the literature while encouraging a collaborative process (Finch, 1993).

### **Interview Schedule**

The focus of the interview schedule (please see Appendix 10) is to obtain data aligned to the specific research question informed by existing research assumptions and yet to be curious, open and attuned to the reflections, insights and new meaning explored and discovered in the interview process (Kvale, 1996). Three key areas drawn from the literature informed the design of the interview schedule: transition to university or college, self-perception and social relations, and practical and emotional support. Everyday language was used to avoid psychological jargon. The interview questions aimed to obtain description of experience by foregrounding thoughts, feelings, perceptions and comparisons relative to time and place hopefully generating new insights (Spradley, 1979). A funnelling process (Smith et al., 2009) was used to probe for more detail and depth with prompts used to encourage discussion.

The interview schedule was evaluated from helpful feedback in the pilot interviews which highlighted the need to re-order the questions to a more thematic and logical progression and be concrete and open in asking questions to elicit engagement and ease of thinking for the participant (Drew, 2005).

The interview schedule (please see Appendix 10) is now reviewed:

#### Topic 1 - Transition to University or College

Question 1 is what Smith et al. (2009) might call 'setting the scene' and aims to encourage description and enable the participant to talk about what is relevant to them. In terms of the lifeworld (Ashworth, 2003) this question locates the participant temporally and spatially by referring to 'university'.

Question 2 is also descriptive but is more specific and begins to funnel for detail and depth. This question attends to embodiment (Ashworth, 2003) explicitly by reference to DCD and there is an implied contrast (Smith et al, 2009) to previous biography.

Question 3 explicitly contrasts (Smith et al., 2009) life as a student with life before in the context of DCD and evokes the embodied experience of DCD while introducing the notion of 'selfhood' or social identity (Ashworth, 2003) as 'university student'.

Question 4 becomes more detailed and contrasts and evaluates (Smith et al., 2009) the 'project' or competence of the participant (Ashworth, 2003) in studying in different times and spaces.

Question 5 is a narrative question (Smith et al., 2009) encouraging the participant to tell a story or vignette of a meaningful situation. This question could evoke any of the seven 'fractions' that Ashworth (2003) ascribes to producing a detailed description of the lifeworld including selfhood, sociality, embodiment, temporality, spatiality, project and discourse.

#### Area 2 - Social relations and self

Question 6 is an evaluative question (Smith et al., 2009) about the perception the participant holds about the impact of DCD on their social life and hence taps into Ashworth's (2003) 'sociality' or interpersonal relations and their social identity.

Question 7 is also evaluative and relates interpersonal relations to selfhood and how the participants make social sense of themselves in the context of DCD.

Question 8 is again evaluative but deepens the agenda into feelings and personal identity tapping into the participant's most personal world (Smith et al., 2009).

#### Area 3 – Support

Question 9 encourages a narrative about obtaining support though is also structural (Smith et al., 2009) in that it implies that stages or procedures may need to be followed. This question again taps into 'project' or agency of the participant and may also evoke the 'discourse' (Ashworth, 2003) or cultural and social expectations of being a student with DCD.

Question 10 is evaluative and descriptive in attempting to tap into interpersonal relationships to find out what is helpful to the participant in obtaining emotional support. This question aims to evoke, selfhood, agency and sociality in the participant's lifeworld.

Finally the participant was asked if they had anything to add to the conversation or if they wanted to withdraw any information.

## **Interview Process**

Interviews took place in the participant's place of study usually a seminar room on the participant's campus and, in one case, a student residence. Rooms were booked in the researcher's name and no participant details were provided. Room booking information was communicated to the participant by personal email and a text message reminder sent the day before the interview. For personal safety, a trusted family member was told of my location and called prior to and after each interview though no details of the participant were divulged. The interviews lasted from fifty minutes to one hour twenty minutes and were recorded using digital voice recorders. Before the interview the digital voice recorders were checked and the room set up in interview style and a 'do not disturb' sign put on the door.

At the beginning of the interview session the participant was requested to complete the demographic form (please see Appendix 9), the purpose of the interview discussed verbally (please see Appendices 6 & 7) including anonymity, confidentiality and ethical considerations such as supervision, taping and role of a researcher as Trainee Counselling Psychologist on a Health Professions Council (HPC) approved programme (HPC, 2009). The interviewee was given time to read, reflect, question and sign the consent form (please see Appendix 7). All forms were produced and printed in accordance with the Dyslexia Association Guidelines (BDA, 2011). Taking into consideration participants had DCD, extra care was taken to communicate clearly and regular breaks were offered and refreshments provided. The participant was reminded that at any point they could withdraw from the interview and the study. Once the participant had provided written consent the tape recorders were switched on.

The interviews were conducted in a Person Centred Approach in valuing the participant unconditionally, being authentic and listening empathically (Rogers, 1957, 1967) while not crossing the line to therapy. The interview location was chosen to reflect the context of the young person and to appreciate the participant's image of the world (Smith, 2003; Van Manen, 1990; Yardley 2000, 2008). An ethical issue that arose was how to deal with my personal interest in DCD while still providing my family member with some privacy. I decided to disclose that I had a family member who had DCD but did not reveal the specific nature of this relationship thereby protecting their privacy. In most cases I did not provide a copy of the interview schedule but two participants asked to read it as the structure helped the participant to think.

During the interviews issues which could not be discussed directly at the time were returned to at a more appropriate point in the interview thereby respecting the participant's flow of

conversation. Key skills from counselling psychology practice, or what Rennie (1998) terms 'basic attending skills', came into their own including eye contact, paraphrasing, clarifying and pacing. This style of interviewing enabled exploration of feelings, thoughts and meaning and evoked contradictions, self-presentation and projective or associative material to emerge (Wilkinson, Joffe, & Yardley, 2004). Each interview followed a similar format though produced a different relationship in the interaction but all were a testament to the openness, goodwill and motivation of the participants. As a relatively experienced recruitment interviewer my interview persona could have seemed imposing however this was tempered by inexperience and caution in conducting research interviews. Therapeutic responses were curbed (Haverkamp, 2005) but emotional issues noted for follow up in the debriefing session.

Following the interview there was a period of up to forty five minutes to discuss any additional supportive resources that the participant needed including information on psychological and social support (please see Appendices 8 & 11). This follow-up discussion was not concluded until the participant was comfortable to leave and followed up with an email with customised resources and a week later a telephone call was made to assess whether any emotional distress had occurred as a result of the interview though none of the participants reported any.

## **Transcripts**

Interviews were taped using an Olympus AS2400 Digital voice recorder and a back-up Olympus VN-31000 voice recorder and professionally transcribed in accordance with guidance from Smith et al. (2009) to produce a semantic record. Such verbatim accounts of the interview are seen by Larkin et al. (2006) as providing a third perspective constructed in the interaction of the interview process but which attempt to get as 'close' to the participant's view as possible. While Potter and Hepburn (2005) contend that transcripts should be transcribed in conversation notation such as 'Jeffersonian' (Jefferson, 2004), including interactional detail such as pause, pitch, volume and speed to demonstrate the co-construction of the dialogue, Hollway (2005) argues that such an approach disrupts contact with the flow of meaning in the transcript. Similarly, Smith (2005) argues that favouring interactional elements over the subject matter in the transcript would lead to the former being the focus of analysis which is not the intention in IPA.

Poland (2001) raises concerns about the quality and trustworthiness of transcripts for analysis and the following steps were taken to address these. A professional confidential transcription service was used to save time and selected on the basis of recommendation from a

professional health researcher in an IPA research group (Morrow, 2005). The main concerns in terms of quality in working with a professional transcription service were to ensure a verbatim or 'faithful' account of the interview. The notation system was agreed with the transcription service based on the transcription guidelines of Smith et al. (2009), which require a semantic record that documents all the words of the interview and includes significant non-verbal expressions such as laughter. One diversion from the guidance was that regional words were included as this was seen as faithfully representing the voice of the participant (Lincoln & Guba, 1985). To assess the quality of the transcription, the content of a portion of the professional transcription was reviewed against the researcher's trial transcription for errors, punctuation and omissions (Poland, 2001). Each transcription was also reviewed against the recording of the interview for the same reason.

An ethical issue arising in working with transcribers is confidentiality and anonymity (Poland, 2001). Following initial contact with the transcriber, we discussed these issues and she sent an e-mail outlining her terms of business (please see e-mail, Appendix 12) including that audio files were transferred using a secure password protected file uploading and downloading platform. Although some situational identifying material is in the recording, this is in the context of the conversation and no personal identifying information about the participant was sent to the transcriber as the audio files were referenced by audio file number only. The transcriber agreed to confidentiality and anonymity requirements (please see Appendix 12) and the contextual information was left in the transcript in the interests of authenticity to be edited later by the researcher.

## **Ethics**

Throughout the research report ethical issues have been touched on but now are considered more explicitly. Kvale (1996) outlines a framework of ethics of informed consent, confidentiality, beneficial consequences and the role of the researcher while Plummer (2001) raises other ethical tenets including ownership, honesty, deception and exploitation. Many of these ethical issues are covered in the minimum standards of ethical approval in psychological research by the British Psychological Society (BPS, 2004), which Plummer (2001) describes as a universalist position, including the principles, rules, guidelines and conduct essential in protecting society in research. However, Plummer (2001) also raises the post-modern position in grappling with ethical dilemmas to balance community safety and individual rights.

Ethical approval and an Ethics Release form were obtained from City University (Appendix 13) and the Dyspraxia Foundation's Medical Panel approved the research project before it

was advertised on their website. As reciprocity for this advertisement, a research report will be provided for the Dyspraxia Foundation though they have no financial or other influential interest in the research.

Written informed consent and agreement to participate in the study and to tape the interview was obtained from participants through discussion and signing of the consent form (please see Appendix 7) with periodic checks made during the interview to ensure the participant was happy to continue (Willig, 2008). Attention was paid to providing verbal and written information in an appropriate format to take account of the participants' learning difficulty.

Anonymity is being preserved by not including personal details or identifying factors on materials (please see Appendix 7). Agreement on publication forms part of the consent form (please see Appendix 7) with explicit written approval obtained. Confidentiality has been protected in that telephone calls have been conducted privately, research interviews have not been discussed and personal information is kept in secure locations. The original audio files are kept on the AS2400 digital recorder in a locked filing cabinet and have been deleted from the VN3100 digital recorder. A copy is kept on a password and finger print protected personal computer and an external hard drive, the latter also kept in a locked filing cabinet. All written personal details and field notes are also kept in a locked filing cabinet and an exclusive e-mail set up for the purposes of communication with participants. A transcription service agreement on confidentiality and anonymity requirements was obtained (please see Appendix 12).

In ensuring no harm was done to participants (BPS, 2004), participants were fully appraised before participating in the research in the telephone interview and the research interview, with verbal, written and web information provided (please see Appendices 6, 8 and 11). Participation was voluntary and participants were made aware that they could withdraw at any time or withdraw sensitive information. A debriefing discussion with supportive information (please see Appendix 11) and individually tailored follow-up information was provided (BPS, 2006).

My pragmatic epistemological position has been chosen with the intention of providing a useful outcome to the participants and others with DCD but could be challenged as the 'ends justifying the means' (Kvale, 1996). While seeking a useful outcome, I believe I am sensitive to the personal and social realities of each of the participants and my primary concern has been to treat the participants with respect (Plummer, 2001).

I chose to communicate at the beginning of the research interview that I had a family member with DCD but not the exact nature of this relationship. On the one hand I wanted to be honest with the participants and at the same time I did not want to expose my family member unnecessarily or over-identify with the participants (Kvale, 1996). I have also made use of personal therapy throughout the research study to reflect on the personal issues raised by the research.

### **Analytic Strategy**

An IPA analysis was conducted in accordance with guidelines by Smith et al. (2009). From the research interviews, conversations with the participants were transcribed verbatim. Transcripts were produced in landscape with two wide margins and analysed on two levels. The first task was to convey the dialogue of the interview to the transcript and the second was to engage in conversation and interpretation of the transcribed text (Kvale, 1996). A series of systematic analytic steps were performed as Henwood and Pidgeon (1992) recommend for qualitative analysis and a worked example and records of the analytic process are provided in Appendices 14 to 27 as an audit trail as Yardley (2008) suggests.

The first step in the analysis began with a review of field notes of the interview to become re-acquainted with the young person and their context (Morrow, 2005). The interview tape and transcript were compared noting any omissions or corrections, picking out emphasis on words and identifying tone. Reflexive notes were made at this early stage to heighten the researcher's awareness of any preconceptions in approaching the analytic process (Larkin & Thompson, 2011) (please see Reflexive extracts, Appendix 14). The transcript was read again a couple of times without coding for 'gist' and a brief descriptive pen portrait produced of the young person (Shaw, 2010) (please see example, Appendix 15).

In the second step of the analysis exploratory coding of the transcript was conducted by reading and re-reading the text with initial comments made and recorded in colour coding in a wide left hand margin on the text (Smith et al., 2009) (please see Transcript example, Appendix 16). Initially, line by line reading focused on small chunks of the transcript to produce a descriptive summary of experiences. Reading then progressed to noting the way in which the young person's language held meaning including vocabulary, tenses, pronouns, time, pace and pauses. A further reading of the transcript focused on potential 'gems' in the text which, as Smith (2011) suggests, is a section of the individual's narrative that catches the attention, magnifies the whole transcript and ripples through the full analysis. A further conceptual reading was completed by stepping back from the detail of the transcript to question the commentary and identify broader threads in the whole transcript in a more

tentatively interpretative stance. Further reflexive notes were made at this stage of exploratory coding (Appendix 14) (Larkin and Thompson, 2011).

In step three, at an even further level of abstraction, potential meaningful themes for the young person were identified and recorded in a wide right hand margin. These themes attempted to capture the young person's words and the researcher's interpretation in a brief analytic label (Smith et al., 2009). The potential emergent themes were drafted with line numbers onto a word document in a chronological list for the individual (Smith et al., 2009) (please see example, Appendix 17).

In step four, the list of emergent themes was then cut up and placed on the floor in the first iteration of trying to organise the emergent themes spatially (Smith et al., 2009). Relationships among the themes were then explored for initial groupings or clusters of themes and a series of iterations performed to reorganise and refine the clusters. In reviewing the arrangement of themes, diagrams were used to record and develop potential patterns or structures in the data (please see example, Appendix 18) and connections made between themes based on guidance from Smith et al. (2009). For example, Functional Processes became an organising principle in the data due to its recurrence while other organising or super-ordinate patterns emerged from their temporal quality, e.g., Transition.

A summary table of each theme for the young person, evidenced by quotations from the interview transcript, was also produced in step four and reconciled against the original transcript data to check for internal consistency (Braun & Clark, 2006) (please see example, Appendix 19). At this stage some quotes were deleted or were subsumed into more relevant themes. Ashworth and Ashworth (2003) caution of the need to be vigilant to the individual case and reflect on what the experience is like 'for the experiencer', so that in such cases where there was doubt about a particular quote, the researcher reflected on the quote asking 'what are they trying to tell me?'. This brought home in real time the hermeneutic cycle of the to and fro of going back to the data, reviewing the context in which the quote was said and relating the quote to threads in the person's narrative in a part-to-whole interpretative endeavour. Finally, a summary table of a super-ordinate cluster of themes with subordinate themes was produced for each person, aligned to quotations from the transcript (please see example, Appendix 20). At the end of each individual analysis, reflexive notes were again made to contribute to the researcher's awareness of her position in relation to the analysis (Appendix 14).

An additional process, step 5, was conducted to produce a narrative account of the individual analysis to capture the specific case of the young adult (please see Appendix 21).

This additional step was seen as a way, as Eatough and Smith (2006) convey, to enhance understanding of the experience of DCD in the context of the person's particular life and to bring the individual story into the final narrative.

In Step 6, an integration process was carried out across cases to produce a master list by comparing the data of all the participants to produce a broader picture of the experience of DCD in the young adults (Willig, 2008). This process was also iterative because although there were many similarities across cases, differences had to be reconciled to produce a coherent structure in the resulting Master Table shown in Appendix 22. A brief descriptive summary of each theme is produced in the Master Table provided in Appendix 23 and the Master Table with quote line numbers is provided in Appendix 24. An extract of one master theme and sub themes with illustrative quotes is also presented in Appendix 25. A graphic representation of the master themes and theme structure across cases illustrating convergence is produced in Appendix 26, while an individual case illustrating divergence is also represented graphically in Appendix 27. A reflexive statement was also recorded at this stage of the analytic process of reviewing patterns across cases (Appendix 14).

### **Methodological and Procedural Reflexivity and Quality Implications**

Madill et al. (2000) points out that researcher reflexivity is a key element of quality from a contextualist stance (please see Appendix 1 - proposed quality criteria) and my aim in this section is to be reflexive about my role in the methodological research procedures and about my consciousness of the participant and the relationship between us to make justifiable validity claims (Pillow, 2003).

In the recruitment phase of the research I had made some assumptions about the inclusion criteria in that I expected that participants would have a clear 'diagnosis' of DCD. In the event, it became apparent that the situation was much less clear than this and I had to reflect on my inclusion criteria. I found it very stressful trying to refine criteria in a context that was not clear cut and in my diary at the time I reflected that I felt I was in 'quicksand'. I also had to make judgements about who fitted the refined criteria and who did not. In some cases this was straightforward, e.g., age, but some prospective participants described characteristics that seemed to fit with DCD but had never had any formal recognition of it. It was difficult to turn these prospective participants away though I made every effort to provide these young people with resources. In one way I was compounding their disempowered position (Fawcett & Hearn, 2004) though at least providing a method to challenge this status by providing useful and potentially empowering knowledge (Cooper, 2009). I was also alerted to my own vulnerability (Fine et al., 2000) in this process and my

empathy (Madill et al., 2000) for the prospective participants who seemed to be caught in a sort of twilight zone, recognizing in themselves that they had learning difficulties but not having had this recognized formally by others (Fawcett & Hearn, 2004).

The issue of criteria also raised my awareness of the difference between the ontological underpinnings of quantitative and qualitative research designs and my initial adherence to DCD as a 'truth', in that, originally I was hoping to have participants who only had DCD in the study. I had read the literature on DCD and knew that co-occurrence with other learning difficulties was more prevalent, I support a more positive framing of recognising individual neuro-developmental profiles (Levine, 2003) and I espouse the uniqueness of the individual from my epistemological stance yet, here I was, still trying to fit individuals neatly into the 'DCD' box. By engaging with my pre-suppositions (Shaw, 2010) and being inclusive in light of participants' diversity (Wallatt & Piazza, 1988) I hope I have maintained a more complete picture of DCD. One criterion which may have been less inclusive was the upper age boundary which may have excluded some young adults with DCD who entered Higher Education later than usual.

In designing the interview schedule, as Potter and Hepburn (2005) contend, there is the risk that I embedded my own implicit theories or interpretation of the literature. However, even though the questions were informed by the literature, the wording was kept in everyday language, e.g., although anxiety is mentioned in the literature (Skinner & Piek, 2001), I was interested in tapping into all emotions and the word 'feel' was used. The semi-structured interview process was designed to enable the participant to bring up issues relevant to them and the use of probes such as 'can you tell me a bit more about that' helped to facilitate this. As I did not want to rigidly direct the interview, I did not show the interview schedule to the participants at the start of the interview but described the areas I was interested in but a couple of participants asked to see the interview schedule as it helped them organise their thoughts. As tangential thinking can be a functional problem in DCD (Drew, 2005) I had to balance providing a helpful structure in consideration of the participant (Yardley, 2000, 2008) with eliciting novel data which demonstrates my power as the researcher and perhaps should have shown each participant the schedule in a more democratic process (Cooper, 2009).

During the interviews I noticed a number of issues that may have impacted on the interview process. I noticed that I felt emotional when participants brought up familiar issues and I had to bracket my emotions and did not show my vulnerability to the participant (Fine et al., 2000). Had I been able to show my feelings, I may have been able to demonstrate the shared humanity that Madill et al. (2000) suggest can be a tool in the research process to

develop a bond with the participant (Haverkamp, 2005). On the other hand I was concerned with not marginalising the participant's story with my feelings. Out of respect for the participant (Madill, 2000) and not crossing the line to a therapeutic relationship (Haverkamp, 2005), I sometimes held back from following up on an issue which may have resulted in less rich description (Geertz, 1973). I also felt that in some interviews I used too many probes which may have felt controlling to the participant (Morrow, 2005).

A key area that is difficult to portray from the interviews is what Finlay (2006) calls 'expressive bodily gestures' in disclosing feelings. Although as Finlay (2006) suggests, I was paying attention to bodily movement, e.g. face touching, fidgeting, tiredness, I was doing so more in the sense of recognising the functional difficulties in DCD (Yardley, 2000, 2008), and though empathic and tuned into this embodiment of DCD, this is somewhat different to what Finlay (2006) seems to be getting at in empathically understanding the participant's feelings, so that perhaps I misinterpreted functional with emotional issues. I was also aware of my own body language and tried as much as possible to maintain a relaxed curious stance (Morrow, 2005) but on occasion my disdain for some of the events the participants experienced was apparent and while this may have reflected my own bias, I also believe it helped validate the young person's own feelings showing a deeper understanding of their situation (Ponterotto, 2005).

In the debriefing section of the interview process, I also noted that participants provided additional information that may have enriched the data (Geertz, 1973) so that I perhaps ended the interview too quickly which brings up issues of control on my part (Fawcett & Hearn, 2002).

## ANALYSIS

### OVERVIEW

The analysis produced a comprehensive organisation of the data which aims to honour, as Larkin and Thompson (2011) advocate, both convergence and divergence. The Master Table of the analysis is the author's attempt to produce an organising heuristic in the data and as outlined in Table 2 includes six master themes or organising principles (Larkin and Thompson, 2011).

<b>Master Theme</b>	<b>Theme</b>	
<b>DCD and Transition</b>	Moving On	1
	Change in Framework	2
	Academic vs. Social	3
<b>DCD in Functional Context</b>	Interference	4
	Organisation and Planning	5
	Control and Attention	6
	Motor-Perceptual	7
<b>DCD in Social Context</b>	Interpersonal	8
	Cultural Narratives	9
	My Community	10
<b>DCD in Psychological Context</b>	Overwhelm	11
	Worry	12
	Social Anxiety	13
	Comparing	14
	Resignation and Accepting	15
	Explaining	16
	Humour	17
	Overcoming	18
	Concealing	19
<b>DCD and Support</b>	Formal Support	20
	Personal Support	21
<b>DCD and Young Adult – Dynamic Self</b>	Discovery	22
	Me and DCD	23

Table 2: Master Theme Table and Theme outline

The first organising principle, DCD in Transition, illustrates the young peoples' experience of the interaction of DCD as they move into the life-world of an independent student.

The next three master themes are organised to amplify the functional, social and psychological experiential contexts of the life-world of the young adult with DCD. The

second organising principle is DCD in Functional Context, which exemplifies the young peoples' embodied experience of the processing difficulties of DCD.

The third organising principle of DCD in Social Context includes the interpersonal, social and cultural life-world of the young person at this point in their life.

The fourth organising principle of DCD in Psychological Context comprises the emotional, cognitive and sensational internal life-world of the young adults as they experience DCD in their daily lives.

The penultimate organising principle of DCD and Support represents the formal and personal support the young people experience in coping with DCD.

The final organising principle of the Young Adult – Dynamic Self reflects the historical, dialogic and creative processes in the dynamic self-development of the young adult.

Though these master themes and themes are illustrated separately in Diagram 1, they are viewed as existing interdependently.

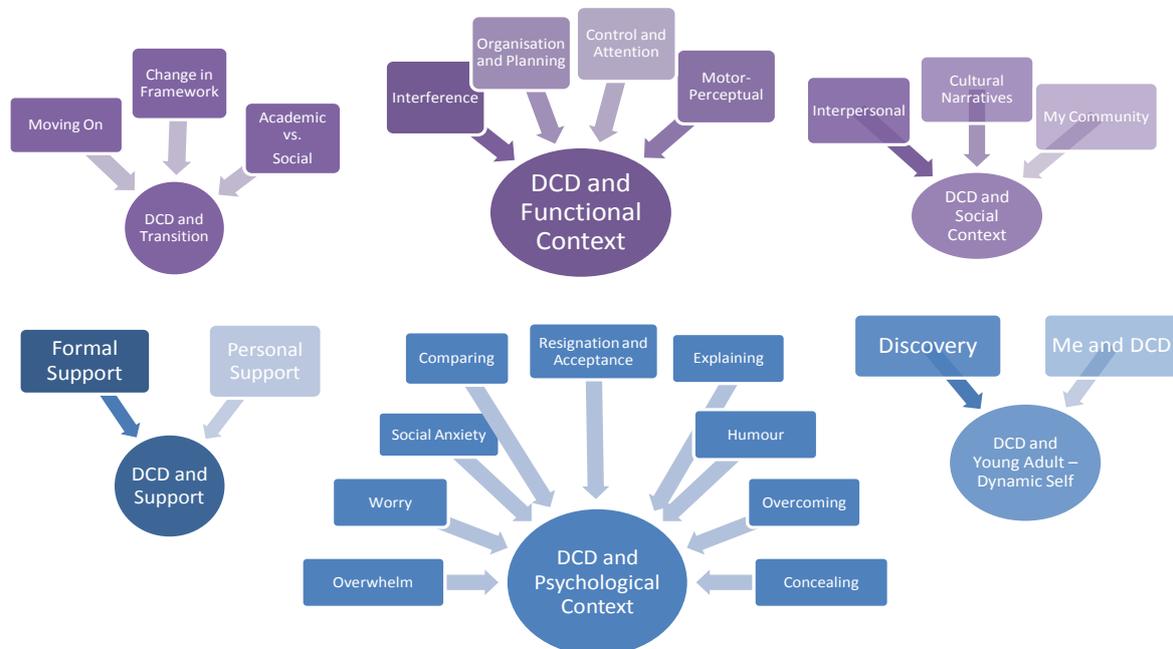


Diagram 1: Master Themes and Themes

Due to the quantity of data generated in the analysis, the narrative produced here is an attenuated version of the full analysis. The aim is to present a coherent compelling account of the data that answers the research question of how young adults experience DCD in their daily lives as students. The researcher has therefore selected data from the young peoples' interviews to provide evocative illustrations of their daily lives and has edited quotes to improve fluency without attempting to change the meaning of the quotes.

The narrative is presented solely from the data and corresponds with the analytic process where the literature was 'bracketed' but as Larkin and Thompson (2012) recognise, the author's hermeneutic relationship with the data is also grounded in her own perspectives and these have been utilised to explore and reflect on observations and interpretations in producing the analysis. The relationship of the data to the research literature will be explored in the Discussion.

## **DCD AND TRANSITION**

In the master theme of DCD and Transition, the students talk about their experience of the interaction of DCD in making the transition from adolescence to independent adulthood as they enter, orient to and navigate their way in their changing lifeworld as a student.

### **Moving On**

Moving On reflects the impact of DCD as the young people prepare to go to university. In the main their accounts reflect trepidation and ambivalence about independence though they also indicate some motivation to take up the challenge of adult life.

Fiona<sup>9</sup>, who came from a close knit family, relates her experience of resistance to the transition to student life. Her emotional rejection of the all-encompassing sense of independence is reflected in her vocabulary of the 'whole independence thing':

You know so just like the whole independence thing was, before I went to uni, I was like crying, "I don't want to do this." (Fiona: 58 – 62)

Sandra, who recently started university, conveys a more ambivalent attitude to independence. Her use of 'half of me' and 'my other half', illustrates the split in her internal

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<sup>9</sup> All names and certain biographical /personal identifying details have been changed throughout in order to preserve anonymity.

self. On the one hand Sandra's strong energetic tone underpins her words 'it'll be exciting', then changes to a rather fearful tone emphasising her uncertainty as she says 'I dunno, it's a bit too daunting'. Sandra's remark of 'a bit of a thing' indicates there had been quite a tussle going on in her mind:

it was a bit of a thing before I came, 'cause I was like... I didn't know whether I should come or not because, erm, like, half of me was like, oh yeah, it'll be exciting and a good experience, but then my other half was like, I dunno, it's a bit too daunting. (small laugh)

(Sandra: 72 – 75)

Like Sandra, Chris, also refers to how 'daunting' he viewed the prospect of independent living. Chris, who remained in his home town for university, discusses the impact of DCD on his need to compromise and live at home, in comparison to his peers who moved away. His reflection that he was 'the only one' perhaps illuminates a sense of isolation in his life-world:

Well, socially, it, it's different coz all my kind of friends from, from sixth form went to all different ends of the country and university...so I was the only one, really, that stayed at home...and even that choice, it was difficult, coz I thought, well, yeah, you know, university, you go out, you explore... you, you, you know, you live away from home, it's, all those things that most people my age would have found exciting... I found quite daunting. (Chris: 1062 – 1081)

However, as Tom explains he has had to live independently for some time and this earlier experience of independence has helped Tom in moving to university,

So I was expected to, well, look after myself – cook, clean, etc. So I built up all my necessary skills by a young age.... So I would say that that, that has definitely helped in the transition, moving to university and taking care of myself, .... (Tom: 780-786)

### **Change in Framework**

In the theme Change in Framework some of the young people describe their experience of the changes in the infra-structure of their life-world in college and university, including changes in academic arrangements, daily routine and personal responsibility as the students struggle to orient themselves to their new environment.

As Kate tries to make sense of her university course work she repeatedly refers to her confusion. The scale of the task at hand is reflected by references to 'a lot more' and 'quite big', leaving Kate expressing a sense of being lost and directionless at university:

Coz there's a couple of things that are really confusing me about, coz I had three modules this time, and two of the practical ones, um, instrumental, composition and recording...and it just seems like it's a, kind of a lot more work than I had in Fairfield, and I've asked if I can do the same project...and I've got different answers from each tutor – so I'm still, like, very confused as to what I can hand in. Coz I'm working on, like, quite a big project, now, but I just can't decide which part to hand in where. Don't know where to go with it. (Kate: 281 – 293)

Additionally, the totality of Kate's sense of responsibility for her academic success or failure can perhaps be gleaned from her language in 'just your own whole':

Yeah. It's just, there's not that much pressure in university, because it's really, like, just your own whole, if you fail, then like, you're paying so much for it...so it's kind of like you just have to do the work yourself. (Kate: 240 – 246)

Fiona, like Kate, also experiences a sense of being lost in the transition to university as the geographical 'maze' seems to mirror her loss of bearings in the new social and academic landscape. Even though Fiona is well into her university career, her language combining past and present tenses perhaps indicates that independence is still a 'massive' challenge, reflected in how isolated she still feels by her repetition of 'lonely':

Yeah, it's just, I can't do it at all. So it's just like being independent is just, like, really new for me and, I don't know – I just felt lonely because I'm not very good at making friends. I haven't made a lot of friends. I think I've got about five friends in uni, so, and all of them spoke to me, so it's, I couldn't go up to someone and talk to someone I wouldn't know. So it's quite, it's quite lonely and it's a massive jump from secondary school, especially. I don't think it prepared for me it, at all. So it's just, all this, like, new stuff and finding my way around, which is also awful. I kept getting lost loads of times...and there was just really like, you had to go upstairs and across the corridor and up more stairs, and that was like a maze. (Fiona: 44 – 54)

Fiona re-iterates her experience, like Kate's, of the total encompassing nature of moving from dependency to independence and similarly refers to it as 'it's just a whole':

Here, it's just a whole, coz when I was at home, I had my parents and stuff, and now it's just like independent and I'm doing everything by myself, and I don't think I was really prepared for that, that much, I think. (Fiona: 1550 – 1553)

Sandra is also coming to terms with her sense of time during the day as the university timetable is quite different from the regularity of the school day. Sandra struggles to find a way to describe what this experience is like for her; it is as though putting her thoughts into words is difficult, which may be a sign in the interview of her functional difficulties:

And, erm... but, yeah, but then it is... like the, erm... but then, 'cause, er, my timetable as well, like I've got, erm, like times where there's like big gaps, or like a...late lecture and then... as opposed to just like the, er, like nine to three like school day where everything's like ...crammed in. (Sandra: 213 – 224)

Not only has Sandra's experience of time on a daily basis changed, her implicit sense of time over the initial period of university seems to have been a source of anxiety. Sandra's excerpt is peppered with expressions of time, 'started', 'time', 'term', 'weeks' 'longer', illustrating how salient the experience of this period of time has been for her. Sandra's inner dialogue attempts to counter her anxiety and self-judgement about settling in by 'reminding herself' that her experience of time is skewed:

Well, then... but also, erm, well, 'cause, erm, in the like first two weeks... then it was like when we, then started like the lectures properly, then I was started like... erm, starting to get like a bit anxious and stuff, but then, erm, it was like I..I don't know, 'cause for some reas... like it... the time has gone really quickly and now I'm like, well, the like first term is over. But then, erm, you have to then, keep ... like reminding myself like it is, erm... 'cause it feels like I've been here like... even though in... when it was like just the first three weeks of like proper lectures, it felt like I'd been here longer than I actually had been. So, I had to keep reminding myself, well, it's only been like the first term, it's only like the first, erm, few weeks, it will take a while to like settle in and everything. (Sandra: 1132 – 1157)

Lisa, who is now well established in her university career, recalls the overwhelming nature of the change to university life. Lisa highlights, as she reels off a string of activities, that she 'couldn't focus' and the extent of her turmoil is exemplified when she explains that she was engulfed by events and did not pass her first year. Though Lisa laughs about it now, her mild hesitation to talk about it perhaps conveys some residual embarrassment:

I didn't pass my first year...and, um, again, it was because, you know, it's like a, so different ... and there's so much you have to do, and I remember, in our first year, there was a lot of, like, you had to do field trips, and your class test and you had your module test and you had, um, you had to do all this other stuff...and it was just, well, I was, uh, overwhelmed with stuff and because my time management is very poor... I couldn't focus, I couldn't, like, manage everything properly...So I was

like, forgetting about other stuff, and then nights, like, the night before, I was like, “oh yeah, I have a test tomorrow.” (Small laugh). (Lisa: 1774 – 1803)

In contrast to Kate, Fiona, Sandra and Lisa, Samuel, who is soon to graduate, happily recalls his experience of transition to university. Samuel seemingly took the combination of changes in his new academic and social environment in his stride:

I mean, I think there was, but that’s only for the reason that your first year is, it’s basic level. You’re sort of, they’re sort of easing you into it... um, you’re learning what it’s, how it’s different... what you’re expected to do ... and, at the same time, you’re trying to live independently ... whilst making new friends. It’s a good experience to have. (Samuel: 339 – 357)

### **Academic vs. Social**

This theme illustrates a particular tension that the students with DCD experience in trying to balance their academic and social lives as they transition to life as a student.

Tom, whose studies are becoming more demanding, emphasises his practical coping strategy of structuring his time to ease his stress in balancing study and relaxation, highlighted by his repeated use of the word ‘rationally’:

that’s the whole reason behind me making this timetable, so I can rationally see and ration, rationally think out that, you know, this is the time you’ve got to study and this is the time you’ve got to relax and...I’ve not, I’ve not actually put it into practice yet, because I only, I, I only made it last week...but, em, right now, I feel a lot less worried because I know that it’s laid out for me. So having, having a plan certainly helped...so that’s why I’m a lot less stressed than I would normally be, just now. (Tom: 1866 – 1883)

Sandra also experiences the dilemma of balancing her work with socialising as her metaphorical expression ‘difficult to juggle’, suggests. Sandra illustrates how she resolves the conflict by bargaining with herself and developing a rule as she states ‘I spend half an hour a day having coffee’:

R: But then also, then, erm, then if I had, erm, plan like, I dunno, I’ll get like that chapter read in the library but then people on my course are like, do you wanna go for a coffee...then I think, erm, then it’ll just be like balancing that, ‘cause I’d be like, well, it’d be good to go to the coffee, but then I wanna be getting this work done, so...

I: So, how do you handle that?

R: Erm, well, then, erm, normally then if we've gone for a coffee then it's been like, erm, yeah, well, I spend half an hour a day having coffee and then I'll go...

I: So, you just go for half an hour ... and then you manage to go back to your work?

R: Em yeah, normally then they...like would follow me then to the library.... Yeah, sometimes it is like difficult to juggle. (Sandra: 1545 – 1576)

Samuel, who is further on in his university career than Tom or Sandra, reflects that he too struggled with 'balancing' academic and leisure pursuits but now seems to be enjoying himself. However, Samuel's repetitive stumble to express 'get' may indicate that it is not as easy as he implies:

It is a bit of a balancing act... but it's quite fun when you get, get, get the right mixture.

(Samuel: 1017 – 1021)

## **DCD IN FUNCTIONAL CONTEXT**

This master theme combines the students embodied experiences of the functional difficulties experienced in DCD and their implicit adaptive learning in managing such problems. The themes represented cover the most numerous functional processes expressed by the students including: interference between writing and listening, organisational difficulties, lack of mind/body control and motor-perceptual problems.

### **Interference**

Some of the students discuss their problems with interference between writing, listening and paying attention in their academic lives and the impact these difficulties have on their learning and acknowledge their relief that alternative strategies are available.

Eileen, who is an established student, mentions her experience of trying to write and pay attention in lectures as she describes trying to make her notes 'writeable'. Eileen's unusual use of language underscores the conscious effort required in her embodied experience of writing and the double impact this has on her learning process:

And if I concentrate on writing my notes enough to make them writeable, I am not paying attention to what's being said in the lecture – so I'm missing out either way. (Eileen: 80 – 81).

Sandra also describes her experience of difficulty in taking lecture notes as well as listening to the lecturer. Sandra's hesitancy in being able to put her thoughts into words, demonstrated by her repeated use of 'erm', again potentially demonstrates the effort that Sandra experiences in the process of communicating in the interview (Sandra: 213 – 224). Sandra conveys that she can't make notes and listen concurrently or she misses information and she sounds relieved to have an alternative strategy to capture the lecture:

Erm, well it was just 'cause I, erm, was like... well, 'cause I, erm, it was when I couldn't... it was really difficult to like make any notes, or like I'd be writing what they'd just said and then I'd miss the next point. So, at least if I've got it in the recording... then it's like a backup. And then, also, I'm getting like note takers notes as well, so... (Sandra: 141 – 148)

Samuel also expresses his need to pay attention in lectures and reflects on his learning, that his embodied sensation of focusing is increased by knowing that he too has a back up strategy to capture the lecture:

But I think they're all, they all do the same job, so as long as, it, at the end of the day, whilst I'm trying to make notes at the same time, think it's good support for me to have a note taker so that I don't feel like I have to take notes, now I can feel that I'm more focused on the, the lecturer and the lecture and can sort of process the information. (Samuel: 271 – 275)

## **Organisation and Planning**

In this theme the young people discuss their experience of organising, planning and constructing their thoughts, highlighting their struggle to produce coherent academic work.

Eileen's ability to write an essay is complicated by her struggle to organise her thoughts into a coherent plan as she experiences being easily distracted in the moment by a compelling array of ideas which leave her feeling disoriented:

I'm, I can say I'm a bit dis-coordinated when it comes to thinking about stuff, and when I write an essay, I'll be like, "ah, I'll work on the introduction. Ooh, I've just had a great idea for the results blah, blah, blah, blah." No, no, no, that shouldn't go in there, I'm all over the place (Eileen: 1557 – 1562)

Fiona reflects on her awareness of the mismatch of her assignment requirements and her functional abilities in organisation and planning to produce the desired result. While Fiona identifies the problem as 'the logical way to put everything', she judges that she does not have the self-efficacy to finesse her work within the set time scales:

And I find, coz as soon as I've, like, finished my assignment, my essay, I don't do a lot to make it, you know, improve it because it's take..., because essays are really confusing to me. Coz I understand, I understand everything – it's just I don't understand the logical way to put everything ,so as soon as I've done that, I won't, like, find little improvements because I've spent, by the time I've finished it, it needs to be in. (Fiona: 461 – 467)

In this extract, Lisa describes constructing an essay which illuminates the difficulties that she has with organising her thoughts. Lisa highlights how different ideas have to be physically separated and the scale of the fragmentation of her thoughts is illustrated by 'my thoughts are, like, just in millions of papers'. Like Eileen, Lisa experiences a proliferation of scattered ideas as she describes how 'everything is everywhere' describing how she tries to bring her disconnected thoughts together into a coherent whole, in a tortured process or 'pain', while repeating her judgement of her process as 'weird':

my desk is a tip (laugh). I have, like, papers everywhere and I, it's a weird, how, um, I process it – like, write things....like, I will write, um, one paragraph on one piece of paper, then I'd have like another piece of paper with something else. It's like I have, like, a million pieces of papers for one essay...and then I have to bring it all together and, yeah, I'd, it's a really weird process, how I write essays. It's sort of, everything's everywhere...yeah, and my thoughts are, like, just in millions of papers...and I have to bring it all together, which is a pain. (Lisa: 830 – 851)

Chris, like Eileen, Fiona and Lisa, also has problems with organising his thoughts and describes a trail of associated thoughts and while his ideas make sense to him, his tutors, he judges, find his work incomprehensible:

And obviously the actual, the task of writing essays because it is about, you know, they want coherency, they want structure, they want ... all those, um, kind of assessment objectives filled, and I find that I'm thinking of one thing...then it goes to another and another and another and although, in my head, they link ... on the page, to an examiner or my tutor.... it's, it's completely incoherent... so that's a struggle. (Chris: 243 – 267)

Samuel too, whilst putting considerable effort into his academic work, experiences problems with making his work logical. Samuel's verbal slip that 'I might come too disjointed', perhaps reveals the extent of the embodied and unconscious nature of his 'disjointed' life-world:

coz I have been told, before, that sometimes, when I'm trying to explain something, that it can, um, I mean, I get a good point, I do, um, a lot of reading....I get, I have good evidence...um, but it's not always very logical...um, I might come too disjointed, in some places. (Samuel: 229 – 243)

### **Control and Attention**

This theme focuses on the lack of control of mind/body that the young people experience both in the moment and over time, which in turn affects sleeping and leads to negative evaluative self-judgement.

Eileen conveys her experience of the separation and control of her thoughts, which often go off at a tangent and seem to have a life of their own. In this extract Eileen seems amusingly exasperated at not being able to switch off intrusive thoughts:

Like, oh, I can't even really remember, but on the dyspraxia, I think I read about it on the dyspraxia foundation – but basically, what happens is I can't get my brain to shut up at night, so my brain won't... I'll just be trying to sleep and then my, and my brain will be, "blah, blah, blah, blah, blah, blah," about some sort of idea or, even just random nonsense or a song which is stuck in my head, which is there all – I always have a song stuck in my head, so that's just a fact of life with me. – (Eileen: 121 – 128)

Eileen has also found that she experiences what seem to be competing ideas that vie for her attention and prevent her from sleeping. It seems that by keeping her attention on one idea coming to fruition enough to be written down, Eileen distracts her wandering attention to deal with the 'building up and building up' of other fulminating ideas in order to hopefully fall asleep.

Plus, when I'm, when I am an insomniac, the reason is usually that I have an idea floating around in my head that keeps on building up and building up...and focusing, if, part of the reason I write is because if I focus on another idea that's already been built up and built up and is pretty much at the point where I can just write it, then that will distract me from the idea that's building up and building up and allow me to, and give me a better chance of falling asleep. (Eileen: 400 – 405)

Kate, like Eileen, describes her problems with control of her sleep, though it could be argued that Kate is not that different to a 'typical' student in her nocturnal life. However, Kate wants to be able to sleep as her experience of repeatedly trying remedies, including sleeping pills, validates. Kate describes her spiky sleep pattern in that she either sleeps 'really intently' or

'lay in bed for hours'. Kate's efforts to improve her sleep pattern are of little avail leaving her feeling exhausted.

R:Um, well, I either, like, if I'm really, really tired, just tend to kind of fall asleep immediately with my clothes on for a few hours, really intently, and then wake up some time at like three or four am and not be able to get back to sleep, or I just, like, lay in bed for hours, and then I've tried to do a few things to help me – like, I got into the habit of watching something on my computer before I went to sleep....and sometimes that helps, sometimes it doesn't, and sometimes I use sleeping pills, but they make me feel really bad the next day. And sometimes just make you feel more tired...when you wake up.

I: Yeah. It sounds as though you're quite drained, then?

R: Yeah (laughs). (Kate: 353 – 372)

Kate laughs incongruently about a topic that is demonstrably not that funny. Kate's laughter may indicate her level of resignation and despondency in trying to cope with her sleep problems and may also be an early sign of a developing thread in Kate's account that she cannot get things right (please see next section: Motor-Perceptual, Kate: 445 – 447).

Fiona too, along with Eileen and Kate, experiences her mind as not in her control, with implications for her sleep pattern and use of sleeping pills:

I never stop feeling, even when, like, I'm in, in bed at night, I'm still thinking. My mind never shuts off...Um, takes a while to get to sleep, so I normally take, um, sleeping tablets and things with, coz if I don't take my tablets, then I just won't get to sleep at all. I'll be up all night. (Fiona: 865 – 872)

### **Motor-Perceptual**

This theme illustrates the perplexing phenomena of the motor-perceptual problems of DCD experienced by the students, which highlights the impact of these issues on day to day living at home and work. Though this issue was not raised by a majority of the students it is included because it is a defining feature of DCD.

Kate is apparently amused at my asking for a specific recent example of DCD indicating that perhaps I haven't quite understood that DCD is embedded in her lifeworld. However, Kate's laughter may also indicate self-deprecating humour in coping with DCD, perhaps inviting my collusion in laughing at it. Kate relates her experience of using an oven, illustrating the perplexing phenomenon that 'nothing seems to fit' and Kate's narrative is that somehow this perceptual difficulty is her own fault, as she notes, 'just coz I was there'. This burgeoning

thread in Kate's account perhaps indicates the impact of DCD on Kate's sense of self-efficacy in living independently:

Well, all the time (laughs). Um, I don't remember what, uh, um (pause), well, I guess the last time that comes to mind was, I think, about two days ago, I was trying to cook this pizza and I'm, like, really confused by our new oven, because it didn't come with any instructions, in our flat, and, uh, one of my flatmates were there, and I was just like, nothing seemed to fit in the oven. It suddenly seemed like everything had just gone wrong and wasn't fitting, just coz I was there. (Kate: 440 – 447)

Chris also comments on his motor skills in his part-time job where he has to tie up packages. Though Chris's learning and comfort level in tying improve during the working day, by the following week Chris dishearteningly reflects that he has to re-learn the tying all over again:

R: Um, but it's, it's kind of like, you know, it's a constant learning process... um, but, and coz... um, going in there and tying the first package of the day is like doing it again, uh, a, again for the first time. Um, you know, as the day passes on, it, it kind of gets a bit easier ... but then, by the time I get back... it's, it's a struggle. (Chris: 597- 610)

## **DCD IN SOCIAL CONTEXT**

This master theme encapsulates a range of interpersonal and social phenomena experienced by the young adults in work and personal relationships. Prevailing cultural narratives are tapped into which impact the young peoples' self-perception, while in their diverse student communities the young people discuss their experience of inclusion and respect.

### **Interpersonal**

The young people describe the consequences of the interaction of DCD in interpersonal situations and relationships, which impacts on their self-confidence and self-perception.

In a work situation where Eileen's functional difficulty with her memory let her down, she experiences her supervisor's anger. While initially open to discussing the situation, Eileen becomes more reticent when we discuss feelings as her avoidance indicates, perhaps highlighting her discomfort in talking about her feelings. Eileen's weariness in the incident is apparent in her reference to time as 'late on', with the lasting impact potentially

undermining Eileen's self-confidence as she adopts a checking strategy to avoid repeating this kind of unpleasant encounter:

I: Well, actually, the best story of me forgetting stuff comes from when I was doing work experience for this builder, and he asked me to get a packet of screws and he told me the specifics of them three times, and when I got to the shop, which was literally five minutes away, I could not remember the size at all. And I didn't even think that he ever specified size even though he'd repeated all of them several times. That's just really stands out because... um, we were late for work because I had to go again.

I: and what was his reaction to that?

R: He was pretty mad....

I: And how did you feel about that?

R: Yeah, well it was pretty late on, and I was getting a bit tired of all of the work that I had to do...um, yeah – since then, in fieldwork and stuff, I just keep on checking ... (Eileen: 224 – 258)

Lisa also experiences the interaction of DCD in an interpersonal situation at work where she felt undermined, exemplified by her mimicking the tone of superiority targeted at her. Lisa's assumption, illustrated by her repetition and emphatic tone on 'I could tell', is that others' ire is related to her 'clumsiness'. Lisa compares her own apparent lack of competence to her colleagues' high level of skill, tapping into a narrative of being the odd one out:

My manager?... No, no, she was a bit, yeah, she was ok, but she used to get annoyed. I could tell... yeah. And like, um, I know a lot of people used to get annoyed about my clumsiness...like, coz, um, like, if someone said something, like, a customer, and I wouldn't, I dunno, it was just like, I felt really dumb there ... because they were very fluent, like, on the phone and stuff, and then... I was very, like, poor at doing, like, all the till stuff and... Yeah, they used to get frustrated. I could tell, coz I would be like, "oh, could you help me?" And they would be like, "oh, don't they teach you anything?"

(Lisa: 2227 – 2270)

Like Lisa, Chris experiences a sense of being undermined in a work situation where DCD interacts with a task. Chris relives the situation by quoting the jibe he felt had been targeted at him. His response of frustration in wanting to 'scream' is palpable in his tone and it is interesting to note that Chris is initially talking about his manager but then uses the plural 'they' perhaps suggesting he has generalised this social perception of himself:

we have to adjust shelves, sometimes, in the store, and the way fixtures are...and trying to just work that out, um, and it really, really upset me a, a few months ago when the manager said, "it's funny how intelligent people have no common sense."...and I just, at that point I really wanted to scream,

because if they had any idea ... how, how something so, so simple to them is, but so difficult for me, then they wouldn't kind of make comments like that. (Chris: 571 – 588)

Tom also relates his experience of the work environment where in a staff meeting his writing is criticised in discriminatory language by his manager. Tom's evident discomfort is apparent by the number of times he says 'em' and he wriggles on his chair. The impact of the prejudice directed at him is shockingly evoked as he relives "it looks like it was written by a retard." Tom's sense of visibility is revealed at being ridiculed 'in front of everyone' which taps into his concern with 'stigmas' (Tom: 1295) and being 'precluded' (Tom: 1014):

I would say in my working life, actually, prime example was, em, when I worked at the superstore, my manager there asked me to write a, eh, it's like a big pricing label for one of the TVs, and me, having my terrible handwriting, I wrote it out, and then the, the following, em, morning, at the debriefing, he blew his lid in front of everyone. He didn't name me specifically, but he said that, he said, and I quote, that, em, "it looks like it was written by a retard." (Tom: 2072 – 2078)

In a more personal context, both Kate and Samuel notice the effect of DCD in their close relationships. In discussing a long-standing friendship, Kate's tone of dismay in quoting her friend's remarks conveys her feeling of hurt that her childhood friend does not believe she has DCD. As Kate relives the interaction, there is the sense, in her friend's remarks, that Kate is making up DCD; that in some way the problems are Kate's fault and subsequently their friendship is damaged:

I've had, uh, a couple of just friendships that dyspraxia has put quite a strain on, so, um, someone who I've been friends with her for a really, really long time – since we were little kids – and she just started getting really annoyed after I got my, um, diagnosis of dyspraxia. Like, she didn't believe me, if I did something really clumsy or especially, if we were trying to find somewhere on a map and I just couldn't read it coz I have so much trouble with map reading. She would just get very, very kind of frustrated at me, and she'd be like, "well, do you really have dyspraxia or is this just an excuse?" ...but it put, like, such a strain on our relationship. It really changed a lot of things. (Kate: 394 – 406)

In Samuel's case there seems to have been a problem communicating with his parents. Samuel struggles to discuss his relationship with his parents as he oscillates between his perception that there is a problem in their communication in 'I can see that' and then isn't sure in 'I don't know'. As Samuel indicates, it is perhaps easier 'not to think too much about' DCD in this context:

I think, I just, I just accepted that I've, I've got it. I just get on with day-to-day life. I do what I have to do and, and I try not to think too much about it... Um, but I can see, I mean, even when I go home for, in the holidays or... and, and see parents, I can see that, sometimes, they have difficulties with me...or they, or they said they, they, they have in the past, maybe, just in terms of having to have clear instructions... maybe more clear than other people....um, just explaining what has to be done, again, the timing... knowing, and how to do it and when, when to do each specific task. I, I can't multitask, personally.... I don't, I don't know if they do, although I don't see them that, that much, now that I'm studying. (Samuel: 718 – 735)

## **Cultural Narratives**

In this theme the young people discuss their experience of the lack of understanding of DCD socially, underpinned by prevailing narratives about the existence and importance of DCD.

While Kate's relationships with close friends have shifted with the recognition of DCD (Kate: 394 – 406), a broader social message seems to be at play as Kate experiences denial of DCD, from within friends' families, which potentially impacts her sense of identity:

I think people have more sympathetic view if they have something, like, a disability or they're, I don't know, they're not neuro-typical in a way. Em, they know, they can kind of understand. So I know a lot of people with dyslexia, really. We have a lot of similarities. But people who have never been diagnosed with that kind of thing, and I think my friends, who have been brought up, um, with their families, say there's nothing wrong with you, and they actually might even be dyspraxic, but they refuse to believe it. They kind of treat me differently. (Kate: 408 – 419)

Kate implies that her friends would have to disagree with their own families' attitudes in order to accept her diagnosis of DCD. Kate, in turn, feels treated 'differently' and now identifies more closely with other people with learning difficulties.

While Chris finds that there is empathy in some social quarters about the difficulties of DCD, he too experiences a more sceptical narrative as to whether DCD exists.

I explain, you know, it's not having the best motor skills, it's, you know, pretty bad at organising stuff and, and, you know and all the various things that I get with it and, you know, most of the time, it is kind of, they think, "oh, that must be, that must be really hard." ...um, but then there are these times where they think, "well, how can that be classed as a learning difficulty? If you're badly organised, you're badly organised. That's just you." Or if, you know, you're clumsy, you're clumsy. There's no kind of...understanding that all these things link up to form, you know (Chris: 622 – 635)

In Lisa's social lifeworld, her use of the metaphorical expression 'brush it aside' evokes the sense that DCD is not taken seriously and perhaps it can be implied that Lisa feels her needs are diminished:

Yeah. Um, see for just, um, immediately think, "oh, you're clumsy," and you're this, but they don't see how it can actually affect someone on a day-to-day life. ..yeah, they sort of just brush it aside like it's not important. (Lisa: 511 – 517)

## **My Community**

My Community reflects the students' experiences of life in their academic communities where student life seems to have provided a more diverse and accepting community than they have sometimes previously experienced.

Eileen contrasts her experience of being respected in her university community with the disrespectful labelling of her learning difficulty elsewhere. Eileen's use of the present tense, her demeaning tone and use of quotation in the expression, 'Retard', possibly indicates that the latter experience is still very vivid in her mind:

They're, most of them, or, are interested or at least respectful. They're not, like, they're not like people who go, "ooh, you've got a disability, Retard." That sort of thing (Eileen: 730 – 732)

Eileen enjoys the diversity of her student experience which seems to offer her greater opportunity to meet a broad range of students, and her internal calculation implies that she can fit in:

students here are very diverse. We've got loads from China...we've...got a few from Japan, India, America... Ireland, Sweden, Eastern Europe. Yeah, but, so, when the students are here, they actually make up a fifth of the population, and this city is pretty big – especially compared to where I come from. So, a fifth of that and you're bound to get some variety. (Eileen 1280 – 1294)

Tom emphasises the diversity of his student community by the number of times he says 'different', perhaps reflecting his own sense of feeling 'different'. Tom expresses that he feels accepted and hints at previous unwanted interest in the past in 'they don't ask questions', while the sensation of 'being 'immersed' is perhaps indicative of his feeling of inclusion in this diverse culture:

at university, it's a more relaxed environment, and, em, obviously there's just lots of different people, different backgrounds, different genders, different races, everything, different religions and, well, because it's an adult learning environment, they, everyone's more tolerant. If you have a learning disability, it doesn't bother them. They don't ask questions, so... (Tom 330 – 335)

All of my roommates were from different countries... it was a very cultural year. I immersed myself there. (Tom: 842 – 848)

Kate reflects sardonically about her experience of the cliquish school environment she has left behind in 'popularity contests'. While Kate now feels more connected in her university community, the implication is that Kate had felt excluded at school.

I guess it is easier in university coz, especially, just coz I'm with people that I have more in common with, in the subject I'm doing, and a lot of kind of, the childish stuff I found was dropped in, like, the cliques and popularity contests. (Kate: 795 – 798)

Fiona's experience of her university community shows a step change from her initial struggle with independence (L58 – 62), as in her confident and positive tone, Fiona begins to appreciate being accepted:

it's just, I think, I don't know how to explain it – it's just so much, even though it's, socially, it's harder, everyone's just grown up and they're more accepting, I think, is the word. (Fiona: 1165 – 1167)

## **DCD IN PSYCHOLOGICAL CONTEXT**

The young people discuss their experiences of a range of psychological phenomena. Some of these experiences are linked to experiencing stress and are conveyed in overwhelm, worry and social anxiety. Additionally, the young people try to make sense of their lived experience of DCD and describe how they compare themselves to others and highlight their difficulty in trying to explain DCD to themselves and others. They cope with DCD by using humour and struggle to maintain personal equilibrium in balancing self reliance and support. Finally, the students describe how they conceal DCD in trying to fit in socially.

### **Overwhelm**

The following extracts from Eileen, Kate, Sandra and Tom convey the experience of the intensity of overwhelm, a sensation of not being in control, of strong emotions and sometimes distressing behaviour.

Eileen's experience of overwhelm seems to affect her capacity to contain emotional distress as she consciously tries to repress her emotions for as long as possible, noticed in the physicality of her language to 'hold them in'. Eileen ignores her emotions until they become so overwhelming that she expresses them in 'crying' or 'shouting' and judges herself as she tries to stop her outbursts. Though Eileen seemingly contradicts herself by saying she 'doesn't really notice' her feelings but is aware of 'holding them in', perhaps not being 'good at telling' how she feels may help to make sense of this disparity:

R: Yeah. I seem to be a bit more of a repressor these days.

I: do you want to tell me about that? What does that mean, a repressor?

R: Um (pause), basically, I hope, basically I hold them in and I don't really notice them until they reach breaking point...

I: So what happens then?

R: Uh, probably end up in my room crying for a while or some, or shouting at something, or... I've been trying to stop myself from being like that but it's difficult when I don't, I'm not really even good at telling how I feel. (Eileen: 976 – 1001)

As Kate encounters challenges in doing household tasks, her experiences can also be suffused with overwhelming anxiety. Kate's experience of getting things wrong (Kate: L446) seems to have developed into a vicious circle of anxiety and avoidance in cooking, with her perceived power of destruction apparent in her exaggerated language of 'burnt down' a microwave:

R: Yeah, no, I just, like, break things. I use them the wrong way and that makes me very, um, nervous to, like, do kind of proper cooking or use gadgets.

I: Yeah, ok. So nervous about it? What, anxious?

R: Yeah. Anxious, just because, like, I've done so many things, like, I've burnt down a microwave in my friend's house coz I was trying to heat up some soup in it. (Kate: 460 – 468)

Kate's anxiety at not being able to do daily tasks 'properly' (Kate: L73) seems to be so great at times that she potentially dissociates as the overwhelming sensation feels like 'a fog in my mind' or 'a blackout'. Her attempt to make sense of this oppressive sensation or 'dyspraxic moment' is to attribute it to DCD, which seems to take over as a malevolent presence as 'it knows I am not going to get this right':

Me, they really don't know what it's like at all, and I don't think I'm using it as an excuse, but I am just thinking that a lot of things that I do are because of dyspraxia, now. And sometimes I get, like, so stressed if I'm lost or things keep going wrong that I just have this feeling, in my mind, that like this is

such a dyspraxic moment and it's like kind of a fog in my mind, or like a blackout or something, that like, nothing is gonna happen. It knows I'm not gonna get this right, which I always think is some kind of, yeah, dyspraxic, um, dyspraxic ten minutes or so happening. (Kate: 562 – 570)

Sandra experienced a sensation of being so overwhelmed in lectures that she felt she might cry and her nervous laugh perhaps demonstrates that this is not an easy topic for her to discuss.

R: Erm, when I first like had the like lectures and stuff.

I: Right. And what happened? How did you know you were anxious?

R: Erm, just 'cause like I wanted to cry (nervous laugh). (Sandra: 681 – 685)

Sandra tries to rationalise that, in these overwhelming situations, she should stay calm and engage cognitively with her distress but her experience is that she is engulfed by the immediacy of her feelings:

R: Erm, well, yeah, it's like.. it's like then if I calm down and then think about it logically, it does make sense...but then it's just like, in the moment... (laughs). (Sandra: 726 – 731)

Tom's experience of emotional overwhelm is to conceal it by constructing a facade. Below the surface though, Tom shares his experience of extremely powerful emotions in his analogy of a 'nuclear reactor going into meltdown'. Though Tom does this with a sense of cartoonish humour in 'all the people with hardhats running around', the analogy chosen indicates how he feels he needs to shield his emotions in case they get out of control continuing his analogy to its natural conclusion potentially implying that an emotional breakdown would be hugely destructive.

R: It's, it's all internal. Uh, if you were to, if you were to look at me from an outside perspective, you probably wouldn't guess it, but...

I: So if I was to, to see inside, what would it be like there?

R: Eh, I would picture a, a nuclear reactor going into meltdown. All the people with hardhats running around panicking and everything. That's, that's it, pretty much.

I: Right.

R: Chernobyl. (Tom: 1897 – 1908)

It's more, well, it's kind of an analogy if I say Chernobyl, but, em, I, I'm kind of more worried about the results than the process...and, as you know, the results of Chernobyl were global, so...

(Tom: 1920 - 1926)

## Worry

In Worry the young people describe their experience of worry, a persistent sensation they struggle to describe.

Tom can only describe his experience of worry by its embodied nature, which he believes is linked to DCD:

I'm in a constant state of worry, I would say. But, em, if I was just, to describe it physically, it's like a constant tightness in my chest. That's probably, that's the only, that's the only way, like, I'm able to describe it, really...but, em, yeah, I would say that's, that's tied in, definitely. (Tom: 1855 – 1862)

Fiona too refers to the persistence of her worry, in her case 'over-thinking', which seems to feed on itself as she too struggles to find words to describe the experience:

R: I'm constantly thinking, but I don't know if that's a good thing or not, coz I tend to over think stuff.

I: What do you mean over think stuff? What sort of stuff?

R: Um, just, um, it's like, if I'm upset about something, I'll start thinking about it, and then I'll think about it even more, and then I'll, I'll just, like, go off on tangents about stuff related – I can't explain it. (Fiona: 849 – 856)

Sandra specifically worries about her academic performance. In this extract in discussing study strategies put forward by her Tutor, Sandra is already experiencing worry about next term. Sandra's Tutor discussed the availability of counselling support with her but Sandra's immediate response, ironically, is one of anxiety. Sandra laughs as she recognises that her anxiety is potentially quite habitual, though seems to be seriously considering talking to someone to deal with her stress:

R: Erm, well they tried to em like break it down into like the smaller bits, like, erm, like the first year's just, er, learning how to write your assignments and it doesn't count towards your final thing. But then I'm like, well, then if, er, I get a bad mark like this year, if though I'm knowing like, it's not a very good indication for ...assess like work next year em. And then... and then... 'cause they were like, well, if it's like a emotional like issue, then you could go to the counselling people.

I: and how did you feel about that?

R: Erm, well, it was like, erm, it was like I do need to talk to someone about it, otherwise it won't get sorted, but then I was anxious about... (laughs). (Sandra: 696 – 711)

Chris worries about his future personal and professional identity. He refers to himself as 'daddy not being able to do shoelaces' and seems to be judging himself against the social identity of a protective and competent father, implying that he feels he might not match up:

Um, and, but it's, there are things that worry me and I get anxious about because I think, uh, obviously I'm thinking about my career ... then, kind of, stuff like that....Um, I mean, obviously having children, and then daddy not being able to do shoelaces ...not being able to do my own shoe, you know? Stuff like that is kind of, you think so much of the future and what, what, what will happen and how, how will it affect you. (Chris: 2134-2150)

### **Social Anxiety**

In Social Anxiety the students describe the sensations, self-perceptions and strategies they experience in social situations.

Tom shares with me that he believes I must have noticed his difficulty with maintaining eye contact, perhaps indicating his self-monitoring focus in social situations.

Well, for what you've probably seen for yourself right now, that I find it very difficult to keep eye contact with people. I can, I can only keep eye contact for a certain amount of time... I compensate this by, like, looking at other facial features and looking back to the eyes (Tom: 506 – 517)

Fiona describes her intense embodied experience in some social situations, including emotions and physical reactions which lead to negative self-judgements:

...or start, em, shaking and feeling re..., more negative than I normally do, so... I start getting paranoid about, like, nobody, like, really likes me and stuff. (Fiona: 918 – 936)

Lisa is uncertain about whether her difficulty in talking to people is related to DCD. Her embarrassment, indicated by her laughter, relates to her uncontrollability as her speech is 'all over the place', which can perhaps be related back to Lisa's experience of fragmented thinking (Lisa: L 847). Lisa's level of anxiety is particularly acute as she compares her discomfort to her peers' lack of nerves, which again positions her as the odd one out:

I don't know if it's to do with the dyspraxia, but I do find it hard to speak to people...um, just approaching someone. I find it very difficult because my speech is very, I'm all over the place, at times, as well. Like, um, I often try and say things but something else comes out. (Laughs.) It can be quite embarrassing. Um, so yeah, I do find it hard to approach people ...and speak to people, but it

varies. There are situations when I can be ok and I'm just talking normally, but other times, I think, I'm very nervous? ... like, when we do group work and stuff...Um, I tend to get more nervous than usual people do...like, my friends will be really calm and then I'll be the one that's, like, panicking...and yeah, I find stuff like that very, um, not comfortable. (Lisa: 604 – 636)

In contrast to Tom, Fiona and Lisa, Samuel seems to turn embarrassing social situations into opportunities for fun. Perhaps Samuel still experiences some tension as he seems hesitant to refer directly to DCD or tell his friends about it, and by making himself amusing he is covering up his DCD:

(Laughs.) Um, I think they find me quite amusing, quite, I think, like, they'd go I don't think they, they all realise that, that I have the, the, the difficulty...um, I might do something unintentionally ... that I might not realise I'm doing... um, but I get, make friends out of it – they, I have some good friends, um, we, we have fun times, we mess around (small laugh) (Samuel: 630-646)

## Comparing

In this theme the young people try to make sense of their lived experience by comparing themselves to others or against their perception of 'normal'.

Eileen shows in comparing herself to 'normal' that her understanding of 'normal' is quite stereotypical though she is tentative as her hesitancy displays:

normal is just people who, yeah, well, mm, normal would just be like, that your average person at this... average person, they (pause) I guess normal for here would be a student who enjoys drinking a lot, probably has all-nighters... (Eileen: 1321 – 1324)

Eileen judgementally refers to herself as 'weird' highlighting how different she feels but also hopes that in a large university social setting she can find a niche. Eileen has a burgeoning understanding that within the broader spectrum of university she might be able to integrate, and 'normal' takes on a less imposing tone expressed as 'just normal':

I guess (pause), I guess, since the population is higher and there's clubs and stuff, I actually have a decent chance of finding people who are as weird as I am, that I can actually talk to, rather than people who are just normal. (Eileen: 1313- 1316)

While Eileen compares herself globally to others, Tom's comparison of himself is more nuanced as he compares himself to 'average' across different situations:

Because it's, because I have DCD, I, I know for a fact I'm going to have to work harder than your average student, so, em, and the DCD ties, well probably ties into the fact my organisational skills as well. (Tom: 955 – 957)

In terms of generally, em, because it makes things harder, I would say I'm more prone to, to stress than the average student. (Tom: 1779 – 1780)

Lisa has compared herself to her colleagues, experiencing herself as the odd one out (Lisa: L604 - 636). This time Lisa compares herself unfavourably to family members, wistfully accepting that she 'can't help' the way she is:

Yeah. And my, my cousins, they're very, um, they're very, they're like the opposite of me. They're very organised, and then it, I'm like the complete opposite. I'm very unorganised, very poor time management and, yeah. It is like quite, it is quite like, oh, I wish I could be like that... I can't help the way I am. (Lisa: 2146 – 2154)

Samuel, who we have seen can adapt embarrassing social situations to his advantage (Samuel: L622 - 646) also acknowledges that DCD poses more social and organisational difficulties for him than his peers:

So I mean, things that I find difficult, or more difficult than other students who, who don't have a disability, perhaps...uh, are things to do with, um, organisation and, maybe, if there's a lecture change or ...no, no, and, and the social life, as well. (Samuel: 90 – 100)

## **Resignation and Acceptance**

The theme Resignation and Acceptance illustrates how the students resign themselves to the circumstances of being a student with DCD even though student life can sometimes be more difficult for them.

In this extract about her choice of living arrangements, Sandra's adjustment to her circumstances is apparent. Finding student accommodation was very challenging for Sandra, illustrated by her exclamation of 'gosh', and the fast pace of her language. Never the less, Sandra relates her adjustment narrative in 'but then it worked out in the end', as she focuses on the positive aspects of her living arrangements:

So, then, erm... and then, yeah, and then at first it was like, gosh what am I gonna do, and then there was a day where you met up with people to... then, erm, then you formed a group and then you went to find a house. So, at first that was like really, really like daunting (laugh)...erm, but then... but then it worked out in the end, 'cause now the house is, erm, like really close to uni. (Sandra: 952 – 960)

In Lisa's case, her inner dialogue of 'just let me see', tempered by her expectations that 'uni's not meant to be a piece of cake', seems to provide Lisa with the motivation to keep going in the face of the uncertainty and challenge of university:

But then, um, I thought, you know, not a lot of people get this opportunity to come to uni, ... and this is not a bad uni and, um, I've got this opportunity – let me just take it. And then I thought, "let me carry on... see what happens." And I met good friends, and I thought, "ok, let me just see." And I just, yeah, I just went by ... and I just thought I'll stand by it. Everything's went, uni's not meant to be a piece of cake. Yeah, exactly. So I thought, it's not going to be easy. It's meant to be difficult, so yeah....this is what it's meant to be. (Lisa: 1954 – 1983)

Chris too relives the internal debate he has experienced in resigning himself to his limitations with DCD as he pragmatically figures out what he can and can't achieve:

you're, you don't trust yourself because you think, "oh well, I can't, I, I shouldn't really do that because..." I shouldn't, you know, allow myself to do that because of this reason. Um, so in many ways, within yourself... you're setting limitations. Um, yeah, I mean, I think there has to be a time when you say, "well, this is what I can do. This is what I can't. This is what I find a struggle, but I could probably do it in the end." (Chris: 1597 – 1610)

## **Explaining**

In the theme Explaining the students relate the frustrating experience of trying to explain DCD to themselves and to others, and in some cases, to justify their difficulties.

Kate tries to get others to understand DCD but her efforts are confounded in a sort of paradox; that she can experience DCD but finds it difficult to explain it without a script. Kate perhaps inadvertently bolsters the perception that there 'is nothing really wrong' (Kate: L417):

I have, um, explained it to them. I live with three girls and one of them's dyslexic, so she seems to understand, but then, I have had a few kind of minor problems with one of the other girls who, I tried to really explain my dyspraxia is to her, but she wants to know, like, in a lot of detail, I'm like, if I'm

just there without any kind of writing about it in front of me, I can't explain it that well (Kate: 512 – 517)

Lisa also tries to explain DCD to others but, like Kate, she is sabotaged by her own poor understanding of DCD. Her repeated use of 'just' emphasises her experience that others underestimate the impact of DCD, leaving Lisa feeling misunderstood:

I have tried to explain it to them, but because I can't explain it myself... I don't think they actually know what dyspraxia is. I think they just, because I have elements of dyslexia as well...they just, I think they just think I have that ... and they completely forget about the main part, which is the dyspraxia.  
(Lisa: 665 – 680)

Chris also wrestles with the difficulty of explaining DCD to himself and others and the use of 'stunted' in his vocabulary maybe hints at the pejorative misunderstanding he is trying to overcome:

Well, it is very difficult to, to explain it to myself, coz I think, well, my thought process is, isn't stunted or, or diff..., it, it's different but it's not worse than anyone else's...um, but it's, it's, it's difficult to, to kind of communicate that. (Chris: 1049 – 1055)

## **Humour**

In the theme Humour, the students illustrate their use of humour as they engage and develop rapport in the research interview, which perhaps reflects a strategy they use to cope in general with DCD.

In the research interview Eileen makes fun of her co-ordination problems. Feeling safe enough to tease me with her humour, we both end up sharing the joke but this self-deprecating stance enabled Eileen to build rapport between us as my response testifies:

R: And dyspraxia can be helpful in doing stuff like that, as well.

I: What's that?

R: Those squiggly lines.

I: how does it help?

R: Um just because it's, without-, with the problems in co-ordination, it's a, easier to make them look more squiggly. (Both laugh).

I: More squiggly squiggles, I love it.

(Both laugh.) (Eileen: 1492 – 1503)

Fiona, like Eileen, uses self-deprecating humour in relating to me, laughing about an embarrassing incident. Although amusing, Fiona again makes negative self-judgements of herself, a thread that repeats in her account (Please see final section: Me and DCD, Fiona: L693 – 711):

R: I feel, like, a stupid ... and I just laugh about it later, coz you have to.

I: but at the time, at the moment, how do you feel about it?

R: Yeah, it's like, 'I don't believe I've just done that'.

I: And do you think anybody's noticed?

R: Well, no-one said, but...

(Both laugh.) (Fiona: 680 – 691)

Although sardonically making fun of DCD in this excerpt in which we both laugh, Kate seriously makes the point that she experiences DCD as having a more severe impact than Dyslexia and sees no redeeming qualities in DCD:

well, I kind of can't see many positives to it...and I've found just people with dyspraxia are saying that they really can't see anything else, because there's always, like, there's books called The Gift of Dyslexia, which like...that title, every single person I meet with dyslexia has that book in their house, somewhere. I've never found The Gift of Dyspraxia.... (Both laugh.) (Kate: 828 – 844)

## **Overcoming**

In the theme Overcoming, the students convey their experience of trying to make up for DCD and provide a glimpse of their complex inner experiential lifeworlds. They persevere in overcoming DCD to retain a sense of self-reliance even though the consequences may be demanding.

Key to Eileen's coping with DCD seems to be a sense of persistence, though in some ways this may also reflect a broader social narrative of overcoming difficulties. Eileen relates her competence in field work with a sense of determination that she can overcome DCD and 'can work past it' as though it is a separate barrier to be negotiated (Eileen: L747):

I'm... uh, part, a partner in fieldwork and stuff, and...who has dyspraxia but doesn't really let it get in her way and acknowledges it. (Eileen: 1071 – 1072)

However, Eileen's sense of personal equilibrium in overcoming her difficulties is finely balanced. In particular, Eileen seems to experience an internal equating process in

balancing her self-efficacy with the support she receives, which, if it gets out of kilter, induces anxiety that in some way she is being privileged over her peers. Her concern about the perceived imbalance of the level of support offered at university is perhaps conveyed in her repeated reference to quantity:

Well, I try, I, I usually try and get everything done, not too, without using too much of my extra time, because (pause) because I just (pause) I don't want..., I know that I have a disability but I don't, I don't want to accept so much help for it that I have an unfair advantage over my friends and stuff, or, indeed, even over the people I don't like, who happen to be in my classes. (Eileen: 1700 – 1706)

While Kate values help academically and emotionally in trying to overcome the problems she faces with DCD (please see Personal Support: Kate, 667 – 676), she paradoxically experiences a dilemma in asking for help. Kate seems to be trying to obtain support but weighing into this equation is her fear that others will find her needs too demanding and perceive her as a 'burden':

R: ...and you shouldn't be afraid to, but I think it's part of dyspraxia that I've kind of discovered that I need, like, very little instructions, so you know like sort of but I just mean for, like, anything anyone asks me to do. I need them to tell me exactly, and sometimes I just feel like I'm taking up too much of their time or annoying them by saying, like, "can you explain this better?" ..or "What exactly should I do?"

I: How would you describe that?

R: It, it, almost just like a burden to people, in a way, if I keep having to ask. (Kate: 1191 – 1206)

Sandra explains how hard she works though she can't quite define if this is a 'perfectionist' characteristic or a way to make up for DCD, perhaps illustrating the duality of Sandra's experience of her sense of self:

I am quite like, erm, well, I do like work really, really hard and em like a bit of a like perfectionist as well, but I..I don't know if that's just like what I'm like anyway or trying to, I don't know, in some way like over, overcompensate (laughs). (Sandra: 655 – 658)

There is a danger in her desire to 'over-compensate' that Sandra can over extend herself. In Sandra's use of a driving metaphor she highlights that she does not always know 'when to put the brakes on'. Extending the metaphorical idea of driving further we could imply that Sandra might crash as she becomes 'really exhausted':

R: But then, erm... and also like with the, erm, the Judo or like work, I'll like push myself like too far, like then I won't know when to stop.

I: And what happens then?

R: Erm, just get like really exhausted.

I: So, you get a bit too tired then... so, it's kind of knowing...

R: When to put the brakes on. (Sandra: 1752 – 1762)

In the following extract Lisa displays a dialogic quality of her experience as she talks to herself to overcome the frustration of DCD. The physicality of her language describes how she 'picks herself up', not only to overcome DCD but to succeed in her life. Lisa's self-talk takes on quite a demanding tone in 'I just have to work myself':

I: So how do you deal with that frustration? What happens, how does that affect you?

R: I just, uh, I just have to pick myself up, really, and just say, "I'm not gonna let this, you know, stop me from doing what I wanna do." ... I just have to work myself and, you know, I've got dyspraxia but I'm not gonna let it stop me from achieving what I wanna achieve. (Lisa: 760 – 769)

## **Concealing**

It has already been illustrated that the students struggle to balance their social and academic lives and can be subject to difficult interpersonal situations. In the theme Concealing, the students cope socially by concealing DCD.

Tom, as has been noted, has experienced instances of ridicule (Tom: L2072 – 2078) and in this extract conveys his coping strategy of concealing DCD to avoid being treated differently. Tom's language is fluent and his tone forceful, emphasising how important it is for him not to be treated differently:

R: there's never really, it's not brought up, really, in conversation at all. No, but it's either a case of people don't care, which I think's pretty good of, I think – I prefer the fact that people don't care, to be honest...coz it shows that I'm not being treated any differently for, or being labelled, so yeah.

I: Is that important not being treated differently?

R: I would say it's very important, yeah, because, um, you don't feel like, like an outcast in any way, if you're treated the same as, eh, as everyone else. You're not, there's no labels applied to you. There's no stigmas applied to you. You're not discriminated against or made fun of. (Tom: 1279 – 1296)

Lisa too has experienced ridicule (Lisa: L2227 - 2270) and she also copes by concealing DCD. Lisa recognises the prejudice inherent in the 'stereotype' of a learning difficulty and her

reticence at letting others know about her DCD is emphasised by the number of times she repeats versions of conceal ,e.g., 'don't really tell', 'keep it to myself' and 'not something I would, like tell'. The clue to Lisa's discomfort at others knowing about her DCD is perhaps provided by her reference to her perception of the stigma of DCD, that others may judge her as unintelligent:

I don't really tell a lot of people... I'd rather just keep it to myself and just, people that are close to me know ...but it's not something I would, like tell people on the course and I just wouldn't feel comfortable telling them...coz, again, people, yeah, they have stereotypes and they'll be like, "oh, she's got a learning difficulty. She must be very, um, dumb," or whatever. (Lisa: 1666 – 1685)

Sandra shares with me in the interview that she has not told her friends about DCD and her reluctance to discuss this topic is indicated by her closed 'No'. By my gentle probing, Sandra reveals that her concealment of DCD is because she believes it may affect how she fits in. There is some ambiguity though, as Sandra flips between agreeing 'yeah' it would affect her ability to fit in and not being sure 'I don't know':

R: Yeah. And then also I don't know if I'd want them to like know anyway (laughs).

I: You don't want them to know?

R: No.

I: Do you want to tell me a bit about that?

R: Erm, just, er, that it's like the thing of like trying to like fit in, so...

I: What, are you concerned if you told them you might not fit in so well?

R: Yeah, I don't know. (Sandra: 344 – 358)

Samuel's usually positive narrative is contradicted here as he too admits that he conceals DCD or 'things like that' as he tries to ensure that he can fit in and have fun:

R: I don't like to publicise things like that too much.

I: No? How come?

R: I just feel that, I mean, I don't sort of see them all that much, in terms of when I, with, with them doing different courses and lectures, and me, that, um, try..., studying, and maybe they might, might have graduated now, they might have, em, they might be doing other things...but, but I think I'm independent. I try and get the reading done, um, and try and get the work done, first ... before I can sort of party too hard, if you like. (Samuel: 842 – 859)

## DCD AND SUPPORT

This master theme outlines two areas of the young peoples' experiences of the support that enables them to cope with DCD. First, there is formal learning support experienced in an educational context. Second, there is personal support experienced in the context of relationships.

### Formal Support

Formal Support reflects the students' experiences of the practical support they receive in the formal educational environment including resources, processes and one-to-one mentoring.

Tom describes how his experience of the student support system filters through unobtrusively so that he can sit his exams without fuss, potentially indicating the importance to Tom of minimising the visibility of DCD (Tom: 1279 – 1296). Tom's verbal slip 'I'm a support' may imply how embedded his need is for a support system:

A prime example, actually, would be last week, because, um, because I'm a support, because I'm in, um, student support, um, I'm entitled to do all of my exams on a computer, and because of that, um, the tutors, um, can put the exams down to the student support base, and then I just go there, sit the exams and leave. So, um, one of the tutors ...she, um, had told me that she'd already put the exam down – so it shows, shows to me, as a student, that it's ok, working, if she's, um, following due process. (Tom: 462 – 477)

Fiona emphasises her beneficial experience of one-to-one mentor support attuned to exact literal instructions, which has helped her pass her re-sits and implies that talking things through has also helped meet her needs:

R: If I'm stuck, he'll recommend me, if I, what I should do...so I think that's been really helpful.

I: What do you think has been the most helpful?

R: Just when I've been talking to him and the suggestions he's given me about, like, simple things I'd, hadn't thought of when I was doing my, um, my case study. I had, um, the re-sits you do, and he just recommended me to go and look at some journals. He showed me exactly where to look and what to look for...and that really, really helped. (Fiona: 549 – 570)

Sandra has also been provided with a Learning Support Tutor at university to help her organise her work, and she seems to have established a relationship with her tutor, illustrated by her use of 'we'. Sandra's tone and language are positive and direct in this next extract in

comparison to her often hesitant communication. While her fluency may reflect that this comment is made towards the end of the interview where she may be feeling more relaxed, it may also reflect Sandra's comfort in having someone to share her academic concerns with:

and also if there's something that comes up in the week then I'll e-mail her and then we'll go to talk about it on the next session, so ...then it's not like I have to remember all for that session kind of.  
(Sandra: 1377 – 1383)

Lisa experiences a change in her Tutor's attitude following recognition of DCD. In reliving her interactions with her Tutor, Lisa assumes that she knows his thoughts as she states 'I can tell', and appreciates the extra effort which she believes he is putting into working with her:

So, (cough) but my Tutor, I feel as though, ever since he's found out, now, he is more, um, he goes through things ...more with me. Like, before, he would just be like, "ok, Lisa, do this." But now, I can tell, like, he looks to go, "ok, does she understand what I'm saying?" ...and he goes through everything more thoroughly, yeah...which is really helpful. (Lisa: 1718 – 1733)

Chris, in contrast to some of the other students, experiences a less supportive attitude from a lecturer. The lecturer seemingly expounds a view that individuals with DCD and Dyslexia will have been diagnosed prior to young adulthood which Chris finds disconcerting and is at pains to refute:

And it was, it was kind of, um, I was, the, um, the guy I met who's dyslexic, we went to one of, of the tutors the other day, who's quite senior ... in the university, and, um, he, he was basically saying that he hadn't had his DSA ... through and, um, had only submitted, um, an essay that was quite severely under the word limit and, um, he was kind of like, "well, yeah, you know, when, when was contact made between you and the disability and dyslexia service?" and what have you – and, um, and I kind of raised the point that lots of people don't know they're dyslexic or dyspraxic until they arrive at university. That was something that he just couldn't believe...people don't, don't, ... don't think that that, that's an issue, and it really is. (Chris: 1843 – 1871)

## **Personal Support**

Personal support is characterised by the young adults' experiences of understanding relationships in their daily lives.

Eileen and Fiona seem to benefit from non-judgemental personal relationships. Eileen refers to her 'big old support network' (Eileen: L1030) in a slightly self-deprecating way but it is apparent that there is one particular friend whom she values as unconditionally accepting:

Well..., she's just a, she just has a really great outlook on life, and she doesn't, if I, there's something, I know that she won't judge me for anything. (Eileen: 1019 – 1020)

Though Fiona keeps her discussions about DCD within the confines of a few close relationships, she does talk about it 'a lot' and really appreciates the experience of others listening and understanding that she is not 'stupid or lazy':

Mm, just, like, listen to me and, um, not making, like, they understand that I'm not stupid or lazy, and just like listening to me about it just really helps. (Fiona: 623 – 625)

Lisa also experiences warmth and acceptance in a friendship but she also implies a more indefinable quality where vocabulary fails her as she describes her friend as 'just one of them people'. Though Lisa never feels 'strange' in her friend's company, the implication is that she has experienced this sensation elsewhere:

there's one friend in particular. Um, I don't know, it's just, she's very, um, she's just a very loving person. She's very, um, warm and friendly...you know ... there are people you can just open up to...and she's just one of them people. Like, you can talk to her about anything and she will never ever, like, think you're strange or whatever, and she does the same to me, as well. (Lisa: 1605 – 1620)

Tom struggles to describe the 'comfortable' felt sense he experiences around his female friends, evoking a social narrative about women as caring and nurturing. Perhaps part of Tom's comfort around his female friends is that he is less vigilant than he would be around other males:

R: Let's see... Oddly enough, I would say it's my female friends who have been more supportive...than my male friends...not that my male friends haven't been supportive, but I'd say that my female friends are a bit more supportive.

I: So tell me about that then, if you can.

R: Um, uh, I know what it is, but I don't know how to put it into words. Maybe it's just female psychology, I would say. You know, it's more of a female, maybe caring, nurturing, etc.

I: Maybe you could tell me how you feel around them?

R: Em..., I wouldn't say I was any different, but I would say I feel a bit more comfortable, to be honest. (Tom: 652 – 675)

Kate's experience of personal support through therapy has been positive as she emphasises the time and depth devoted to the therapeutic process. Kate refers to her relationship with the Psychologist in terms of 'we' potentially indicating some closeness while highlighting the importance to her of someone who implicitly understood DCD:

R: Um, just going to talk to someone, I think, at length each week, and someone who really understood, especially, like, in-depth, the kind of, the science of it. We didn't really talk about that, but I just knew that he understood.

I: You just knew it?

R: (Laughs). Mm, I just, like, if we mentioned it he would say, "oh, this is because of," whatever, and he had the jist of, had a lot of, like, other experience with dyspraxic people.

(Kate: 667 – 676)

Contrary to Kate, Chris does not feel his emotional concerns about DCD would be taken seriously. Chris's use of 'excuse' potentially suggests that he may feel judged in utilising a therapeutic relationship for a learning difficulty though Chris expresses his feeling of isolation in coping with DCD:

I don't, because I don't think people really would take it seriously...and I think, you know, if you, if you talk to a psychologist, you know, you go to a psychologist for, you know, all sorts of reasons...but I don't think coping with a learning difficulty is something that people really think about as a, as a reason or an excuse to go to a psychologist or a therapist or a counsellor. It just isn't there, and when I was diagnosed, and again, when I was reassessed recently, that wasn't suggested to me ... is there someone you want to talk to about your, you know, your learning difficulty or your struggle with that. It's never offered as, as something, ... um, so you're kind of, it's, you're very much, you know, I felt, personally, very much alone ... in, in that. (Chris: 2098 – 2130)

## **DCD AND YOUNG ADULT – DYNAMIC SELF**

Across the testimonies of the young adults' accounts of their lifeworlds there has been a trail of the ongoing impact of DCD on issues of the self, including self-confidence, self-efficacy, self-perception and identity, which dynamically combine with the young person's background in the evolving young adult self. A particular theme in the students' backgrounds has been the impact of the discovery of DCD on their sense of themselves. However, it is through the young peoples' experience of the relationship of the self with DCD

in the theme 'Me and DCD' that the impact of these cumulative experiences on the self can be further illustrated.

### **Discovery**

In the theme Discovery, the young people reflect on the way that finding out about DCD was disruptive to how they saw themselves. In some cases childhood memories are evoked emotionally in the here and now, while in other cases the memory is more recent but with implications for the student's view of him or herself.

Eileen's evokes vividly the repercussions of the recognition of DCD in the classroom. Eileen's child view of herself was apparently disrupted and was now that of being outside looking in on how she previously saw herself. We get a sense of the salience of this experience of exclusion being relived through Eileen's narrative in that, even though she says she does not seem to remember much about the childhood events surrounding the discovery of DCD, and, that she perhaps tries to play them down as expressed in her repeated use of 'just', there is a sense of loss in her expression of who she 'was supposed to be':

Well, I was just really, don't even really remember that but I just remember, I think I would look, look at the year I was supposed to be table (Eileen: 873 – 874)

We can perhaps picture the young child, Eileen, sitting in class, detached now from her peers, and understand the perceived turmoil in her childhood life-world which, post DCD discovery, has transformed her into a 'scary' child:

And I think ... I think that might be the time, now, about the time that I became the really scary child (small laugh). (Eileen: 880 – 881)

Tom also recalls his confusion in the process of discovery of DCD as a child, in his expression of how he 'found myself' in disciplinary situations without, it seems, a sense of how he got there:

And, em, basically, what's, what, what was my DCD, she (teacher) assumed was bad behaviour.... So I found myself constantly at the head masters office and everything, at that year. (Tom: 1083 – 1089)

While Kate had always experienced a range of discrete learning problems and had thought they must be connected, she did not realise until university that her constellation of problems

could be DCD. Kate's language produces a negative narrative about her abilities including the repetition of 'bad' and the emphasis she puts on 'really' clumsy:

I just like, always had quite a bad memory and in, in a way, un-coordinated and bad at sports and really clumsy and stuff, and all these things just kind of linked together, and I always thought there must be something that is wrong with me, somehow. But I never knew that it could be like one thing or one diagnosis. (Kate: 764 – 768).

Kate now has a coherent answer to some of the difficulties she has experienced in her life-world but her conclusion has been, and still seems to be, that there is something inherently 'wrong' with her.

Lisa's experience of the discovery of DCD as a young adult also has an impact on her sense of herself. In this extract, Lisa had assumed that her learning problems in school were because she was unintelligent. On learning that she has been assessed as having DCD at university, we can see that this discovery has been a revelation for Lisa and her repeated use of 'never' underscores how far from her mind it was that she had a learning difficulty:

the thing is, at school, I had all of these problems, but I just thought, um, I was maybe a bit, just a bit on the dim side, maybe. I never thought, like, oh, maybe you have a learning difficulty or something. (Lisa: 372 – 375)

Along with the recognition of DCD, for Lisa, comes frustration that in some way now this discovery means that she is now identified as being not 'normal'. Consequently Lisa experiences low mood and the intensity of her emotion is captured by her use of 'really down', while her resignation to her new status is exemplified by her sigh. Lisa's sense of self has shifted away from 'dim', but her revised sense of self seems to leave her feeling excluded from being 'normal':

It makes me feel really frustrated. Um, it gives, like, I suppose it gives, like, a reason behind it, now ...but I do get really down in the dumps, at times, and it does frustrate me a lot because you just want to be normal. (sigh) Yeah. (Lisa: 397 – 414)

Chris, who had been given a diagnosis of DCD as an adolescent, however, experiences a feeling of relief and a sense of inclusion that there are 'people like me'. While for Chris the experience of recognition means his identity is now not 'abnormal', his narrative also

illuminates the scale of adjusting to the discovery in his repetition of 'coping with that', 'knowing about it' and 'even just thinking about it':

I mean, I think it's bad that I was only diagnosed at sixteen ... but if there are people that are getting to eighteen, nineteen and not, not knowing... But it's such a relief ... when you do know. It's such a relief, coz you think, "well, it's fine." You kind of, there is this kind of, um, you know, just, you just feel that, ok, well, it's got a name. I'm not abnormal. Um, there are people like me, not, I'm not unique in, in this. Um, obviously each dyspraxic person has, has their own individual struggles but there is a common, um, diagnosis. But coping with that, particularly, you know, and knowing about it, even just kind of thinking about (Chris: 1875 – 1895)

## **Me and DCD**

In Me and DCD, the testimonies of the young people illustrate the impact of DCD on their sense of self, highlighting their dualistic and ambivalent relationship with DCD and in some cases the active construction of their identity in relation to DCD.

Fiona does not want to be defined by DCD alone:

I didn't know about it (Disabled Students Allowance)...and I didn't wanna apply for it because I didn't, it's hard to explain...like I didn't wanna be known for just having dyspraxia. (Fiona: 515 – 517)

Perhaps Fiona's reluctance to be identified with DCD can be understood as she associates negative value judgements with DCD, which she generalises and attributes to herself:

R: Em, it's just like, when I was in the kitchen the other day, I went to get, we have, em, you know those tea/coffee things?...and the pots, and we had one full of sugar and I picked it up, and I think I picked it up by the lid, and then the sugar went everywhere – so I spent ages trying to clear that up, and just, I seem to do stupid things like that all the time...if it was just, like, once, so, in a while, I wouldn't, I wouldn't feel that bad. It's just when I do them, like, every day.

I: Mm. And, and, and what do you say when you do that,...when you've spilled the sugar all over the kitchen?

R: I'm like, I am a dunce, I'm stupid. (Fiona: 693 – 711)

Kate also wants to be known for more than DCD as she identifies divergent components of her percolating sense of self. On the one hand Kate identifies with DCD and the DCD community, while, at the same time, she argues that there is more to her than DCD. In this

extract, Kate identifies with another young woman's experiences of DCD by relating to the endurance of coming through a difficult experience:

With dyspraxia...Um, I think she wrote it in quite a casual way. Well, coz she was only sixteen when she wrote it and it wasn't that kind of scientific or anything. It was just really good to read – almost like a novel about dyspraxia and her experiences with it... which was just in, like, such an accessible format...for me, and it was great to read that and read what she'd been going through. (Kate: 892 – 904)

Kate does not, however, agree with all of the author's views on DCD. Reflecting on a quote in the book, Kate in talking hypothetically about how teenage girls' with DCD experience their femininity comments that identity is more complex than the author would suggest, perhaps highlighting that this view of DCD cannot be reconciled with her own femininity:

And like, there was advice for boys and stuff, and she was very kind of against girls that wore makeup and she always suggested that it was a dyspraxic thing that girls wouldn't be so feminine – which I really don't think is true at all. And she was like, "well, I can't be into any of that kind of girly stuff," which I think would be really alienating for a lot of girls, reading that...if you were in adolescence. (Kate: 991 – 1000)

Eileen's lack of knowledge of DCD means uncertainty as she attributes her experiences either to herself or to DCD, perhaps posing the question: is it me or DCD? , potentially indicating that Eileen has not fully integrated DCD with her sense of self:

Yeah, a lot that could be linked (to DCD) or could just be something of me, because I don't really know too much. (Eileen: 137 – 138)

However, Eileen sees DCD as a 'blessing' as the source of her creativity, yet her language of 'it' still seems to treat DCD as an external object:

most of my ideas, I come up with like at night when I can't get my brain to shut up, which is, well in the coming up with good ideas thing is actually a bit of a blessing. Um, and I can, but I can come up with idea-, random ideas at other, any time and is..., yes, the scattered brain-ness is a bit to do with it, dyspraxia, then I think I might even be a bit thankful, because I really enjoy coming up with creative ideas (Eileen: 564 – 570)

Tom, like Eileen, sees the 'blessing' in DCD though elucidates his dualistic experience of DCD in his phrase 'bane and blessing'. On the plus side, he rather hesitantly describes how his experience of DCD has helped develop his personal characteristic of determination:

well, I would say that, because, because of, as I just said, em, put it as both bane and blessing. I would say it is a blessing because, em, it's made me a more determined person and, um, well, I know that because people, em, well, as I, as I said before, they've, um, cited me as, um, an inspiration and, um, well, I mean, like my exam results as well as, have, has proven that, em, I wanted to succeed, so...  
(Tom 1045 – 1050)

However, on the negative side, Tom alludes to his experience of being left out of team sports and his phrase 'I always felt precluded', can tentatively be extended to being left out of a key aspect of male culture; potentially implying that DCD has been difficult to integrate with Tom's male identity.

because of my DCD, em, it affects any sports that I could have done, and I always felt precluded because I can't play football at all, so, just because of my terrible hand-eye co-ordination. Certain sports I can do, like, for example, em, individual sports....Everything else, absolutely awful, you know?  
(Tom: 1013 – 1019)

However both Tom and Eileen are constructing narratives about their relationship with DCD. Eileen's discovery and experience of herself as creative seems to be used as a tool in the construction of her own self development. During the interview Eileen shows how she plays with new perspectives of herself through the development of storylines and identification with characters. A key part of this identity is an agentic self:

R: Well, until that point the character was just basically a young girl who happens to have a really useless ability and wants to be a superhero and so was a bit boring, but then I got the idea, yesterday, and suddenly she became a lot more interesting as a character.

I: and what made her more interesting?

R: Well, she just became a lot more well-rounded. She wasn't so, such a cliché... She wasn't just a whiny brat who wanted to be a superhero and... that sort of thing. She was a, someone who would act-, was actually willing to work towards her goals. (Eileen: 633 – 658)

Tom also through identification with a particular culture seems to be constructing a narrative for himself that integrates his struggle with DCD into his sense of self. Though hesitant in his reflection, Tom is able to communicate and accept his feeling of sadness:

I mean, for example, it's a country that's been demonised... It's, it's had a, a gory, thought-provoking past...and, they always seem to be under the, the harshest and worst conditions but they, they, they've, they've, they, always seem to struggle through it, so...I would say that I see a bit of myself in the people, to be honest, maybe not, maybe not quite.... That's definitely, em, I, I see, I see a bit of myself there, and, em, during the time I was there, it's like there's a kind of, there's a kind of sadness that lingers in the air... it's like nothing I've ever encountered before...but oddly enough, I felt very much at home, there...so things are difficult for the people there, but they know it, and, em, they're aware of it and live with it. (2218 – 2254)

## SUMMARY

In the transition to young adulthood the students with DCD face challenges in their structural, educational, social and emotional everyday lives. It can be argued that other young people without DCD face similar challenges as they make the transition to young adulthood and that being a student produces particular demands. However, it is hoped that the illustration provided by the narrative of the analysis demonstrates the particular lived experience of the young people with DCD at this time of their lives. From these rich descriptions a sense of the temporal, sensational, active and narrative aspects of the students' lifeworlds are obtained (Eatough & Smith, 2006) from which the commonality of the overall thematic structure can be demonstrated. However, it is also hoped that within the themes, the particular expression of the meaning of the theme is communicated for each student, and in this way, divergence is also honoured.

## DISCUSSION AND SYNTHESIS

The review of the existing literature on DCD in young adults revealed that this topic is a relatively new area of research straddling the transition to young adulthood, identity development and the psychological well being of young people. IPA (Smith et al., 2009) as the methodology chosen for the study aimed to provide a contextualised understanding of the 'lifeworld' of the students. The IPA analysis in which engagement with the literature was 'bracketed' to a considerable extent produced a thematic structure to illustrate component parts of the students' lived experience (please see Diagram 1).

In this chapter, the discussion therefore attempts to integrate the literature and research findings and cautiously suggest potential links within the thematic structure to further explore latent meaning in the data (Braun & Clarke, 2000). A heuristic, Diagram 2, illustrating the author's exploratory conceptualisation of the embedded nature of the thematic structure is produced as a guide to this discussion but it should be emphasised that while this developing knowledge is incomplete, partial and restricted, it may be useful in the understanding of the phenomenon of DCD in the students' lives (Jaeger & Rosnow, 1988).

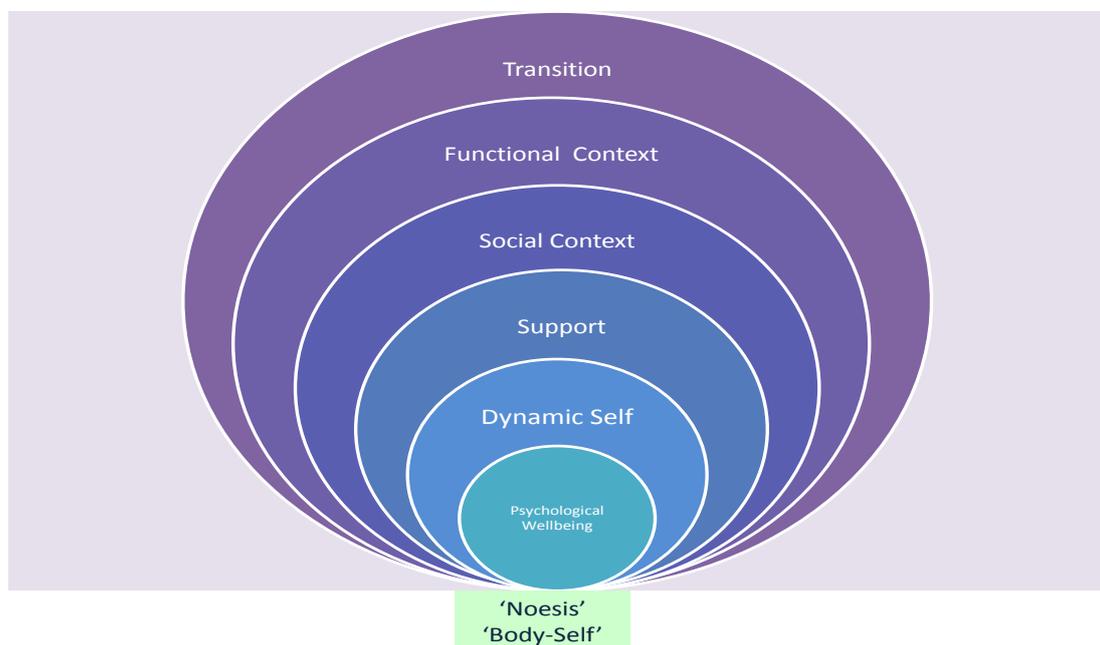


Diagram 2: Heuristic - DCD Embedded Experience

It is suggested that understanding DCD from this contextualised and holistic perspective may help Counselling Psychologists reflect (Schon, 1991) on the complexity of DCD in the 'lifeworld' of the students to develop their personal learning and inform their collaboration with colleagues in supporting the needs of students in a similar context (Smith et al., 2009).

Comments will therefore also be made in the discussion for Counselling Psychology practice in line with the pragmatic stance of the project (Cornish & Gillespie, 2009) and recommendations for further research will also be suggested.

A reflexive evaluation of the project against the quality criteria established in the Methodology chapter and the project's limitations will also be discussed. A final personal reflexivity section will conclude the Discussion.

## **DCD – THEORY, RESEARCH AND LIVED EXPERIENCE**

The analysis has shown that the experience of DCD in the students' 'lifeworld' is a complex and challenging phenomenon. DCD is embedded in the students' daily lives as their 'body-self' interacts in social and academic contexts, impacting on the students' academic performance, psychological well being and identity development.

### **DCD - TRANSITION AND DAILY LIVING**

Theoretically the transition from adolescence to young adulthood is portrayed as a major developmental phase in life-stage theories of development (Erikson, 1950, 1968; Tanner & Arnett, 2009) or, as a significant life experience in the lifespan (Baltes, 1979). Considering the experiences of the students with DCD in the context of life-stage theories of adolescent to adult development immediately highlights that 'normative' development trajectories (Daneffer, 1984) permeate the students' lifeworld as they compare themselves to their 'normal' peers. The lifespan approach to adult development acknowledges social influences in individual development and the disability literature particularly highlights the impact of social structures on disabled young adults' development paths. However, the 'agency' narrative within these theoretical approaches (Heinz, 2009; Irwin, 2001), which suggests that young people have the power to 'negotiate' within social structures, is challenged by the students' experiences.

### **Moving On - Separation, Identity and Independence**

Making the decision to leave home is viewed as a key task in young adulthood (Wagner, Ludtke, Jonkmann, & Trautwein, 2013) and while most of the students in this study had moved away from home to university, some of the students discussed this independent step as 'daunting'. Though Tanner and Arnett (2009) emphasise independence as a core attribute of emerging adulthood they suggest that the sense of being adult is 'fluid' and the students

therefore may not yet see themselves as adult. This may be the case as some of the students in this study were at the younger end of the emerging adult age range.

Sandra and Chris highlight the difficulties experienced in making the decision to move away or stay at home in light of the normative expectations of life-stage adult development theories (Erikson 1950, 1968; Tanner & Arnett, 2009). Sandra's experience of ambivalence in making the decision to go to university may reflect the dichotomy of normative expectations of achieving separation (Erikson, 1950, 1968) and independence (Tanner & Arnett, 2009) versus a realistic appraisal of her difficulties with DCD and the support she received at home. Sandra's polarised internal dialogue reflected the process of exploration of her choices in making the decision to go away to university, and though deciding to leave home to attend university, Sandra's commitment to her decision seemed tentative, contrary to Harrist's (2006) suggestion that resolution of ambivalence is accompanied by relief and a sense of freedom. However, as Willcoxson, Cotter and Joy (2011) suggest, perhaps Sandra's lack of commitment reflects a first year student's tentativeness as they try to understand academic expectations and build confidence.

Sandra seemed caught in two minds about her decision to go to university and another explanation may be that she was split between identifying with the 'normative' identity of 'student' and her DCD identity. As Crocker and Major (1989) highlight, a strategy in protecting global self-esteem, or general self-worth, is to selectively identify, in the 'similarity principle' (Festinger, 1954; Tajfel & Turner, 1979) with the performance of one's in-group, and particularly, with one's disadvantaged 'in-group'. In other words, one part of Sandra may have attempted to retain self-esteem by evoking her DCD identity in wanting to play safe and stay at home. However, another part of Sandra wanted to be the 'normative' student and go away to university, a potentially riskier strategy to her self-esteem if her decision goes wrong (Crocker and Major, 1989).

Chris, on the other hand, decided to stay at home and his case illustrates the risks of a negative self fulfilling prophecy (Daneffer, 1984; Merton, 1948; Fazio, Effrein & Falender, 1981); that one begins to react in line with the false beliefs of others. Erikson (1950; 1968) and Adotto (1991) argue that young people separate from their parents in the search for identity and in Chris's case, separation and identity seemed intrinsically linked as Chris felt constrained in exploring his identity by the need to live at home (Meeus, Ideema, Maasson, & Engels, 2005). Additionally, Chris's continued dependence on his parents may bring into question his ability to develop equality in this relationship (Tanner & Arnett, 2009).

Chris's ensuing sense of isolation perhaps reflects the incongruence of the ideal or normative self (wanting to be like his peers) and actual self (feeling different). However, an alternative framing of Chris's developmental situation based on the social model of disability and personal life histories (Kasnitz, 2001) could encompass a perspective that Chris is neither dependent nor independent, but rather somewhere in between these poles, or alternatively, inter-dependent with his parents (Walmsey, 1993). Inter-dependence has been shown to be a marker of adulthood related to the development of close relationships whereas independence is not (Barry, Madsen, Nelson, Carroll & Badger, 2009). Developing alternative narratives of transition to adulthood to reflect the unique pattern of DCD in the life-course may be less isolating. Examples of the life histories of other young adults with DCD may be helpful in communicating an alternative perspective and demonstrate that identity development can be constructed in more subjective timeframes (Luckmann, 1983).

However, Fisher and Hood (1988) may offer an alternative explanation for the reluctance of some of the students to leave home. Some students who have not been away from home previously may be vulnerable to homesickness which can be apparent prior to leaving home. Tom's case may bear out Fisher and Hood's (1987; 1988) conclusions as Tom had no qualms about moving away to university, having looked after himself therefore developing resourcefulness prior to moving to university may be a useful strategy for students with DCD who may have relied on parental support at home.

### **'Lost in Transition' – Change in Framework vs. DCD in Daily Living**

On entering university or college the students 'collide' (Buffon, 2003) with the structural framework of the new educational environment. They seem 'lost in transition' as their fundamental existential life-world is experienced as spatially, temporally, bodily and relationally alien and disorienting (Van Manen & Whitbourne, 1997). Like Lynch and O'Riordan's (1998) 'outsider', the students land in this new academic world where others have the power to set timetables, lectures, academic assessments and disabled student support, as the students enter a world of 'givens' (Irwin, 2001).

The alterations to the framework of the students' daily lives challenged their functional abilities in managing timetables, getting lost, and dealing with academic challenge and confusion. Though the defining feature of DCD in childhood is motor skill difficulty, and motor perceptual problems were experienced by some of the students, these issues were overshadowed by problems the students described that impacted on their academic life including interference, organisation and attention difficulties.

Fisher and Hood (1988) suggest that the stressful demands of the new university environment can produce cognitive impairments such as absent-mindedness, particularly for female students. However, the difficulties described by the students in this study seem more profound and akin to the executive functioning problems of planning and organising noted in young adults with DCD by Kirby et al. (2011). Executive function problems which impact on working memory, behavioural inhibition and reaction time have been demonstrated in children with DCD (Piek et al, 2004). Though the frequency and intensity of the organisation and attention problems experienced by the students in this study is not a base for generalization, combined with the findings of Kirby et al. (2011) and Piek et al. (2004), it is cautiously suggested that the link between DCD and executive function problems in young adults warrants further investigation.

It is apparent from most of the young adults' testimonies that they experienced DCD as interfering with academic performance (Criterion B: DSM-IV-TR, APA 2000) potentially indicating that the students could not always produce work consistent with their intellectual potential (Vaivre-Douret et al., 2011) or their peers' achievements (Riddell, 2009). Given that students who believe they have the competence to do well outperform those who lack such academic self-efficacy (Richardson, Abraham, & Bond, 2012; Zimmerman, Bandura, & Martinez-Pons, 1992) and, that success breeds success in the development of the academic self-concept (Stanovich, 1986), it would seem important to develop academic self-efficacy early on in the students' university career (Lent & Brown, 2006). Unlike students without specific learning difficulties, where academic performance has been shown to be related to past results in high school, this relationship does not seem to hold for students with specific learning difficulties (Murray & Wren, 2003) and DaDeppo (2009) suggests that current academic performance may be more relevant in predicting academic success in this group of students. Richardson et al. (2012) also identify organisation and attention skills as necessary for meta-cognition or learning about one's own learning in maximising academic potential and while some of the students had devised idiosyncratic strategies to manage their difficulties, providing additional support in these areas may be important to negotiating risks in the academic environment (Riddell, 2009).

### *Psychological Context*

In the clash of the 'body-subject' (Merleau-Ponty, 2002) in the new academic environment, most of the students described distress, captured in the theme of 'Overwhelm'. Overwhelm encompassed descriptions of acute sensations experienced viscerally, emotionally, cognitively and behaviourally in the moment that had the power to engulf the students' ability to cope. There are potential explanations for the experience of 'overwhelm',

including 'transient depersonalization' (Rosenberg, 1984) - a temporary response to unpredictable changes in one's local surroundings, or, for example, a symptom of a panic attack (DSM-IV-TR, APA 2000). Though conclusions cannot be made based on the outcome of a research interview, the level of distress described by the students might reflect that the students may be at risk in navigating the developmental tasks which impact their psychological well-being (Schulenberg et al., 2004). Though Shanahan (2000) accepts that there are diverse trajectories in the progress to young adulthood, he argues that being able to regulate emotion is important to the young person's ability to thrive, which the students, in fact, sometimes struggled to manage.

As O'Connor et al. (2012) pointed out, young people who are at risk of 'thriving' may have difficulty with 'self-control' or emotional regulation, and either internalise or externalise emotions. Bonnano (2004) has also shown that repressing distress in some situations can be adaptive and being able to distance oneself from emotional distress is a sign of resilience (Wolin & Wolin, 1993). However, lest we locate the problem of 'overwhelm' totally in the students' personal ability to cope with emotional regulation, which may be the interpretation of 'self-control' (O'Connor et al., 2012), it is important to contextualise the experience of 'overwhelm'. As Eatough and Smith (2006) argue, emotional experience is a response to the world, connected with our developmental story and is experienced as a bodily felt sense. Examining the descriptions of the students' experience of 'overwhelm' illustrates how each student relates a storyline in a specific context that triggers their bodily processes which did, in some cases, intensify until uncontrollable. It is argued that it is in this embedded context (Irwin, 2001) that the students' experience of overwhelm needs to be understood. However, Willcoxson et al. (2011) still focus on student personal factors as responsible for 'a student's inability to integrate into university social or academic systems', while accepting that students report a feeling of institutional unresponsiveness (Mohr, Eiche, & Sedlacek, 1998).

The students in this study seemed to take 'whole' personal responsibility in navigating their new academic world, contrary to Tisdall's (2001) suggestion that they should make 'claims' on university systems. Though the students did exhibit considerable personal agency and determination, as illustrated in the theme 'Overcoming', their endeavours did not equate to Heinz's (2009) or Irwin's (2001) notion of 'agency' in challenging university arrangements, rather their efforts portrayed a significant level of self-reliance. Self-reliance may be a critical step in the path to independence in young adulthood (Carroll et al., 2007) and determination in pursuing goals has been identified as a psychologically resilient attribute in the ability to withstand adversity (Hauser, 1999). However, Luthar (2006) suggests that coping strategies, such as those illustrated in 'Overcoming', which seemingly demonstrate resilience, can, over time, have harmful effects for those who internalise their distress. Persistence

should also be differentiated from perfectionism where the risk of unrelenting standards may lead to compulsivity and stress (Young, Klosko, & Weishaar, 2003) and is a particular issue for students (O'Connor & O'Connor, 2003). Further investigation of whether 'Overcoming' represents an adaptive strategy on the part of the students may be required.

Additionally, in the theme 'Resignation and Acceptance' some of the students accepted that this was how their life was meant to be with DCD; that constraints on their abilities and limiting expectations were to be endured. Breakwell (1986) suggests that acceptance strategies, when one assimilates new information about one's identity (such as the acceptance of DCD as part of one's identity) removes stress. However, there is a potential risk that acceptance masks compliance which may be another way to relieve stress (Breakwell, 1986) and achieve social acceptance particularly for females (Wagner et al., 2013), but potentially colludes with prevailing social stereotypes robbing the student of the power to be independent.

However, it may be that the students had been prohibited from doing activities by others or in pursuing goals due to DCD, and, in a form of 'learned helplessness' (Seligman, 1975), have given up. Learned helplessness is associated with depression and a particular attributional style of blaming oneself for negative outcomes by thinking that consequences are enduring and permeate everything one does, rather than a resilient attributional style in which external events are blamed for problems and problems are seen as temporary and specific (Rosenhan & Seligman, 1984). It may be useful to investigate further the nature of acceptance in students with DCD and prudent to encourage personal efficacy in problem solving, e.g., providing structural avenues at university for the students to advocate for themselves (Goodley, 2000). If an attributional style of learned helplessness is observed, therapists or other support staff should be alert that, even if depressive symptoms are not currently present, depression may occur when faced with a future negative life event (Peterson & Seligman, 1984). Cognitive Behaviour Therapy (CBT) (Beck, Rush, Shaw & Emery, 1979) and Interpersonal Therapy (IPT) (Bleiberg & Markowitz, 2008) are recommended as effective therapies in resolving depression (NICE, 2009), and CBT particularly challenges the negative thoughts, assumptions and beliefs underpinning learned helplessness.

Samuel was perhaps the only student who reported taking the transition to university in his stride. Perhaps it is worth considering issues that may be relevant in Samuel's case. First, Samuel was nearing completion of his studies and, as Willcoxson et al. (2011) point out, final year students are more concerned with future plans, which did reflect Samuel's concerns. Samuel could also look back on his early university career from a distance where the intensity of the experience was perhaps diminished. Finally, Samuel also described himself as

outgoing and sociable, key personal characteristics which Richardson et al. (2012) suggest support being successful at university.

### **Academic vs Social**

Academic competence and social relations have been reported as the two predominant factors in self-confidence (Shrauger & Schon, 1989) and self-concept (Tesser, Miller, & Moore, 1988) in students. However, for some of the students in this study, a particular challenge that emerged in the university or college environment was the conflict between maintaining the academic self-concept and developing the social self. The continuity of the academic self-concept was important to these students as observed in their personal values of determination and motivation to persevere in their academic work which may have represented their private self (Fenigstein, Scheier, & Buss, 1975). On the other hand the students wanted to interact in their salient or prominent social role (McCall & Simmons, 1978; Stryker 1980) or group identity (Tajfel & Turner, 1979) as 'student' which, more likely, represented their public self. As Breakwell (1986) suggests, we are often not aware of our public or private self until there is conflict between the two and it seems that, in the university environment, the students struggled to integrate their academic and social identities.

Integration of the public and private aspects of the students' identity has a practical implication. Tinto (1975) suggests that academic and social integration is critical to success in university and predicts student commitment and retention. However, DaDeppo (2009) has demonstrated that social integration is a better indicator of commitment and persistence at university for students with specific learning difficulties. The strategies employed by some of the students in this study to reconcile their academic and social demands prioritised their academic time implying that the students were more committed to their academic identity but DaDeppo's findings suggest that it may be more adaptive for them to develop their social identity. The rub is that, for the students in this study, social interaction has not always been a comfortable experience, and it is to the social context which the discussion now turns.

### **DCD IN SOCIAL CONTEXT**

The students experienced themselves in a range of interpersonal situations and social contexts and there was a particular contrast between the experiences underpinning the university setting and previous settings as well as current work and relationship contexts.

## **DCD - Existing Lexicon, Interpersonal Interaction and Cultural Narratives**

For the students in this study DCD was difficult to communicate in the context of the lack of a personally meaningful and socially acceptable understanding of DCD, which often put the students at a disadvantage in explaining their problems.

### *Under-specification of DCD*

A key reason IPA methodology (Smith, 2011) was chosen for this project was its phenomenological philosophy which seemed suited to developing description of the lived experience of DCD in the daily lives of young adult students. It is apparent that DCD is recognised as a lifespan 'disorder' but description of what DCD means in the daily lives of adults is currently under-specified (Green et al., 2002) therefore it is important to explore the students' descriptions of the embodied experience of DCD. As Morris (2008) explains, 'patterns of movement' express our 'being in the world' and DCD is embedded in the students' conscious interaction with the world (Ashworth, 2008; Kloppenberg, 1996), which Kate so aptly brought home to me. I asked Kate for an example of the last time DCD impacted on her and with some incredulity Kate responded:

'Well all the time (laughs).' (Kate: L440)

Developing description of DCD may help empower the students socially and psychologically by giving them a voice (Irwin, 2001; Larkin et al., 2006). There are a couple of reasons for this: First, many of the students often found it difficult to explain DCD to themselves and others. The lack of a meaningful description of DCD, which may reflect the lack of a comprehensive definition for DCD in adults, and consequently broader social understanding, engendered frustration for the students in interpersonal encounters. Second, the students often found it difficult to reconcile the generic definition and description of DCD with their particular difficulties, which may be linked to the theoretical debate of co-occurrence of DCD with other developmental issues, e.g., ADHD, dyslexia and autism (Kaplan et al., 2006; Rasmussen & Gillberg, 2000). The unique individual profile of each student reported in the analysis perhaps reflects such co-occurring difficulties (please see Appendices 22 and 27).

### *Interpersonal Relationships and Cultural Positioning*

In current social contexts, including work and relationships, the students experienced negative evaluation and stereotyping and found communication about DCD difficult in interpersonal encounters. Some of the students had experienced, at its worst, stigmatising

labelling and were keen to avoid 'stereotyping', or had experienced undermining social narratives that DCD did not really exist, or was not taken seriously. Through these social interactions (Burke & Stets, 2009; Cooley 1902; Mead 1934) the students developed a sense of themselves from others, as can be seen in the language that some of the students used or denied about themselves, which set up narratives about their identity, e.g., 'dumb', 'lazy', 'stupid', 'dunce' and 'burden'. Underpinning these interactions seemed to be negative socio-cultural views about DCD which, when internalised, were a particular risk to self-esteem and the self-concept (Jones et al., 1984), perhaps leading the students to compare themselves negatively with their peers using judgmental language and categorising themselves as, for example, 'weird' versus 'normal'.

Additionally, at university the institutional narrative is arguably one of academic success and the students showed great determination in trying to overcome DCD and position themselves as academically successful and act 'as if' they were typical students in a bid to 'fit in' (Baines, 2012; Harre & Moghaddam, 2003). The difficulty with a strategy like this of 'passing' is that the threat to the student's identity may be increased as revelation of DCD may result in some of the stigmatising they had previously experienced and potentially risks a split in identity between the public and the private self (Breakwell, 1986).

### *Psychological Context*

Given some of the social interactions the students experienced it is perhaps unsurprising that a consistent response in coping with DCD was to conceal it. Crocker and Major's (1989) outline of the relationship of social stigma and the maintenance of self-esteem may offer some explanation for this strategy. A concealing strategy may make sense for an 'invisible' stigma like DCD (Jones et al., 1984) as prejudice cannot be evoked. However, paradoxically, according to Crocker and Major (1989), if discrimination is experienced concealment provides little self-protection because negative evaluation is experienced personally. Concealing DCD and comparing themselves (Festinger, 1954) with 'typical' students or 'out-group' (Tajfel & Turner, 1979) and not comparing themselves to a DCD 'in-group', may result in a negative evaluation of global self-worth.

The students' concealment of DCD to potentially mitigate damage to self-esteem may also be considered a form of avoidance. Avoidance is typically found in anxiety and in addition to avoidance some of the students also described characteristics of worry including persistent rumination (Borkovec, Ray, & Stober, 1998; Craske & Barlow, 2006), somatic symptoms and negative thoughts. Although Morrison and O'Connor (2005) in their study on students did not replicate the link found by Nolen-Hoeksema (2000) between rumination and

anxiety, they did conclude that avoidance is a paradoxical strategy in dealing with stressful life events that may only serve to increase anxiety. While it is not possible to evaluate a clinical level of anxiety from the students' interviews, never the less, the characteristics mentioned of avoidance and worry, in conjunction with sleep disturbance and problems with concentration, may potentially be indicative of Generalised Anxiety Disorder (GAD) (DSM-IV-TR, APA, 2000).

Given the growing concern of mental health issues in student populations (Connel, Barkham, & Mellor-Clark, 2007) and the increased levels of anxiety that have been reported in children with DCD (Dewey et al., 2002; Schoemaker & Kalverboer, 1994; Skinner & Piek, 2001), it is perhaps unremarkable that the students reported considerable anxiety. Morrison and O'Connor (2005) argue for clarifying the components of distress in student populations, including anxiety, depression, social dysfunction and somatic symptoms. For the students in this study, anxiety in the form of worry seems to be a particular concern and may be useful to investigate further. Being able to distinguish between different types of anxiety is important in selecting appropriate interventions. For example, there are a range of Cognitive Behaviour Therapy (CBT) approaches for particular anxiety problems (Clark & Beck, 2010; Wells, 1997). While CBT is recommended as an evidence-based therapy for clinical anxiety in the general population (NICE, 2007), a caveat is that there is not an evidence base for young adults with DCD. Counselling Psychologists may therefore need, as part of their professional development, to refer to CBT clinical case studies and a CBT case study of a young adult with DCD is presented in Section D of this portfolio.

Given the social experiences of some of the students, it is perhaps foreseeable that some of them were self-conscious in social situations, becoming aware of their performance and engaging in socially protective behaviours. While again the students' comments are not predictive of social anxiety (DSM-IV-TR, APA, 2000), the link between rumination, stressful life events and social anxiety in students reported by Morrison and O'Connor (2005) and the enduring social concerns of children with DCD (Kanioglou, Tsorbatzoudis, & Barkoukis, 2005; Skinner & Piek, 2001) may suggest that social confidence is an area where the students would benefit from therapeutic or skills based input. One way the students did try to cope socially and build a relationship was the use of self-deprecating humour. Wolin & Wolin (1993) suggest that the ability to use humour is a resilient personal attribute when employed in difficult situations. However, Breakwell (1986) suggests that dark humour can be a ploy to withdraw from others' prying, in a bid to protect personal boundaries, and perhaps more assertive strategies may be helpful.

It is worth considering Chris's case in the context of anxiety and worry. Chris was the only student who seemed to freely communicate about DCD to his peers, yet he too worried, particularly about future salient social role identities e.g. father (Stryker, 1980). Chris's ability to talk about DCD openly with his peers potentially contradicts the notion that concealing DCD contributes to worry, however, he did not talk about DCD in an emotional context reflecting that he wouldn't be taken 'seriously' while acknowledging that this left him feeling 'alone'.

### *Communication*

For the young people in this project, IPA methodology provided the opportunity to describe their embodied daily life (Smith, 2011), which for most of the students was the first opportunity they had to reflect about DCD in this way. In itself such a conversation may be transformative in developing emerging understanding (Bernstein, 1983; Dewey, 1951) and individual meaning (Cooper, 2009) and fits with a Counselling Psychology perspective of empowering participants in the research process (Kasket, 2011). It seems that these students did not have a personal and meaningful way to talk about DCD with others (Burke, 1980). As Burke and Stets (2009) argue, the fundamental building block of an identity is a durable array of meanings, or the 'identity standard' which acts as an anchor to an identity, and which others validate in social interaction. Without such verification of the meaning of an identity in a given situation, or that there is misunderstanding about who you perceive yourself to be, individuals can become distressed (Zanna & Cooper, 1976). Additionally, the more frequently one's identity is questioned, as seems to have been the case for the students' DCD identity, the negative effect on self-esteem can be cumulative (Cast & Burke, 2002).

One way which may assist communication about the impact of DCD on a student's functional, educational, social and psychological needs is an individual profile; a useful starting point of communication in promoting a holistic understanding and discussion across contexts (please see example, Appendix 27). It should be emphasised that the example provided is based on the analysis developed in this study and many other permutations may be possible, but the holistic concept is advocated. While the individual profile described in this project (Appendix 27) may reflect some of the assessment criteria for DCD in adults (Drew, 2005; Kirby et al., 2011), it is cautiously suggested that the students' social and emotional concerns are provided in more detail. Naturally, this type of profile would need to be supported by further research, but the student could potentially choose to use such a profile for self reflection and development or to share with others, including Counselling Psychologists, Occupational Therapists and Learning Mentors. This approach not only

provides the students with a communication tool across contexts, but potentially a sense of ownership and control to set the agenda of communication (Fawcett & Hearn, 2002).

### **My Community**

In contrast to the social interactions experienced in other contexts, the social community and culture of university offered a new set of connections and relationships experienced by the students as diverse and accepting. Such life experiences, argues Breakwell (1986), impact identity development more than maturation through the social testing, reflection and resolution of internal conflicts. Contrary to the students in Bufton's (2001) study, whose academic identity was not supported, the students in this study reported feeling included by their peers.

Social inclusion by ones' peers can improve self-esteem (Dennison, Penke, Schmitt, & Van Aken, 2008) and the diversity of the university environment seemed to open up new strategies to develop the students' self-esteem as the students began to experience others in their immediate environment similar to themselves or with whom they could identify (Harter, 1986), opening up group membership strategies to protect their self-esteem and self-concept (Crocker & Major, 1989). Kate, for example, began to distance herself from her adolescent friends and was more discerning in her comparison with other students with dyslexia or 'neuro-typical'. Eileen began to modify stereotypes of 'normal' and selectively value her talent for creativeness which she attributed to DCD while devaluing attributes she did not associate with DCD.

### **YOUNG ADULT - DYNAMIC SELF**

Throughout the students' testimonies of the transition process and social interactions were threads of how DCD impacted on the student's identity. In the discussion so far, we have noted the impact of DCD on: the ability to explore identity, differences between the ideal and actual self, integration of the academic and social self and developing a shared meaning of a DCD identity. These identity defining processes, as Breakwell (1986) contends, are layered onto existing identity through 'assimilation and accommodation' in the dynamic shaping of the young adult self. In this section, a particular aspect of historical identity is discussed briefly as a significant layer of pre-existing identity mentioned by the students, while the relationship of DCD to the students' developing personal identity is also examined.

## **Discovery**

Dunford (2009) accepts that DCD impacts on a child's self-concept and it is apparent that others, including peers, teachers and parents, often have negative perceptions of children with DCD (Kanioglou et al., 2005) while Kirby et al. (2011) comment similarly on the perceptions of some parents of young adults with DCD. In this study, the students illustrated that the stability of their sense of who they were and how they were valued (Breakwell, 1986) had been challenged by the discovery of DCD. For Eileen and Tom, who had discovered DCD in childhood, memories evoked in the present illustrated how this discovery disrupted or 'broke the loop' (Burke, 1996) in their foundational sense of themselves and how they experienced themselves in quite alien ways which negatively affected their relationships with others.

For others, the discovery of DCD in adolescence or as an adult sometimes helped make sense of confusion in identity, but as in the case of Kate and Lisa, the outcome still impacted self-esteem, by the evaluation that they, as a person, did not seem to meet a perceived standard of acceptability. For Chris, on the other hand, the discovery of DCD was a positive experience which enabled him to identify with a DCD 'in-group' rather than blame himself for his difficulties. With discovery of DCD, the students had assimilated a historical self-perception in which DCD was an involuntary aspect of identity (Breakwell, 1986) which, in the main, had evoked socially negative evaluations. It was with this historical context of DCD that the processes of identity formation in the transition to adulthood reciprocally interacted.

## **Me and DCD**

Burke and Stets (2009) suggest that the 'master' identity is the person identity or 'me' and it is this identity that makes the person unique. Uniqueness, as Breakwell (1986) has also argued, is a key principle of identity and it can be seen in the students' testimonies how DCD can be a potential threat to their unique identity or to 'me'. Cooper (2003) draws attention to Buber's (1958) 'I-Thou' and 'I-It' relationships in the interpersonal context and attempts to translate them in the intrapersonal plane of 'I-I' and 'I-me' relationships. In Buber's (1958) interpersonal terms 'I-Thou' is a relational way of being with another that does not seek wants or gains, while an 'I-It' relationship is about categorising and objectifying the other. Cooper (2003) argues that an intrapersonal 'I-I' relationship is one in which one identity is accepting and validating of the other, while in the 'I-me' relationship, one identity externalises and vilifies the other.

Fiona expresses how encompassing DCD can be and fears that DCD may be all that she is known for, particularly as she seems to have internalised very negative views about DCD. The negative impact of an identity that one does not choose has been linked to lower self-esteem by Thoits (2003), and while Burke and Stets (2009) might disagree, suggesting that it is the validation of an identity, whether positive or negative, that matters to self-esteem, it seems likely that Fiona may be more inclined to agree with Thoits (2003).

Breakwell (1986) argues that making a choice about identity is part of the dialectic process that enables identity to flourish, but Sandra's inner dialogue seemed to illustrate an ambivalent relationship with her DCD identity, revealed in the split sense of self and ensuing conflict she experienced. Kate, like Sandra, also illustrated some ambivalence about the impact of DCD on her identity and, while identifying with DCD and finding support through this identification emphasised that there was more to her than DCD particularly in relation to her gender identity.

Tom's ambivalence in his relationship with his DCD identity relates to the impact of DCD on his male identity, linked to typical boy socialisation in playing in a team. Chris too was concerned about future male social role identity. As already noted Tom was very concerned to hide his anxiety while Chris did not think his emotional concerns would be taken seriously. These features may be consistent with masculine gender role stress apparent in students, e.g., in sports competence, showing your feelings and role performance failure (Levant, Wimer, & Williams, 2011), which have been linked to anxiety and health problems.

Although Schwartz et al., (2011) assert that some ambiguity is necessary in the exploration of personal identity they demonstrate that achieving clarity about one's self-concept protects against anxiety. These authors suggest that excessively re-visiting one's view of oneself may be related to a risk of GAD (DSM-IV-TR, APA, 2000) and discourage habitual revisiting of identity commitments in the interests of alleviating distress.

According to Cooper (2003), the students' internal dialogic relationship (Herman, 2001a) between the self they own and the DCD self being disowned may account for the distress at being dominated by the DCD identity or being in conflict with it. A non validating internal dialogue may be understandable as the 'I-Me', or, 'Me and DCD' relationship, perhaps evokes negative historical schemas of the stigmatizing, anxiety-provoking vulnerable DCD self. In transforming this 'I-Me' relationship, Cooper (2003) suggests that a Rogerian (1957, 1967) therapeutic approach of warmth, empathy and congruence can enable a 'real meeting' of parts of the self from which an 'I-I' self relationship that validates the whole self can develop. Spivack and Willig (2010) also encourage integration in the case of a split

sense of self and suggest methods therapists can utilise including: accommodating parts of the self, encouraging parts of the self to work together and building on the virtues of parts of the self. However, Cooper (2003) argues against a variety of experiential or projection techniques to achieve integration of the self; rather he believes such approaches increase fragmentation and instead proffers that an 'I-Thou' encounter in a therapeutic relationship produces a 'bridge' to developing a validating internal 'I-I' voice. As Eileen and Tom perhaps illustrate, valuing the strengths associated with a DCD identity seem to be working to their benefit in developing integration of DCD into their personal identity and story (Spivack & Willig, 2010).

#### FORMAL VS. PERSONAL SUPPORT

All of the students in this study commented that they were receiving formal support in academic settings. Formal support was intended to assist mainly with functional difficulties, though often the supportive relationship that some of the students had developed with their tutors or learning mentors was also, arguably, emotionally protective (Reddy, Rhodes, & Mulhall, 2003) and important to the students' integration into university life (DaDeppo, 2009). While some of the students' anxieties were allayed by practical resources, only one student had been able to access direct psychological support, though outside the university setting.

In managing the demands of the university environment, often the students did not seek help until their personal efficacy had been exhausted and, even when they were provided with support, the amount of support was often assessed by the student so that they would not be visible, perceived as privileged or, in the extreme, burdensome to others (Olney & Brockelman, 2003). The belief of being a burden to others should be paid careful attention when expressed by those in psychological distress, especially depression, because it is a particular risk factor in suicide (Joiner, 2005).

Personal or social support was more often experienced through a close personal relationship or friendship by the students, though mainly in the female students. In one case, a therapeutic relationship was established where the student felt unconditionally accepted and understood. As a Counselling Psychologist it is not a surprise that unconditional positive regard, a touchstone of our humanistic identity (Rogers, 1957, 1967), was experienced as helpful. Students with DCD may therefore need to be able to reflect about DCD in a personally meaningful way where their identity is accepted unconditionally (Cooper, 2003) so that they can learn to communicate about themselves in different contexts (Stamp & Loewenthal, 2008).

It may be the case for some of these students that there is a natural resolution of identity dilemmas and improved emotional coping for students as they progress through university (Ribeiro et al., 2012). However, given the normative expectations they seem to be trying to live up to, the social and structural demands of the transition to university life and the emotional coping strategies they have employed, psychological support may be helpful to them. Building on their determination and motivation constructively may also be beneficial to their capacity to thrive.

## CONCLUSION

This study has illustrated that lived experience of DCD intersects a number of contexts. Though there are no boundaries between these contexts and the lived body is embedded in them all at the point of experience, the distinctions drawn in this report between structural, social and personal contexts may help portray the daily life of young adults with DCD. It has been illustrated that in the transition to university or college the students encounter social expectations and educational structures that challenge their body-self and, though motivated and determined, they sometimes struggle to cope emotionally. Socially, the students experience difficulty in making sense of DCD in some interpersonal interactions where discriminatory cultural narratives can undermine and impact their self-esteem. However, the university culture has enabled the students to experience themselves in new and liberating ways, opening up strategies to build self-esteem. Historically, the students have built self-concepts in which DCD may have been disruptive to who they thought they were, and which they are still in the process of integrating into their developing young adult identity. In this ongoing project of identity development, acceptance and developing a meaningful personal dialogue about DCD seem to be key processes through which a cohesive sense of identity can emerge. Though the students have learned to cope with DCD, their psychological wellbeing could potentially be enhanced, and it is open to further inquiry as to whether some of the coping strategies they have employed put their psychological resilience into credit or debit. Perhaps when DCD ceases to be an issue and the students are accepted and, can accept themselves, as unique talented human beings without labels, this topic will be redundant (Jaeger & Rosnow, 1988).

## EVALUATION, QUALITY AND METHODOLOGICAL REFLEXIVITY

In evaluating the research project against its quality targets (Appendix 1), comments are drawn from reflexive notes kept throughout the project.

A strength of IPA methodology has been the descriptive and contextualised picture (Jaeger & Rosnow, 1988; Madill et al., 2000) produced of the young adults' experience of DCD in their daily lives as a student. The analysis and discussion have also generated an exploratory account of the structural, social and personal 'intermingling' of DCD in the students' life-world. On reflection however, perhaps the research question was too broad and some depth has been sacrificed. For example, within the themes, descriptions were sometimes limited to only a few quotes to describe a complex phenomenon, e.g., overcoming. However, the principal aim of the project was always to highlight the complex interrelatedness of the experience of DCD in its embodied and constructed sense (Nightingale & Cromby, 1999) and to that end the project has been worthwhile.

While Paley (2005) accuses phenomenological studies of collapsing 'experience and meaning with reality and causation', I have attempted to offer only provisional claims about the knowledge developed (Yardley, 2000, 2008). This tentativeness was reinforced by the difficulty of developing the themes and master themes. Many iterations of the thematic structure were considered and decisions about the essence of quotes deliberated on to try to represent what each student meant in the hermeneutic process, so it is accepted that other interpretations are entirely possible. However, attending training in IPA analysis and receiving feedback on analytic examples from peers which corroborated my attempts instilled some confidence in completing the analysis.

An effort was made to represent each particular case to portray divergence (Wallatt & Piazza, 1988) by completion of a thematic narrative (Appendix 21) for each student. While this process was helpful in understanding the 'story' of the young person, it added considerable time in completing the project. The data collected provided some rich evocative material, however it may have been improved in some cases by having more than one interview to develop the relationship with the student. Another issue with the data is that, being language-based, the students were sometimes 'lost for words' (Nightingale & Cromby, 1999) or resorted to metaphor to convey extra-discursive experience which gets close to conveying the experience but never is the experience.

In terms of my engagement with the research process and empathy with the participants (Madill et al., 2000), one of the most difficult aspects of the project was not to become fused in working with the data as, at times, it was 'gut-wrenching'. However, this emotional connection had some benefits as it energised my efforts when the research process was exhausting and demanded that I communicate the students' narratives faithfully. My empathy for the students was also helpful when divergent narratives were expressed as my

attention was immediately, if sometimes defensively, sparked, and led to questioning my personal bias.

An issue related to engagement with the data is being democratic and empowering in the research process (Cooper, 2009; Fawcett & Hearn, 2002) and this has been a difficult dilemma. Given that I did not want to over-identify with the students, I did not involve the students as much as I would in a more emancipatory stance. This has been an uneasy position for me to hold but has partly been due to my relative inexperience as a researcher, and may have, potentially, disempowered the students (Oliver, 1999).

Another issue that has been a dilemma in conducting the project is the language surrounding DCD and my part in using it. I have wherever possible tried not to reinforce the diagnostic labelling of 'DCD' because I believe that it does not represent the uniqueness of the individual, but it has been very difficult given the relevance of the DSM-IV-TR criteria (APA, 2000) and the utility of communicating in the psychological and professional community. My Counselling Psychology identity underpins the whole project in seeking a holistic understanding of the students' situation but my pragmatic stance recognises that I need to work within the existing system.

## IMPLICATIONS FOR RESEARCH AND PRACTICE

### **Counselling Psychology**

The knowledge created in this research project is based on a topic where there is little existing research and accords with the Counselling Psychology humanistic aim to value and understand the particular context and life-world of the students. In this light the practice issues discussed are offered to other practitioners for reflection (Schon, 1991).

Working with the students with DCD in this research project has challenged my own 'givens' (Irwin, 2001) in developing self-awareness and thinking about the culture and context of the student (Morrow, 2005). One way of developing this awareness further in the therapeutic relationship (Prilleltensky, 2002) would be to borrow the principles from the Culturally Appropriate Career Counseling Model (Byers-Winston & Fouad, 2006), e.g., questioning my reactions to the impact of DCD on the student to bring my own cultural assumptions to mind.

However, Allen (2010) suggests that Counselling Psychologists need to go beyond their conscious level of awareness as many cultural prejudices are embedded in our language and body language (Sue et al., 2010) that unintentionally disempower clients and should be

reviewed in supervision (Ponteretto & Park-Taylor, 2007). Allen (2010) suggests that the Identity Saliency Model (Yashuko, Davidson, & Nutt-Williams, 2009) offers scope for Counselling Psychologists to use as a reflective tool and to surface multiple identities of the client, including socially structured identities. Given the intersection of identities (Cole, 2009) in the students' life-world, this creative approach can potentially highlight variation and inclusivity and generate new narratives of identity for the student.

For the majority of the students, the research interview was the first time they had experienced a reflective conversation about DCD. Given their difficulty in talking about DCD and the relationship that Cooper (2003) makes between experiencing a validating interpersonal relationship and the development of an internal dialogue that values one's self-worth, a conversation with a Counselling Psychologist may be helpful. With humanistic values based on unconditional positive regard, congruence and empathy (Rogers, 1957, 1967), Counselling Psychologists could provide a safe, accepting and reflexive relationship where the student could explore what DCD means to them (Stamp & Loewenthal, 2008).

The therapeutic approach advocated for the students to explore identity and meaning would be a one-to-one 'I-Thou' therapeutic relationship as advocated by Cooper (2003, 2009), which Mitchell and Gordon (2007) suggest students generally prefer. However, given that the budget per student in University counselling services has been decreasing (AUCC, 2004) and the number of students requiring access to psychological services is increasing (Royal College of Psychiatrists (RCP), 2003, 2011), attention may need to focus on targeting specific problems with shorter term therapy. The students seemed to experience anxiety in various forms, and CBT has been demonstrated as an effective shorter term therapy in Anxiety Disorders (NICE, 2007). However, even if working within shorter term diagnosis-based frameworks, e.g., Improving Access to Psychological Therapies (IAPT) in the NHS, Cooper (2009) suggests that as Counselling Psychologists we retain our holistic approach to the person. A particular issue relevant to anxiety in young adults (Riggs & Han, 2009) apparent in the study was the potential impact of DCD on self-esteem. Butler, Fennel and Hackman (2008) also suggest low self-esteem may undermine CBT approaches to anxiety and therefore provide a CBT model of self-esteem that may be helpful to therapists.

However, a particular problem with young adults, especially young men, is that they are unlikely to access counselling services (Biddle, Gunnell, Sharpe, & Donovan, 2004) and stigma also prevents students accessing therapy (Davis-McCabe & Winthrop, 2010). An alternative to face-to-face therapy for students suggested by Davis-McCabe and Winthrop (2010) is computerised self-help, e.g., Computer Aided Lifestyle Management (CALM), though this type of provision is most suitable for motivated clients with mild to moderate

psychological concerns (Mitchell & Gordon, 2007). Given that the students with DCD are apt to conceal it to avoid being stigmatised, CALM or a similar online self-help program may provide an alternative choice in accessing support for distress.

In recruiting the students, the Dyspraxia Foundation provided access to the students through their online resources and network as the students were looking for support and information about DCD. In the resources given to the students various online forums were provided which they seemed to utilise, but the students did not seem to belong to local self-help groups (Breakwell, 1986) or challenge the social representation of DCD. Supporting the establishment of local forums like this for the students may be helpful in developing social connectedness and challenging social stereotypes of DCD and may be of interest to Counselling Psychologists with an interest in promoting Community Psychology (Seider, Davis, & Gardener, 2007).

An over-arching message from this research is the contextualist view that DCD is experienced by the students across functional, educational, social and psychological contexts. As Counselling Psychologists espousing systemic, community and multicultural awareness (Lane & Corrie, 2006) we may need to be proactive in collaborating and developing a network of colleagues in academic, pastoral and learning support roles (Forsyth, MacIver, Howden, Owen, & Shepherd, 2008) to support students like those in this study. Counselling Psychologists could also contribute to diversity training and develop person-centred skills workshops for front-line university staff who may be in direct contact with the students by 'giving Psychology away' (Cooper, 2009).

### **Limitations and Future Research**

The sample was a small situated sample, and therefore no claims are being made about the generalizability of the findings though the geographical dispersion of the participants may lead one to explore some of the findings in the larger student population. As the age range of the students was distributed in the lower end of young adulthood and at different stages in academic progression, it may be useful to consider the experience of young adults in even more specific contexts. The students were well-educated and motivated to take part in the study, and it may be useful to investigate the experience of other young adults with DCD in different transitional contexts including in employment, training or unemployed situations.

While the findings of this study cannot be generalized, they may, in the 'context of discovery' (Reichenbach, 1938), have opened up new research questions to stimulate further investigation (Kuhn, 1962). It may be helpful to understand further if the students do

represent a sub-group of young adults whose coping strategies affect their ability to thrive (O'Connor et al., 2012; Schulenberg, 2004). Consideration may also be given to further research on the relationship of DCD and Executive Function as discussed.

Many of the measures of wellbeing and anxiety used in the studies reviewed in the Introduction were generic. Given the students' description of anxiety and worry in this study, future research may also seek to investigate the relationship of types of anxiety and DCD.

The importance of social integration in the academic development of students with DCD may also be another fruitful area of investigation (DaDeppo, 2009). Enabling students with DCD to communicate holistically about their needs at university may be supported by the use of a personal profile (Appendix 27), and a pilot study designed to find out if this approach would be helpful to students with DCD.

Some issues relevant to DCD have not been discussed at all, or only minimally, including family relationships but this omission is justified on the grounds that much of the existing literature on DCD takes a parental perspective and the aim of this study was to focus on the young adults themselves.

#### PERSONAL REFLEXIVITY

In this section, I return full circle and review where I am now. I need to ask myself, have my fore-understandings been challenged and changed by the research process and where is the research taking me, and the students, now (Shaw, 2010)? I am again asking myself to show how my identity is linked to that of the students (Fine et al., 2000).

As the project comes to a close I realise I too am experiencing a transition, an ending of the DPscyh programme and the beginning of a new career, which reminds me that all life is a transition of sorts. I might be positioned as middle-aged and be offered seats on the tube but I still believe I have the personal agency and efficacy to pursue my individuality. This stance demonstrates my pre-supposition of agency which was challenged in the research as the students were also agentic but constrained by expectations and structures. In my current context I realise how all encompassing the research has been over the preceding months and how socially isolated and overtaken my identity has felt at times. However, I remind myself my research identity is a voluntary identity and I wonder if, like the students, I can welcome and integrate some involuntary identities e.g. that might come with ageing.

This research will likely take me into new communities of researchers and practitioners and I wonder what the students are doing now, what social communities they are engaged in. I think of them entering the workplace and hope my next project will be in that arena too. Does this mean I am fused with their progress, no, it is much more pragmatic than that, and reflects my previous career in employment training which I can combine with Counselling Psychology. However, there is no denying that listening to the students' accounts of workplace social interactions sparked my motivation and has impacted my future career identity.

A major shift in my fore-understandings has occurred in completing the project as I have a much fuller picture of the complexity of the impact of having a learning profile that does not mesh with existing education systems and some 'cultural' norms. My assumptions about DCD did encompass functional issues, peer relationships and stress but the extent of the lack of social understanding was a revelation, though the university cultural environment was a hopeful sign. My assumptions have been challenged not only by the research process but through professional development activities to support the research, and no doubt I will be challenged again and again as I go forward and work with others in this area. As I develop my professional identity as a Counselling Psychologist, I am aware that, I too, am in a minority, up against some powerful narratives and structures. However, a key driver is hoping that I can find a way, even if only a small way, to generate a different narrative about 'DCD' and diverse learning profiles. Perhaps I over-estimate what can be done and am guilty of 'aims and lusts' (Mearns & Cooper, 2005) but I believe it is worth trying.

Finally, as the mother of a young adult with DCD, the project has brought home to me many issues that, as a parent, I had not understood. I am therefore reciprocally changed as parent and researcher.

## REFERENCES

- Adatto, C., P. (1991). Late adolescence to early adulthood. In S.I. Greenspan & G. H. Pollock (Eds.), *The course of life: Adolescence, Vol IV* (pp. 357 – 405). Madison, Connecticut: International Universities Press, Inc.
- Ainsworth, M. D. S. (1991). Attachment and other affectional bonds across the life cycle. In P. Marris, J. Stevenson-Hinde & C. Parks (Eds.), *Attachment across the life cycle* (pp. 33-51). New York: Routledge.
- Akhtar, S., & Byrne, J. P. (1983). The concept of splitting and its clinical relevance. *American Journal of Personality*, 53, 407-424.
- Allen, L. (2010). The identity salience model: Self-imposed limitations and potential contributions. *Counselling Psychology Review*, 25(4), 56-64.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders. (4th ed., text revision)*. Washington, DC: Author.
- American Psychiatric Association. (2012). *Commentary takes issue with criticism of new Autism definition: DSM 5 experts call study flawed*. Arlington, VA: Author.
- Andrews, G., Pollock, C., & Stewart, G. (1989). The determination of defense style by questionnaire. *Archive of General Psychiatry*, 46, 455-460.
- Arnett, J.J. (2000). Emerging adulthood: A theory of development from the late teens through the twenties. *American Psychologist*, 55, 469-480.
- Arnett, J.J. (2004). *Emerging adulthood: The winding road from the late teens through the twenties*. New York: Oxford University Press.
- Ashworth, P. (1987). *Adequacy of description: the validity of qualitative findings*. Sheffield Papers in Educational Management, No. 67, Sheffield Centre for Education and Management, Sheffield City Polytechnic, Sheffield, UK.
- Ashworth, P. (2003). An approach to phenomenological psychology: The contingencies of the lifeworld. *Journal of Phenomenological Psychology*, 34(2), 145-156.

- Ashworth, P. (2008). Conceptual foundations of qualitative psychology. In J.A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods* (2nd ed.). London: Sage.
- Ashworth A. & Ashworth, P. D. (2003) The lifeworld as phenomenon and as research heuristic, exemplified by a study of the lifeworld of a person suffering Alzheimer's disease. *Journal of Phenomenological Psychology, 34*, (2) 179-205
- AUCC (2004). *Annual Survey of Counselling in Further and Higher Education 2002/03*. Rugby: British Association of Counselling.
- Baines, A.D. (2012). Positioning, strategizing, and charming: how students with autism construct identities in relation to disability. *Disability and Society, 27*(4), 547 – 561.
- Baltes, P.B. (1979). Life-span developmental psychology: some converging observations on history and theory. In P.B. Baltes & O.G. Brim, Jr. (Eds.), *Life-span development and behaviour Vol. 2*. New York: Academic Press.
- Barry, C. M., Madsen, S. D., Nelson, L. J., Carroll, J. S., & Badger, S. (2009). Friendship and romantic relationship qualities in emerging adulthood: Differential associations with identity development and achieved adulthood criteria. *Journal of Adult Development, 16*, 209-222.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive Therapy of depression*. New York: Guildford Press.
- Bell, S. & Lee, C. (2008). Transitions in emerging adulthood and stress among young Australian women. *International Journal of Behavioural Medicine, 15*(4), 280-288.
- Bernstein, R. J. (1983). *Beyond objectivism and relativism: Science, hermeneutics and praxis*. Pennsylvania: University of Pennsylvania Press.
- Bewick, B. M., Gill, J., & Mulhern, B. (2008). Using electronic surveying to assess psychological distress within the UK university student population: a multi-site pilot investigation. *E-Journal of Applied Psychology, 4*, 1–5.
- Bhaskar, R. (1997). *A realist theory of science* (2nd ed.). London: Verso.

- Biddle, L., Gunnell, D., Sharp, D., & Donovan, J. L. (2003). Factors influencing help seeking in mentally distressed young adults: A cross-sectional survey. *British Journal of General Practice*, *54*, 248-253.
- Bleiberg, K. L., & Markowitz, J. C. (2008). Interpersonal psychotherapy for depression. In D.H. Barlow (Ed.), *Clinical Handbook of Psychological Disorders: A step-by-step treatment manual*. (4<sup>th</sup> Ed.). New York: The Guildford Press.
- Blos, P. (1967). The second individuation process of adolescence. *Psychoanalytic Study of the Child*, *22*, 162-186.
- Blumer, H. (1969). *Symbolic Interactionism*. Englewood Cliffs: Prentice Hall.
- Bonanno, G. A. (2004). Loss, trauma, and human resilience: Have we underestimated the human capacity to thrive after extremely aversive events? *American Psychologist*, *59*, 20-28.
- Bourdieu, P. (1977). *Outline of theory and practice*. Cambridge: Cambridge University Press.
- Borkovec, T. D., Ray, W. J., & Stöber, J. (1998). Worry: A cognitive phenomenon intimately linked to affective, physiological, and interpersonal behavioral processes. *Cognitive Therapy and Research*, *22*(6), 561-576.
- Boyzatis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. London: Sage Publications.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101.
- Braverman, S. (1987). Chronic ambivalence: An individual and marital problem. *Psychotherapy*, *24*, 85-89.
- Breakwell, G.M. (1986). *Coping with threatened identities*. New York: Methuen.
- British Dyslexia Association (2011). Dyslexia style guide. Retrieved January 22nd, 2011, from <http://www.bdadyslexia.org.uk/about-dyslexia/further-information/dyslexia-style-guide.html>

- British Psychological Society. (2004). *Guidelines for minimum standards of ethical approval in psychological research*. Leicester: BPS.
- British Psychological Society. (2006). *The British Psychological Society position paper (October, 2006) Autistic Spectrum Disorders: Guidance for chartered psychologists working with children and young people*. Leicester: BPS.
- British Psychological Society. (2009). *Code of ethics and conduct: Guidance published by the ethics committee of the British Psychological Society*. Leicester: BPS.
- Brown, R. J. (1996). Intergroup relations. In M. Hewestone, W. Stroebe & G.M. Stephenson, (Eds.), *Introduction to Social Psychology* (2<sup>nd</sup> Ed.). Oxford: Blackwell.
- Buber, M. (1958). *I and Thou* (R.G. Smith, Trans. 2<sup>nd</sup> Ed.). Edinburgh: T & T Clark Ltd.
- Bufton, S. (2003). The lifeworld of the university student: Habitus and social class. *Journal of Phenomenological Psychology*, 34(2), 207 -234.
- Burke, P. J. (1980). The self: Measurement implications from a symbolic interactionist perspective. *Social Psychology Quarterly*, 43, 18-29.
- Burke, P. J. (1996). Social identities and psycho-social stress. In H.B. Kaplan (Eds.), *Psychosocial stress: Perspectives on structure, theory, life course, and methods* (pp. 141-174). San Diego: Academic Press.
- Burke, P. J. (2004a). Identities and social structure: The 2003 Cooley-Mead award address. *Social Psychology Quarterly*, 67, 5-15.
- Burke, P. J. & Stets, J. E. (2009). *Identity Theory*. Oxford: Oxford University Press.
- Burr, V. (1999). The extra-discursive in social constructionism. In D.J. Nightingale & J. Cromby (Eds.), *Social constructionist psychology: a critical analysis of theory and practice*. Buckingham: Open University Press.
- Butler, G., Fennel, M., & Hackmann, A. (2008). *Cognitive behavioural therapy for Anxiety Disorders: Mastering clinical challenges*. New York: Guildford Press.

- Byers-Winston, A. M., & Fouad, N. A. (2006). Metacognition and multicultural competence: Expanding the Culturally Appropriate Career Counselling Model. *The Career Development Quarterly*, 54, 187-198.
- Cantell, M.H., Smyth, M.M., & Ahonen, T.P. (2003). Two distinct pathways for developmental coordination disorder: persistence and resolution. *Human Movement Science*, 22(4-5) 413-431.
- Carlson, E. S., & Sroufe, L. A. (1995). Contribution of attachment theory to developmental psychopathology. In D.C.D. Cohen (Ed.), *Developmental Psychopathology: Theory & methods*, Vol. 1 (pp. 581 – 617). New York: Wiley.
- Carroll, J. S., Willoughby, B., Badger, S., Nelson, L. J., Barry, C. M., & Madsen, S. D. (2007). So close, yet so far away: The impact of varying marital horizons on emerging adulthood. *Journal of Adolescent Research*, 22, 219-247.
- Casey, E. (1998). The ghost of embodiment: On bodily habitudes and schemata. In D. Welton (Ed.), *Body and flesh: a philosophical reader*. Oxford: Blackwell.
- Cast, A. D., & Burke, P. J. (2002). A theory of self-esteem. *Social Forces*, 80, 1041-1068.
- Cermak, S. (1985). Developmental Dyspraxia. In E. Roy (Ed.), *Advances in psychology: Neuropsychological studies of apraxia and related disorders*, Vol. 23 (pp. 225-248). New York: North Holland.
- Charmaz, K. (2008). Grounded Theory. In J. A. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods* (2nd ed.). London: Sage.
- Clark, D. A. & Beck, A. T. (2010). *Cognitive therapy of anxiety disorders: Science and practice*. New York: The Guildford Press.
- Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, 64(3), 170-180.
- Collins, N. L., & Read, S. J. (1990). Adult attachment, working models, and relationship quality in dating couples. *Journal of Personality and Social Psychology*, 58, 644-663.

- Connell, J., Barkham, M., & Mellor-Clark, J. (2007). CORE-M mental health norms of students attending university counselling services benchmarked against an age-matched primary care sample. *British Journal of Guidance & Counselling*, 35(1), 41-57.
- Conrad, P. (1987). The experience of illness: recent and new directions. *Research in the sociology of health care* 6, 1-31.
- Cooley, C. H. (1902). *Human nature and the social order*. New York: Scribner.
- Cooper, M. (2003). 'I-I' and 'I-Me': Transposing Buber's interpersonal attitudes to the intrapersonal plane. *Journal of Constructivist Psychology*, 16(2), 131-153.
- Cooper, M. (2009). Welcoming the other: Actualising the humanistic ethic at the core of counselling psychology practice. *Counselling Psychology Review*, 24(3), 119-129.
- Cousins, M., & Smyth, M. M. (2003). Developmental coordination impairments in adulthood. *Human Movement Science*, 22, 433-459.
- Cornish, F., & Gillespie, A. (2009). A pragmatist approach to the problem of knowledge in health psychology. *Journal of Health Psychology*, 14(6), 800-809.
- Craske, M., G., & Barlow, D., H. (2006). *Mastery of your anxiety and worry*. (2<sup>nd</sup> ed.). New York: Oxford University Press.
- Crocker, J., & Major, B. (1989). Social stigma and self esteem: The self protective strategies of stigma. *Psychological Review*, 96, 608-630.
- Cutrona, C. E. (1982). Transition to college: Loneliness and the process of social adjustment. In L.A. Peplau & D. Perlman (Eds.), *Loneliness: A source book of current theory, research, and therapy* (pp. 291-309). New York: John Wiley.
- DaDeppo, L. M. W. (2009). Integration factors related to the academic success of and intent to persist of college students with learning disabilities. *Learning Disabilities Research & Practice*, 24(3), 122-131.
- Dannefer, D. (1984). Adult development and social theory: A paradigmatic reappraisal. *American Sociological Review*, 49, 100 – 116.

- Davies-McCabe, C., & Winthrop, A. (2010). Computerised CBT: University students experiences of using an online self-help programme. *Counselling Psychology Review*, 25(4), 46-55).
- Dcdresearchproject. (2011). Retrieved May 14, 2012 <http://www.dcdresearchproject.com/>
- Dennison, J. J. A., Penke, L., Schmitt, D. P., & van Aken, M. A. G. (2008). Self-esteem reactions to social interactions: Evidence for sociometer mechanisms across days, people and nations. *Journal of Personality and Social Psychology*, 95(1), 181-196.
- Denzin, N. K. (1988). *The research act: A theoretical introduction to sociological methods* (3<sup>rd</sup> ed.). Englewood Cliffs: Prentice Hall.
- Department for Education and Employment. (2001). *S.E.N. code of practice on the identification and assessment of pupils with special educational needs*. London: Department for Education and Employment.
- Department of Health (2004). *The Children Act*. London: Department of Health.
- Department for Skills and Education (2005). *SpLD working group guidelines*. Nottingham: Department for Skills and Education Publications.
- Department for Work and Pensions, (1995). *Disability Discrimination Act*. London: The Stationery Office
- Derogatis, L. R. (1977). *SCL-90-R: Administration, scoring and procedures: Manual*. Baltimore: Clinical Psychometric Research.
- Dewey, J. (1951). *Experience and nature*. Dover.
- Dewey, D., Kaplan, B. J., Crawford, S. G., & Wilson, B. N. (2002). Developmental coordination disorder: Associated problems in attention, learning, and psychosocial adjustment. *Human Movement Science*, 21(5-6), 905-918.
- Douane, G. (2003). Reflexivity as a presence: a journey of self enquiry. In L. Finlay & B. Gough, (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences*. Malden, MA: Blackwell Science.

- Dozois, D. J. A. & Westra, H. A. (2004). The nature of depression: Implications for prevention. In D.J.A. Dozois & K.S. Dobson (Eds.), *The prevention of anxiety and depression: Theory, research and practice* (pp. 9-42). Washington, DC: American Psychological Association.
- Drew, S. (2005). *Developmental co-ordination disorder in adults*. Chichester: Whurr Publishers Ltd.
- Dreyfus, H. L. (1991). *Being-in-the-world: A commentary on Heidegger's being and time*. Cambridge, MA: MIT Press.
- Dryden, W. & Neenan, M. (2003). *The REBT therapist's pocket companion*. New York: Albert Ellis Institute.
- Dunford, C. (2009). Recognising Developmental Coordination Disorder. *Assessment & Development Matters*, 1(2), 30 – 32.
- Dyspraxia Foundation (2009). Findings from a national consultation with young people living with dyspraxia. Retrieved January 22, 2011, from [http://www.dyspraxiafoundation.org.uk/news/show\\_news.php?id=65](http://www.dyspraxiafoundation.org.uk/news/show_news.php?id=65)
- Eatough, V., & Smith, J. A. (2006). 'I feel like a scrambled egg in my head': An idiographic case study of meaning making and anger using interpretative phenomenological analysis. *Psychology & Psychotherapy: Theory, Research & Practice*, 79(1), 115-135.
- Eatough, V., & Smith, J. (2006). 'I was like a wild wild person': Understanding feelings of anger using interpretative phenomenological analysis. *British Journal of Psychology*, 97, 483-498.
- Elder, G.H. (1998). The life course and human development. In W. Damon & R.M. Lerner (Eds.), *Handbook of child psychology: Theoretical models of human development*, Vol. 1 (pp. 939-991). New York: Wiley.
- Elliott, S. & Ageton, S. (1980). Reconciling race and class differences in self-reported and official estimates of delinquency. *Journal of Drug Issues*, 35, 235-25.
- Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38(3), 215-229.

- Endicott, J., Nee., Harrison, W., & Blumenthal, R. (1993). Quality of life enjoyment and satisfaction questionnaire: A new measure. *Psychopharmacology Bulletin*, 29, 321-326.
- Erikson, E.H. (1950). *Childhood and Society*. New York: Norton.
- Erikson, E.H. (1968). *Identity: Youth and Crisis*. New York: Norton.
- Evans, A., & Furlong, A. (1997). Metaphors of youth transitions: niches, pathways, trajectories or navigations. In J. Bynner, J. Chisolm & A Furlong (Eds.), *Youth, citizenship and social change in a European context*. Aldershot: Avebury.
- Fairclough, N. (1992). *Critical language awareness*. London: Longman.
- Fawcett, B., & Hearn, J. (2004). Researching others: Epistemology, experience, standpoints and participation. *International Journal of Social Research Methodology: Theory & Practice*, 7(3), 201-218.
- Fazio, R. H., Effrein, E. A., & Falender, V. J. (1981). Self-perception following social interaction. *Journal of Personality and Social Psychology*, 41, 232-242.
- Feixas, G., Saul, L. A., & Avila, A. (2009). Viewing cognitive conflicts as dilemmas: Implications for mental health. *Journal of Constructivist Psychology*, 10, 445-457.
- Fenigstein, A., Scheier, M. F., & Buss, A. H. (1975). Public and private self-consciousness: assessment and theory. *Journal of Consulting and Clinical Psychology*, 41, 422-436.
- Fernandes, E. (2007). When what I wish makes me worse... to make coherence flexible. *Psychology and Psychotherapy: Theory, Research and Practice*, 80, 165-180.
- Festinger, L. (1954). A theory of social comparison processes. *Human Relations*, 7, 117-140.
- Fine, M., Weiss, L., Weseen, S., & Wong. L. (2000). For whom: Qualitative research and social responsibilities. In N. Denzin and Y. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed.). London: Sage.

- Finlay, L. (2003). Through the looking glass: intersubjectivity and hermeneutic reflection. In L. Finlay & B. Gough, (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences*. Malden: Blackwell Science.
- Finlay, L. (2006). Embodied experience of multiple sclerosis: an existential- phenomenological analysis, in L.Finlay and C.Ballinger (Eds.), *Challenging choices: qualitative research for therapists*. London, John Wiley Publishers
- Finlay, L. (2009). Debating phenomenological research methods. *Phenomenology & Practice* 3, 6-25.
- Fisher, S. & Hood, B. (1987). The stress of transition to university: A longitudinal study of psychological disturbance and vulnerability to homesickness. *British Journal of Psychology*, 78, 425-442.
- Fisher, S., & Hood, B. (1988). Vulnerability factors in the transition to university: Self reported mobility history and sex differences as factors in psychological disturbance. *British Journal of Psychology*, 79, 309-320.
- Flick, U. (2006). *An introduction to qualitative research*. London: Sage Publications.
- Forsyth, K., MacIver, D., Howden, S., Owen, C., & Shepherd, C. (2008). Developmental Coordination Disorder: A synthesis of evidence to underpin an allied health professions' framework. *International Journal of Disability, Development and Education*, 55(2), 153-172.
- Foucault, M. (1972). *The archaeology of knowledge*. London: Tavistock.
- Fransella, F., Bell, R., & Bannister, D. (2004). *A manual for repertory grid technique* (2<sup>nd</sup> ed.). Chichester: Wiley.
- Furr, S. R., Westefeld, J. S., McConnel, G. N., & Jenkins, J. M. (2001). Suicide and depression among college students: A decade later. *Professional Psychology: Research and Practice*, 32, 97-100.
- Gadamer, H. G. (1989). *Truth and method* (2nd ed.). London: Sheed and Ward Continuum.

- Gardner, G. G., Mancini, F., & Semerari, A. (1988). Construction of psychological disorders as invalidation of self-knowledge. In F. Fransella & L. Thomas (Eds.), *Experimenting with Personal Construct Psychology* (pp. 259-272). London: Routledge.
- Geertz, C. (1973). *The interpretation of cultures: Selected essays*. New York: Basic Books.
- Gergen, K.J. (1977). Stability, change and chance in human development. In N.D. & H.W. Reese (Eds.), *Life-span development psychology*. New York: Academic Press.
- Geuze, R.H. (2005). Motor impairment in DCD and activities of daily living. In D. Sugden & M. Chambers (Eds.), *Children with Developmental Coordination Disorder* (pp. 119 – 134). London: Whurr Publishers.
- Geuze, R.H., Jongmans, M.J., Schoemaker, M.M., & Smits-Engelsman, B.C.M. (2001). Clinical and research diagnostic criteria for developmental coordination disorder: a review and discussion. *Human Movement Science, 20*, 7-47.
- Ghaziuddin, M., Butler, E., Tsai, L., & Ghaziuddin, N. (1994). Is clumsiness a marker for Asperger Syndrome? *Journal of Intellectual Disability Research, 38*, 519-527.
- Gilger, J.W., & Kaplan, B.J. (2001). Atypical brain development: a conceptual framework for understanding developmental learning disabilities. *Developmental Neuropsychology, 20*(2), 465-481.
- Gillberg, I.C., & Gillberg, C. (1983). Three-year follow-up at age 10 of children with minor neurological disorders. I: Behavioural problems. *Developmental Medicine and Child Neurology, 25*, 438-449.
- Giorgi, A. (1992). Description versus interpretation: Competing alternative strategies for qualitative research. *Journal of Phenomenological Psychology, 23*(2), 119-135.
- Giorgi, A. (1997). The theory, practice, and evaluation of the phenomenological method as a qualitative research. *Journal of Phenomenological Psychology, 28*(2), 235-261.
- Giorgi, A., & Giorgi, B. (2008). Phenomenological psychology. In C. Willig and W. Stainton Rogers (Eds.), *The Sage Handbook of Qualitative Research in Psychology*. London: Sage.

- Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Englewood Cliffs: Prentice Hall.
- Gold, R.L. (1958). 'Roles in sociological field observation'. *Social Forces*, 36, 93.
- Goldberg, D.P. (1978). *Manual of the general health questionnaire*. Horsham: General Practice Research Unit.
- Gomm, R., & Davies, C. (Eds.). (2000). *Using evidence in health and social care*. London: Sage.
- Goodley, D. (2000). *Self-advocacy in the lives of people with learning difficulties: The politics of resilience*. Buckingham: Open University Press.
- Gough, B. (2003). Deconstructing reflexivity. In L. Finlay & B. Gough (Eds.), *Reflexivity: A practical guide for researchers in health and social sciences*. Malden, MA: Blackwell Science.
- Gordon, C., & Gergen, K. J. (Eds.). (1968). *The self in social interaction*, Vol. 1. New York: Wiley.
- Green D., Baird, G., Barnett, A. L., Henderson, L., Huber, J., & Henderson, S. E. (2002). The severity and nature of motor impairment in Asperger's syndrome: a comparison with Specific Developmental Disorder of Motor Function. *Journal of Child Psychology and Psychiatry*, 43(5), 655 – 668.
- Griffin, C. (1995). Feminism, social psychology and qualitative research. *The Psychologist*, 8(3), 119-121.
- Grundy, S., & Jamieson, L. (2007). European identities: From absent-minded citizens to passionate Europeans. *Sociology*, 41 (4), 663-680.
- Gumley, D. (2005). *Behaviour and social functioning in children with developmental coordination disorder*. Unpublished doctoral thesis, City University, London, United Kingdom.
- Güth, W., Schmittberger, R., & Schwarze, B. (2005). An experimental analysis of ultimatum bargaining. In M. H. Bazerman, & M. H. Bazerman (Eds.), *Negotiation, decision*

*making and conflict management* (pp. 342-363). Northampton: Edward Elgar Publishing.

Halling, S., Leifer, M., & Rowe, J.O. (2006). Emergence of the dialogical approach: forgiving another. In C.T. Fischer (Ed.), *Qualitative research methods for psychology: Introduction through empirical studies*. New York: Academic Press.

Harre, R. (2003). *The self and others: Positioning individuals and groups in personal, political, and cultural contexts*. Westport: Praeger Publishers.

Harre, R., & Moghaddam, F. (2003). Introduction: The self and others in traditional psychology and positioning theory. In R. Harre, & F. Moghaddam (Eds.), *The self and others: Positioning individuals and groups in personal, political, and cultural contexts*. Westport: Praeger Publishers.

Harrist, S. (2006). A phenomenological investigation of the experience of ambivalence. *Journal of Phenomenological Psychology, 37*(1), 85-114.

Hauser, S. T. (1999). Understanding resilient outcomes: Adolescent lives across time and generations. *Journal of Research on Adolescence, 9*, 1-24.

Haverkamp, B. E. (2005). Ethical perspectives on qualitative research in applied psychology. *Journal of Counseling Psychology, 52*(2), 146-155.

Health Professions Council. (2009). *Standards of proficiency: Practitioner psychologists*. London: HPC.

Hefner, J., & Eisenberg, D. (2009). Social support and mental health among college students. *American Journal of Orthopsychiatry, 79*(4), 491-499.

Hegel, G. W. F. (1807). *Phenomenology of spirit*. (translated by A.V. Miller). Oxford: Clarendon Press.

Heidegger (1993, 2010). *Phenomenology of intuition and expression*. London: Continuum.

Heinz, W. (2009). Youth transitions in an age of uncertainty. In A. Furlong (Ed.), *Handbook of youth and young adulthood: New perspectives and agendas*. (pp. 39 – 45). Abingdon: Routledge.

- Hellgren, L., Gillberg, C., & Gillberg, I.C. (1994a). Children with deficits in attention, motor control and perception (DAMP) almost grown up: The contribution of various background factors to outcome at the age of 16 years. *European Child and Adolescent Psychiatry*, 3, 1-15.
- Henwood, K. (2008). Qualitative research, reflexivity and living with risk: Valuing and practicing epistemic reflexivity and centering marginality. *Qualitative research in psychology* 5, 45-55.
- Henwood, K.L. & Pidgeon, N.F. (1992). "Qualitative research and psychological theorising". *British Journal of Psychology*, 83, 97-111.
- Hill, E. L. (2005). Cognitive explanations of the planning and organization of movement. In D. Sugden & M. Chambers (Eds.), *Children with Developmental Coordination Disorder* (pp. 47 – 71). London: Whurr Publishers
- Hill, E.L., Brown, D., & Sorgardt, K.S. (2011). A preliminary investigation of quality of life satisfaction reports in emerging adults with and without developmental coordination disorder. *Journal of Adult Development*, 18, 130 – 134.
- Hockney, J., & James, A. (1993). *Growing up and growing older: Ageing and dependency in the life course*. Sage: London.
- Hollingshead, A.B., & Redlich, F.C. (1958). *Social class and mental illness: a community study*. New York: Wiley.
- Hollway, W. (2005). Commentaries on Potter & Hepburn, 'qualitative interviews in psychology; problems and possibilities'. *Qualitative Research in Psychology* 2, 300 – 325.
- Holstein, J. A., & Gubrium, J.F. (1995). *The active interview: Qualitative research methods*. Thousand Oaks: Sage.
- Honneth, A. (1995). *The struggle for recognition: The moral grammar of social conflicts*. Cambridge: Polity Press.

- Hornsey, M. J. (2008). Social Identity Theory and Self Categorization Theory; A historical review. *Social and Personality Psychology Compass*, 2(1), 202-222.
- Husserl, E. (1931). *Cartesian meditations: an introduction to phenomenology*. The Hague: Martinus Nijhoff.
- Irwin, S. (2001). Repositioning disability and the life course: a social claiming perspective. In M. Priestley (Ed.), *Disability and the life course: Global perspectives*. Cambridge: Cambridge University Press.
- Jaeger, M. E. R., & Rosnow, R. L. (1988). Contextualism and its implications for psychological inquiry. *British Journal of Psychology*, 79(1), 63.
- James, W. (1907). *Pragmatism: A new name for some old ways of thinking*. New York: Longman Green and Company.
- Jefferson, G. (2004). Glossary of transcript symbols with an introduction. In G.H. Lerner (Ed.), *Conversation Analysis: Studies from the first generation*. Amsterdam: John Benjamin.
- Jeffries, S., & Everatt, J. (2004). Working memory: Its role in dyslexia and other specific learning difficulties. *Dyslexia* 10, 196-214.
- Johnson, J.M. (1997). Generalizability in qualitative research: excavating the discourse. In J.M. Morse (Ed.), *Completing a qualitative project: Details and dialogue*. London: Sage.
- Johnson, S., Burrows, A., & Williamson, I. (2004). 'Does my bump look big in this': The meaning of bodily changes in first-time mothers-to-be'. *Journal of Health Psychology*, 9(3), 361-374.
- Johnson, J.H., & McCutcheon, S.M. (1980). Assessing life stress in older children and adolescents. In I.G. Sarason & C.D. Spielberger (Eds.), *Stress and Anxiety*, Vol VII. Washington: Hemisphere Publishing.
- Joiner, T. (2005). *Why people die by suicide*. Cambridge: Harvard University Press.
- Jones, E. E., Farina, A., Hastorf, A. H., Markus, H., Miller, D. T., & Scott, R. A. (1984). *Social stigma: The psychology of marked relationships*. New York: Freeman.

- Kannellakis, P. (2010). Counselling psychology and disability. *Europe's Journal of Psychology*, 2, 123-149.
- Kanioglou, K., Tsorbatzoudis, H., & Barkoukis, V. (2005). Socialization and behavioural problems of elementary school pupils with developmental coordination disorder. *Perceptual and Motor Skills*, 101, 163-173.
- Kaplan, B. J., Wilson, B. N., Dewey, D., & Crawford, S.G. (1998). DCD may not be a discrete disorder. *Human Movement Science*, 17, 471 – 490.
- Kaplan, B., Crawford, S., Cantell, M., Kooistra, L., & Dewey (2006). Comorbidity, co-occurrence. continuum: what's in a name? *Child: Care Health and Development*, 32(6), 723-731.
- Kasket, E. (2011). 'Counselling Psychology research in training and beyond'. British Psychological Society, Division of Counselling Psychology Trainee Talk, London 16th November 2011.
- Kasnitz, D. (2001). Life histories and the independent living movement. In M. Priestley (Ed.), *Disability and the life course: Global perspectives*. Cambridge: Cambridge University Press.
- Kelly, G. A. (1955). *The psychology of personal constructs*. New York: Norton.
- Keniston, K. (1971). *Youth and dissent: The rise of new opposition*. New York: Harcourt Brace Jovanovich.
- Keyes, C. (2007). Promoting and protecting mental health and flourishing. A complementary strategy for improving national mental health. *American Psychologist*, 62, 95-108.
- Khun, T.S. (1962). *The structure of scientific revolutions* (3rd ed.). Chicago: The University of Chicago Press.
- King, G., Cathers, T., Brown, E., & MacKinnon, E. (2003). Turning points: Emotionally compelling life experiences. In G. King, E. Brown & L. Smith (Eds.), *Resilience: Learning from people with disabilities and turning points in their lives* (pp. 31-88). Westport: Praeger.

- Kirby, A., Edwards, L., & Sugden, D. (2011). Emerging adulthood in developmental co-ordination disorder: Parent and young adult perspectives. *Research in Developmental Disabilities, 32*, 1351 – 1360.
- Kirby, A., Edwards, L., Sugden, D. A., & Rosenblum, S. (2010). The development and standardization of the adult developmental co-ordination disorders/dyspraxia checklist (ADC). *Research in Developmental Disabilities, 31*, 131-139.
- Kirby, A., Salmon, G., & Edwards, L. (2007). Attention Deficit Hyperactivity Disorder and developmental co-ordination difficulties: knowledge and practice among child and adolescent psychiatrists and paediatricians. *Psychiatric Bulletin, 31*, 336-338.
- Kirby, A., Sugden, D., Beveridge, A., Edwards, L., & Edwards, R. (2008). Dyslexia and developmental co-ordination disorder in further and higher education-similarities and differences. Does the 'label' influence the support given? *Dyslexia 14*, 197-213.
- Kloppenber, J.T. (1996). Pragmatism: An old name for a new way of thinking? *Journal of American History 83*, 100-183.
- Knouse, L. E., Barkley, R. A., & Murphy (2012). Does executive functioning (EF) predict depression in clinic referred adults?: EF tests vs. rating scales. *Journal of Affective Disorders, 145*(2), 270-275.
- Koro-Ljungberg, M. (2008). Validity and validation in the making in the context of qualitative research. *Qualitative Health Research, 18*(7), 983-989.
- Kubany, E. S., Haynes, S. N., Leisen, M. B., Owens, J. A., Kaplan, A. S., & Watson, S. B. (2000). Development and preliminary validation of a brief broad spectrum measure of traumatic exposure: The traumatic life events questionnaire. *Psychological Assessment, 12*, 210-234.
- Kumar, N., Scheer, L., & Steenkamp, J. (1995). The effects of supplier fairness on vulnerable resellers. *Journal of Marketing Research 52*, 54-65.
- Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. London: Sage.

- Lacan, J. (1977a). *The four fundamental concepts of psycho-analysis*. (Trans. A. Sheridan) London : Hogarth.
- Lane, D. A., & Corrie, S. (2006). Counselling psychology: Its influences and future. *Counselling Psychology Review*, 21 (1), 12-24.
- Langdridge, D. (2007). *Phenomenological psychology : Theory, research and method*. Harlow: Pearson Prentice Hall.
- Langdridge D., & Hagger-Johnson, G. (2009). *Introduction to research methods and data analysis in Psychology* (2nd ed.). Harlow: Pearson Education Limited.
- Larkin, M., & Griffiths, M.D. (2004). Dangerous sports and recreational drug-use: Rationalizing and contextualizing risk. *Journal of Community & Applied Social Psychology*, 14 (4), 215-232.
- Larkin, M. & Thompson, A. (2011). Interpretative Phenomenological Analysis. In D. Harper & A. Thompson (Eds.), 'Qualitative research methods in mental health and psychotherapy: An introduction for students and practitioners'. Oxford: Wiley.
- Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. *Qualitative Research in Psychology*, 3(2), 102-120.
- Larochette, A.C., Harrison, A. G., Rosenblum, Y., & Bowie, C.R. (2011). Additive neurocognitive deficits in adults with attention-deficit/hyperactivity disorder and depressive symptoms. *Archives of Clinical Neuropsychology*, 26, 385-395.
- Lent, R. W., & Brown, S.D. (2006). On conceptualizing and assessing social cognitive constructs in career research: A measurement guide. *Journal of Career Assessment*, 14, 12-35.
- Leonard, P. (1984). *Personality and ideology: Towards a materialist understanding of the individual*. London: Macmillan.
- Levant, R. F., Wimer, D.J, & Williams, C. M. (2011). An evaluation of the psychometric properties of the Health Behavior Inventory-20 (HBI-20) and its relationships to masculinity and attitudes towards seeking psychological help among college men. *Psychology of Men and Masculinity*, 11, 26-41

- Levine, M (2003). *The myth of laziness*. New York: Simon & Schuster.
- Levinson, D.J. (1978). *The season's of a man's life*. New York: Ballantine.
- Levitas, R. (1998). *The inclusive society: Social exclusion and New Labour*. London: Sage.
- Levitz, R., & Noel, L. (1989). Connecting students to institutions: Keys to retention and success. In M.L. Upcraft & J.N. Gardner & Associates (Eds.), *The freshman year experience: Helping students survive and succeed in college* (pp. 65-81). San Francisco: Jossey-Bass.
- Lewin, K. (1946). 'Action research and minority problems'. *Journal of Social Issues* 2, 65.
- Lincoln, Y. S., & Guba, (1985). *Naturalistic Inquiry*. Beverly Hills, CA: Sage.
- Lingam, R., Hunt, L., Golding, J., Jongmans M., & Edmond, A. (2009). Prevalence of developmental coordination disorder using DSM-IV at 7 years of age: A UK population-based study. *Pediatrics*, 123, 693-700.
- Lovibond, S., & Lovibond, P. (1995). *Manual for the depression anxiety stress scales* (2<sup>nd</sup> ed.). Sydney: Psychology Foundation.
- Luckmann, T. (1983). Remarks on personal identity: inner, social and historical time. In A. Jacobson-Widding (Ed.), *Identity: Personal and socio-cultural*. Uppsala: Uppsala University Press.
- Lukes, S (1967). Alienation and anomie. In P. Laslett & W.G. Runciman (Eds.), *Philosophy, politics and society*. Oxford: Basil Blackwell.
- Luthar, S. S. (2006). Resilience in development: A synthesis of research across five decades. In D. Cicchetti & D.J. Cohen (Eds.), *Developmental psychopathology: Risk, disorder and adaption*. (2<sup>nd</sup> Ed., pp. 739-795). New York: Wiley.
- Lynch, K., & O'Riordan, C. (1998). Inequality in higher education: a study of class barriers. *British Journal of Sociology of Education*, 19, 445-478.

- MacCallum, R. C., Wegener, D.T., Uchino, B. M., & Fabrigar, L. R. (1993). The problems in equivalent models in applications of covariance structure analysis. *Psychological Bulletin*, 111, 185-199.
- McCall, G. J., & Simmons, J. L. (1978). *Identities and interactions*. New York: Free Press.
- Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology*, 91(1), 1-20.
- Mann, S.J. (2001). Alternative perspectives on the student experience: alienation and engagement. *Studies in Higher Education*, 26(1), 2001.
- Marcia, J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology*, 3, 551-558.
- Markova, I. (1984). *Knowledge of the self through action*. Paper presented at the BPS Self and Identity Conference, University College, Cardiff, July.
- May, T. (1998). Reflexivity in the age of reconstructive science. *International Journal of Social Science Research Methodology* 1(1), 7-24.
- Mead, G. H. (1934). *Mind, self and society*. Chicago: University of Chicago press.
- Mearns, D. & Cooper, M. (2005). *Working at relational depth in counselling and psychotherapy*. London: Sage.
- Meeus, W. (2011). The study of adolescent identity formation 2000-2010: A review of longitudinal research. *Journal of research on adolescence*, 2(1), 75 – 94.
- Meeus, W., leedema, J., Maassen, G. & Engels, R. (2005). Separation-individuation revisited: on the interplay of parent-adolescent relations, identity and emotional adjustment in adolescence. *Journal of Adolescence*, 28, 89 – 106.
- Meltzoff, J. (1998). *Critical thinking about research: Psychology and related fields*. Washington, DC: American Psychological Association.

- Merleau-Ponty, M. (1964). Eye and mind. In J. Edie (Ed.), *The primacy of perception*. Evanston: Northwestern University Press.
- Merleau-Ponty, M. (2002). *Phenomenology of perception*. (first published 1945) London: Routledge.
- Merton, R. K. (1948). The self-fulfilling prophecy. *The Antioch Review*, 8, 193-210.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis*. London: Sage
- Missiuna, C., Moll, S., King, G., Stewart, D., & Macdonald, K. (2008). Life experiences of young adults who have coordination difficulties. *Canadian Journal of Occupational Therapy*, 75(3), 157 – 166.
- Mitchell, N., & Gordon, P. K. (2007). Attitudes towards computerised CBT for depression amongst a student population. *Behavioural and Cognitive Psychotherapy*, 35, 421-430.
- Mohr, J. J., Eiche, K. D., & Sedlacek, W. E. (1998). So close, yet so far: Predictors of attrition in college seniors. *Journal of College Student Development*, 39, 343-354.
- Morris, D. (2008). Body. In R. Diprose & J. Reynolds (Eds.), *Merleau-Ponty: Key concepts*. Stocksfield: Acumen Publishing Ltd.
- Morrison, R., & O'Connor, R. (2005). Predicting psychological distress in college students: the role of rumination and stress. *Journal of Clinical Psychology*, 61 (4), 447-460.
- Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology*, 52(2), 250-260.
- Murphy, P.D. (2002). The anthropologist's son (or living and learning in the field). *Qualitative Inquiry* 8(2), 246-261.
- Murray, C., & Wren, C. T. (2003). Cognitive, academic and attitudinal predictors of the grade point averages of college students with learning disabilities. *Journal of Learning Disabilities*, 36, 407-415.

- National Institute for Health and Clinical Excellence. (2007). *Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care*. London: NICE.
- National Institute for Health and Clinical Excellence. (2009). *Depression: the treatment and management of depression in adults*. London: NICE.
- Needham, J. (1968). *Order and life*. Cambridge: MIT Press.
- Nichols, S. A., McLeod, J. S., Holder, R. L., & McLeod, H. S. T. (2008). Screening for dyslexia, dyspraxia and Meares-Irlen Syndrome in higher education. *Dyslexia* 15, 42-60.
- Nightingale, D. J., & Cromby, J. (1999). Reconstructing social constructionism. In D.J. Nightingale & J. Cromby (Eds.). *Social Constructionist Psychology: A critical analysis of theory and practice*. Buckingham: Open University Press.
- Nolen-Hoeksema, S. (2000). The role of rumination in depressive disorders and mixed anxiety/depressive symptoms. *Journal of Abnormal Psychology*, 109, 504-511.
- Oliver, M. (1999). Final accounts and the parasite people. In M. Corker & S. French (Eds.), *Disability discourse*. Buckingham: Open University Press.
- O'Connor, R.C., & O'Connor, D.B. (2003). Predicting hopelessness and psychological distress: The role of perfectionism and coping. *Journal of Counseling Psychology*, 50, 362-372.
- O'Connor, M., Sanson, A., Hawkins, M., T., Olsson, C., Frydenberg, J., W., & Letcher, P. (2012). The relationship between positive development and psychopathology during the transition to adulthood: A person-centred approach. *Journal of Adolescence*, 35, 701 – 712.
- Olney, M. F. & Brockelman, K. F. (2003). Out of the disability closet: Strategic use of perception management by select university students with disabilities. *Disability & Society*, 18(1), 35-50.
- Paley, J. (2005). Phenomenology as rhetoric. *Nursing Inquiry*, 12(2), 106-116.

- Parker, I. (1998). Realism, relativism, and critique in psychology. In I. Parker (Ed.), *Social constructionism, discourse and realism*. London: Sage.
- Patton, M. Q. (2002). *Qualitative research & evaluation methods* (3rd ed.). London: Sage.
- Peterson, C. and Seligman, M.E.P. (1984). Causal explanations as a risk factor for depression: Theory and evidence. *Psychological Review*, 91, 347-374.
- Piek, J. A., Dyck, M. J., Dyck, Nieman, A., Anderson, M., Hay, D., Smith, L. M., McCoy, M., & Hallmayer, J. (2004). The relationship between motor coordination, executive function and attention in school aged children. *Archives of Neuropsychology*, 19, 1063-1076.
- Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *Qualitative Studies in Education* 16(2), 175-196.
- Plummer, K. (2001). *Documents of Life 2: an invitation to a critical humanism*. London: Sage.
- Poland, B. D. (2001). Transcription quality. In J. F. Gubrium and J.A. Holstein (Eds.), *Handbook of interview research: context and method*. London: Sage.
- Polatajko, H., Fox, M., & Missiuna, C. (1995). An international consensus on children with developmental coordination disorder. *Canadian Journal of Occupational Therapy*, 62, 3-6.
- Pollard, K.M., & O'Hare, W.P. (1999). America's racial and ethnic minorities. *Population Bulletin* 54(3), 1-48.
- Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counseling Psychology*, 52(2), 126-136.
- Ponterotto J. G., & Park-Taylor, J. (2007). Racial and ethnic identity theory, measurement, and research in counselling psychology: Present status and future directions. *Journal of Counselling Psychology*, 54(3), 282-294.
- Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and possibilities. *Qualitative Research in Psychology*, 2(4), 281-307.

- Prilleltensky, I. (2002). *Doing psychology critically: Making a difference in diverse settings*. Basingstoke: Palgrave MacMillan.
- Rasmussen, P., & Gillberg, C. (2000). Natural outcome of ADHD with developmental coordination disorder at age 22years: A controlled, longitudinal community based study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(11), 1424-1431.
- Reddy, R., Rhodes, J. E., & Mulhall, P., (2003). The influence of teacher support on student adjustment in the middle school years: A latent growth curve study. *Development and Psychology*, 15, 233-237.
- Reichenbach, H. (1938). *Experience and prediction*. Chicago: University of Chicago Press.
- Reicher, S. (2000). Against methodolatry: Some comments on Elliott, Fischer, and Rennie. *British Journal of Clinical Psychology*, 39(1), 1.
- Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist* 18(1), 20-23.
- Rennie, D. L. (1998). *Person-centred counselling*. London: Sage.
- Rennie, D.L. (1999). Qualitative research: a matter of hermeneutics and the sociology of knowledge. In M. Kopala & L.A. Suzuki (Eds.), *Using qualitative methods in Psychology*. London: Sage.
- Ribeiro, E., Feixas, G., Maia, A., Senra, J., & Dada, G. (2012). Changes in the construct of first-year university students: impact on psychological symptoms and problem-solving skills. *Journal of Constructivist Psychology* 25, 170 – 180.
- Richardson, M., Abraham, C., & Bond, R. (2012). Psychological correlates of university students' academic performance: A systemic review and meta-analysis. *Psychological Bulletin*, 138(2), 353-387.
- Riddell, S. (1998). Transitions to adulthood for young disabled people. In C. Robinson & K. Stalker (Eds.), *Growing up with disability*. London: Jessica Kingsley.

- Riddell, S. (2009). Disability, exclusion, and transition to adulthood. In A. Furlong (Ed.), *Handbook of youth and young adulthood: New perspectives and agendas* (pp 39 – 45). Abingdon: Routledge.
- Riddell, S., Tinklin, T., & Wilson (2005). *Disabled students in Higher Education*. London: Routledge.
- Riggs, S. A., & Han, G. (2009). Predictors of anxiety and depression in emerging adulthood. *Journal of Adult Development*, 16, 39-52.
- Ritvo, S. (1971). *Late adolescence: Developmental and clinical considerations. The psychoanalytic study of the child*. New York: Quadrangle.
- Roberts, J. E., Gotlib, I. H., & Kassel, J. D. (1996). Adult attachment security and symptoms of depression: The mediating roles of dysfunctional attitudes and low self-esteem. *Journal of Personality and Social Psychology*, 70, 310-320.
- Rogers, C. R. (1957). The necessary and sufficient conditions of personality change. *Journal of Consulting Psychology*, 21 (2), 95-103.
- Rogers, C. R. (1967). *On becoming a person: A therapist's view of psychotherapy*. London: Constable.
- Romans, S.E., Martin, J.L., Morris, E., & Herbison, G.P. (1999). Psychological defense in women who report childhood sexual abuse: A controlled community study. *American Journal of Psychiatry*, 156, 1080-1085.
- Rorty, R. (1979). *Philosophy and the mirror of nature*. Princeton, NJ: Princeton University Press.
- Rosenberg, M. (1984). Transient depersonalisation: the loss of identity in adolescence: British Psychological Society Self and Identity Conference. University College, Cardiff, July.
- Rosenhan, D. L., & Seligman, M. E. P. (1984). *Abnormal Psychology*. New York: Norton.
- Rosner, B. (1979). The analysis of longitudinal data in epidemiologic studies. *Journal of Chronic Disease*, 32, 163-173.

- Rothbaum, B. O., & Foa, E. B. (1996). Cognitive Behaviour Therapy for posttraumatic stress disorder. In B.A. van der Kolk, A.C. McFarlane, C. Alexander & L. Weisaeth (Eds.), *Traumatic Stress: The effects of overwhelming experience on mind, body and society* (pp. 491-509). NY: Guildford.
- Royal College of Psychiatrists (2003). *The mental health of students in higher education*. London: Author.
- Royal College of Psychiatrists (2011). *Mental health of students in higher education*. London: Author.
- Rutter, M. (1996). Transitions and turning points in developmental psychology: As applied to the age span between childhood and mid-adulthood. *International Journal of Behavioural Development*, 19, 603-626.
- Rutter, M & Sandberg, S. (1992). Psychosocial stressors: concepts, causes and effects. *European Child and Adolescent Psychiatry*, 1, 3-13.
- Sayer, A. (1999). *Realism and social science*. London: SAGE.
- Silbereisen, R. & Lerner, R. (2007). Approaches to positive youth development: a view of the issues. In R. Silbereisen & Lerner (Eds.), *Approaches to positive youth development* (pp 3-30). London: Sage.
- Scheer, L. K., Kumar, N., & Steenkamp, J. E. M. (2003). Reactions to perceived inequity in U.S. and Dutch interorganizational relationships. *Academy of Management Journal*, 46(3), 303-316.
- Schleirmacher, F. (1998). *Hermeneutics and criticism and other writings*. Cambridge: CUP.
- Schoemaker, M.M., & Kalverboer, A.F. (1994). Social and affective problems of children who are clumsy: How early do they begin? *Adapted Physical Activity Quarterly*, 11 (2), 130-140.
- Schon, D. A. (1991). *The reflective practitioner: how professionals think in action*. London: Ashgate.

- Schulenberg, J. E., Sameroff, A. J., & Cicchetti (2004). The transition to adulthood as a critical juncture in the course of psychopathology and mental health. *Development and Psychopathology*, 16, 799 – 806.
- Schwartz, S. J., Klimstra, T. A., Luyckx, K., Hale III, W. W., Frijns, T., Oosterwegel, A., et al (2011). Daily dynamics of personal identity and self-concept clarity. *European Journal of Personality* 25, 373-385.
- Seider, S., Davis, K., & Gardner, H. (2007). Good work in Psychology. *The Psychologist*, 20, 11, 672-676.
- Seligman, M. E. P. (1975). *Helplessness: On depression, development and death*. San Francisco: Freeman.
- Shakespeare, T. (1997). Researching disabled sexuality. In C. Barnes & G. Mercer (Eds.), *Doing Disability Research*. Leeds: The Disability Press.
- Shanahan, M. J. (2000). Pathways to adulthood in changing societies: Variability and mechanisms in life course perspective. *Annual Review of Sociology*, 26, 667-692.
- Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. *Qualitative Research in Psychology*, 7(3), 233-243.
- Shonkoff, J.P., & Phillips, D.A. (2000). *From neurons to neighbourhoods: The science of early childhood development*. Washington, DC: National Academy Press.
- Strauger, J. S., & Schohn, M. (1989). *Self confidence: Its conceptualisation, measurement, and behavioural implications*. Unpublished manuscript, State University of New York at Buffalo.
- Silverman, D. (2010). *Doing qualitative research*. (3rd ed.). London: Sage.
- Sinason, V. (1992). *Mental handicap and the human condition: New approaches from the Tavistock*. London: Free Association.
- Skinner, R.A., & Piek, J.P. (2001). Psychosocial implications of poor motor coordination in children and adolescents. *Human Movement Science*, 20(1-2), 73-94.

- Smart, D., & Sanson, A. (2003). Social competence in young adulthood, its nature and antecedents. *Family Matters* 64, (4-9).
- Smith, J.A. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative Psychology*. London: Sage.
- Smith, J.A. (2005). Commentaries on Potter & Hepburn, 'qualitative interviews in psychology; problems and possibilities'. *Qualitative Research in Psychology* 2, 300 – 325.
- Smith, J. A. (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health and Well-being* 2, 3-11.
- Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. London: Sage.
- Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health Psychology Review* 5(1), 9-27.
- Smith, J. A. (2011). 'We could be diving for pearls': the value of the gem in experiential qualitative psychology. *Qualitative Methods in Psychology Bulletin*, 12, 6-15.
- Smith, J.A., & Osborn, M. (2003). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative Psychology*. London: Sage.
- Smith, J.A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J.A. Smith (Ed.), *Qualitative Psychology* (2nd Ed). London: Sage.
- Smucker, M. R., Grunert, B .K., & Weis, J. M. (2003). Posttraumatic Stress Disorder: A new algorithm. In R. Leahy (Ed.), *Roadblocks in cognitive-behaviour therapy: Transforming challenges into opportunities for change*. New York: Guildford Press.
- Spivack, A., & Willig, C. (2010). 'There is a battle within yourself': Exploring the experience of a split sense of self among inpatients with eating disorders. *Journal of Counselling Psychology*, 25(4), 7-18.
- SpLD Standards Assessment Committee (SASC). Suitable Tests for the Assessment of Specific Learning Difficulties in Higher Education (Revised September 2011). Retrieved May 9, 2012, from <http://www.sasc.org.uk/Default.aspx?id=2>

- Spradley, J. P. (1979). *The ethnographic interview*. New York: Holt, Rinehart & Winston.
- Stamp, R. & Loewenthal, D. (2008). Can counselling/psychotherapy be helpful in reducing barriers to learning for the person with specific learning difficulties? *Counselling Psychology Quarterly*, 21(4), 349-360.
- Stanovich, K. E. (1986). Mathew effects in reading: some consequences of individual differences in the acquisition of literacy. *Reading Research Quarterly*, 21, 360-406.
- Stone, W., & Huhges, J. (2002). *Social capital: Empirical meaning and measurement validity* (Working paper No. 27). Melbourne: Australian Institute of Family Studies.
- Strawbridge, S. (2006). Thoughts on becoming, being and developing as a counselling psychologist. *Counselling Psychology Review*, 21(1), 27-30.
- Stryker, S. (1980). *Symbolic Interactionism: A social structural version*. Caldwell: Blackburn Press.
- Sue, D. W., Nadal, K. L., Capodilup, C. M., Lin, A. I., Torino, G. C., & Rivera, D. P. (2008). Racial microaggressions against Black Americans: Implications for counselling. *Journal of Counselling & Development*, 86, 330-338.
- Sugden, D.A. (2006). *Developmental Coordination Disorder as Specific Learning Difficulty. Leeds Consensus Statement. ERSC Seminar Series, 2004-2005*. Cardiff, UK: Dyscovery Trust.
- Sugden, D.A. & Chambers, M.E. (1998). Intervention approaches and children with developmental coordination disorder. *Pediatric Rehabilitation*, 2, 139-147.
- Sugden, D., Kirby, A., & Dunford, C. (2008). Issues surrounding children with Developmental Coordination Disorder. *International Journal of Disability, Development and Education*, 55(2), 173-187.
- Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), *The Social Psychology of Intergroup Relations* (pp. 33-47). Monterey: Brooks/Cole.

- Tanner, J. T., & Arnett, J. J. (2009). The emergence of 'emerging adulthood': the new life stage between adolescence and young adulthood. In A. Furlong (Ed.), *Handbook of youth and young adulthood: New perspectives and agendas* (pp 39 – 45). Abingdon: Routledge.
- Taylor. (1994). Ethnography. In P. Banister, E. Burman, I. Parker, M. Taylor & C. Tindall (Eds.), *Qualitative methods in psychology: A research guide*. Buckingham: Open University Press.
- Tessar, A., Millar, M., & Moore, J. (1988). Self-definition: The impact of the relative performance of and similarity of others. *Social Psychology Quarterly*, 43, 341-347.
- Tinto, V. (1975). Dropout from higher education: A theoretical synthesis of recent research. *Review of Educational Research*, 45, 89-125.
- Tisdall (2001). Failing to make the transition? Theorising the 'transition to adulthood' for young disabled people. In M. Priestley (Ed.), *Disability and the life course: Global perspectives*. Cambridge: Cambridge University Press.
- The Scottish Government. (2012). *Scottish index of multiple deprivation*. Edinburgh: Author
- Thoits, P. (2003). Personal agency in the accumulation of role-identities. In P.J. Burke, T.J.Owens, & R.T. Serpe (Eds.), *Advances in identity theory and research* (pp.179-194). New York: Kluwer Academic/Plenum.
- Turner, J. C., Hogg, M. A., Oakes, P. J., Reicher, S. D., & Wetherell, M. S. (1987). *Rediscovering the social group: A self-categorization theory*. New York: Blackwell.
- Tuulio-Henriksson, A., Poikolainen, K., Aalto-Setälä, T., & Lonnqvist, J. (1997). Psychological defense styles in late adolescence and late adulthood: a follow up study. *Journal of American Child and Adolescent Psychiatry*, 36, 1148-1153.
- Tuulio-Henriksson, A., Poikolainen, K., Aalto-Setälä, T., Marttunen, M., & Lonnqvist, J. (2000). Life events and increase in immature defense style during transition to adulthood. *Nord J Psychiatry* 54(6), 417 – 421.

- University of Lancaster (2011). Guidance on Demographic questionnaires. Retrieved May 9, 2012 from <http://www.lancs.ac.uk/shm/dhr/research/documents/Guidance-on-Demographic-Questionnaires.doc>
- Usher, R. (1998). The story of the self: education, experience and autobiography. In M. Erben (Ed.), *Biography and education: A reader*. London: Falmer Press.
- Vaivre-Douret, L., Lalanne, C., Ingster-Moati, I., Boddart, N., Cabrol, K., Dufier, J., Golse, B., & Falissard, B. (2011). *Developmental Neuropsychology*, 36(5), 614 – 643.
- van Deurzen, E. (2006). My memories of the start of counselling psychology in Britain. *Counselling Psychology Review*, 21(1).
- Van Manen, M. (1990). *Researching lived experience: Human science for an action sensitive pedagogy*. Albany, NY: State University of New York Press.
- Van Manen, K., & Whitbourne, S., K. (1997). Psychosocial development and life experience in adulthood: A 22-year sequential study. *Psychology and Aging*, 12(3), 239 – 246.
- Vaz-Serra, A. (1989). A study of coping: The problem solving inventory. *Psiquiatria Clinica*, 9, 301-316.
- Villenas, S. (1996). The colonizer/colonized Chicana ethnographer: Identity marginalization and cooptation in the field. *Harvard Educational Review* 66, 711-731.
- Wagner, J., Ludtke, O., Jonkmann, K., & Trautwein, U. (2013). Cherish yourself: Longitudinal patterns and conditions of self-esteem change in the transition to young adulthood. *Journal of Personality and Social Psychology*, 104(1), 148 – 163.
- Wallat, C., & Piazza, C. (1988). The classroom and beyond: Issues in the analysis of multiple studies of communicative competence. In J.L. Green & J.O. Harker (Eds.), *Multiple perspective analysis of classroom discourse*. Norwood: Ablex Publishing Corporation.
- Waller, R., Mahmood, T., Gandi, R., Delves, S., Humphrys, N., & Smith, D. (2005). Student mental health: how can the psychiatrists better support the work of university medical and counselling services? *British Journal of Guidance & Counselling*, 33(1), 117-128.

- Walmsley, J. (1993). Contradictions in caring: Reciprocity and interdependence. *Disability and Society*, 8(2), 129 – 141.
- Warnock, M. (1987). *Memory*. London: Faber and Faber.
- Webb, J. & Whittaker, S. (2012). Defining learning disability. *The Psychologist* 25 (6), 440 – 443.
- Wells, A. (1997). *Cognitive therapy of anxiety disorders: a practice manual and conceptual guide*. Chichester: John Wiley.
- Wendell, S. (1996). *The rejected body: Feminist philosophical reflections on disability*. London: Routledge.
- West, W. (2011). Using the tacit dimension in qualitative research in counselling psychology. *Counselling Psychology Review*, 26(4), 41-46.
- Willcoxson, L., Cotter, J., & Joy, S. (2011). Beyond the first-year experience: the impact on attrition of student experiences throughout undergraduate degree studies in six diverse universities. *Studies in Higher Education*, 36(3), 331-352.
- Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method (2<sup>nd</sup> Ed.)*. Maidenhead: Open University Press.
- Wilkinson, S., Joffe, H., & Yardley, L. (2004). Interviews and focus groups. In D.F. Marks & L. Yardley (Eds.), *Research Methods for Clinical and Health Psychology*. London: Sage.
- Wilson, C. (1963). *The Outsider*. London: Pan.
- Wilson, P.H., (2005). Practitioner review: Approaches to assessment and treatment of children with DCD: an evaluative review. *Journal of Child Psychology and Psychiatry*, 46(8), 806-823.
- Wilson, B. N., Kaplan, B.J., Crawford, S. G., Campbell, A., & Dewey, D. (2000). Reliability and validity of a parent questionnaire on childhood motor skills. *American Journal of Occupational Therapy*, 54, 484-493.
- Wittgenstein, L. (1972). *Philosophical investigations*. Oxford: Blackwell.

- Wolf, M. M. (1978). Social validity: The case for subjective measurement or how applied behavior analysis is finding its heart. *Journal of Applied Behavior Analysis*, 11 (2), 203-214.
- Woolfe, R., Dryden, W., & Strawbridge, S. (Eds.) (2004). *Handbook of Counselling Psychology* (2nd Ed.). London: Sage.
- Wolin, S. J., & Wolin, S. (1993). *The resilient self*. New York: Villard.
- World Health Organization (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva: Author.
- Yakushko, O., Davidson, M. M., & Nutt-Williams, E. (2009). Identity salience model: A paradigm for integrating multiple identities in clinical practice. *Psychology Theory, Research, Practice, Training*, 46(2), 180-192.
- Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15(2), 215-228.
- Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. Smith (Ed.), *Qualitative Psychology: A practical guide to research methods*. (2nd ed., pp. 235-251). London: Sage.
- Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: The Guildford Press.
- Zafirovski, M. (2005). Labor markets' institutional properties and distributive justice in modern society: A comparative empirical analysis. *Social Indicators Research*, 72(1), 51-97.
- Zanna, M., & Cooper, J. (1976). Dissonance and the attribution process. In J.H. Harvey, W.J. Ickes & R.F. Kidd (Eds.). *New directions in attribution research* (pp. 199-217). Hillsdale: Erlbaum.
- Zimmerman, B.J., Bandura, A., & Martinez-Pons, M. (1992). Self motivation for academic attainment: the role of self-efficacy beliefs and personal goal setting. *American Educational Research Journal*, 29, 663-676.

	<b>Proposed Quality Criteria</b>	<b>Reflexive notes – selected extracts</b>
1	<p>Willig (2008), argues, that to enable others to evaluate a qualitative study:</p> <p>The researcher has to be clear about what she wanted to find out through an appropriate research question and the type of knowledge she was trying to generate from her epistemological position.</p> <p>The researcher needs to outline her assumptions about the world and her role in the research process relevant to stances in these broad epistemological areas through the researcher's standpoint or position and hence subjective interaction with the data and analysis.</p> <p>The epistemological stance in this project has been described as pragmatic contextualist which produces useful knowledge commensurate with a pragmatic stance and encompasses critical realist and light social constructionist positions broadly aligned to Madill's (2000) 'contextual constructionist' position. The research method, procedures and analysis can be appraised in alignment with the researcher's epistemological stance.</p>	<p>I have been trying to make sense of my epistemological position and still find it confusing but perhaps have made a breakthrough but I need to check it out with Susan. I am hoping to go for a pragmatist epistemology as it fits with so much I want to achieve in a practical way as I can't do Action Research because I am not in an organisation and it would probably take too long. I hope this works as I feel comfortable with it.</p>
2	<p>Madill (2000) refers to reflexivity or the researcher's subjective engagement in the research process:</p> <p>Bracketing / engagement/Make implicit assumptions explicit (West, 2011)/engage with presuppositions from literature (Shaw, 2010)</p>	<p>As soon as I say my introduction in the interview I draw attention to what I am looking for.</p> <p>I want to remain uninfluenced by the literature and really try to listen to the participant's account without taking a theoretical perspective at this stage</p>

	<b>Proposed Quality Criteria</b>	<b>Reflexive notes – selected extracts</b>
	<p>Unearth previously unknown assumptions (Morrow, 2005)</p> <p>Awareness of emotional involvement/vulnerability (Fine et al, 2000)</p> <p>Interaction with participants based on shared humanity and empathy (Madill, 2000).</p> <p>Awareness of embodied response (Douane, 2003).</p> <p>Awareness of personal bias (Hill et al, 1997).</p> <p>Utilise research team to debrief in a critical research community (Morrow 2005).</p>	<p>which I can do later in the Discussion stage.</p> <p>My understanding of sensory sensitivity has been challenged, it can be in just one sensory area, e.g., taste and it hasn't really come up much at all.</p> <p>What am I scared of closing down a topic too early? Attending to their needs so divert back to topic later.</p> <p>I realise when I listen to the interviews again how energised I am by this part of the process.</p> <p>I always feel emotional when I listen to the tapes as I hear the struggle with DCD.</p> <p>I wonder what I might think if I met my 19 year old self? –precocious and naive.</p> <p>I am aware that after the interview I reacted defensively to a colleague who talked about a young person with DCD which showed my sensitivity to a narrative that underestimates the impact of DCD.</p> <p>I need to make sure that I listen to their concerns and not be swayed by issues that are salient for me so check I pay attention to differences as well as similarities.</p> <p>I presented my analysis to the IPA group today for feedback and was very nervous but received good feedback on the thematic structure and diagram but didn't really get time to discuss quotes. I think I am still being a bit tentative in presenting my work and hiding myself. I discussed being left</p>

	<b>Proposed Quality Criteria</b>	<b>Reflexive notes – selected extracts</b>
		out in the IPA training with my therapist and realised my feelings were historical but very impactful – it was an important insight.
3	<p>Johnson (1997) suggests theoretical, vertical or logical generalizability is needed in qualitative research. This means that researchers do not expect their findings to be repeatable but by illustrating and analysing a specific context they can cautiously contribute to understanding of situations with similar features.</p> <p>Yardley (2000, 2008) suggests producing provisional developments of knowledge and researcher needs relationship with the literature through analytic endeavour so that careful exploratory perspectives may be produced.</p>	
4	<p>Henwood and Pidgeon (1992) require systematic process.</p> <p>Elliot et al (1999) recommend diligent methodology.</p> <p>Yardley (2008) advocates systematic retraceable audit trail of analysis worked examples and records of analytic process.</p>	
5	<p>Henwood and Pidgeon (1992) recommend clear presentation of analysis grounded in data.</p> <p>Elliot et al (1999) advocate analysis grounded empirically and conceptually.</p>	Going back over the data as the Discussion progressed to check that I am not moving too far away from the data. Time consuming but worth it to keep refreshing the data in my mind.

	<b>Proposed Quality Criteria</b>	<b>Reflexive notes – selected extracts</b>
6	Wallatt & Piazza's (1988) suggest maintaining diversity and completeness as contextualist stance with reference to triangulation. IPA requires honouring both convergence and divergence so that uniqueness is retained.	Difficult to fully do justice to in the narrative as so many quotes left out but individual profile concept aims to make sure that each participant is seen as an individual.
7	Disconfirming case analysis (Yardley, 2008) as a quality criterion in which data that does not adhere to your pre-suppositions is taken into account in the analysis is also addressed by IPA's adherence to convergence and divergence, researcher reflexivity and the hermeneutic process of analysis which always refers back to the data.	<p>I need to do final mapping across all cases but tempted as I am to do comparisons, I am diligently trying to honour each case as each case has its own individual emphasis and idiosyncratic issues.</p> <p>P's case does challenge my preconceptions of DCD because he is fairly positive but I don't feel I really got to some of the underlying issues that he wanted to talk about which may have required building a more trusting relationship.</p> <p>P brought a new take on developmental issues and rites of passage into adulthood with driving which I had not considered before.</p>
8	Smith (2003) endorses Yardley's (2008) sensitivity to context which can be established by awareness of the substantive literature and the key theoretical concepts of the chosen approach. In this project that means demonstrating familiarity with the DCD, life transition and related literature as well as an understanding of the Phenomenological approach.	I know what ideas I am trying to achieve as I approach the Introduction but I am reminding myself that I need to pay attention to literature that challenges the work I have already read and my own personal theories so that I can demonstrate a range of perspectives, in a sense view DCD through a few lenses.... I also need to be open for new areas that I haven't fully considered so need to think more about the self and aspects of the self.

	<b>Proposed Quality Criteria</b>	<b>Reflexive notes – selected extracts</b>
9	<p>Smith (2003) endorses the socio-cultural context of the participant which Yardley (2008) emphasises should be reflected in how you position yourself as researcher, the construction of your interview schedule and the setting and process of the interview itself.</p> <p>Morrow (2005) advocates that the researcher familiarise herself with the context and culture of the participant.</p>	<p>P has quite a bit of difficulty expressing herself and I give quite a bit of time in the interview to respond but maybe I should have given even more time yet her account on the transcript is very coherent.</p> <p>I observed some occupational therapy assessments today to familiarise myself with the process as I want to be able to work with Occupational Therapists and noticed how psychological and emotional issues are immediately brought up in the volunteers' conversations with the Occupational Therapist, e.g., frustration, social interaction problems, panic, avoidance, anxiety, social anxiety, strong feelings (hate)and bullying. I also notice that some of the Occupational Therapists were quite empathic but others were advising and this may be where I could play a role. I felt that the work I am doing in my research is being validated.</p>
10	<p>Commitment (Yardley, 2008), Smith (2003) suggests that commitment is shown by the researcher's methodological skills, theoretical depth and how considerately they work with participants.</p> <p>Being democratic and empowering (Cooper, 2009) and not marginalising through power relationships (Fawcett &amp; Hearn, 2002).</p>	<p>I wonder how each of the participants is doing and feel guilty I have not kept in touch. I'd like to do a focus group to do a follow up and see if I can link into a research community.</p>
11	<p>Rigour is, Smith (2003) suggests, endorsing Yardley (2008), achieved through the appropriateness of the sample and completeness of the analysis</p>	<p>So many iterations to check for internal consistency/ overlap and making difficult choices about which theme, I feel like I am in quicksand.</p>

	<b>Proposed Quality Criteria</b>	<b>Reflexive notes – selected extracts</b>
12	Smith (2003) endorses Yardley views impact and importance as based on making a difference through, for example, developing a topic, influencing social systems or encouraging individual interest.	
13	Cornish & Gillespie (2009) suggest useful knowledge may take the form of knowing how to take care of oneself, designing helpful interventions or being able to critically comment on social practices based on everyday experiences.	
14	Cornish & Gillespie (2009) advocate moving practice forward which links to Wolf's (1978) principle of "social validity" in Counselling Psychology as we aim to help individuals improve their emotional and psychological well being.	
15	<p>Patton's (2002) notion of 'praxis' or integrating theory and practice and paying attention to the individual in aiming for deep understanding (Ponteretto, 2005) and development of meaning (Morrow, 2005) in the research relationship.</p> <p>In Morrow's view (2005), to attain depth of understanding as a goal in qualitative Counselling Psychology research requires 'participatory consciousness' or the ability to empathically attend and develop an emotional bond with the participant without overstepping the mark into a therapeutic relationship (Haverkamp, 2005).</p>	<p>I notice how stressed p sounds and that I sounded calm. Again I notice that when faced with emotional material that I thought may evoke too personal material I stopped as I did not want to stray into therapeutic territory. This may denude the richness of my data and perhaps I should have asked p if they wanted to discuss the matter further but I conscious of my Counselling Psychology skills, I thought in some ways I had a level of control /power and decided to draw a line myself.</p> <p>This was a long interview because as first p was very nervous and I was keen to keep the conversation going to ensure it was a helpful process for her; ethically given her anxiety this was important for me to do.</p>

	<b>Proposed Quality Criteria</b>	<b>Reflexive notes – selected extracts</b>
	Naive enquirer/ clarification in the process and after (Morrow, 2005). Referential reflexivity (May, 1998) or being reflexive together.	Taking quite a bit of time with p in the follow up session – I noticed her body language was quite different when she left than when she came in.
16	In 'acceptable' IPA research the aims are as Smith (2009) outlines: to adhere to the theoretical basis of IPA in phenomenology, hermeneutics and idiographic focus; to be transparent by showing your working; and to produce an articulate and appealing analysis that makes sense and shows density of themes by which he means using enough quotes from participant data.	Having met with my Susan now going back to review some articles on IPA to clarify what I have to do; sort of an audit check of my analytic process.  I want to convey in descriptive and evocative language what their experience is like.
17	In a 'good' IPA study, the paper additionally, according to Smith (2011), needs to be honed in on a particular issue producing a powerful, informative and stimulating analysis based in rich data. Exemplars of good IPA papers produce highly readable reports that include "thick descriptions" (Geertz, 1973, 1983) of sensitive, human topics with subtle, perceptive and multi faceted interpretations.	

**Disability Service Manager/Student Counselling Services Manager**

Dear

**Developmental Coordination Disorder (DCD) / Dyspraxia**

Understanding the needs of students is paramount in maintaining the widening participation agenda and as Manager of Disability Services/Student Counselling Services, I thought you may be interested in my research.

To better understand the needs of students with DCD/Dyspraxia, I am carrying out research into students' daily living experiences. This project is part of my Doctorate in Counselling Psychology at City University, London. The effects of DCD/Dyspraxia on daily living and academic performance in children are well documented but little research exists for young adults even though DCD/Dyspraxia is now seen as a 'lifespan' issue. This research project focuses on the everyday social and psychological experiences of young adults in Higher Education living with DCD/Dyspraxia. The aim is to obtain rich, meaningful data about this group of young adults to inform supportive resources including counselling. I aim to interview eight students in total and hope you can help me in this recruitment.

As a member of staff responsible for providing Disability services/Counselling support to students with DCD/Dyspraxia, would you be willing to display the attached poster/flyer? In return, I am offering a summary report of my research findings when completed in 2012.

Although I am currently studying in London, I have a home in the West of Scotland and will return there in the summer of 2012, aiming to continue post doctoral research into Counselling/DCD/Dyspraxia. As you may want to know more about the current research project, I will follow up my letter with a call in the next few days.

Yours sincerely

Linda Raleigh  
Trainee Counselling Psychologist

The Dyspraxia Foundation Medical Panel,  
8 West Alley,  
Hitchin, Herts  
SG5 1EG

Dear Medical Panel

**Developmental Coordination Disorder - Daily Living Experiences of Young Adults**

As the leading UK charity providing support and resources for young adults with DCD (or Dyspraxia), I wondered if you would be willing to assist in supporting my research. My research project seems to match the ideas for dissertations described on your website and in my research proposal I cited the Dyspraxia Foundation research with young adults (2009). My research project aims to focus on the everyday social and psychological experiences of young adults living with this lifespan disorder with the intention of developing practical outcomes. The project methodology is qualitative using semi-structured interviews.

To carry out the research I need to recruit a small sample of 8 to 10 participants who have a diagnosis of DCD/Dyspraxia or who had an Individual Learning Plan at school indicating DCD/Dyspraxia and who are currently in Higher Education. I am carrying out research into Developmental Coordination Disorder or Dyspraxia as part of my DPsych program in Counselling Psychology at City University, London. However, my interest in DCD/Dyspraxia is not only academic as I have a close family member who has DCD/Dyspraxia.

I appreciate that you probably get many such requests and may need to know more about my credentials or the project before being able to help with any recruitment so I have attached my CV and contact details. I have also provided an Information sheet and a presentation of my research project. I would be more than happy to do a presentation of my research project to your panel or any of the local Dyspraxia Foundation support groups who may be interested.

Yours sincerely

Linda Raleigh  
Trainee Counselling Psychologist



## Telephone Interview Schedule - Eligibility Criteria

Refer to Information sheet (Appendix 6) to answer any questions about the research project) and check the selection criteria for inclusion in the study with the following questions:

1. How did you find out about the research project?
2. What made you interested in the project?
3. How old are you?
4. Can you describe what you know about your own diagnosis or previous assessments for DCD?
5. Where are you studying?
6. Have you registered with you university/college Special Needs Department?

Ensure that the potential participant understands the reasons for their suitability or not for the project, thank them for making the effort to call, send written information (Appendices and ) and if appropriate arrange a provisional date/time for interview.



## **Information for Participants**

### **Developmental Coordination Disorder - Daily Living Experiences of Young Adults**

You are being invited to take part in a research study. Before you decide if you want to participate it is important that you understand why the research is being done and what is involved. Please take time to read the following information carefully.

#### **What is the purpose of this study?**

This study is being undertaken to explore the experiences of daily and academic life of young adults with Developmental Coordination Disorder (or Dyspraxia). The aim is to gain a deeper understanding of the meaning and impact of DCD on young people's lives as they transition into young adulthood.

#### **Why have I been approached?**

The aim is to gain an appreciation of how DCD affects the lives of young adults. You have been asked to be involved in this project because you are representative of this group of people.

#### **What will happen if I do take part?**

If you would like to take part in this study you will be invited to an interview which will be undertaken in a semi structured format which will be taped. The transcript

from the interview will be analysed using a technique known as Interpretative Phenomenological Analysis (IPA) to identify key psychological themes which are involved in your individual experience. The themes identified from your interview will be collated with those from other interviews taking place to create an understanding of the experiences and impact of DCD on daily life for young adults with DCD.

### **Do I have to take part?**

You do not have to take part, participation is completely voluntary. Even if you start the interview you may withdraw at any time without giving a reason.

### **Will what I say in this study be kept anonymous?**

All responses will be kept anonymous with no identifying information used in the write up of the study. The material discussed in our interview will be used for research purposes only.

### **What will happen to the results of the research study?**

This project is a required element of the Professional Doctorate in Counselling Psychology at City University, London. It will form part of a Thesis but it will not be possible to identify individual results and your anonymity will be assured. A summary of the findings will be available if you are interested.

Please do not hesitate to contact me or my Research Supervisor with any questions or queries about this study. Thank you for taking the time to read this.

### **Contact Information:**

Researcher:

Linda Raleigh

07531 654447

dcdresearchproject@gmail.com

Research Supervisor

Susan Strauss

020 7040 0167

[Susan.Strauss.1@city.ac.uk](mailto:Susan.Strauss.1@city.ac.uk)



## Consent Form

**Full title of Project:**

Developmental Coordination Disorder - Daily Living Experiences of Young Adults.

This research project is being carried out as part of my Doctorate in Counselling Psychology at City University and is being supervised by Dr. Susan Strauss, Chartered Counselling Psychologist.

This research project has been ethically approved by City University and will be conducted in accordance with the Code of Ethics and Conduct of the British Psychological Society.

**Please read this section carefully and sign both copies of this agreement, one of which you should retain.**

- I confirm that I have read and understood the information sheet for the above study and have had this research study explained to me and have had the opportunity to ask questions.
- I understand that my rights to anonymity will be respected and protected with no identifying information included in any write up of this study or in journal publication. I understand that the material from this study is for research purposes only.

- I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason and to have my to have the data returned to me if requested or destroyed.
- I understand that the interview will be audio-taped and will be transcribed.
- I agree to the use of anonymised quotes in publications.

Name of Participant	Date	Signature
---------------------	------	-----------

Name of Researcher	Date	Signature
--------------------	------	-----------

Please do not hesitate to contact me or my Supervisor if you have any questions or queries about this research project. Thank you for agreeing to take part.

**Contact Information:**

Researcher:	Research Supervisor
Linda Raleigh	Susan Strauss
07531 654447	020 7040 0167
dcdresearchproject@gmail.com	<a href="mailto:Susan.Strauss.1@city.ac.uk">Susan.Strauss.1@city.ac.uk</a>



## Resource list for participants

This resource list provides information on organisations that can provide you with help and advice on Developmental Coordination Disorder.

Further resources are also provided on the DCD Research Project Web site [www.dcdresearchproject.com](http://www.dcdresearchproject.com)

If you feel you need support to deal with emotional issues that feel difficult to handle on your own, please contact your GP or University Medical Practice. In addition information is provided on organisations who can offer support and counselling.

### **Dyspraxia Foundation**

8 West Alley,

Hitchin,

Herts, SG5 1EG.

Helpline: 01462 454 986 (10 am - 1 pm) Mon - Fri

Fax number: 01462 455 052

Email: [dyspraxia@dyspraxiafoundation.org.uk](mailto:dyspraxia@dyspraxiafoundation.org.uk)

<http://www.dyspraxiafoundation.org.uk/>

### **The British Dyslexia Association**

Unit 8 Bracknell Beeches,

Old Bracknell Lane,  
Bracknell, RG12 7BW.

Admin Telephone: 0845 251 9003

National Helpline: 0845 251 9002 - for all **dyslexia** related enquiries. Our Helpline, staffed by volunteers, is open from 10:00am until 4:00pm Monday to Friday, and open late on Tuesday and Wednesday from 5:00pm- 7:00pm.

**Fax:** 0845 251 9005.

<http://www.bdadyslexia.org.uk/>

**The Dyscovery Centre**

University of Wales, Newport

Allt-yr-yn Campus

Newport

NP20 5DA

Telephone: 00 44 1633 432330

Fax number: 00 44 1633 432331

Email: [dyscoverycentre@newport.ac.uk](mailto:dyscoverycentre@newport.ac.uk)

<http://www.newport.ac.uk/research/researchcentres/Centres/Dyscovery%20Centre/Pages/default.aspx>

## Counselling Support and Advice

### **The British Psychological Society**

St Andrews House

48 Princess Road East

Leicester LE1 7DR

**Tel:** +44 (0)116 254 9568

**Fax:** +44 (0)116 227 1314

**E-mail:** [enquiries@bps.org.uk](mailto:enquiries@bps.org.uk)

[http://www.bps.org.uk/e-services/find-a-psychologist/register/register\\_home.cfm](http://www.bps.org.uk/e-services/find-a-psychologist/register/register_home.cfm)

### **Student Counselling Services in the UK**

Dave Berger

Senior Counsellor

University of Hull

138 Cottingham Road

Hull HU6 7RY

01482 465166

d.c.berger@hull.ac.uk

[www.hucs.org](http://www.hucs.org)

<http://www.student.counselling.co.uk/>

### **British Association for Counselling and Psychotherapy**

BACP House

15 St John's Business Park

Lutterworth

Leicestershire LE17 4HB

United Kingdom

Tel: 01455 883300

Email: [bacp@bacp.co.uk](mailto:bacp@bacp.co.uk)

<http://www.itsgoodtotalk.org.uk/therapists/>

### **MIND - nationally and in your area**

<http://www.mind.org.uk/>

[http://www.mind.org.uk/help/mind\\_in\\_your\\_area](http://www.mind.org.uk/help/mind_in_your_area)

### **Samaritans**

In the UK dial 08457 90 90 90.

<http://www.samaritans.org/>

[http://www.samaritans.org/talk\\_to\\_someone/find\\_my\\_local\\_branch.aspx](http://www.samaritans.org/talk_to_someone/find_my_local_branch.aspx)

The Samaritans

<http://www.samaritans.org/>

08457 909090

### **Get Connected Help Resource for under 25s**

<http://www.getconnected.org.uk/129/about-us/about-get-connected-the-young-peoples-help-resource-for-under-25s.html>

### **Health Professions Council**

<http://www.hpc-uk.org/>

<http://www.hpc-uk.org/landing/?id=4>



## Demographic form

The purpose of this study is to provide useful insights about young adults with Developmental Coordination Disorder. It will be helpful in describing the research to others to include some general characteristics of the group being studied. This information is confidential and your answers are anonymous and will not be used to identify you in any way. If you feel you do not want to answer any of the questions you do not have to.

Please specify your age:

Gender (please tick relevant category)

Male	
Female	
Transgender	
Intersex	

Qualifications (please tick your current highest level of qualification)

Secondary Education/Foundation GNVQ/Level 1 NVQ or equivalent	
GCSEs A* - C/Intermediate GNVQ/Level 2 NVQ or equivalent	
AS/A level/Advanced GNVQ/Level 3 NVQ or equivalent	
Degree/ Level 4 NVQ/ or equivalent	

What is your current partnership status? (Please tick one of the following)

Single/Never married	
Married	
Cohabiting	
Separated	
Divorced	
Widowed	
Other	

Do you have any caring responsibilities? (Please circle the one that applies).

Yes/No

How would you describe your ethnicity? (Please tick relevant category)

White British	
White other	
White Irish	
Mixed raced	
Indian	
Pakistani	
Other Asian (non- Chinese)	
Black Caribbean	
Black African	
Black (other)	
Chinese	
Other (please describe)	

Physical Status (please tick any that apply)

No Disability	
Dyslexia	
Blind/partially sighted	
Deaf/hearing impairment	
Wheelchair user/mobility difficulty	
Personal care support	
Mental Health Difficulty	
Unseen disability (e.g. diabetes, epilepsy)	
Multiple disability	
Other disability	
Autistic spectrum disorder	

Are you employed? Please tick relevant category.

Full-time	
Part-time	
Not employed	

Where do you live? Please tick relevant category.

Live with parents	
Student accommodation	
Private Rental	
Owner Occupier	
Other	



## Interview Schedule

### Introduction

I am interested in talking to you about your experiences of living with Developmental Coordination Disorder (Dyspraxia) at this particular stage of your life. My aim here is to build a picture of what your daily life is like living with DCD/Dyspraxia as a young adult. I have some questions to help frame the interview, though I'd like you to feel you can contribute openly throughout our conversation. You do not have to answer a question if there is something you would rather not discuss. The interview should last about an hour and as agreed the interview will be taped. We can take a break at any time - just let me know if you want one.

Although I am a Trainee Counselling Psychologist this is not a therapeutic interview but I am interested in your experiences, perspectives, thoughts, feelings and sensations in relation to DCD/Dyspraxia. If following this interview you feel that it has raised emotional material that you would like to explore in more depth, I will provide you with contact details for support or Counselling.

Are there any questions you would like to ask before we begin?

1. Can you tell me what life is like at university?
2. What in particular are you experiencing about having DCD now that you are at university?

3. What is different now about having DCD now that you are a university student?
4. How is this different from when you lived at home/attended school?
5. Can you tell me about a story about a recent situation that brought your DCD into focus? What happened?
6. What impact do you think DCD has on your social life at university?
7. Having DCD, how do you think others perceive / understand DCD?
8. How does having DCD make you feel about yourself?
9. What has your experience been of finding support for DCD at college?
10. When you feel you need someone to talk to about issues related to DCD who is most supportive. Prompt - Can you tell me about that?

## **Summary**

Thank you for taking part in this interview. Would you like to withdraw or add anything to what you have said today?



## Debrief for Participants

Thank you for your participation in this research project, your help is very much appreciated.

The purpose of this project is to provide understanding of how young adults live with Developmental Coordination Disorder and how this impacts their daily and academic lives.

By contributing to this project, your information will hopefully be used to assist other young adults with DCD and by universities, colleges and other agencies providing support to young people with DCD. More generally your contribution will provide insight into the lives of young adults with DCD and may be useful to charities, parents and partners of those living with DCD.

If you have any questions about the research or you wish to withdraw from the study, you have the right to do this at any time. If you withdraw from the study, you can have any materials destroyed or returned to you including the tape and transcript of your interview.

If participation in this research project has raised any difficult issues for you that you feel you need further support with or would like to talk to someone about, I have provided a list of resources and counselling services that may be helpful. Please do not hesitate to contact me if you need further information.

Researcher:

Linda Raleigh      07531 654447      [dcdresearchproject@gmail.com](mailto:dcdresearchproject@gmail.com)

Research Supervisor:

Susan Strauss      020 7040 0167      [Susan.Strauss.1@city.ac.uk](mailto:Susan.Strauss.1@city.ac.uk)

Content of email outlining Transcription Services.

Hi there,

Lovely to speak with you. I feel you've been kind of deluged with huge amounts of information! Here's a summary...

We have extensive experience - since 1987, of working with sensitive materials including: palliative care, sexual health, documentaries, etc... and

maintain confidentiality procedures.

1. Cost: £100 per hour of recording no VAT required.
2. Schedule to be advised.
3. Work: upload information via File Factory dot com (you register using your e-mail and password – phone me with the password do not e-mail it).
4. Typed work to be returned via e-mail (using reply button) or File Factory.
5. When files downloaded from File Factory, we will delete the File Factory files. (Ensure you have a back-up!).
6. Word files are deleted a) once we receive confirmation that you have received them and opened them, and b) payment has been made.
7. Format – whether you want ems ums and stutters – and also verbatim or standard English – verbatim is 'oot' 'didnae' 'windae' ... etc.

We normally do bold for interviewer, non bold for respondent, Arial 12, and page numbers top right, all of this is suitable for various analysis software which may be used on completion of transcript,

however, any specific requirements will be adhered to, just give us a note if you have other preferences.

If you need more details – don't hesitate to give me a call...

Karen McCaig, Smallbiz Transcripts (Established 1987)

## Ethics Release Form for Student Research Projects

All students planning to undertake any research activity in the School of Arts and Social Sciences are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal clearly stating aims and methodology**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department or the Schools does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2009) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by Research Supervisor and the Department's Ethics Representative.**

### Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc            M.Phil            M.Sc            D.Psych            n/a

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

*Developmental Coordination Disorder: Daily Living Experiences of Young Adults*

2. Name of student researcher (please include contact address and telephone number)

Linda Raleigh  
18 Montpelier Row  
TWICKENHAM, TW1 2NQ  
0208 892 0232  
07531 654447  
Linda.Raleigh.1@city.ac.uk

If yes,  
a. Please detail the possible harm?

While it is not intended that a participant would experience psychological distress, there is the potential that the interview will bring up issues that the interviewee may find distressing. As the researcher and Trainee Counselling Psychologist, I aim to make the interview as calm and pleasant as I can through careful preparation, organisation and management of the setting and sensitive handling of the interview however I am alert to the potential signs of distress and appropriate ways to handle this in the interview e.g. relaxation and breathing exercises and for the longer term I will provide information on therapeutic support.

b. How can this be justified?

While there is minimal risk to the participants I believe the research interviews may also provide the participants with an opportunity to discuss their experience of DCD/Dyspraxia in a way they may not have had the opportunity to do before developing their personal knowledge of DCD/Dyspraxia and supported by the information provided throughout the research process. The research process will also be making a novel contribution to the area of Counselling Psychology research and expanding the body of knowledge on DCD/Dyspraxia in young adults which is currently minimal. The aim of this research project is that this knowledge should make a practical contribution to how Counselling Psychology supports individuals with DCD/Dyspraxia and the broader community of young adults with DCD/Dyspraxia and others who support them should benefit from this research.

c. What precautions are you taking to address the risks posed?

In relation to the specific risk of psychological distress, the interview process will have additional allocated time of at least 30 minutes after the conclusion of the research interview to discuss suitable follow up information and de-briefing. This will include not only the debriefing handout and information but the contact numbers of BPS/HPC qualified Counselling Psychologists in the geographical area and a brief psycho educational appraisal of the therapeutic process if required. The researcher will also have on hand, emergency numbers for immediate psychological support should this be required. The participant as part of the consent process is able to withdraw at any time from the research and should this happen at whatever stage, the participant will be provided with a de-briefing process including follow up information, psycho-education on counselling support and relevant direct contact numbers for suitably qualified Counselling Psychologists and emergency contacts numbers.

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

No

*(Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way be compromised if they choose not to participate in the research?

**Yes**  **No**

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

**Yes**  **No**

If no, please justify

If yes please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

*Field notes of interviews, digital voice recordings, transcripts of interviews.*

12. What provision will there be for the safe-keeping of these records?

*All paper records will be kept in a locked filing cabinet, digital voice recordings and word processed material will be stored/uploaded to a finger print and password protected laptop pc.*

13. What will happen to the records at the end of the project?

*Records will be kept for a period of five years from date of approval of the research as part of an audit trail and then destroyed.*

14. How will you protect the anonymity of the subjects/participants?

*A simple code will be used to identify participants e.g. in discussion with the research supervisor i.e. PR plus three digits and no personal identifying material will be used. In reporting the research material the identity of the participants will be disguised to maintain anonymity.*

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

*An information sheet has been prepared for de-briefing purposes on DCD/Dyspraxia and contact information for counselling support is included. It is also intended that the interview process will include provision for at least thirty minutes post research questions to discuss supporting information and psycho education on therapy if necessary. Once the location of the participant is known further local information on counselling support will be provided by providing BPS/HPC registered Counselling Psychologists contact information.*

(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in **underlined bold** print or wish to provide additional details of the research please provide further explanation here:

Attention has been paid to the presentation of research materials in terms of ease of reading and visual stress in accordance with British Dyslexia Association Guidelines.

Signature of student researcher Linda Raleigh

Date 21/3/11

*L. Raleigh*

**CHECKLIST:** the following forms should be appended unless justified otherwise

Research Proposal  
Recruitment Material  
Information Sheet  
Consent Form  
De-brief Information

---

### Section B: Risks to the Researcher

1. Is there any risk of physical or psychological harm to yourself?  Yes  No  
If yes,

a. Please detail possible harm?

There are two potential risks to the researcher. The first is in meeting strangers and the second potential risk is of psychological harm but the researcher feels this to be a minimal risk.

b. How can this be justified?

This minimal risk can be justified because the research aims to develop the existing knowledge and practice base for Counselling Psychologists to support a significant proportion of the young adult population with the recognised disorder of DCD/Dyspraxia (DSM-IV, APA 1994) and which is currently under researched in this age group.

c. What precautions are to be taken to address the risks posed?

In response to the physical risk of meeting strangers, the researcher will arrange the research meeting at a public meeting place e.g. make a room booking in a university or college that she will book. The researcher will notify close family of her location and record the meeting time and place in an accessible diary and notify a designated family member at the beginning and ending of the meeting as well as conform to any organisational processes for safety and security in the required setting e.g. signing in and out and fire precautions.

In terms of Psychological risk, as a Trainee Counselling Psychologist, the researcher has in place current arrangements for therapeutic support where she can discuss any distressing or difficult material related to the research process.

**Section C: To be completed by the research supervisor**

*(Please pay particular attention to any suggested research activity involving minors or vulnerable adults. Approval requires a currently valid CRB check to be appended to this form. If in any doubt, please refer to the Research Committee.)*

Please mark the appropriate box below:

Ethical approval granted

Refer to the Department's Research and Ethics Committee

Refer to the School's Research and Ethics Committee

Signature Susan Gorman Date 23 Mar 11

**Section D: To be completed by the 2<sup>nd</sup> Departmental staff member**

*(Please read this ethics release form fully and pay particular attention to any answers on the form where underlined bold items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above

Signature M. Gulina Date 23/03/11

## ANALYTIC PROCESS - REFLEXIVE DIARY EXTRACTS

**Reflection 1 - Sandra**

I am struck that when I listen to the interview with Sandra that I had to ask lots of question to encourage Sandra to talk. I asked myself at one point if I was being too leading though I usually tried to give Sandra options. I feel like I was trying to pick at the end of a piece of string to unravel it. Toward the end of the interview Sandra relaxed and opened up a bit about her anxiety. I think that this tells me that in this research process, perhaps more than one interview would help the person to get to know you.

As I listened again to Sandra I became quite emotional. Even during the interview I could hear emotion in my own voice which reminds me that I need to acknowledge my own closeness to this subject. At the same time as I am doing this phase XXXXX is about to be re-assessed to help them though the final year at college and I still grapple with providing support without interfering too much. Sandra in many ways tapped into this dilemma in me as she seems to epitomise the desire to be independent.

**Reflection 2 - Sandra**

I noticed how much I cut Sandra off when she was about to open up (L 713).

Sandra has quite a bit of difficulty expressing herself and on the tape I give her quite a bit of time before I respond but on the transcript it looks like I jump in.

Am I putting words in Sandra's mouth? (L1669)

Again I feel this was an abrupt ending to an interview though I did follow up in the debrief much more about her anxiety.

**Reflection 3 - Sandra**

Having just completed the analysis of Sandra's transcript I am left trying to maintain separation from the patterns that are developing from the others' emerging themes by trying to stay true to Sandra and not compare her analyses to theirs. I am not looking forward to reconciling these differences because somehow that feels like it might be a big job.

I feel my interview with Sandra was a bit stilted but I recognised at the time that Sandra had some problems communicating or rather in producing communication because in reading the transcript hers is a coherent account. Although it was a longish interview the data seems less rich for that reason.

Personally I am feeling that I need to get a move on but however hard I try, the analysis takes time. This analysis has been the shortest to do and I don't think I have ever had such a problem with time before in my work but IPA is just a time

consuming process.

#### **Reflection 4 – across cases**

I have learned a lot at this stage of the analytic process. Up till now I have been trying to keep a very idiographic focus in the analysis which means I have not referred back to previous cases for comparison. While I believe this has enabled me to produce individualised accounts for each young person, it has created some challenges in the reconciliation across cases including use of different language for the same issue, slightly different organisation of themes in each case and reviewing quotes again to better place them in a theme. I have noticed, much as I learned with NVQ's, that the same piece of evidence or quote can serve more than one purpose and that over time and a few iterations my interpretation or assessment of the essence of a quote can change.

I have also spent some extra time producing individual narratives which has been helpful in writing up the narrative, it has cost me a lot of time but I hope that this will be paid back when I come to write up the final analyses. I hope to present the narrative from one of the themes at the IPA meeting.

## PEN PORTRAIT EDITED EXTRACT - SANDRA

Sandra is enjoying Agricultural College and has made friends. She has been provided support and she is pleased with the level of support she has been given though some of her learning support resources have not arrived yet this year.

Sandra has not told anyone about her DCD except the Special Needs department. She doesn't tell anyone because she finds it difficult to explain and because she doesn't want her friends to know as she finds most of the description of DCD negative. Sandra describes herself as a hard worker and puts in lots of effort in her studies but now that she is at college she is finding the work a bit more difficult to calibrate. Sandra has felt quite anxious about the workload at college but she has coped by telling herself that she has previously succeeded in her exams.

Sandra finds it difficult to talk at times and seems a bit self conscious but also describes herself as determined and is able to put strategies into place which usually involve her working harder or planning carefully.



1146 I: Right, yeah. So that was... it sounds like that was a way to... like your  
 1149 own sort of way to talk to yourself to keep yourself calm, is that right, is that  
 1150 how you...?  
 1151  
 1152 R: Yeah.  
 1153  
 1154 I: Have... got... I mean, have I got that right?  
 1155  
 1156 R: Yeah, 'cause erm, yeah, 'cause then I think erm, yeah, then I was like  
 1157 not trying to rush it, but I like...  
 1158  
 1159 I: Right. And did you... I mean, with anybody there even if you didn't say to  
 1160 them about your dyspraxia, did you share anything about your anxiety about  
 1161 just classes and things like that? 'Cause I can imagine a lot of, erm, teachers  
 1162 will feel quite anxious.  
 1163  
 1164 R: Erm, well, some of, erm, the people on my course they're like, oh, erm,  
 1165 er like do you understand it? Or, erm, or like, erm, they're like, oh yeah, I'd  
 1166 forgotten about that; the lecturer had mentioned that or whatever, so...

Adjusting / Pacing

Trying not to get ahead of myself.  
 Yeah, 'cause etc - trying to explain  
 Sense of wanting to get it sorted / demonstrated and having to rethink whilst it's - sense of too fast (see part on the screen)

Some people were a bit nervous that they didn't understand the lectures.  
 Erm - explaining

So other people being open with her in a way she can't hear says that anticipates a nervous

Concealment / stigma  
 Interplay Social / Self  
 ↳

- 1167
- 1168 I: So, you're talking to people in your classes as well?
- 1169
- 1170 R: Yeah
- 1171
- 1172 I: Right. And... and how's that... how's that going?
- 1173
- 1174 R: Erm, yeah, it's alright, but I haven't, er... but I didn't like... but then if, erm,
- 1175 they ask me, oh I'd like, like are you like... ch, how are you? I'd say I was like,
- 1176 fine, ever though...
- 1177
- 1178 I: Even though you were anxious?
- 1179
- 1180 R: Yeah.
- 1181
- 1182 I: Right, ok, right. And... and what would make you... what would make you
- 1183 do that? Would you not want them to know you were a bit concerned?
- 1184
- 1185 R: Erm, yeah, I would just, erm... then like just explain it all (laughs).
- So they have told me about  
their concerns but even  
though I wasn't, I'd say I  
was OK.  
haven't said - can't wait  
saw  
feeling  
can't reciprocate to  
concerns which are  
feelings not understanding  
the social rules of being  
there in classes  
relationships / more  
concerned with how they  
see her + keeping her on  
top + anxiety / potentially  
self-fulfilling prophecy.  
So I'd have to explain  
all about it and it's  
harder not say / just  
say hi. Ok.  
'it all' - a girl to explain  
(laugh - nervous)

ingotia Chem

crush your leads together  
- something more than  
being / use like amalgamate.

At school was like the  
teachers wanted to mix  
our leads together to  
make ~~an~~ people who  
are lazy and not doing  
it we was not why.  
But it doesn't work  
because I get too nervous  
that my standards will drop.

standards - repeats / imp.  
Create for almost all  
made them  
together

perfectionist narrative -  
standards / obsession?

↳ but frankensteinish

↳ sort of make a  
new person / can't  
be accepted for  
who you are?

↳

not sure she's tried this / got too anxious  
↳ not disappointing that she needs to work so hard

04

1771 R: Yeah

1772

1773 I: ... and that's it the kinda... it sounds like there's quite a lot of juggling going

1774 on in your head a lot of the time.

1775

1776 R: Yeah. And then, yeah, cause then like teachers and stuff, like with

1777 people that don't work hard then they've wanted to like crush your heads

1778 together us: to like rub off a bit of each of us and like each other, erm, but

1779 then... so, they work harder and then I work like a little bit less hard, erm,

1780 but I then... but then even if it was like... I've, erm, tried to do that

1781 then I've got anxious because I'm not like working at the like... like usual

1782 standard. So, then

1783

1784 I: Right

1785

1786 R: ... my standards slip if... yeah.

1787

1788 I: And you get a bit worried, what, if your standards slip?

1789

Perfectionist / compulsive

## EMERGENT THEMES CHRONOLOGICAL LIST - SANDRA

Parts of me 72 – 75

Parts of me 84 – 92

Concentration 96 – 100

Change - Getting used to new academic system 104-115

Change -getting used to the new academic system 132 – 135

Writing / Listening interference 141 – 148

Support- what's working 148-173

Change in learning process- interacting 191 – 195

Change in learning environment 208 – 209

Change in daily routine 213-224

Change in daily routine 228 – 234

Calibrating work / me hard worker 239 – 245

Socialising/being part of 281-295

Balancing my needs vs social perceptions 300-312

Concealment 314 – 317

DCD intrinsically me 322 – 324

DCD not me 328 – 340

Fitting in / concealment I dilemma 344 – 358

DCD Work vs. Socialising 364 – 370

Change in getting support 379 – 382

Support / Functional and Personal 387 – 402

Change / struggle 409- 411

Support / personal 422 – 436

Overload / overwhelm 441 – 442

Adjustment (panic- hope) 460-463

Concealment / uncertainty 479-483

Initiative / competence 516 -524

Recognition (of struggle) 537- 538

My Expectations I acceptance 547- 577

My Expectations / acceptance 586

Concealment / Avoidance 602-621

My perception of DCD/ negative 628

Making up for DCD / Me compulsive hard-worker 655- 671

Anxiety/ overwhelm 681 – 686

Anxiety / worry 696 – 700

Anxiety I worry 704 – 711

Anxiety / overwhelm 726- 731

Communication / getting it right 742-756

Me Blind to me / me others see 780- 793

Critical Me 795-801

Me lacking self confidence 811-817

Positive me / have a go 833 – 843

Decision making / support 871-882

Working out for the best narrative / coping 886 – 900

Me motivation / enthusiastic learner 910

Change - new horizons 921 – 922

Change - familiarisation 931 – 937

Missing out / acceptance 947-948

Change - pushing boundaries 952 – 956

Missing out / acceptance 959 – 965

Worry / anxiety 969 – 979

Socialising / peers 995 – 996

Adjustment to change / balancing personal I social 1000 – 1006

Personal vs Social 1034-1040

Adjustment / personal vs social 1060-1067

Social Anxiety 1085 – 1088

Coping / rationalising 1101 – 1102

Social I friends 1115 – 1130

Adjusting / settling in 1132- 1146

Adjustment / pacing 1156 – 1157

Concealment / stigma 1164 – 1189

Academic vs. social 1191 – 1199

Me positive / give it a go 1203 – 1208

Pushing boundaries 1220 – 1225

Making sure / coping 1229 – 1244

Being late / compulsion / Frustration/ annoyance 1252 – 1267

Concealment / avoidance /emotions 1288 – 1292

Concealing emotions 1301-1310

Support/personal/my needs 1333-1335

Support / my needs 1339 – 1345

Support / functional 1355 – 1357

Me motivation / make the best of 1359-1373

Support / process I learning what works 1377 – 1383

Anxiety / chronic 1391 – 1392

Me overcoming / determined 1396-1407

Anxiety /knowing what to do 1424-1448

Judgemental self / do things properly 1450-1455

Worry / panic 1480-1496

Comparing / compulsion1506-1520

Change / exhaustion 1532 – 1537

Balancing / Social vs. work 1545 – 1559

Balancing work vs. social 1576

Concealment peers 1606-1637

Challenge / positive 1647- 1650

Concealment / social 1661 –1667

Concealment / social 1677 –1692

Insecure me 1699-1711

Proving /overcoming 1729 – 1735

Pushing boundaries / challenge 1739 – 1748

Overwhelm / overload 1752- 1762

Perfectionist / compulsive 1776 – 1802

Identifying / self esteem 1807- 1810

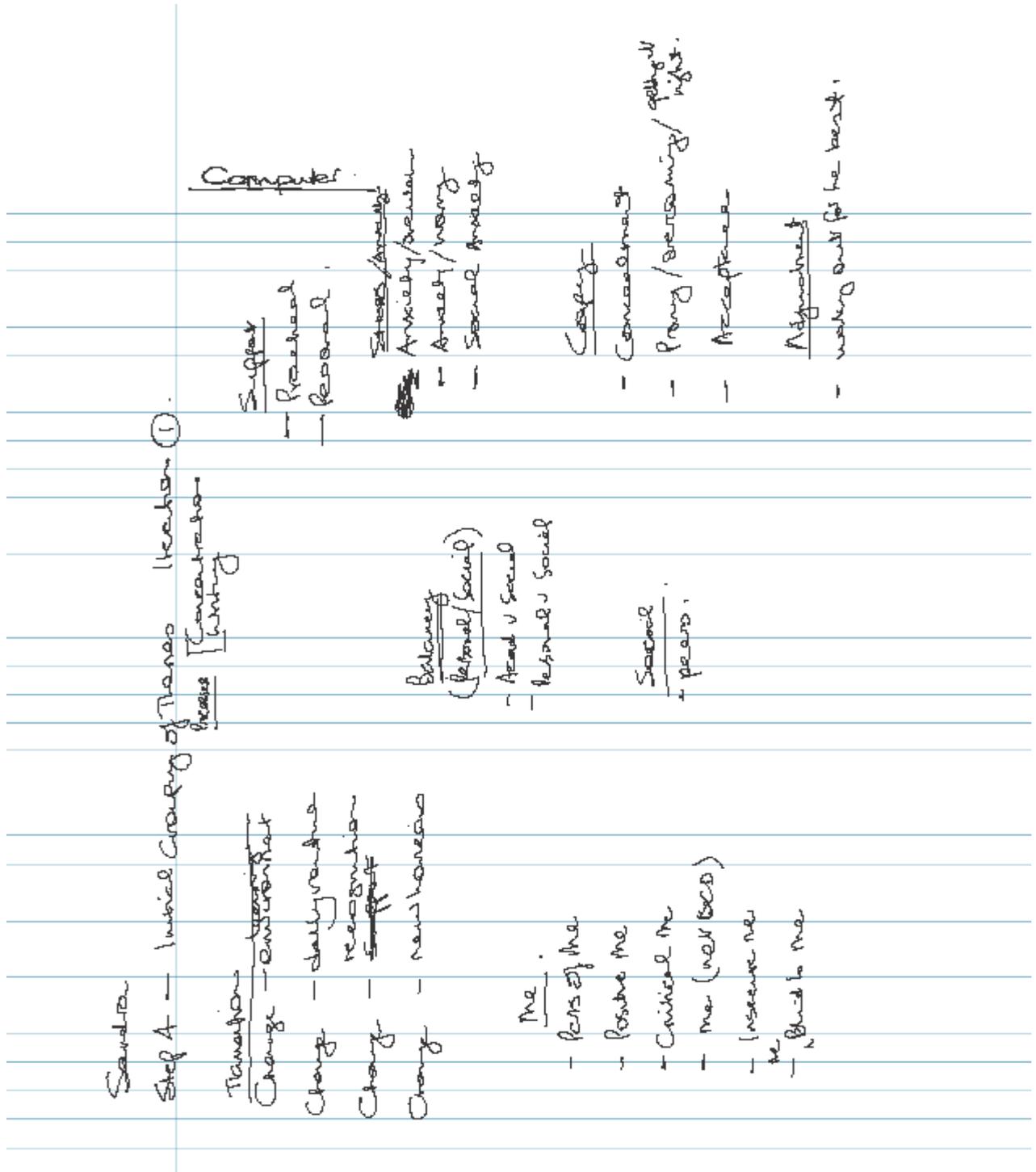
Proving myself /overcoming 1820 – 1821

Change / framework / isolation 1831 – 1838

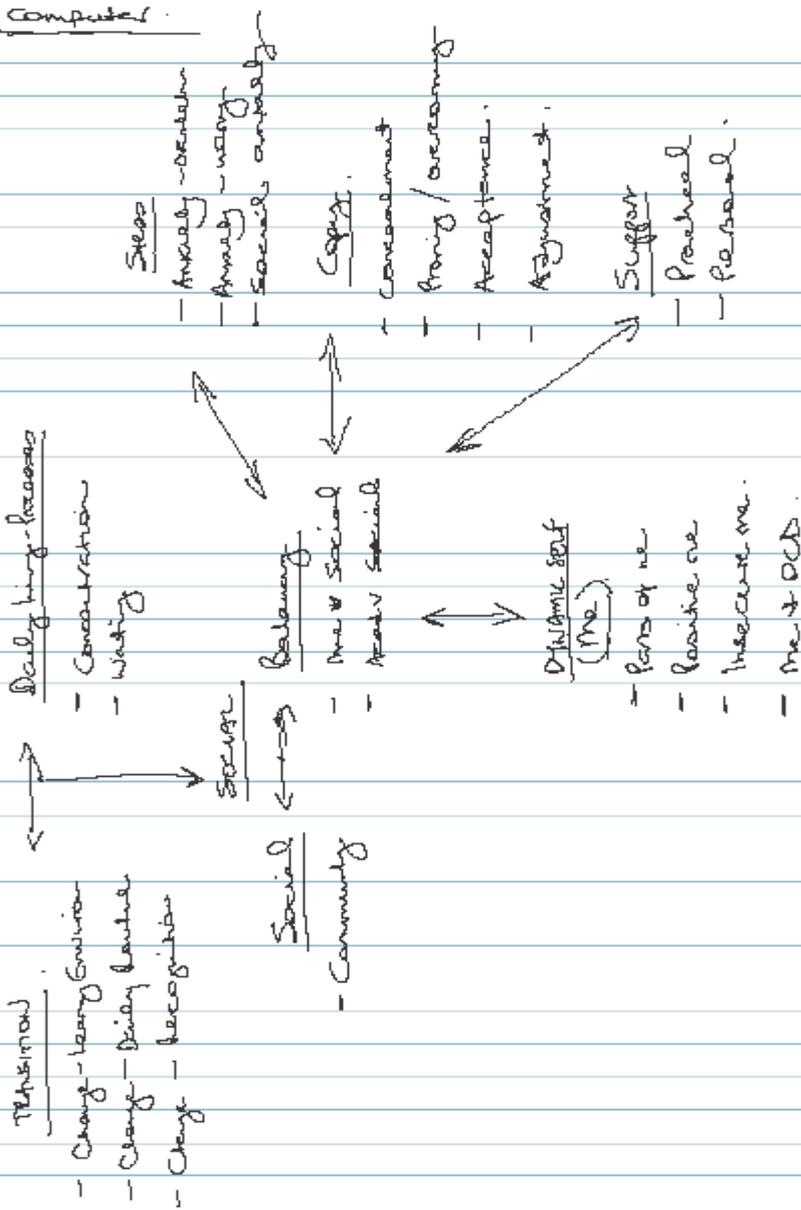
Change / isolation 1856 – 1857

Adjustment / process 1884-1924

DIAGRAM - ITERATIONS OF THEME CLUSTERS - SANDRA



Sandra - STEP A Iteration 2.



Computer

## EMERGENT THEMES AND SUB THEME QUOTES – SANDRA

## Theme 1 – Transition / Academic framework

Line No	Quote
104 – 115	<p>R: And erm, and then just 'cause it was a different like set up, like, then, erm... 'cause I was like trying to get down like everything they were saying, but I did make a recording of the</p> <p>I: Right.</p> <p>R: ...lecture as well. And then, erm... and then I think it has got easier as I... Now I've got more used to the</p> <p>I: Right.</p> <p>R: ...lecture situation.</p>
132 - 135	<p>R: I've... I've been enjoying it the course, but erm... and then, 'cause I haven't had, erm, all my assignments and that are for next term, so, it's just been doing the like reading stuff. So, I haven't had any like challenges with like academic work so far.</p>
191 – 199	<p>R: Erm, well, I think I, erm... well, it's a like really good to be able to be like learning the stuff I'm learning, but then I think the biggest thing was like the going to lectures instead of just like a... as opposed to like a class lesson with... when you could, erm, just like, if you miss something you could just like stop the like teacher.</p> <p>I: Right.</p> <p>R: Whereas the lecturers just like keep on going.</p>
208 - 209	<p>R: Erm, the... it does, er, seem quite more like relaxed like atmosphere to like school.</p>

Theme 2 –Transition / Daily Routine

Line No	Quote
213 – 224	<p>R: And, erm... but, yeah, but then it is... like the, erm... but then, 'cause, er, my timetable as well, like I've got, erm, like times where there's like big gaps, or like a</p> <p>I: Hmm</p> <p>R: ...late lecture and then... as opposed to just like the, er, like nine to three like school day where everything's like</p> <p>I: Right.</p> <p>R: ...crammed in.</p>
228 – 234	<p>R: Erm, that's, er, been better. 'Cause, erm, before at school it was like working 9 to 3, then I come home like just work the rest of the evening to get all like my homework and work done, whereas</p> <p>I: Hmm mm.</p> <p>R: ...now like, erm, I've got time.</p>
252 – 274	<p>R: Erm, yeah, like now you have to like think for yourself (laughs), like oh, I need to do that.</p> <p>I: Like what sort of things? Tell me about...</p> <p>R: Erm (nervous laugh)...</p> <p>I: I'm just wondering if, you know, when you were at home, the day to day things might have... I don't know, what do you think? Were they done for you or did you do them yourself or what's different?</p> <p>R: Erm, yeah, bit of both. But yeah, it is like, er... have to, erm, then like think about like, finding what like meals you're gonna (mumble) ?? and stuff.</p> <p>I: And how are you managing with all of that?</p>

<p>931 – 937</p>	<p>R: Erm, yeah, I think it's ok. And then, er, if I do get stuck then I'll just like call my Gran or whatever, just to say what am I doing? (laughs).</p> <p>I: Ok. So, what kinda things do you get stuck at? Gi... gimme an example.</p> <p>R: Erm, well, just to like ask her about like timing, like how long things will take to cook and stuff (laughs).</p> <p>R: Erm, well, 'cause I came to, erm, a, erm, like open day after I got in</p> <p>I: Right.</p> <p>R: ...just to... so I could like familiarise myself with the campus and stuff.</p>
<p>1132 – 1157</p>	<p>R: Well, then... but also, erm, well, 'cause, erm, in the like first two weeks... erm, then it was like when we, erm, then started like the lectures properly, then I was started like... erm, starting to get like a bit anxious and stuff, but then, erm, it was like I..I don't know, 'cause for some reas... like it... the time has gone really quickly and now I'm like, well, the like first term is over. But then, erm, you have to then, er, keep re... like reminding myself like it is, erm... 'cause it feels like I've been here like... even though in... when it was like just the first three weeks of like proper lectures, it felt like I'd been here longer than I actually had been.</p> <p>I: Right.</p> <p>R: So, I had to keep reminding myself, well, it's only been like the first term, it's only like the first, erm, few weeks, it will take a while to like settle in and everything.</p> <p>I: Right, yeah. So, that was... it sounds like that was a way to... like your own sort of way to talk to yourself, to keep yourself calm, is that right, is that how you...?</p> <p>R: Yeah.</p> <p>I: Have I got... I mean, have I got that right?</p> <p>R: Yeah, 'cause, erm, yeah, 'cause then I think, erm, yeah, then I was like not trying to rush it, but like...</p>
<p>1532 – 1537</p>	<p>R: Erm, don't like work, erm, that late, because it... then it's like when I'm coming from like a day at uni, then</p>

1854 - 1857	<p>I: Hmm.</p> <p>R: ...I'm totally like exhausted.</p> <p>I: And what else about not being at home has been a bit difficult or different?</p> <p>R: Erm, I think that it's just like, er, made (mumble) just like just being away from...</p>
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## SUMMARY TABLE OF THEMES - SANDRA

<b>Theme</b>	<b>Sub Theme</b>	<b>Line Number</b>
Transition	Learning Environment	104 – 115, 132 – 135, 191 – 199, 208 - 209
	Daily Routine	213 – 224, 228 – 234, 252 – 274, 931 – 937, 1132 – 1157, 1532 – 1537, 1854 – 1857
	Recognition	379 – 382, 409 – 411, 537 – 538
Daily Living - processes	Concentration	90 - 100
	Writing / Attention	141 – 148
Stress	Anxiety/overwhelm	441 – 442, 681 – 685, 726 – 731, 1424 – 1446, 1752 – 1762, 1831 – 1838
	Anxiety / worry	696 – 711, 969 – 979, 1389 – 1392, 1480 – 1496
	Anxiety / social	1085 – 1088
Coping	Concealment	314 – 317, 344 – 358, 479 – 483, 602 – 621, 1164 – 1189, 1301 – 1310, 1606 – 1637, 1661 – 1667, 1677 – 1692
	Proving Myself	239 – 245, 655 – 671, 742 – 756, 795 – 801, 1220 – 1235, 1241 – 1267, 1450 – 1455, 1506 – 1520, 1729 – 1735, 1752 – 1762, 1776 – 1802, 1820 - 1821
	Accepting	544 – 577, 586
	Adjustment	453 – 463, 886 – 900, 947 – 965, 1101 – 1102, 1884 – 1924
Support	Practical	148 – 173, 387 – 394, 1333 – 1345, 1355 – 1357, 1377 - 1383

<b>Theme</b>	<b>Sub Theme</b>	<b>Line Number</b>
	Personal	422 – 436, 871 – 882
Social	Community	281 – 295, 995 – 996, 1115 - 1130
	Balancing	300 – 312, 364 – 370, 1000 – 1006, 1034 – 1040, 1060 – 1067, 1191 – 1199, 1545 - 1576
Dynamic Self	Parts of Me	72 – 75, 84 – 92
	Agentic Me	516 – 524, 833 – 843, 910 – 922, 1203 – 1204, 1359 – 1373, 1647 – 1650, 1739 – 1748
	Insecure Me	780 – 793, 811 – 817, 1699 – 1711, 1807 – 1810
	Me and DCD	322 – 340, 628

## EXTRACT FROM NARRATIVE – SANDRA

## TRANSITION

The over arching theme of Transition is about the changes that Sandra experiences as she moves from home and school to university. Sandra experiences changes in learning processes which interact with her ability to keep up in lectures and also changes in her daily routine and relationship with time. At university Sandra also experiences a feeling of recognition of her learning difficulties for the first time.

**Transition – Learning Process**

Sandra is experiencing a different way of working in the lecture situation and we get a sense of the completeness of this change in her use of the expression 'set up'. In particular Sandra seems to be anxious that in the lecture her learning will not be complete and she will miss something. Sandra seems to have struggled with the pace in lectures and her anxiety not to miss anything is apparent as she describes her experience of trying to write down 'everything' that was said, but in the end has had to rely on a back up recording. Although Sandra suggests that she is getting used to the lecture situation, her hesitancy and self questioning in 'erm...I think it has got easier', potentially suggests that Sandra is still has not quite mastered this learning process.

And erm, and then just 'cause it was a different like set up, like, then, erm... 'cause I was like trying to get down like everything they were saying, but I did make a recording of the...lecture as well. And then, erm... and then I think it has got easier as I... Now I've got more used to the ...lecture situation. (Sandra: 104 – 115)

While Sandra's is enjoying her new topics at university exemplified by her language in that they are 'really good', we also get a sense of Sandra's experience of the scale of the change in attending lectures instead of class as she refers to it as the 'biggest thing'. Again, Sandra's concern about missing something comes to the fore as she seems to experience a loss of control in the new lecture situation illustrated in her expression that 'lecturers like keep on going', perhaps in a sense that the pace is running away from her. Whereas previously in school she could stop the teacher, inferring that she would not miss out anything, she is not able to do this now:

R: Erm, well, I think I, erm... well, it's a like really good to be able to be like learning the stuff I'm learning, but then I think the biggest thing was like the going to lectures instead of just like

a... as opposed to like a class lesson with... when you could, erm, just like, if you miss something you could just like stop the like teacher...whereas the lecturers just like keep on going. (Sandra: 191 – 199)

### **Transition - Daily Routine**

In this theme the changes in Sandra's daily routine from home and school to university seems to have been underpinned by her experience of time. Sandra still seems to be coming to terms with her sense of time during the day and over the first few weeks of university.

Sandra's experience of the timetabling at university is quite different from the regularity of the school day and she struggles in the moment to find a way to describe what this experience is like for her; it is as though putting her thoughts into words is difficult and this may be an in vivo sign in the interview of the processing difficulties she experiences with DCD. While the school day had been experienced with a sense of pressure with 'everything crammed in', the university day in contrast is experienced by Sandra as having long periods of empty time exemplified as 'big gaps':

And, erm... but, yeah, but then it is... like the, erm... but then, 'cause, er, my timetable as well, like I've got, erm, like times where there's like big gaps, or like a ...late lecture and then... as opposed to just like the, er, like nine to three like school day where everything's like ...crammed in. (Sandra: 213 – 224)

Not only is Sandra's experience of time on a daily basis different, her implicit sense of time over the initial period of university seems to have been a source of anxiety. Sandra's excerpt is peppered with expressions of time, 'started', 'time', 'term', 'weeks' 'longer', illustrating how salient the experience of this period of time has been for her. Sandra is also apparently having an explicit dialogue with herself as she says 'reminding herself' that her implicit experience of time is skewed because it seems as though she feels that she has been at university longer than she has. Sandra's dialogue with herself in trying to manage her own expectations as in 'it's only been like the first term' seems to be countering her source of her anxiety, in that in a self judging way, she should have settled in by now:

Well, then... but also, erm, well, 'cause, erm, in the like first two weeks... erm, then it was like when we, erm, then started like the lectures properly, then I was started like... erm, starting to get like a bit anxious and stuff, but then, erm, it was like I..I don't know, 'cause for some reas... like it... the time has gone really quickly and now I'm like, well, the like first term is over. But then, erm, you have to then, er, keep re... like reminding myself like it is, erm... 'cause it

feels like I've been here like... even though in... when it was like just the first three weeks of like proper lectures, it felt like I'd been here longer than I actually had been...so, I had to keep reminding myself, well, it's only been like the first term, it's only like the first, erm, few weeks, it will take a while to like settle in and everything. (Sandra: 1132 – 1157)

### **Transition – Recognition**

While Sandra seems to be struggling with the new learning experience at university and is still trying to adjust in her experience of time at university, a more positive outcome of the transition to university is that Sandra experiences recognition of her experience of struggling with DCD as a learning difficulty.

Sandra compares her experience of support for her learning difficulties at school compared to university explaining that at school she did not receive support. Her language of 'struggling on my own' gives the sense of being adrift:

R: Erm, well, I think it was just because like at school like, erm, didn't really have any help. So, like I felt like I was struggling on my own, whereas now like... (Sandra: 409 – 411)

In contrast, Sandra's experience of the recognition that she needs help with DCD at university is quite ecstatic 'wow', and she can hardly believe, as she states 'actually', that she will now get some support.

R: Yeah, 'cause, erm, I think, yeah, 'cause then like it was like, wow, I'm actually gonna get some help, so... (Sandra: 537 – 538)

In the overarching theme of Transition, as Sandra moves from the school and home life-world of her adolescence to the life-world of her young adulthood we get a glimpse of the changes Sandra experiences in time and learning processes accompanied by feelings of anxiety on the one hand and elation on the other.

## MASTER THEME TABLE – CONVERGENCE RECONCILIATION

Master Theme	Theme		Eileen	Tom	Kate	Fiona	Sandra	Lisa	Chris	Samuel	More than 4
<b>DCD and Transition</b>	Moving On	1		X	X	X	X		X	X	Y
	Change in Framework	2		X	X	X	X	X	X	X	Y
	Academic vs. Social	3		X		X	X			X	Y
<b>DCD in Functional Context</b>	Interference	4	X	X		X	X	X	X	X	Y
	Organisation and Planning	5	X		X	X		X	X	X	Y
	Control and Attention	6	X	X	X	X	X	X			Y
	Motor Perceptual	7			X	X			X		N
<b>DCD in Social Context</b>	Interpersonal	8	X		X	X		X	X	X	Y
	Cultural narratives	9		X	X	X		X	X		Y
	My Community	10	X	X	X	X	X				Y
<b>DCD in Psychological Context</b>	Overwhelm	11	X	X	X	X	X	X	X		Y
	Worry	12	X	X		X	X		X		Y
	Social Anxiety	13		X		X	X	X			Y
	Comparing	14	X	X		X		X	X	X	Y
	Resignation and Acceptance	15	X			X	X	X	X	X	Y
	Explaining	16	X		X			X	X	X	Y
	Humour	17	X	X	X	X		X			Y
	Overcoming	18	X	X	X	X	X	X	X	X	Y
	Concealing	19	X	X		X	X	X	X	X	Y
	<b>DCD and Support</b>	Formal Support	20	X	X	X	X	X	X	X	X
Personal Support		21	X	X	X	X	X	X	X	X	Y
<b>DCD and Young Adult – Dynamic Self</b>	Discovery	22	X	X	X	X		X	X	X	Y
	Me and DCD	23	X	X	X	X	X		X	X	Y

## MASTER THEME TABLE – EXPERIENTIAL THREADS

Master Theme	Theme		Evidence/Experiential Threads – summary points; time/stages/speed/loss of; action/process; sensation/feeling; narratives (Smith & Eatough, 2006)
<b>DCD and Transition</b>	Moving On	1	Decision /goals/agency vs. fear/separation; DCD impact/compromise/false starts.
	Change in Framework	2	Learning environment – loss of structure, culture & relationships; scale and scope of impact on daily routine; responsibility and self judgement.
<b>DCD in Functional Context</b>	Academic vs. Social	3	Tension/balance of study time allocation vs. social self/fun
	Interference	4	Interference in writing and listening, negative sense of competence, taking longer, persistent problem.
	Organisation and Planning	5	Disorientation, fragmentation, proliferation, confusion (makes sense to themselves but not to others), time perception, incompetence, self judgement, creativity, implicit strategies.
<b>DCD in Social Context</b>	Control and Attention	6	Mind as separate, no control, doing more than one thing, variance over time, memory, experiential strategies, self-deprecation, self- judgement.
	Motor Perceptual	7	Constancy, learning/relearning, perplexity, justifying, trying, embarrassment, friction.
	Interpersonal	8	Misunderstanding, visibility, embarrassment, demeaned, powerless, defensiveness, rupture, stigma, discrimination/bullying.
	Cultural Narratives	9	Lack of understanding, denial, diminishing.
	My Community	10	Inclusion, respect, diversity and equality.
	Overwhelm	11	Overwhelming emotions/sensations, intensity, immediacy, inability to deal with.
	Worry	12	Future, persistent, uncontrollable thoughts.
<b>DCD in Psychological Context</b>	Social Anxiety	13	What others think of them, lack of social skills,
	Comparing	14	Comparing to normal, peers, missing out, self judgement.
	Resignation and Accepting	15	The way it is, limitations, acceptance, annoyance, despair.
	Explaining	16	Need to prove, justifying, inability to explain to self or others, frustration.
	Humour	17	Self deprecating, build relationships, ease tension.
	Overcoming	18	Self reliance, agency, motivation, perseverance/determination, perfectionism, make up for.
	Concealing	19	Fitting in, perceptions (self and others), self-monitoring, vigilance.
<b>DCD and Support</b>	Formal Support	20	Functional, resources/'stuff', information, processes, mentoring.
	Personal Support	21	Relationship, warmth, felt sense, comfort, acceptance, therapy, talk/listen.
<b>DCD and Young Adult – Dynamic Self</b>	Discovery	22	Discovery and stage of development; realising/reliving something wrong/confusion/distress/scale; coherence/relief; impact on self-perception/exclusion.
	Me and DCD	23	Personal characteristics; integration/plus and minus; dialogic; not whole identity; constructing me/future story, identification.

## MASTER THEME TABLE WITH QUOTE LINE NUMBERS

Master Theme	Theme		Eileen	Tom	Kate	Fiona	Sandra	Lisa	Chris	Samuel
<b>DCD and Transition</b>	Moving On	1		66 – 70, 74 – 76, 89 – 91, 780 – 786, 932 - 934	8 – 22, 47 – 59, 1079 – 1111	58 - 60	72 – 75, 84 – 92		499 – 522, 1062 - 1081	1387 – 1406, 1410 – 1461
	Change in Framework	2		339 – 343	26 - 33, 37-45, 65 -73, 78 -79, 84 -110, 115 - 117, 121-122, 140 -145, 164 – 178, 240 -246, 266 – 272, 281 – 293, 319 – 326, 784 – 790, 875 – 876, 1038-1039, 1248-1262	44 – 54, 83 – 91, 95 – 106, 114 – 118, 153 – 157, 182 – 186, 307 – 312, 1550 – 1553, 1562 – 1563, 1572, 1580 – 1582	104 – 115, 132 – 135, 191 – 199, 208 – 209, 213 – 224, 228 – 234, 252 – 274, 931 – 937, 1132 – 1157, 1532 – 1537, 1854 – 1857	1774 – 1803, 1863 – 1916,	63 – 88, 120 – 134, 149 – 164, 174 – 190, 312 – 327, 383 – 408,	77 – 86, 125 – 140, 170 – 185, 281 – 313, 339 – 357, 445 – 469, 520 – 542, 548 – 572, 596 – 608, 1233 – 1254, 1615 – 1634
	Academic vs. Social	3		961 – 973, 981 – 984, 1800 – 1803, 1866 – 1883, 1940 – 1946, 1978 – 1983, 1987 - 1990		337 – 351, 355-358	300 – 312, 364 – 370, 1000 – 1006, 1034 – 1040, 1060 – 1067, 1191 – 1199, 1545 – 1576			111 – 120, 144 – 150, 473 – 497, 585 – 592, 991 – 1001, 1017 – 1021, 1087 – 1094, 1169 – 1177, 1198 – 1220
<b>DCD in Functional Context</b>	Interference	4	80 -81, 92 – 93, 300 – 301, 351 – 352, 456 – 457, 1720 - 1724	139 – 145, 1514 – 1522, 1531 – 1542		1387 – 1389	141 – 148	912 – 936, 1069 – 1082, 1209 – 1210	761 – 772	271 – 275
	Organisation and Planning	5	112 – 113, 208 – 209, 224 – 229, 278 – 281 562 – 572, 755 – 769, 1557 – 1562, 1578 – 1581, 1593 – 1598, 1603 –		298 – 300, 310 – 317	203 – 213, 461 – 467, 493 – 500		167 – 170, 275 – 289, 330 – 346, 379 – 395, 481 – 489, 497 – 502, 810 – 826, 830 – 851, 863 – 872, 1212 – 1271, 1280 – 1285,	110 – 116, 243 – 267, 1135 – 1140, 1962 – 1969	217 – 243, 1264 - 1286

Master Theme	Theme		Eileen	Tom	Kate	Fiona	Sandra	Lisa	Chris	Samuel
			1608					1855 – 1861, 2015 – 2030, 2049 – 2078, 2100 – 2112		
	Control and Attention	6	112 – 117, 121 – 128, 196 – 197, 308 – 314, 327 – 328, 335 – 342, 351 – 356, 360, 365 – 373, 394-405, 415 – 420, 440 – 445, 1110, 1231, 1466 – 1468, 1859 – 1867	347 – 351, 356 – 377, 389-391, 988-997, 1616-1620, 1633-1637, 1638-1684	330 – 348, 353 – 372	865 – 866, 870 – 872	90 - 100	226 – 229, 293 – 309, 740 – 753, 1467 – 1478, 1507 – 1522, 1543 – 1555, 1425 – 1463		
	Motor Perceptual	7			440 – 447, 579 – 590, 603 – 613,	36 – 42, 1212 – 1221			597 – 610, 738 – 757, 818 – 846, 934 – 957, 961 – 972, 1454 – 1490	
<b>DCD in Social Context</b>	Interpersonal	8	224 – 244, 778 – 782, 804 – 820, 831 – 836	123 – 127, 192 – 197, 270 – 272, 411 – 420, 477, 555 – 559, 584 – 591, 595 – 596, 679 – 682, 707 – 715, 907 – 910, 1013 – 1019, 1023 – 1024, 1252 – 1272, 1304 – 1306, 1310 – 1311, 1332 – 1337, 1379 – 1381, 1397 – 1398, 1628 – 1629, 1642 – 1647, 2072 – 2078, 2091 – 2093	390 – 406, 541 – 550, 709 – 714, 718 – 729, 737 – 753, 1125 – 1143, 1159 – 1163	258 – 271, 1094 – 1108, 1126 – 1135, 1452 – 1465, 1688 – 1706, 1729 – 1738		233 – 238, 242 – 251, 255 – 257, 1397 – 1407, 1482 – 1487, 2183 – 2215, 2227 – 2270, 2279 – 2285, 2412 – 2433, 2442 – 2455, 2459 – 2469, 2473 - 2478	532 – 568, 571 – 588, 1034 – 1045, 1227 – 1249, 1301 – 1334, 1350 – 1379	718 – 749, 875 – 928, 930 – 943, 1116 – 1155, 1591 - 1611

Master Theme	Theme		Eileen	Tom	Kate	Fiona	Sandra	Lisa	Chris	Samuel
	Cultural Narratives	9		165 – 166, 170 – 171, 294 – 296, 584 - 591, 595 - 596, 1628 - 1629, 1642 - 1647, 2106 – 2125	408 – 419	1043 -1045, 1068 – 1082,		511 – 517, 1312 – 1313, 1695 – 1714,	616 – 635, 643 – 665, 683 – 696, 798 – 799, 884 – 898, 1494 – 1527, 1623 – 1652, 1803 – 1823, 1998 – 2024, 2279 – 2292, 2296 – 2308, 2321 – 2332	
	My Community	10	682 – 691, 730 – 738, 1084, 1269 – 1275, 1280-1294	151 – 160, 330 – 335, 399 – 407, 693 – 696, 805 – 828, 842 – 848, 884 – 892, 1460 – 1467, 1676 – 1679, 2267 – 2279, 2292 – 2294	26 – 33, 240 – 246, 485 – 487, 500 – 506, 795 - 801	1165 – 1167, 1665 - 1672, 1681 - 1682	281 – 295, 995 – 996, 1115 - 1130			
<b>DCD in Psychological Context</b>	Overwhelm	11	931 – 935, 976 – 1001, 1191 – 1207	1734 – 1739, 1760 – 1765, 1897 – 1908, 1920 – 1926	460 – 468, 562 – 570, 594 – 602, 619 - 627	163 – 165, 223 – 231, 248 – 254, 1778 - 1791	441 – 442, 681 – 685, 726 – 731, 1424 – 1446, 1752 – 1762, 1831 – 1838, 1884 - 1924	95 – 115, 119 – 141, 961 – 971, 1055 – 1065, 1139 – 1150, 1807 – 1826	138 – 141	
	Worry	12	915 – 916, 953 - 954	1421 – 1426, 1790 – 1796, 1855 – 1862		849 – 856, 902 – 908, 918 – 921, 1357 – 1366	696 – 711, 969 – 979, 1389 – 1392, 1480 – 1496		919 – 926, 1144 – 1163, 1167 – 1189, 1559 – 1570, 2070 – 2077, 2134 – 2150, 2199 – 2208	
	Social Anxiety	13		281 – 284, 309 – 315, 436 -444, 506 – 517, 620 – 626, 2049 - 2061		126 – 136, 289 – 291, 299 – 306, 417 – 418, 925 – 936, 1440 – 1444, 1778 - 1791	1085 – 1088, 1101 - 1102	604 – 636, 644 – 660, 1411 – 1421, 1624 – 1634, 2390 – 2408		

Master Theme	Theme		Eileen	Tom	Kate	Fiona	Sandra	Lisa	Chris	Samuel
	Comparing	14	106 – 108, 262, 267 – 269, 327 – 331, 861 – 862, 866 – 867, 1100 – 1102, 1313 – 1324, 1887 – 1892	521 – 522, 534 – 536, 603 – 605, 790 – 791, 955 – 957, 1001 – 1003, 1192 – 1196, 1218 – 1219, 1546 – 1547, 1779 – 1780		169 – 171, 649 – 653		351 – 367, 2146 – 2154	416 – 422, 1283 – 1290, 1541 – 1554, 1574 – 1592, 1614 – 1619, 2050 – 2065	90 – 100, 708 – 710
	Resignation and Acceptance	15	128, 186, 1744 – 1747, 1437 – 1440			940 – 946, 1767 – 1776	453 – 463, 544 – 577, 586, 886 – 900, 947 – 965,	1954 – 1983	438 – 477, 455 – 477, 1597 – 1610	1027 – 1052, 1067 – 1083, 1485 – 1491
	Explaining	16	74 – 76, 185 – 187, 1732 – 1733		424 – 434, 512 – 517			453 – 473, 481 – 489, 665 – 680, 689 – 691, 1344 – 1348	1049 – 1055	673 – 675, 962 – 981
	Humour	17	305 – 307, 1030, 1492 – 1511	1440 – 1443, 1720 – 1733, 1961 – 1963	472 – 479, 828 – 844	680 – 691, 1720		2136 – 2138		
	Overcoming	18	308 – 309, 323, 456 – 457, 562 – 563, 746 – 747, 1071 – 1072, 1675 – 1681, 1686 – 1689, 1693 – 1694, 1700 – 1706, 1711 – 1712	107 – 113, 898 – 903, 943 – 946, 1057 – 1061, 1321 – 1328, 1430 – 1436, 1447 – 1454, 1471 – 1481, 1660, 1664 – 1667, 1698 – 1703, 1807 – 1812, 1824 – 1825, 2149 – 2156, 2160 – 2164, 2176 – 2179, 2205 – 2206, 2210 – 2212	524 – 527, 1179 – 1187, 1191 – 1206, 1216 – 1220	426 – 433, 437 – 439, 1503 – 1504, 1511 – 1518, 1534 – 1541, 1608 – 1620	239 – 245, 516 – 524, 655 – 671, 742 – 756, 795 – 801, 833 – 843, 910 – 922, 1203 – 1204, 1220 – 1235, 1241 – 1267, 1359 – 1373, 1450 – 1455, 1506 – 1520, 1647 – 1650, 1729 – 1735, 1739 – 1748, 1752 – 1762, 1776 – 1802, 1820 – 1821	760 – 769, 1585 – 1591, 1832 – 1851, 1991 – 2006, 2317 – 2319	1383 – 1394	1503 – 1538
	Concealing	19	250 – 258, 1336 – 1337	319 – 325, 607 – 611, 1279 –		390 – 407, 502 – 507	314 – 317, 344 – 358, 479 – 483,	1090 – 1103, 1121 – 1130,	902 – 915, 864 – 878, 1723 –	622 – 646, 842 – 859, 1310 –

Master Theme	Theme		Eileen	Tom	Kate	Fiona	Sandra	Lisa	Chris	Samuel
				1296, 1352 – 1365, 1389 – 1391, 1402 – 1405, 2043 – 2045			602 – 621, 1164 – 1189, 1301 – 1310, 1606 – 1637, 1661 – 1667, 1677 – 1692	1666 – 1685, 2323 – 2348, 2358 – 2382	1738, 1899 – 1918, 1977 – 1985, 2241 – 2254	1314, 1336 – 1351, 1554 – 1654
<b>DCD and Support</b>	Formal Support	20	73 – 74, 174 – 176, 185 – 187, 191 – 192, 203 – 204, 1118 – 1119, 1536 – 1538, 1542 – 1544, 1570, 1650, 1720 – 1724	232 – 239, 258 – 261, 265 – 266, 347-351, 356- 377, 388-391, 452 – 457, 462 – 466, 470 – 473	1232 – 1235, 1248 – 1262, 1288 – 1293	540 – 570, 588 – 590, 743 – 756, 1203 – 1210, 1408 – 1412, 1622 – 1631, 1637 – 1640, 1842 – 1866, 1886 – 1894	148 – 173, 379 – 382, 387 – 411, 537 – 538, 1333 – 1345, 1355 – 1357, 1377 - 1383	562 – 595, 1718 – 1733, 1737- 1755	40 – 64, 92 – 100, 275 – 308, 336 – 367, 379 – 381, 1843 – 1871, 2258 – 2266	161 – 166, 197 – 213, 247 – 267, 410 – 439, 813 – 834
	Personal Support	21	1118 – 1119, 1154 – 1164, 1019 – 1020, 1024 – 1030, 1037 – 1038, 1128 – 1131, 1135 – 1136, 1149 – 1150, 1154 – 1156	201 - 202, 563 – 579, 652 – 675, 719 – 736, 852 – 876, 1117 – 1124, 1128 – 1135, 1139 – 1141, 1150 – 1153, 1157 – 1159, 1485 – 1488, 1501 - 1504	129 – 136, 153 – 154, 250 – 261, 641 – 645, 649 – 661, 667 – 681, 692 – 697, 1267 - 1279	24 – 32, 596 – 614, 623 – 625, 764 – 775, , 1152 – 1153, 1742 – 1748, 1842 – 1843	422 – 436, 871 – 882	684 – 685, 773 – 787, 1154 – 1165, 1169 – 1188, 1567 – 1581, 1605 – 1620, 1638 – 1656, 1935 – 1950, 2163 – 2176	194 – 220, 1782 – 1803, 1928 – 1958, 2098 – 2130, 2171 – 2189	318 – 329
<b>DCD and Young Adult – Dynamic Self</b>	Discovery	22	153 – 170, 174 - 185, 756 – 758, 773 – 774, 873 – 874, 880 – 881, 885 – 890, 899 – 900, 966 – 967, 1454 – 1455 1530 – 1531, 1617 – 1630, 1635 – 1638, 1650 – 1667	182 – 188, 206 – 211, 216 – 227, 428 – 434, 495 – 498, 523 – 528, 541 – 553, 932 – 934, 1069 – 1075, 1083 – 1089, 1101 – 1113, 1164 – 1174	159 – 160, 183 – 185, 189 – 212, 216 – 218, 220 – 226, 764 – 768, 775 – 780, 1055 – 1065	1086 – 1090		143 – 158, 185 – 216, 324 – 326, 372 – 375, 397 – 414, 532 – 558, 975 – 986, 1003 – 1035, 2220 – 2225, 2552- 2558	1201 – 1223, 1253 – 1279, 1682 – 1700, 1875 – 1895	699 – 704

Master Theme	Theme		Eileen	Tom	Kate	Fiona	Sandra	Lisa	Chris	Samuel
	Me and DCD	23	97 – 99, 137 – 138, 354, 415, 435 – 436, 455 – 457, 477 – 482, 495 – 503, 540 – 549, 580 – 582, 519, 523 – 524, 537 – 538, 586, 595 – 624, 633-658, 673 – 675, 705, 746 – 747, 791 – 797, 962, 1056 – 1067, 1088 – 1089, 1094 – 1096, 1364 – 1367, 1380 – 1382, 1391- 1399, 1404 – 1405, 1425 – 1426, 1446 – 1449, 1480, 1543 - 1544, 1777 – 1788, 1797 – 1799, 1812 – 1813	919 – 928, 938, 1013 – 1019, 1223 – 1229, 1237 – 1238, 1315 – 1317, 1341 – 1348, 1496 – 1497, 1708 – 1711, 2013 – 2014, 2025 – 2028, 2038 – 2039, 2191 – 2193, 2218 – 2238, 2242 – 2254, 2262 - 2263	846 – 857, 892 – 904, 948 – 955, 962 – 971, 991 – 1000, 1011 – 1014	515 – 524, 630 – 645, 655 – 674, 693 – 711, 777 – 787, 799 – 815, 876 – 878, 1267 – 1269, 1230 – 1239, 1296 – 1311, 1330 – 1345, 1478 – 1481, 1870 - 1882	322 – 340, 628, 780 – 793, 811 – 817, 1694 – 1711, 1807 – 1810		986 – 1030, 1093 – 1131, 1419 – 1430, 1434 – 1454, 2154 – 2169	361 – 388, 503 – 516, 772 – 802, 1372 – 1378, 1638 – 1657, 1676 – 1705

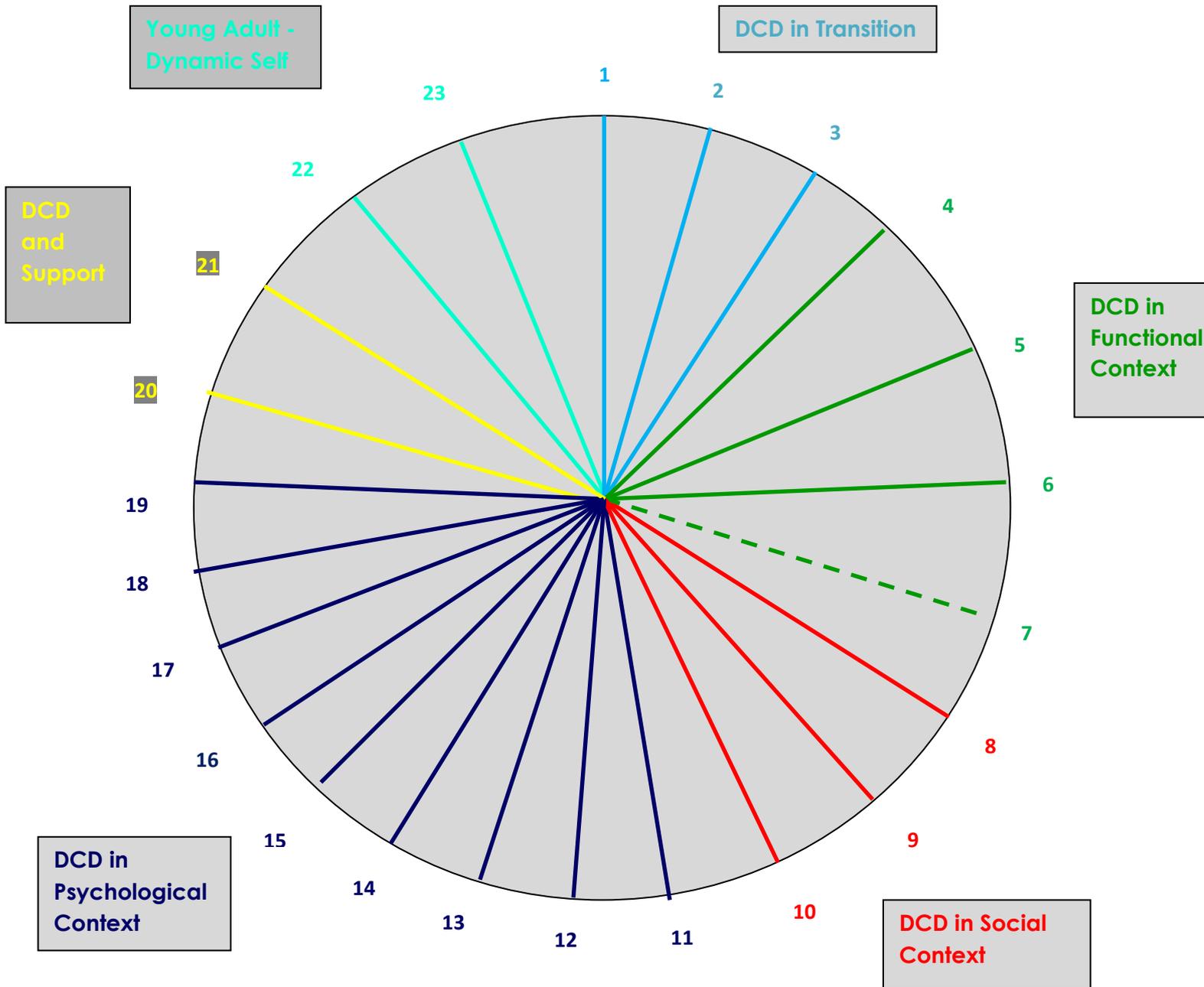
## EXTRACT OF MASTER THEME TABLE WITH ILLUSTRATIVE QUOTES – DCD IN PSYCHOLOGICAL CONTEXT

Master Theme	Theme	No.	Illustrative Quotes
DCD in Psychological Context	Overwhelm	20	<p>I, I mean, I was basically in a panic. I was basically having a panic attack the whole time. I had, every time I got a chance, and when I eventually did it, I was so emotionally drained that I, I basically, ins..., I basically slept for a whole day which is really weird for me. (Eileen: 931 – 935)</p> <p>R: It's, it's all internal. Uh, if you were to, if you were to look at me from an outside perspective, you probably wouldn't guess it, but...</p> <p>I: Mm. So if I was to, to see inside, what would it be like there?</p> <p>R: Eh, I would picture a, a nuclear reactor going into meltdown. All the people with hardhats running around panicking and everything. That's, that's it, pretty much.</p> <p>I: Right.</p> <p>R: Chernobyl. (Tom 1897 – 1908)</p> <p>Um, I just get, like, kind of really panicky and hot and it, it, you know, start kind of thinking of, like, catastrophic scenarios – but it really depends if I'm late for, like, an appointment.... Or I'm just trying to get somewhere (Kate: 619 – 627)</p> <p>Em, talking to someone I don't know. I find that really difficult because I, eh, struggle with trying to, em, understand what people mean – coz sometimes Claire will say something, my friend will say something and mean, she means as a joke, and I'll just, I'll start crying coz I, if I'm, I thought, "did she really mean that?" Or she'll say something and I won't understand what, how she meant it at all, and I've just gotta keep asking and asking. (Fiona: 248 – 254)</p> <p>Yeah, it's just, erm, because I have like... there've been times when I've been like, erm, yeah, like everything's ok like, I can do this, I've got to for uni and then just times where then like it's just like anxiety, anxiety, anxiety. (Sandra: 1884 – 1887)</p> <p>It's pretty hectic. It's very, very overwhelming. Um, because it's my second year, now. Um, I have been very</p>

			<p>flustered, all over the place. (Lisa: 95 – 115)</p> <p>Um, so that was really difficult, and even took a, one, one day, I got in there and, um, I was late and I, I couldn't find the room, and it was, I felt so kind of frustrated that I just didn't, didn't wanna bother and just wanted to go straight home. (Chris: 138 – 141)</p>
	Worry	21	<p>But I just don't, I really hate the idea that someone will be dis..., will be disappointed in me, and I..., and that if something bad happens to someone I won't be able to help (Eileen: 915 – 916)</p> <p>I'm in a constant state of worry, I would say. But, em, if I was just, to describe it physically, it's like a constant tightness in my chest. That's probably, that's the only, that's the only way, like, I'm able to describe it, really. (Tom: 1855 – 1862)</p> <p>I'm, I'm constantly worrying about stuff. I get really, really jealous and a bit paranoid about things, so that's, that's why, that's probably what the anxiety – I'm a lot worse. I don't talk, I practically won't talk to anyone. (Fiona:918 – 921)</p> <p>Erm, just, er, well, erm, 'cause one, erm, one... well, 'cause I've got all my like assignments next term...but one has already been set which we need to be like doing reading and preparing for...So, that is on like my mind quite a lot. (Sandra:1480 – 1490)</p> <p>Um, and you know, most people, you know, they'd hold a glass of something in one hand. I have to hold it with two...So it's, it's, it's kind of, you know, and even then, it's, um, you knock something or you're so, you're so worried about knocking it that you end up knocking it. (Chris: 919 – 926)</p>
	Social Anxiety	22	<p>And, um, they determined this because, um, as, well, for what you've probably seen for yourself right now, that I find it very difficult to keep eye contact with people... I can, I can only keep eye contact for a certain amount of time. (Tom: 506 – 517)</p> <p>So I wouldn't go and just talk to someone, like, I've got a friend in uni who just talks to everyone. She's friends with practically everyone. I couldn't do that. I'd have to ... they'd have to talk to me first and stuff. (Fiona: 299 – 306)</p>

		<p>Erm, yeah, well, erm, well, 'cause then, erm, like some people from my class then made friends with other people, so then we like joined up as like a big group and then that's why I started... erm, just like sit there quite quiet (laughs). Sandra: (1085 – 1088)</p> <p>Um, just approaching someone. I find it very difficult because my speech is very, I'm all over the place, at times, as well. Like, um, I often try and say things but something else comes out. (Laughs.) It can be quite embarrassing. Um, so yeah, I do find it hard to approach people (Lisa:609 -613)</p>
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## ANALYSIS – CONVERGENCE PROFILE



**Key:**

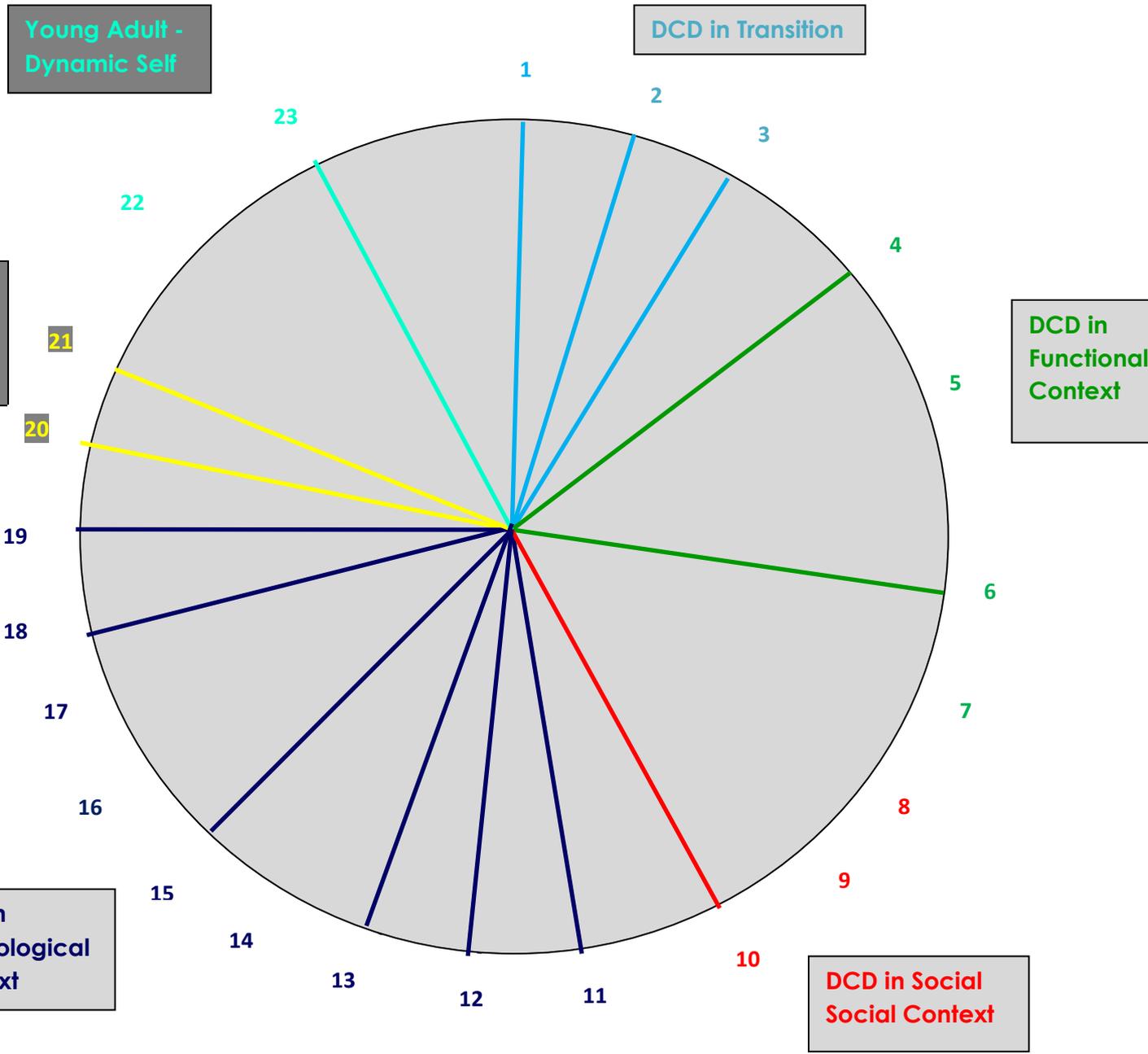
Nos.1 – 23 Theme numbers (please see Table 2)

————— > 4 participants

- - - - - < 4 participants

## ANALYSIS – INDIVIDUAL PROFILE

Sandra - All names and certain biographical /personal identifying details have been changed throughout in order to preserve anonymity.



**Key:**

Nos.1 – 23 – Theme numbers (please see Table 2)

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SECTION D

General Anxiety Disorder and Social Phobia in the context of  
Developmental Coordination Disorder: A CBT Approach

Client Study and Process Report

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# **General Anxiety Disorder and Social Phobia in the context of Developmental Coordination Disorder: A CBT Approach**

## **Client Study and Process Report**

### PART A – INTRODUCTION AND START OF THERAPY

#### **Introduction and Rationale**

This client study is about Zoe<sup>10</sup>, a young woman, who provided me with a unique opportunity to combine development of my therapeutic practice with my research topic on Developmental Coordination Disorder (DCD) (DSM-IV-TR; American Psychiatric Association (APA), 2000) aligned to my genuine interest in working with young adults with DCD. Through working with Zoe, I have been able to develop and review my competence in Cognitive Behaviour Therapist skills and examine the theory and efficacy of Cognitive Behaviour Therapy with this client. Additionally, I have had to reflect on the ethics of my decisions in working with Zoe.

#### **Theoretical consideration**

##### *CBT*

Cognitive Behaviour Therapy (CBT) as outlined by Knapp & Beck (2008) is based on Beck's (1963) cognitive model of psychotherapy which explains the impact of cognitive processes on emotion and behaviour. The CBT model embraces the client's development and relationships which Clark, Beck, & Alford (1999) suggest create enduring schemas. Clients use these schemas or core beliefs to perceive and structure their reality which Knapp & Beck (2008) argue can be accessed by eliciting Negative Automatic Thoughts (NATs) and conditional assumptions through Socratic dialogue and guided discovery. By engaging the client in the therapeutic alliance as an active agent (Bandura, 1997) in the collaborative process of therapy, CBT enables the client to develop skills to change their personal interpretations (Butler, Chapman, Foreman, & Beck, 2006). CBT is characterised by a collaborative formulation of the client, structure, plan and agreed goals for therapy. Additionally the client is encouraged as outlined by Bennett-Levy et al. (2004) to be curious

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<sup>10</sup> All names and certain biographical /personal identifying details have been changed throughout in order to preserve confidentiality.

and exploratory through homework and behavioural experiments and to develop problem solving and social skills.

A number of DSM-IV-TR (APA, 2000) diagnostic categories are relevant to Zoe's case and a brief review of the theoretical models and evidence underpinning each is presented.

### *Generalized Anxiety Disorder*

In General Anxiety Disorder (GAD) (DSM-IV-TR; APA, 2000) pervasive and long standing worry are key features. GAD is more common in women with a prevalence rate of 4.3 % for women compared to 2% for men, with at least half of cases beginning before thirty one years of age (Kessler et al., 2005). GAD tends to have a chronic path impacting on social, occupational and everyday living (Clarke & Beck, 2010). GAD often co-occurs with other Anxiety and Mood Disorders including major depression and social phobia and GAD in adolescence is predictive of adult GAD, social anxiety and major depressive disorder (Pine, Cohen, Gurley, Brook, & Ma, 1998).

Watson (2010) outlines a number of theoretical models of GAD which have identified mechanisms in worry: 1) Borkovec, Ray and Stober (1998) describe a model of emotional avoidance in which worry suppresses anxiety symptoms through verbal rumination to avoid distressing imagery and emotions. Unhelpfully 'preparing for the worst' mitigates against action and encourages superstition that the worrying itself prevents disaster; 2) Wells Metacognitive Model of GAD (1995) identifies two levels of worry; Level 1 worries tend to reflect external or internal non cognitive experiences which are catastrophized, while Level 2 worries are meta beliefs about worry itself. In this model worry is seen as a double bind because worry is used as a dysfunctional coping mechanism but is itself catastrophized and seen to have a dangerous effect; 3) the mechanism identified by Koerner & Dugas (2008) associated with persistent worry is intolerance of uncertainty (IU). While IU is not seen by Koerner & Dugas (2008) as pathological, IU in worry comprises a set of beliefs which produce a cognitive bias predicting non discriminating negative appraisals of situations and negative self evaluation.

### *Social Phobia/Anxiety*

Social Phobia (DSM-IV-TR; APA, 2000) is one of the most common of anxiety disorders with a lifetime prevalence of 12.1 % (Ruscio et al., 2008) often beginning in childhood or adolescence and left undiagnosed until chronic (Rapee, 1995). Social Phobia is characterised by extreme fear in interpersonal or performance situations with avoidance of these contexts creating debilitating problems in everyday life and significant emotional distress (Clark & Beck, 2010). Clark & Wells (1995) outline key processes maintaining social

phobia including self focused attention, fusing of internal body and emotional sensations with external appearance, safety behaviours to avoid rejection and unhelpful cognitive processing before and after events.

#### *Developmental Coordination Disorder*

Developmental Coordination Disorder (DCD) (DSM-IV-TR; APA, 2000) is predominantly seen as a motor skills problem, and depending on severity has been observed in 5-15% of school age children (Wilson, 2005). DCD affects daily activities and academic performance but is not due to a general medical condition, a Pervasive Developmental Disorder or mental retardation (DSM-IV-TR, APA, 2000). DCD also has a psychosocial element including anxiety, peer relationship difficulties and low self esteem (Schoemaker & Kalverboer, 1994; Dewey, Kaplan, Crawford, & Wilson, 2002) and co-occurs with other learning and development problems including ADHD, Dyslexia (Geuze, Jongmans, Schoemaker, & Smits-Engelsman, 2001) and Autism Spectrum (Gumley, 2005). While girls' motor skills development problems are often missed (Revie & Larkin, 1993), Kirby and Davies (2006) note that they are more likely to be identified through Joint Hypermobility Syndrome (JHS). DCD is now recognised as a 'lifespan' issue (Hill & Barnett, 2011) with significant mental health implications for young adults (Rasmussen & Gillberg, 2000). DCD affects adults' physical, executive, day to day living and psychological function e.g. poor coordination, writing and copying problems, poor short-term memory, poor organisational skills, lack of awareness of time, sensitivity to sensory stimuli e.g. light, touch, noise and emotional regulation problems. Drew (2005) argues that psychosocial issues become the prime problem in adulthood bringing individuals into contact with mental health services where their developmental and learning difficulty issues may not be fully appreciated.

While CBT has been demonstrated as effective in numerous studies across anxiety disorders (Butler, Chapman, Foreman & Beck, 2006) including GAD (Butler, Fennell, Robson & Gelder, 1991) and Social Phobia (Clark et al., 2003) and is the recommended treatment by NICE (2007) for GAD, Yonkers, Bruce, Dyck & Keller (2003) found GAD and Social Phobia to be resistant in at least a third to a half of clients undergoing CBT. Though cognitive strategies have been helpful in supporting the motor skills training of young children with DCD (Polatajko, Missiuna, Mandich, & Macnab, 2001), there do not seem to be any specific studies examining CBT and DCD in adults, however, in other commonly co-occurring conditions of ADHD (Hesllinger et al., 2002) and Asperger Syndrome (Weiss & Lunsky, 2010), CBT has been used in group settings with significant if minor improvements in symptoms and outcomes for clients.

This case study therefore provides the opportunity to review individual CBT for GAD and Social Phobia in the context of DCD.

## **START OF THERAPY**

### **Context of Work and Referral**

#### *Client Referral*

Zoe was referred by her college medical service General Practitioner (GP) for anxiety and depression to the local Improving Access to Psychological Therapies Service (IAPT) of my placement where CBT is the main therapy. Zoe was initially assessed through a telephone protocol system and her case reviewed in case management by a senior Clinical Psychologist. She was offered a place on a CBT group Stress Management Programme of six sessions but she had been unable to tolerate the large group setting and left. My supervisor then referred Zoe to me as a suitable case for a Trainee for one to one Cognitive Behaviour Therapy at High Intensity level i.e. suitable for clients with moderate to severe levels of anxiety and depression.

While Hamilton & Dobson argue that co-morbidity of anxiety and depression and severity of symptoms in depression can hamper therapeutic outcome in CBT, they also emphasise that goal orientation, homework completion and self-efficacy may mediate these difficulties. Zoe, while highly anxious and depressed, demonstrated in assessment that she was motivated, accepted responsibility for making change and could articulate her goals which Safran, Segal, Vallis and Shaw (1993) accept as indicators of client suitability for CBT, so I thought Zoe would be an appropriate candidate for CBT and I was pleased to work with her.

#### *Client*

Zoe is an attractive 20 year old young woman with distinctive short black curly hair who dresses in casual yet creative clothes and has a 'quirky' appearance. On first meeting Zoe, I noticed that she seemed to have difficulty concentrating and that I had to repeat myself regularly. Observationally, I also noted her highly flexible fingers and that she was unable to sit still, playing with her hair and one way or another touching her body or moving. Zoe triggered my implicit model of DCD (DSM-IV-TR, APA, 2000) which I carefully bracketed as a potential stereotype while noticing that Zoe evoked a strong caring response in me.

#### *Presenting problem – client view*

Zoe described her intense worries about her academic work, her employment and what others think of her and described severe headaches, nausea and tiredness. She explained

that she was frightened of being on her own and that she was finding some social situations threatening. She reported having nightmares about being sexually attacked and had in the past self harmed by cutting herself. She came for therapy because she wanted to stop taking prescription drugs and have a better work life balance.

## **Assessment and Initial Formulation**

### *Background*

Zoe is the youngest of four children with a sister and two brothers who are considerably older (please see Appendix 1 – Formulation diagram which includes family background factors). Her mother has had a life threatening chronic health condition since Zoe was a child. Zoe did well at school despite teachers' low expectations and her poor organizational skills though she left school prematurely due to bullying and health problems. She has since attended college, is doing well and has a stable long term personal relationship. Zoe enjoys artistic and creative pursuits, and wants to support other people.

### *Critical Incidents*

Zoe reported that her mother nearly died when she left home for college and her belief is that she (Zoe) was 'not being helpful'. Zoe also reported that she has been sexually assaulted and believes strangers want to harm her.

### *Medical*

Zoe is being prescribed strong medication for severe headaches and anti-depressants by her GP but stated that she was not a recreational drug user. She also reports joint hyper-mobility and associated pain.

### *Risk*

A risk assessment (Zahl & Hawton, 2004) was completed as Zoe had previously self harmed. The trigger for Zoe's self harm tended to be overwhelming guilt and the self harm helped Zoe regain focus. She stated that in the year prior to therapy she had experienced suicidal ideation and while under the influence of alcohol had engaged in risky behaviour. Zoe has stopped drinking and stated no current intent to kill herself as she does not believe this would solve her problems (Linehan, 1993a) though she still experiences occasional suicidal ideation. She does not want to hurt anyone else. Zoe does not feel her family would be helpful but she does have a GP she can turn to and she lives in a communal setting on a college campus where she could tell a housemate if she felt suicidal. Although I did not assess Zoe's risk as high, in line with the IAPT policy, I made sure that she was aware of local emergency services

to contact including a crisis line.

### *GAD*

Zoe presented with severe levels of anxiety and depression in assessment as shown by GAD-7 (19) (Spitzer, Kroenke, Williams & Lowe, 2006) and PHQ-9 (17) (Kroenke & Spitzer, 2002) and described social anxiety, worry and traumatic experiences using an IAPT screening tool. Zoe outlined long standing and pervasive worry about 'everything' (DSM-IV-TR, APA, 2000) and experienced typical symptoms associated with GAD: restlessness, fatigue, poor concentration, irritability, muscle tension and erratic sleep patterns.

### *Social Anxiety*

Zoe described Social Anxiety (DSM-IV-TR, APA, 2004) in that she was particularly concerned about evaluation by her peers and that these situations had induced panic attacks in the past and she endured academic evaluations with great distress and occasionally dissociation.

### *DCD?*

The GAD criteria overlap with indicators in adult checklists of DCD (Drew, 2005) e.g. restlessness (GAD) and overflow/exaggerated accessory movements (DCD); difficulty concentrating (GAD) and unfocused, messy, cluttered, erratic thought (DCD); irritability (GAD) and tendency to be easily frustrated (DCD). There were also signs in Zoe's developmental history indicating DCD (Cermak & Larkin, 2002) including problems with physical education, general clumsiness, poor organizational skills, difficulties with reading and writing despite high intellectual abilities and as Kanioglou, Tsorbatzoudis and Barkoukis (2005) noted, being pejoratively labelled by teachers. Zoe's joint pain and hyper-mobility potentially indicate DCD (Kirby & Davies, 2006).

### *Trauma*

Zoe mentioned having dreams about being attacked and we discussed the incidents where she was sexually assaulted. While her symptoms of arousal of poor sleep, irritation and difficulty concentrating met some of the criteria for Post Traumatic Stress Disorder (PTSD) (DSM-IV-TR, 2000) they did not seem to meet the full criteria for PTSD.

### *Depression*

Although Zoe's PHQ-9 score indicates severe depression and Zoe did have sad mood, sleep problems, psychomotor agitation, fatigue and suicidal ideation she was still very active and pursuing college. GAD is highly co-morbid with major depressive disorder (MDD) (DSM-IV-TR, APA, 2004) (Wittchen, Carter, Pfister, & Kessler, 2000) with GAD seen as contributing to the

development of depression rather than the reverse and as more persistent (Hettema, 2008) and Allen et al. (2010) argue that CBT may treat common underlying emotional regulation difficulties in both disorders. Taking this information into account and given Zoe's concerns, I initially judged the depressive symptoms as secondary to the main presenting problems of GAD and Social Anxiety.

#### *Difficulties in Assessment and use of Supervision*

Though I had a hypothesis about DCD, I am not qualified to diagnose or assess DCD (HPC, 2009; p13); a diagnosis of DCD generally requires multiple inputs including physical assessment of motor developmental milestones, educational attainment and parent observations (Cermak, Gubbay, & Larkin, 2002). However, I noted Zoe's developmental history and observational indicators of DCD in adults (Drew, 2005). In supervision I enquired how Zoe could be assessed for DCD and found out that this service was not available through my NHS placement. My supervisor encouraged me to discuss my concerns about DCD with Zoe and to have Zoe use her college special educational needs service to obtain an assessment. While I reflected on the ethical dilemma (BPS, 2009; p15) of my personal motivation and research interests in DCD in supervision (Lairieter & Willutzki, 2003) my clinical responsibility was to focus on the evidence based treatments for Zoe's problems. However, I did not think it would be ethical not to share information on DCD which could be further investigated and potentially support Zoe. Following the discussion with my supervisor I felt I could raise the topic of DCD with Zoe and suggest some resources that she might use to find out about DCD as a basis to discuss further assessment.

#### *Initial Formulation*

My initial tentative formulation shared with Zoe (Appendix 1) was based on our initial reflective conversation having first explained to Zoe the format of the CBT formulation. This provisional formulation was that her developmental family situation, with a mother who had a serious health problem and for whom Zoe believed she was 'useless', had contributed to vulnerability for anxiety (De Bellis et al., 2000). Additionally, we discussed that development of Zoe's social anxiety had potentially been primed by bullying as a teenager (Rapee, 1995). Her long standing peer problems and academic difficulties may have also stemmed from an undiagnosed learning difficulty (Clarkin & Kendall, 1992). Zoe's experiences of sexual assault had added to her sense of vulnerability and her persistent worry may be an emotionally avoidant strategy as Borkovec et al. (1998) suggest to suppress her distress about these events.

## **Contract and therapeutic aims**

### *Setting the direction of therapy*

In exploring Zoe's priorities for therapy and hence the direction of intervention, Kuyken et al (2009) suggest using a cross sectional formulation to determine the impact of problems. Zoe rated worry as having major impact, scoring a nine out of ten and her top priority. Her second priority which she gave 6 out of ten, were her social concerns focused on how others saw her. It seemed the most helpful way forward for Zoe was to focus treatment initially on GAD keeping in mind social anxiety and remain alert for signs of trauma while encouraging Zoe to obtain an assessment for learning difficulty. I prepared a mind map for GAD interventions (please see Appendix 2).

### *Defining the contract*

In the IAPT service provision where Zoe is a client, the initial contract is for twelve sessions of CBT which we initially discussed and agreed. There is provision to extend to a maximum of twenty sessions, seen as optimal in the NICE Guidelines for GAD (NICE, 2007) but this needs review in supervision. In defining the contract we discussed confidentiality, an outline of CBT therapy, the structured content of sessions including agenda setting, the expectation of homework and the process of feedback.

### *Goals*

Zoe's goals for therapy were discussed using a pictorial image of 'Dream Time' (Sunderland, 1993), the metaphor of 'three wishes' and goal oriented questions in line with Bennett-Levy et al (2004). Zoe's goals were operational manifestations of her presenting problems; to focus on developing only one outline for a piece of course work rather than having multiple outlines completed 'just in case', reflecting intolerance of uncertainty (Koerner & Dugas, 2008). Her second goal reflected social anxiety and potentially fusion with her internal somatic sensation of fear as reflecting threat from others (Clark & Wells, 1995). Zoe wanted to be more optimistic in her appraisal of others.

## **PART B – THE DEVELOPMENT OF THE THERAPY**

### **Phase 1 (sessions 1 – 6) - Therapeutic approach, plan and patterns in therapy**

#### *Content and Intervention*

Using my mind map of GAD models and interventions (see Appendix 2) and using Well's (1995) CBT model of worry as a psycho-educational tool, we started therapy with a focus on

worry (Leahy & Holland, 2000). We used thought records (Greenberger & Padesky, 1995) in combination with Socratic Dialogue to discuss NATs and re-frame and test evaluations that generated worry e.g. Session 5 - forgetting a birthday or Session 6 - an academic assessment (Please see Appendix 3 – Summary of sessions). Using Craske and Barlow's recommendations (2006), we reviewed real risks and catastrophizing for Level 1 worries (Wells, 1995) e.g. about a missed tutor appointment where Zoe predicted that the tutor would believe that she could not manage herself and did 'not fit in to normal society'. When we reviewed whether this was a real worry rather than a hypothetical one she was ruminating about, she realised she could act and re-arranged the appointment with no problem.

Even though worry was the main strategic direction of therapy, Social Anxiety was also part of the formulation and Session 4 was about a visit with a highly respected theatre director where Zoe had been very worried about how she would be seen. In this case, we used Clark & Well's (1995) model of Social Anxiety as a mini-formulation of the incident, identifying Zoe's pre-appraisal of the situation and self-perception that she would be seen as gauche evaluated against the fact that she ended up enjoying the interaction and how this changed her belief that she was not 'valuable'.

#### *Process Issues - Adaption of CBT practice*

Observationally in session, I noticed that Zoe was sensitive to light, it often took her a couple of times to digest what I was saying or to produce her own response, she could be distracted, felt nauseous, fidgeted and was sometimes late. These characteristics are potentially linked to her anxiety and/or hypothesised DCD. To cope with this in session a theme that developed was that we spent a few minutes of mindfulness which Zoe found helped her focus (Williams, Teasedale, Segal, & Kabat-Zinn, 2007) and we developed pleasant 'oasis' imagery (Rothschild, 2000) for somatic and emotional dysregulation. I also semi-closed the blinds or only had one fluorescent tube on. Zoe appreciated these compensatory considerations (Drew, 2005) which Hardy, Cahill and Barkham, (2007) discuss show empathy and develops the therapeutic alliance.

As Zoe had communicated problems with writing, I decided to do the writing in sessions. Handwriting is a complex skill involving visual perception, tactile discrimination, kinaesthesia/proprioception and visual motor integration (Cermak, Gubbay, & Larkin, 2002) and in children with DCD can be a laborious task. The choice to write for Zoe is generally contrary to practice in CBT where mastery is encouraged (Greenberger & Padesky, 1995) and is not my usual practice. I hoped in Zoe's case, to free up time and energy to focus on cognitive processing through Socratic dialogue. An alternative would have been to extend

session times and perhaps this is where my own subjugation schema to take care of others came into play (Young & Klosko, 1994) in the therapeutic alliance. Leahy (2008) warns that therapist self sacrifice may maintain a lack of self efficacy in the client but Liotti (2007) suggests an attachment-caregiving relationship in the therapeutic alliance need not be detrimental and can potentially correct a former relationship schema, particularly relevant to Zoe's main caregiving relationship with her mother. Klein, Schwartz, Santiago, Vivian, Vocisano, Castonquay et al. (2003) demonstrate that early establishment of the therapeutic alliance is predictive of client change in CBT and showing care for Zoe could be potentially helpful to the outcome of therapy.

### **Phase 1 - Difficulties in the work and supervision**

#### *DCD?*

Bearing in mind the DCD hypothesis, I did allow time for Zoe's lateness as time management and transition can be problematic (Drew, 2005) and paced the sessions to enable her to find words. I made an extra effort to contact Zoe when she missed a session in case she had forgotten. My supervisor gave me leeway to be flexible with Zoe because I am a Trainee, which potentially enhanced my power in the therapeutic relationship as Proctor (2009) contends. Other indicators of DCD emerged, including that Zoe had developed handedness late, frequently gets lost, and blurts out inappropriate remarks (Portwood, 2011). Zoe had used some of the information I provided to find out about DCD and identified with many of the indicators. I encouraged her to obtain an assessment for Special Learning Difficulties (SpLD) at her college which she arranged.

#### *Homework*

While Zoe did her homework, she did not always bring a product as Shelton & Ackerman suggest (1974) often because she had forgotten it. I am paying attention to homework in my CBT practice (Trepka, Rees, Shapiro, Hardy, & Barkham, 2004) as Burns & Spangler (2000) found it improved outcome particularly review of the previous session's homework (Bryant, Simons & Thase, 1999). Zoe knows that we always review homework at the start of the session and we have discussed its importance. However, I struggle, as Tompkins (2003) suggests, with homework in Zoe's case between balancing the needs of Zoe's potential learning difficulty and reinforcing the notion that homework is not important. Proctor (2008) particularly targets homework as a power dynamic in CBT which signifies 'compliance' and not collaboration which raises the notion of 'historical' powerlessness for me in dealing with DCD in 'societal' systems' and I am conscious of not disempowering Zoe.

## **Phase 1 - Brief summary client progress and outcome**

Zoe utilises mindfulness well in session and she has responded intellectually to thought records but reports not feeling an affective change. She has been able to evaluate real risks and challenge catastrophizing and instead take problem solving actions (Craske & Barlow, 2006). By the end of phase 1, Zoe's anxiety reduced slightly i.e. her GAD-7 score was 15 but her depression score had changed less i.e. her PHQ-9 score was 15.

### *Pause in therapy*

Zoe obtained a summer job in Ireland which meant a break in therapy from Session 6 for eight weeks. I requested in supervision that I continue to see Zoe on her return and again my supervisor was supportive and I was given this flexibility as a Trainee. The break in therapy could have been, as Leahy (2008) suggested, potential self sabotage on Zoe's part to discontinue therapy. However, I followed up to remind her on her return because I recognise that young people with DCD often do not seek or utilise help (Kirby, Sugden, & Edwards, 2011). Zoe did return to therapy.

## **Therapy Phase 2 – Sessions 7 – 15**

### **Phase 2 - Changes in the formulation and the therapeutic plan**

On Zoe's return she reported that DCD had been confirmed in a SpLD assessment (DfES, 2005) at college. This report indicated slow memory processing, problems with timelines, vision difficulties, and poor spatial awareness, left/right confusion, poor sequencing, poor symbol and digit memory, slow reading ability, poor copy writing and motor skill and joint problems. Zoe also had excellent oral, comprehension and practical/creative abilities. In terms of how we continued with therapy this information was supportive of my strategies to be structured yet flexible, to minimise writing, be very patient and accepting of Zoe's struggle to find words and to repeat myself often. The SpLD report also directed future interventions to use visual or practical means. While Zoe was 'relieved' at the outcome of DCD, I monitored her reactions for signs of loss (Worden, 2010) in case she had difficulty accepting the implications of the assessment.

The formulation was updated with DCD and other relevant information using Beck's diagram (2005) (please see Appendix, 4 – revised formulation). We could now explain many of Zoe's situations when she forgot deadlines, could only do academic tasks with exceptional effort and was worried about academic evaluation. Although we had hypothesised that Zoe's

mother's illness had contributed to Zoe's vulnerability to GAD, we could also add other information from Phase 2; that Zoe's mother had been highly demanding of Zoe academically, demeaning to her publically and blamed her for risks associated with her illness, leading Zoe to feel responsible yet helpless for her mother's health. Additionally, we could add that the bullying that Zoe had suffered as a teenager had been protracted and that those in authority had not supported Zoe and subsequently she felt helpless. Even though I had kept aware for signs of trauma about the sexual assault, this had not materialised.

## **Phase 2 - Content, Intervention and Process**

While we continued to work on GAD and elements of worry in the second phase of therapy an underpinning theme in Zoe's worries was her evaluation by others which matched the focus on Social Anxiety. Key interventions which seemed to have a significant impact were the emphasis on Level 2 worry or meta-beliefs (Wells, 1995) and the emotional processing of childhood and adolescent memory through the use of imagery (Hirsch, Hayes, Mathews, Perman, & Borkovec, 2011; Hackmann, Clark, & McManus (2000). The following vignettes illustrate:

### *Meta Beliefs and Fusion – the penny drops*

In session 8, using Well's (1995) model of GAD, we used the metaphor of a funfair game where the 'critter' keeps popping up and needs to be hammered down to illustrate how Level 1 worries can keep coming back (Craske & Barlow, 2006) to provide the rationale of the need to understand the underlying process of worry. Well's (1997) meta-worry questions evoked a positive worry belief that 'if you don't think about the bad things you might not be ready', including that someone might die. I checked 'how would that work' and asked 'if someone worried about not catching a cold then would this would prevent them being infected?' which Zoe reflected was 'not realistic'. This raised doubt about her superstitious beliefs that she could prevent 'bad things' by worrying about them. In a similar vein, repeating 'what if' questions (Wells, 1997) to simulate Zoe's process of verbal rationalising about her grades (Borkovec, 1994) illustrated what happens with this type of rumination e.g. what if you fail, what if you drop out, what if you always have to worry, what if it dominates your life. Zoe could see how this line of thought made her 'really stressed' in situ. In response she tried to 'dismiss' her anxious thinking which provided an opportunity to do a thought suppression exercise (Wegner et al, 1987). I asked Zoe not to think of a pink elephant for a couple of minutes and she realised that 'I can't stop thinking about it'. At this point she acknowledged that these were insights that she had never had before and seemed quite

intrigued. I was also pleased to communicate meta-worry with confidence because it has been an area I have found hard to explain.

### *Verbal to Imagery – emotional processing*

#### *Sessions 11 and 14*

As Hirsch et al. argue (2011) worry is predominantly a verbal strategy and individuals with GAD have a tendency to truncate imagery increasing intrusive worry rather than preventing it. They propose using extended imagery work with GAD clients to help them adopt imagery to reduce negative intrusions. In session 11, in reviewing Zoe's homework, a memory came up and she started to cry. As Zoe had fed back previously that she intellectually understood what we were doing but still could not feel it emotionally, I thought this was a good opportunity to process emotional material through imagery (Hackmann et al, 2000). As Leahy (2003) suggests emotional processing targets 'hot' cognitions and can assist in tapping into and changing the dysfunctional beliefs underpinning them. I weighed up whether or not to proceed with reliving and while in the past my own anxiety at conducting re-living or imagery work may have made me think twice about doing it, now my consideration was only about Zoe, demonstrating that my confidence has improved as a therapist. Perhaps though, as Proctor criticises (2008), this was an example of my power over Zoe and was not collaborative and an alternative would have been to sit in silence with Zoe's emotion. Rather than power, this need to intervene may also indicate my responsibility schema though I have been working on this issue in personal therapy and I am aware of it. I did ask Zoe if she wanted to talk about the memory in a reliving process for today's agenda though potentially underestimating her capability to say no to me in my therapist role (Proctor, 2008). I carefully explained the rationale for bringing the memory into awareness to fully explore it for missing information and to set it into a current context as Hackmann, Bennett-Levy and Holmes (2011) suggest. I checked that Zoe was comfortable to proceed, that we had the time and also made sure that she was able to look after herself following the session. Having previously worked with Zoe on an 'oasis' image, I reminded her of this as a way to tolerate distress (Rothschild, 2000).

During the reliving, I was particularly patient and prompted Zoe gently but steadily, took my time and was aware of how quietly and slowly Zoe was speaking. Zoe described a scene; a loud and aggressive public haranguing of Zoe as a teenager by her mother at a school sports event with most of Zoe's peers and teachers watching and a palpable sense of Zoe's confusion and shame and silent plea for it to stop. On further enquiry, this memory led seamlessly into an earlier childhood memory where a surprise outing to the circus that Zoe excitedly anticipated turned into an ugly family argument and was abandoned leaving Zoe feeling responsible. It transpired too that Zoe's father had excused her mother's behaviour

on these occasions, as on many others, on the basis of her health and promises that it would not happen again were always broken. When Zoe could identify a feeling of safety we stopped the reliving process.

We then moved on, using the white board to develop differences in Zoe's situation between the memories and her current situation in a 'then' and 'now' process (Hackmann et al., 2011). Although on reflection I feel the transition between the reliving and review seemed too fast and perhaps I could have left it for a later session, I did not want Zoe to leave without updating the image, an issue I have previously discussed in supervision. Zoe reported feeling calmer and we used the information gleaned to challenge Zoe's interpretation that her mother's behaviour was her responsibility. This enabled Zoe to do a responsibility pie as homework where she could clearly see her influence on her mother's behaviour was minimal.

In session 14, we used a similar re-living imagery process about a traumatic memory of school bullying which as Hackmann et al. (2000) contend contributes to the development of social anxiety. Zoe reported an image that still had a significant impact on her in current social situations but she was experiencing more as a 'felt sense' (Hackmann et al., 2000). In reviewing this reliving we used manipulation of the image to demonstrate that there was no longer a threat by changing the bullies into toads and the teacher into a crow which took away some of the power of the image for Zoe (Hackmann et al., 2011).

## **Phase 2 - Difficulties in the work and supervision**

### *Homework feedback from Zoe*

At the beginning of every therapy session we have a feedback section where both Zoe and I, use Kolb's (1984) experiential learning process for review. In Session 13, Zoe explained that the continuum work we had used the week before had been very confusing for her because it was very abstract which provoked a 'debate' in her head and only when we illustrated it with real people did it become more understandable. While this may reflect poor explanatory skills on my part, it could also reflect communication difficulties identified in students with DCD (Drew, 2005) where tangential thinking can be a functional problem. This was a key learning point for me to find appropriate techniques to suit Zoe and also suggests that the therapeutic alliance was collaborative as Zoe felt she had the power to tell me this. Proctor (2008) challenges the collaborative nature of the alliance in CBT suggesting that CBT therapists have a power 'over' clients based on spurious scientific claims, telling their clients what is best for them and ultimately abdicating responsibility to the client if therapy does not work. Relative to Zoe's feedback, I hope I am behaving more like Schon's (1991) reflective

practitioner in which the situation 'talks back' and new meaning can be used to transform theory and practice.

### *Supervision*

Although the therapeutic contract had originally been for twelve sessions, I requested in supervision that we extend the sessions to twenty because Zoe was experiencing difficulties in coming off her medication, a long term goal. I reported my concerns about the medication and explained with Zoe's approval that I had contacted her GP. I also judged that the break in therapy and the contribution of Zoe's DCD meant there was still work to be done. I knew that while my abiding concern was with Zoe as a client, extending work with her also contributed to my professional gain. However, I justified to myself, and to my supervisor, that continuation of the work with Zoe could benefit other clients with similar problems. My supervisor encouraged me to ensure that I find ways to feedback my learning and to find resources to support clients with DCD for the IAPT service.

### **Phase 2 - Brief summary client progress and outcome**

In the second phase of therapy, Zoe engaged in more emotional processing, accessing hot cognitions (Leahy, 2003) through reliving of childhood and adolescent memories (Hackmann et al, 2000) and challenging core beliefs about responsibility and helplessness. Zoe also developed insight about her worry beliefs which enabled her to question her strategy of worry and change it. Her anxiety score measure on the GAD-7 by session 15 was 8 and her PHQ-9 score for depression was 13. So although her anxiety has improved, the low mood is more persistent. We discussed what might be happening and Zoe could not think of anything except coming off her medication. Alternatively, as Borkovec et al. (1998) suggest worry may have been a strategy to deal with other emotionally distressing material and now that the worry was subsiding, the other material was more available. However, Zoe was indicating a shift in that she was beginning to quite like her non-conformist and creative attributes and seeing shades of herself rather than the black and white thinking of being 'strange'.

## **PART C – THE CONCLUSION OF THE THERAPY AND THE REVIEW**

### **The therapeutic ending and follow up**

In planning ahead with Zoe over the remaining sessions, I believe a strategy which incorporates practical, learning and psychological needs is required and this will involve some problem solving with Zoe. Another issue that I believe is important is that Zoe obtains

an Occupational Therapy Assessment targeted at day to day living and sensory integration (Kirby et al , 2011) and I am making enquires about how this can be set up for Zoe. Zoe and I have already discussed some additional assistance the college could provide but the administrative processes to put resources in place are quite challenging for Zoe and just talking them through with her seems to help her get organized. Again I am conscious of balancing the needs of an adult client with being over helpful and not encouraging self efficacy.

### **Evaluation of the work**

In terms of the therapeutic work we have done together, I believe that Zoe has made significant progress in reducing her level of worry through our focus on GAD and has made some progress on Social Anxiety particularly developing a more nuanced and positive view of herself. Zoe has now successfully come off her medication with fewer somatic symptoms however, I think the Social Anxiety is quite entrenched (Rapee, 1995) and perhaps I could have used other interventions to tackle this issue e.g. video work (Hackmann et al., 2011) or more role play. We have done some assertiveness role play and I think assertiveness training would be helpful for Zoe. Another area that has always been in the background is the potential trauma related to the sexual assault and very recently this came up in a session but my concern was that it is perhaps too late in therapy to work on this but my supervisor suggested asking Zoe more directly what is keeping the trauma alive and working out how it is being maintained. Once therapy is completed in IAPT, Zoe has access to a college counselling service and I have encouraged her to go there if she needs further assistance or to self- refer back to IAPT.

### **Learning from the case – theory, practice and the self**

#### *CBT and DCD*

#### *Evidence base and theory development*

In working with Zoe, I have been using evidenced based models of CBT for GAD and Social Phobia though with no evidence base for individuals with DCD. As Proctor (2008) contends, CBT could be considered as imbued with power based on rationality and objective scientific evidence to the detriment of the power of the client which is part of a psychological 'normalizing' process where the therapist has significant power. To an extent I agree with Proctor that the prevailing CBT evidence base is heavily focused on the positivist quantitative paradigm as is the DCD research arena (Geuze, 2001). However, there is no evidence base for CBT with DCD and I have been adapting my practice based on academic and personal knowledge of DCD as well as reflecting in action (Schon, 1991) with Zoe's feedback. I would

argue that CBT can impact the development of theory and practice by reference to case studies like Zoe's and Karp and Dugas (2003) which allows for an alternative method in CBT to that put forward by Proctor (2008). For example, a question that has arisen from my experience of working with Zoe is 'Does the functional thinking processes (problems in abstract thinking) in DCD make CBT a more stressful therapy?'

A fundamental problem which occurred in Zoe's case related to the assessment and classification of GAD, Social Phobia and DCD with overlap of 'symptoms', as Marzillier (2004) points out. Though the CBT models utilized with Zoe, targeted specific problems, I did my best to integrate the two main presenting problems of GAD and Social Phobia into treatment and to accommodate DCD. However, I am left thinking that in the treatment of DCD, a cross functional approach with input from occupational therapy and learning and teaching is necessary for an adult client newly assessed with DCD to address physical and learning difficulties as well as psychological interventions. In terms of the psychological treatment, although Allen et al. (2010) indicate a common base for anxiety and depression, it is interesting to note in Zoe's case that her anxiety levels improved more than her low mood. Also on a fundamental level, Zoe has particular creative strengths and interests and therapy that plays to these such as Art or Drama therapy may be better alternatives for Zoe. However, I don't necessarily agree with Proctor (2002) that Person Centred Therapy (PCT) (Rogers, 1967) would develop more 'power within' for a client like Zoe than CBT for a couple of reasons: CBT offers structure and organization which for Zoe was helpful (Drew, 2005) and she struggled with finding words and abstraction which may make unstructured reflection as in PCT more difficult for her; secondly, by Proctor's (2002) own account, PCT like CBT can fail to take account of socially structured oppression which is particularly relevant for a client like Zoe.

I do agree with Proctor (2008) that, particularly in my role as a Trainee, I had considerable flexibility or 'role' power in Zoe's case and because of this was able to circumvent some of the IAPT system boundaries. However, this does raise questions about how to accommodate clients with DCD within the highly time bound and measurement focused system of IAPT without creating the structural 'system' power Proctor is concerned about. In Zoe's case that structural power is reflected in the fact that there is not an assessment process in my IAPT placement for learning difficulties so potentially, the learning difficulty is not accommodated in CBT practice as Drew fears (2005), and a normalising process (Proctor, 2008) is expected of clients with functional difficulties.

In terms of CBT theory, evidence and practice, homework is a critical feature and one as a CBT therapist I have been working to improve in line with Cognitive Therapy Scales (CTS)

(Trepka et al, 2004). Insistence on a client bringing a homework 'product' (Shelton & Ackerman, 1974) and in CBT, often a written product, is potentially more anxiety provoking for a client like Zoe. This challenged me to think more creatively about homework e.g. use of drawing and technology and to accept that verbal report can be preferential and empowering for a client like Zoe. On the issue of technology, boundaries in my IAPT placement on e-mail and allowing clients to take tapes home, potentially really useful for memory difficulties, mitigate against these options. Also being aware of Proctor's (2008) point about 'doing to the client' as negating their choice is a danger in CBT with reliance on techniques and perhaps provides a false sense of security for the therapist, so for example, in Zoe's case, I felt my confidence in using reliving and imagery improve but I needed to weigh that up with what was best for Zoe. I don't think there is an easy answer except to say, I did 'show my working' with Zoe to help us decide the best way forward and to remain aware not to be seduced by techniques.

Although Proctor (2008) focuses on the CBT therapist's power 'over' the client, I would argue that her view is rather one dimensional and fails to acknowledge fully her own point on the client and therapist personal history and its' impact on the therapeutic relationship. In my own case, I am not only a CBT therapist but have personal experience and knowledge of DCD and bring myself to therapy. While the danger of this is that I bring my own 'powerlessness' history to the client relationship, it also means I bring an awareness and empathy for Zoe's situation. Proctor (2008) argues that self awareness in supervision is not part of the CBT model and while Laireiter & Willutzki (2003) agree that self exploration is in its infancy in CBT, they do offer theoretical and practical aspects of self-reflection in CBT including in supervision. Throughout working with Zoe, I have paid attention in supervision to monitoring my motivation and communicating my personal history of DCD so that my prime concern has been with Zoe and that my personal schema of being over protective doesn't become intrusive to the therapy or block helpful therapeutic interventions.

## PART D – REFERENCES AND APPENDICES

### REFERENCES

- Allen, L. B., White, K. S., Barlow, D. H., Shear, M. K., Gorman, J. M., & Woods, S. W. (2010). Cognitive-behavior therapy (CBT) for panic disorder: Relationship of anxiety and depression comorbidity with treatment outcome. *Journal of Psychopathology and Behavioral Assessment, 32*(2), 185-192.
- American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders*. (4<sup>th</sup> ed., text revision). Washington, DC: American Psychiatric Association.
- Bandura, A. (1997). *Self-efficacy: The exercise of Control*. New York: W.H. Freeman and Company.
- Beck, J. S. (2005). *Cognitive therapy for challenging problems: What to do when the basics don't work*. New York, NY US: Guilford Press.
- Beck, A. T. (1963). Thinking and depression: I. idiosyncratic content and cognitive distortions. *Archives of General Psychiatry, 9*(4), 324-333.
- Bennett-Levy, J., Butler, G., Fennell, M., Hackmann, A., Mueller, M., & Westbrook, D. (2004). *Oxford guide to behavioural experiments in cognitive therapy*. Oxford: Oxford University Press.
- Borkovec, T. D. (1994). The nature, functions, and origins of worry. In F. Tallis (Ed.), *Worrying: Perspectives on theory, assessment and treatment* (pp. 5-33). Oxford England: John Wiley & Sons.
- Borkovec, T. D., Ray, W. J., & Stöber, J. (1998). Worry: A cognitive phenomenon intimately linked to affective, physiological, and interpersonal behavioral processes. *Cognitive Therapy and Research, 22*(6), 561-576.
- British Psychological Society. (2009). *Code of ethics and conduct: Guidance published by the ethics committee of the British psychological Society*. Leicester: BPS.
- Bryant, M. J., Simons, A. D., & Thase, M. E. (1999). Therapist skill and patient variables in homework compliance: Controlling an uncontrolled variable in cognitive therapy outcome research. *Cognitive Therapy and Research, 23*(4), 381-399.

- Burns, D. D., & Spangler, D. L. (2000). Does psychotherapy homework lead to improvements in depression in cognitive-behavioral therapy or does improvement lead to increased homework compliance? *Journal of Consulting and Clinical Psychology, 68*(1), 46-56.
- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavioral therapy: A review of meta-analyses. *Clinical Psychology Review, 26*(1), 17-31.
- Butler, G., Fennell, M., Robson, P., & Gelder, M. (1991). Comparison of behavior therapy and cognitive behavior therapy in the treatment of generalized anxiety disorder. *Journal of Consulting and Clinical Psychology, 59*(1), 167-175.
- Cermak, S.A., Gubbay, S.S. & Larkin, D. (2002). What is Developmental Coordination Disorder? In Cermak, S.A. & Larkin, D. (Eds.), *Developmental Coordination Disorder* (pp. 2-22). New York: Delmar .
- Clark, D. A. & Beck, A. T. (2010). *Cognitive therapy of anxiety disorders: Science and practice*. New York: The Guildford Press.
- Clark, D. M. & Wells, A. (1995). A cognitive model of social phobia. In R.Heimberg, M. Liebowitz, D. A. Hope & F. R. Schneier (Eds.), *Social Phobia: Diagnosis, Assessment and Treatment*. New York: Guildford Press.
- Clark, D. M., Ehlers, A., McManus, F., Hackmann, A. Fennell, M., Campbell, H., Flower, T., Davenport, C., & Louis, B. (2003). Cognitive therapy versus fluoxetine in a generalized social phobia: a randomized placebo-controlled trial. *Journal of Consulting & Clinical Psychology, 71*(6), 1058 – 1067.
- Clark, D. A., Beck, A. T., & Alford, B. A. (1999). *Scientific foundations of cognitive theory and therapy of depression*. Hoboken, NJ US: John Wiley & Sons Inc.
- Clarkin, J. F., & Kendall, P. C. (1992). Comorbidity and treatment planning: Summary and future directions. *Journal of Consulting and Clinical Psychology, 60*(6), 904-908.
- Craske, M., G. & Barlow, D., H. (2006). *Mastery of your anxiety and worry*. (2<sup>nd</sup> ed.). New York: Oxford University Press.
- De Bellis, M. D., Casey, B. J., Dahl, R. E., Birmaher, B., Williamson, D. E., Thomas, K. M., et al. (2000). A pilot study of amygdala volumes in pediatric generalized anxiety disorder. *Biological Psychiatry, 48*(1), 51-57.

- Dewey, D., Kaplan, B.J., Crawford, S.G., & Wilson, B.N. (2002). Developmental coordination disorder: Associated problems in attention, learning and psychosocial adjustment. *Human Movement Science, 21* (5-6), 905-918.
- Drew, S. (2005). *Developmental coordination disorder in adults*. Chichester: Whurr Publishers
- Ehlers, A., & Clark, D. M. (2000). A cognitive model of posttraumatic stress disorder. *Behaviour Research and Therapy, 38*(4), 319-345.
- Geuze, R.H., Jongmans, M.J., Schoemaker, M.M., & Smits-Engelsman, B.C.M. (2001). Clinical and research diagnostic criteria for developmental coordination disorder: a review and discussion. *Human Movement Science, 20*, 7-47.
- Gumley, D. (2005). *Behaviour and social functioning in children with developmental coordination disorder*. Unpublished doctoral thesis, City University, London, United Kingdom.
- Greenberger, D. & Padesky, C.A. (1995). *Mind over mood: Change the way you feel by changing the way you think*. New York: The Guildford Press.
- Hackmann, a., Bennett-Levy, J. & Holmes, E. A. (2011). *Oxford guide to imagery in cognitive therapy*. Oxford University Press: Oxford.
- Hackmann, A., Clark, D. M., & McManus, F. (2000). Recurrent images and early memories in social phobia. *Behaviour Research and Therapy, 38*(6), 601-610.
- Hardy, G., Cahill, J., & Barkham, M. (2007). Active ingredients of the therapeutic relationship that promote client change: A research perspective. In P. Gilbert, R. L. Leahy, P. Gilbert & R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies* (pp. 24-42). New York, NY US: Routledge/Taylor & Francis Group.
- Health Professions Council. (2009). *Standards of proficiency: Practitioner psychologists*. London: HPC.
- Hesslinger, B., van Elst, L. T., Nyberg, E., Dykieriek, P., Richter, H., Berner, M., et al. (2002). Psychotherapy of attention deficit hyperactivity disorder in adults: A pilot study using a structured skills training program. *European Archives of Psychiatry and Clinical Neuroscience, 252*(4), 177-184.

- Hettema, J. M. (2008). The nosologic relationship between generalized anxiety disorder and major depression. *Depression and Anxiety*, 25(4), 300-316.
- Hill, E., & Barnett, A. (2011). Movement difficulties in children. *The Psychologist*, 24(1), 34-37.
- Hirsch, C. R., Hayes, S., Mathews, A., Perman, G., & Borkovec, T. (2011). The extent and nature of imagery during worry and positive thinking in generalized anxiety disorder. *Journal of Abnormal Psychology*,
- Kanioglou, K., Tsorbatzoudis, H., & Barkoukis, V. (2005). Socialization and behavioural problems of elementary school pupils with developmental coordination disorder. *Perceptual and Motor Skills*, 101, 163-173.
- Karp, J. & Dugas, M. J. (2003). Stuck behind a wall of fear: how cognitive-behaviour therapy helped one woman with Social Phobia. *Clinical Case Studies*, 2(3), 171-187.
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, 62(6), 593-602.
- Kirby, A., Edwards, L., & Sugden, D. (2011). Emerging adulthood in developmental coordination disorder: Parent and young adult perspectives. *Research in Developmental Disabilities*, 32(4), 1351-1360.
- Kirby, A. & Davies, R. (2006). Developmental coordination disorder and joint hypermobility syndrome – overlapping disorders? Implications for research and clinical practice. *Child: care health and development* 32(5), 513-519.
- Klein, D. N., Schwartz, J. E., Santiago, N. J., Vivian, D., Vocisano, C., Castonguay, L. G., et al. (2003). Therapeutic alliance in depression treatment: Controlling for prior change and patient characteristics. *Journal of Consulting and Clinical Psychology*, 71(6), 997-1006.
- Knapp, P., & Beck, A. T. (2008). Cognitive therapy: Foundations, conceptual models, applications and research. *Revista Brasileira De Psiquiatria*, 30, S54-S64.
- Koerner, N., & Dugas, M. J. (2008). An investigation of appraisals in individuals vulnerable to excessive worry: The role of intolerance of uncertainty. *Cognitive Therapy and Research*, 32(5), 619-638.

- Kroenke, K., & Spitzer, R. L. (2002). The PHQ-9: A new depression diagnostic and severity measure. *Psychiatric Annals*, 32(9), 509-515.
- Kolb, D. A. (1984). *Experiential learning: experience as the source of learning and development*. Englewood Cliffs, New Jersey: Prentice-Hall.
- Kuyken, W., Padesky, C.A., & Dudley, R. (2009). *Collaborative case conceptualisation: Working effectively with clients in cognitive-behavioural therapy*. London: The Guildford Press.
- Leahy, R. L. (2003). Emotional schemas and resistance. In R. L. Leahy, & R. L. Leahy (Eds.), *Roadblocks in cognitive-behavioral therapy: Transforming challenges into opportunities for change* (pp. 91-115). New York, NY US: Guilford Press.
- Laireiter, A., & Willutzki, U. (2003). Self-reflection and self-practice in training of cognitive behaviour therapy: An overview. *Clinical Psychology & Psychotherapy*, 10(1), 19-30.
- Leahy, R. L. (2008). The therapeutic relationship in cognitive-behavioral therapy. *Behavioural and Cognitive Psychotherapy*, 36(6), 769-777.
- Leahy, R. & Holland, S.J. (2000). *Treatment plans and interventions for depression and anxiety*. New York: The Guildford Press.
- Linehan, M.M. (1993a). *Cognitive-behavioral treatment of borderline personality disorder*. Guilford Press.
- Liotti, G. (2007). Internal working models of attachment in the therapeutic relationship. In P. Gilbert, R. L. Leahy, P. Gilbert, & R. L. Leahy (Eds.), *The therapeutic relationship in the cognitive behavioral psychotherapies*. (pp. 143-161). New York, NY US: Routledge/Taylor & Francis Group.
- Marzillier, J. (2004). The myth of evidence-based psychotherapy. *The Psychologist*, 17(7), 392-395.
- Miller, L. T., Polatajko, H. J., Missiuna, C., Mandich, A. D., & Macnab, J. J. (2001). A pilot trial of a cognitive treatment for children with developmental coordination disorder. *Human Movement Science*, 20(1-2), 183-210.
- National Institute for Health and Clinical Excellence. (2007). *Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder)*

*in adults in primary, secondary and community care.* London: NICE.

Pine, D. S., Cohen, P., Gurley, D., Brook, J., & Ma, Y. (1998). The risk for early-adulthood anxiety and depressive disorders in adolescents with anxiety and depressive disorders. *Archives of General Psychiatry*, 55(1), 56-64.

Portwood, M. (2011). *Dyspraxia, dyslexia, Autism Spectrum Disorders, ADHD: Identification and intervention.* Dyspraxia Foundation

Proctor, G. (2008). CBT: The obscuring of power in the name of science. In R. House, D. Loewenthal, R. House & D. Loewenthal (Eds.), *Against and for CBT: Towards a constructive dialogue?* (pp. 241-255). Ross-on-Wye England: PCCS Books.

Proctor, G. (2002). *The dynamics of power in counselling and psychotherapy: ethics, politics and practice.* Ross-on-Wye: PCCS Books.

Rapee, R. M. (1995). Descriptive psychopathology of social phobia. In F. R. Schneier (Ed.), *Social phobia: Diagnosis, assessment, and treatment* (pp. 41-66). New York, NY US: Guilford Press.

Rasmussen, P. & Gillberg, C. (2000). Natural outcome of ADHD with developmental coordination disorder at age 22 years: A controlled, longitudinal community based study. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(11), 1424-1431.

Revie, G. & Larkin, D. (1993). Task-specific intervention with children reduces movement problems. *Adapted Physical Activity Quarterly*, 10, 29-41.

Rogers, C. R. (1967). *On becoming a person: A therapist's view of psychotherapy.* London: Constable.

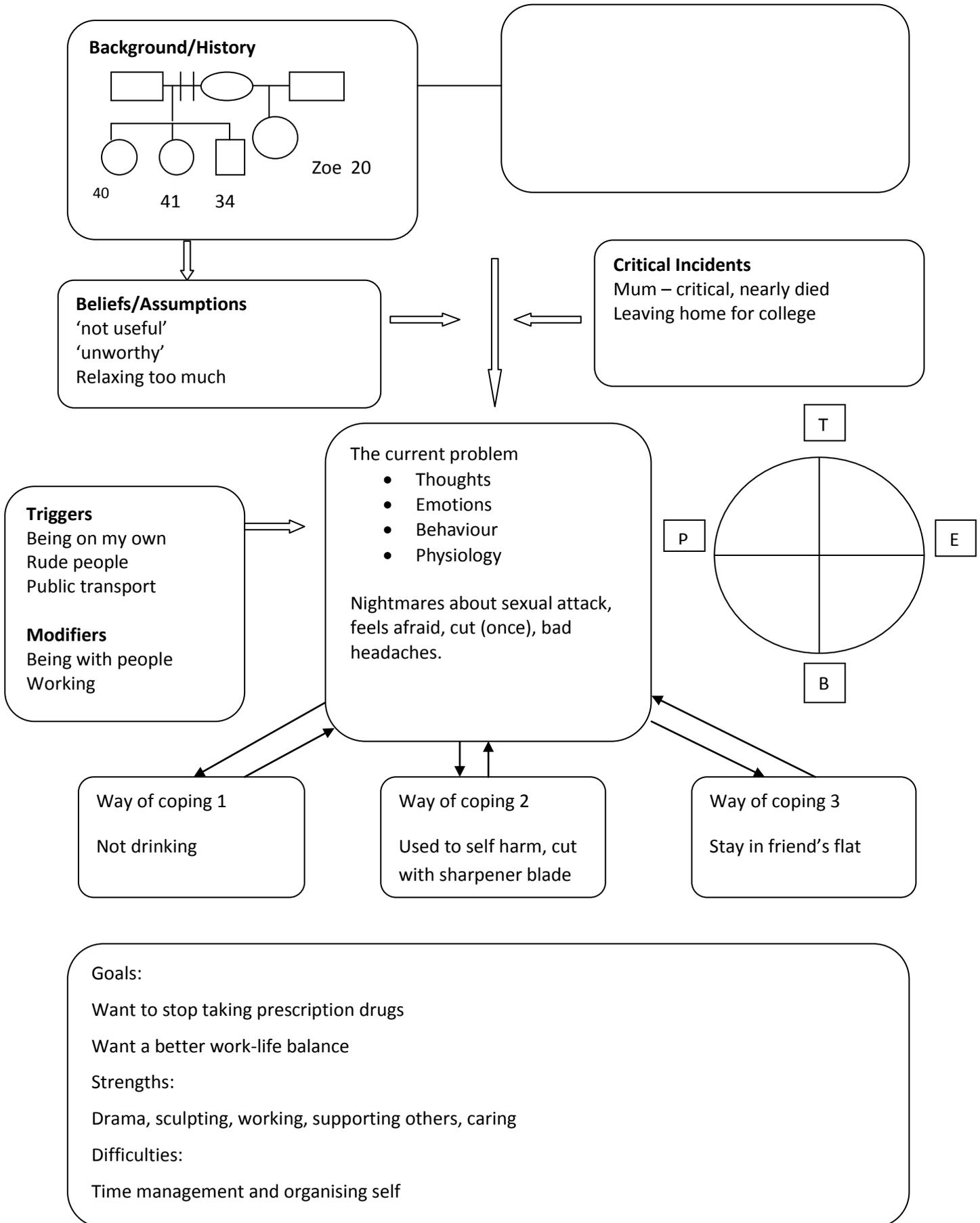
Rothschild, B. (2000). *The body remembers: The psychophysiology of trauma and trauma treatment.* New York: W. W. Norton & Co. Inc.

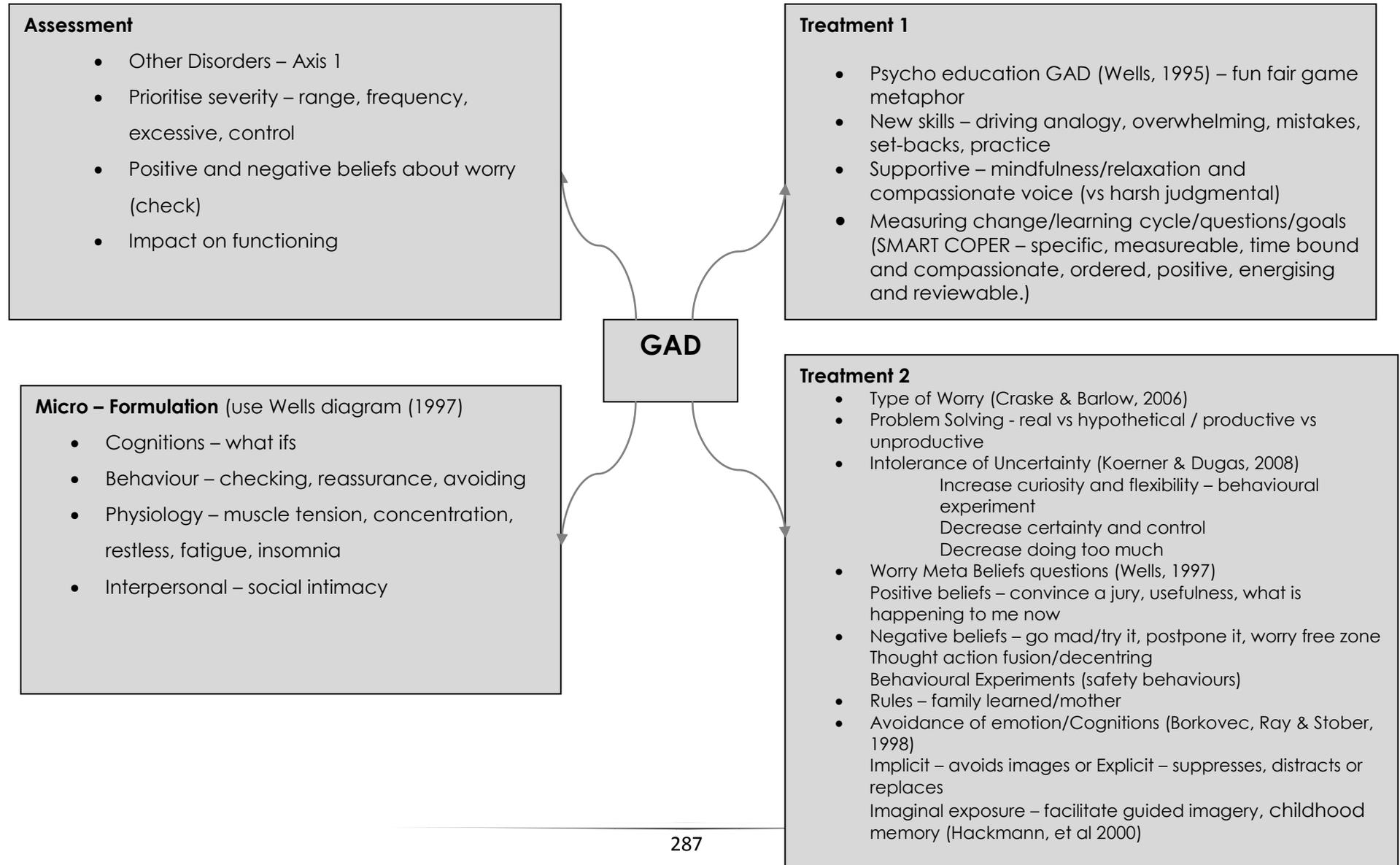
Ruscio, A. M., Brown, T. A., Chiu, W. T., Sareen, J., Stein, M. B., & Kessler, R. C. (2008). Social fears and social phobia in the USA: Results from the national comorbidity survey replication. *Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences*, 38(1), 15-28.

- Safran, J. D., Segal, Z. V., Vallis, T. M., & Shaw, B. F. (1993). Assessing patient suitability for short-term cognitive therapy with an interpersonal focus. *Cognitive Therapy and Research*, 17(1), 23-38.
- Schoemaker, M.M. & Kalverboer, A.F. (1994). Social and affective problems of children who are clumsy: How early do they begin? *Adapted Physical Activity Quarterly* 11(2), 130-140.
- Schon, D. A. (1991). *The reflective practitioner: how professionals think in action*. London: Ashgate.
- Shelton, J. L., & Ackerman, J. (1974). *Homework in counseling and psychotherapy: Examples of systematic assignments for therapeutic use by mental health professionals*. Oxford England: Charles C Thomas.
- Sunderland, M. (1993). *Draw on your emotions*. Milton Keynes: Speechmark Publishing
- Spitzer, R. L., Kroenke, K., Williams, J. B., & Lowe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, 166(10), 1092-1097.
- SpLD working Group (2005). *DfES Guidelines*. London: DfES.
- Tompkins, M. A. (2003). Effective homework. In R. L. Leahy, & R. L. Leahy (Eds.), *Roadblocks in cognitive-behavioral therapy: Transforming challenges into opportunities for change* (pp. 49-66). New York, NY US: Guilford Press.
- Trepka, C., Rees, A., Shapiro, D. A., Hardy, G. E., & Barkham, M. (2004). Therapist competence and outcome of cognitive therapy for depression. *Cognitive Therapy and Research*, 28(2), 143-157.
- Watson, S. (2010). *CBT for GAD*. University College London.
- Wegner, D. M., Schneider, D. J., Carter, S. R., & White, T. L. (1987). Paradoxical effects of thought suppression. *Journal of Personality and Social Psychology*, 53(1), 5-13.
- Weiss, J. A., & Lunsky, Y. (2010). Group cognitive behaviour therapy for adults with asperger syndrome and anxiety or mood disorder: A case series. *Clinical Psychology & Psychotherapy*, 17(5), 438-446.

- Wells, A. (1995). Meta-cognition and worry: a cognitive model of generalised anxiety disorder. *Behaviour and Cognitive Psychotherapy*, 23(3), 301-320.
- Wells, A. (1997). *Cognitive therapy of anxiety disorders: a practice manual and conceptual guide*. Chichester: John Wiley.
- Williams, M., Teasdale, J., Segal, Z., & Kabat-Zinn, J. (2007). *The mindful way through depression: Freeing yourself from chronic unhappiness*. New York: Guildford Press.
- Wilson, P.H., (2005). Practitioner review: Approaches to assessment and treatment of children with DCD: an evaluative review. *Journal of Child Psychology and Psychiatry* 46(8), 806-823.
- Wittchen, H., Carter, R. M., Pfister, H., Montgomery, S. A., & Kessler, R. C. (2000). Disabilities and quality of life in pure and comorbid generalized anxiety disorder and major depression in a national survey. *International Clinical Psychopharmacology*, 15(6), 319-328.
- Worden, J. W. (2010). *Grief counselling and grief therapy: a handbook for the mental health practitioner*. (4<sup>th</sup> ed.). New York: Routledge.
- Yonkers, K. A., Bruce, S. E., Dyck, I. R., & Keller, M. B. (2003). Chronicity, relapse, and illness--course of panic disorder, social phobia, and generalized anxiety disorder: Findings in men and women from 8 years of follow-up. *Depression and Anxiety*, 17(3), 173-179.
- Young, J. E. and Klosko, J. S. (1994). *Reinventing your life: the breakthrough program to end negative behaviour ...and feel great again*. New York: Penguin Group.
- Zahl, D.L. and Hawton, K. (2004). Repetition of deliberate self-harm and subsequent suicide risk: long-term study of 11583 patients. *British Journal of Psychiatry*, 185, 70-75.

**My situation** (adapted from Westbrook, Kennerley & Kirk, 2007)





## Summary of Sessions

Session	Session Summary
1	Assessment session on background, critical incidents, triggers, current problem, coping, strengths and goals. IAPTUS screening for particular anxiety and risk assessment. GAD, Social Anxiety and trauma potential issues. DCD?
2	Reviewed mood diary - some events more anxiety provoking than others and some good mood. Completed mindfulness breathing and observation of somatic symptoms. Discussed sleep hygiene and diet. Identified topics for agenda and started Socratic discussion of one issue. Homework to work on sleep hygiene, keep daily mood record. Discussed DCD.
3	Zoe checked Dyspraxia/Developmental Coordination Disorder after last appointment and recognises many features. Discussed checking out assessment of this with her college special needs department. Anxiety still high - key triggers this week include losing travel card. Discussed development of conceptualisation with client based on social anxiety and worry with worry seemingly more of a priority. Completed some psycho education on worry and asked client to do some homework on evaluating risk based on a couple of key worry situations e.g. presentation.
4	Sleep and eating a bit erratic and Zoe has had severe migraine headaches. Hypothesised unrecognised learning problem based on previous observations and history (DCD) and suggested Visual Stress Test. Referred back to formulation (Worry and Social Anxiety) and worked on Social Anxiety using Wells Social Anxiety model to reflect on thoughts, feelings, behaviour, physiology and self-perception. Developed thoughts using Socratic dialogue/thought record and hot thought 'I will be rejected' and underlying belief and that 'I'm not valuable'. Worked on gathering evidence and next time we will review for alternative thought. Did some psycho education on thinking errors, Zoe to observe this week.
5	Started the session with mindfulness relaxation as Zoe usually arrives very stressed and disoriented. We also tried to use the Perfect Nurturer Exercise but Zoe found it difficult to think of something though we did use a fantasy game persona to help her see a different perspective. We did a thought record about a birthday she had forgotten and challenged the core belief that 'I am unreliable' which helped with her anxiety and guilt but not too much. Zoe could intellectualise it but not really feel it. We also discussed JHS which the Zoe is aware she has and again talked about the link with this issue and DCD especially for girls.
6	Zoe still feeling highly anxious even nauseous and reported an incident with her work mate which we reviewed using a thought record. Zoë's hot thought was that she was useless but on review we were able to dispute these beliefs with evidence. We also used REBT to challenge her demandingness and review her anger. More issues came up independently in relation to DCD - her lack of handedness, blurting out and poor organisational skills for which some of her tutors had given her low grade predictions but in the end she got a distinction. Zoe is leaving for a few weeks and I gave her a review sheet for her return.

Session	Session Summary
7	Reviewed formulation, priorities and goals as Zoe has had a break of a few weeks. Zoe's focus is on worry, social anxiety and potential DCD/Dyspraxia. She has now had assessment and DCD has been confirmed with resources now being provided. Based on goals we agreed homework to keep tally/journal of good and bad points about people for next two weeks and to experiment with a mind map for a project restricted to one option (targeting tolerance of uncertainty and doing too much) Also to keep a record of worries and outcomes this week.
8	Zoe lowering medication and is waking up at night with tight chest but sleeping pattern otherwise improved. Zoe has maintained strategy to focus on one piece of work as per goals even though anxious (tolerating uncertainty). Tackled process of worry with reference to Wells model and drew distinction of type 1 worries by using an example and challenging catastrophising and asking questions about beliefs about worry for Type 2 worries. Zoe surprised to note thought action fusion in that she believes if she worries that it will make an event less likely to occur. Zoe also believed that if she did not prevent worrying that she would become paralysed/not able to act and also believes if she does not prevent worrying it will affect her health. Used experiment to demonstrate that trying to suppress her worrying may be making it worse – pink elephant and demonstrated the 'what if' process only makes her feel worse. Zoe was requested to complete a sheet on the advantages disadvantages of worrying for homework and suggestion of letting feelings be welcomed.
9	Zoe had reflected on thought action fusion and thought suppression and had begun to notice it in her life. She was still feeling anxious with chest tightness and felt 'out of it', and we discussed hyperventilation effects and we did a brief mindfulness body scan which the client finds helpful. We reviewed rules underpinning her anxiety which triggered some memories of childhood in relation to her physical competence and recently assessed DCD which led to discussion of a belief 'of not fitting in' explored in a thought record. Zoe was given the blueprint for endings to prepare for homework.
10	Zoe has been putting worry time and postponing worry into practice and has felt calmer. She had also found out that taking action rather than ruminating was proving helpful. Zoe had also reflected that not fitting in had some attractions. In this session we focused on the rules underpinning her worry and found that there were demanding family rules operating which led to belief that she was 'negligible'. Zoe is to observe her own rules and use a verbal challenge that was worked on in the session that gave a more compassionate rule.
11	Zoe was feeling dizzy as she has decided to come off her medication and I advised her to see her doctor. Having covered family rules the previous week and reflected on this in her homework Zoe came up with an emotional memory which we explored in a reliving experience. This led her to an even earlier memory and an appraisal of herself as responsible for her mother's behaviour. We used a then and now analysis to review what was different at ages 7 and 14 and now and a responsibility pie as homework to think through the issues underpinning her mother's behaviour.
12	Zoe chose to work on an issue that I noticed last week that she does not like being on her own because of what others would say about her when she wasn't there. We used a continuum to

Session	Session Summary
	<p>explore this phenomenon to challenge her thoughts and she noted her black and white thinking and was able to make more realistic judgements about aspects of herself rather than a global rating of herself. Although this is CBT I used a more psychodynamic tool for homework – drawing, to compare herself to others.</p>
13	<p>Zoe had reported that she initially found the continuum a bit abstract and it helped when I made it concrete in relation to real people. While this may be my explanation technique at fault, it could also be an artefact of Zoe's learning difficulties so was useful feedback which I thankfully took on board modelling assertiveness in taking feedback to Zoe. We role played a scenario with a work colleague as Zoe feels submissive in many relationships. Although initially embarrassed she took part, though I feel like a teacher and don't like the superiority of this dynamic so need to encourage Zoe's independence with me.</p>
14	<p>Reflected on Behavioural Experiment from previous session on assertiveness which Zoe found quite difficult. We reviewed the formulation briefly in that Worry and Social Anxiety had been prime concerns with a hypothesis of dyspraxia which had been confirmed. Judging from her scores and self report, worry has decreased but social anxiety is still a concern and her depressive score on the PHQ remains fairly stable. Zoe could not account for this except to say that she had been feeling irritable. In discussing the agenda, Zoe reported her irritation with a friend and we used a thought record to review this situation which revealed an image of Zoe as a teenager who had been bullied and unsupported for some time. I reminded her where we were and evoked her safe place image before exploring the image to prevent re-traumatising. Zoe was surprised to note how much this image still affected her especially in social situations. We cognitively re-structured the image from a then and now perspective and also introduced some manipulation of the image which alleviated some of the Zoe's distress. As homework I asked Zoe to think of a way she could interact with her friend more openly.</p>
15	<p>Zoe reflected how much an impact past experiences were still having on her but the imagery had helped to take away some of the power. She had noticed this week in a new group that people she had previously worried about turned out to be OK. We reviewed the overall formulation again with situations we had discussed previously. The main issue discussed today was related to her social anxiety and how she had felt small and dissociated in a group with NATs that they would not like her enough though she was able to think of evidence to challenge this independently. Although the outcome had been helpful through Socratic dialogue, the client alluded to recent suicidal ideation. We reviewed the risk around this - no plan or method, no immediate plan, shared a house though might not say to anyone, had emergency numbers, little support from family, feels comfortable to have this idea in the background, reason for living is her creative work and she will come back next week. The client seemed worried that I might think she was wasting my time and although the client's anxiety has improved there still seems to be an underlying unease but she found it difficult to talk about this.</p>

**COGNITIVE MODEL OF ANXIETY**

**Early Experiences**

Youngest child – half siblings older  
 Mother – chronic health condition and demanding/demeaning  
 School – bullying by peers/ teachers labelling  
 DCD/self consciousness of difference

**Events, early attachments, living conditions**

Mother spoiling treats / family arguments  
 Mother creating scene at school repeatedly

**Core Beliefs**

**Fundamental conclusions about self, others, world**

<p><i>I am helpless                  They are powerful                  The world is scary</i></p>	<p><i>I am unreliable                  I am useless                  I am not valuable                  I am responsible                  They are judgemental                  The world is confusing                  I am an imposter</i></p>	<p><i>I am snappy                  I am demanding                  I am difficult to get on with                  They are entitled                  The world is not fair</i></p>
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**Conditional (Dysfunctional) Assumptions**

**Guidelines for Living**

<p><i>If I stay quiet I won't get hurt</i></p>	<p><i>If I work really hard then I can compensate                  If I don't meet expectations then I will be left on my own                  If I am clever I will be accepted</i></p>	<p><i>If I am easy going then I will fit in                  If I get angry I will be rejected                  I should not aggravate others problems</i></p>
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**Critical Incidents**

**Events impacting on pre-existing beliefs/assumptions**

Mother nearly dying  
 Exclusion by peers at secondary school/persistent bullying/leaving school  
 Sexual Molestation incidents

### Activation of Beliefs/Assumptions (Triggers)

<i>Teacher who bullied Interaction with peers at college Being on my own</i>	<i>Forgot to do article Missing deadlines</i>	<i>Discussion with housemate CD return</i>
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### Symptoms

#### (Negative Automatic Thoughts, images, meanings, emotions, behaviour, body sensations, reinforcement)

<i>NAT: they don't value me, they are attacking me.</i>	<i>NAT: She will be annoyed at me.</i>	<i>NAT: She is stupid She has a difficult situation</i>
<i>Physiology: overwhelmed, dissociation</i>	<i>Physiology: tight chest, acid reflux</i>	<i>Physiology: tight chest, acid reflux</i>
<i>Feelings: angry, hurt, fear, confusion.</i>	<i>Feelings: anxiety and guilt</i>	<i>Feelings: irritated and confused</i>
<i>Behaviour: defended self and sought support. Making an effort to meet new people</i>	<i>Behaviour: avoided getting in touch. Ruminating/worry.</i>	<i>Behaviour: avoided confrontation/discussion. Avoided asking for explanation.</i>
<i>Reinforcers/coping: got support.</i>	<i>Reinforcers/coping: didn't need to face hypothesised annoyance.</i>	<i>Reinforcers: did not have to assert my position.</i>
<i>Thoughts: Other people value my creativity and I am sought after for work.</i>	<i>Behaviour: made the call</i>	<i>Behaviour: passive/snaps But next time asked for book more assertively.</i>
<i>Feelings:</i>	<i>Thoughts: it wasn't that bad.</i>	<i>Thought: Still seems harsh but managed to do it and get explanation.</i>
	<i>Feelings: less anxious.</i>	