



Children's claims to knowledge regarding their mental health experiences and practitioners' negotiation of the problem



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ABSTRACT

Objective: The objective was to identify how children's knowledge positions were negotiated in child mental health assessments and how this was managed by the different parties.

Methods: The child psychiatry data consisted of 28 video-recorded assessments. A conversation analysis was undertaken to examine the interactional detail between the children, parents, and practitioners.

Results: The findings indicated that claims to knowledge were managed in three ways. First, practitioners positioned children as 'experts' on their own health and this was sometimes accepted. Second, some children resisted this epistemic position, claiming not to have the relevant knowledge. Third, some children's claims to knowledge were negotiated and sometimes contested by adult parties who questioned their competence to share relevant information about their lives in accordance with the assessment agenda.

Conclusion: Through question design, the practitioner was able to position the child as holding relevant knowledge regarding their situation. The child was able to take up this position or resist it in various ways.

Practice implications: This has important implications for debates regarding children's competence to contribute to mental health interventions. Children are often treated as agents with limited knowledge, yet in the mental health assessment they are directly questioned about their own lives.

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1. Introduction

In this article, we explore the dynamic negotiation of 'knowledge' in child mental health assessments, attending to how the positioning of children as 'knowledgeable' reframed who had the rights to claim that their version of the proposed problem was accurate. Indeed, the assessment context is one where issues of knowing, rights to demonstrate knowledge, and rights to formulate descriptions inherently generate local sensitivities, and can have extra-interactional consequences in terms of diagnosis and access to further treatment. This context is particularly pertinent as these interactions have multiple members, including children. For the practitioner, therefore, there is a need to balance a child-centred assessment against establishing a credible version of the presenting problem.

Most research on child mental health has examined patients/families already known to services. There has been little research exploring initial child mental health assessments [1] and virtually no qualitative work on these encounters [2]. The initial assessment, an inherent aspect of any health institution, serves to collect information, engage with the family, and determine future need [3]. These assessments are designed to investigate whether the child has a mental health disorder that requires specialist mental health input. The initiative arguably reduces waiting times, increases patient satisfaction [4], and functions as a gateway to specialist services.

The institutional character of child mental health assessments is characterized by knowledge elicitation by practitioners and the production of information by families about potential psychiatric conditions, with the goal of producing diagnoses and implementing interventions [5]. These assessments are complex encounters, particularly as practitioners work with multiple family members and the patient during a single session [6]. While assessments typically aim for the practitioner to establish a definition of the nature of the presenting 'problem' in order to ascertain whether further service contact is indicated, contestation and/or explicit

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disagreement between the various parties about what this 'problem' might actually be is likely. For example, children may resist practitioners' attempts to access their mental health experiences, thereby hindering the progress of the activity [7]. Children themselves are rarely the main initiators of attendance [8], which has been argued potentially to affect their engagement with the therapeutic process [9]. Alternatively, family members may attempt to resist clinicians' accounts of the presenting problem, although this may in turn be resisted by the practitioner [10].

What becomes of particular interest is the manner in which matters of knowledge are managed and negotiated between participants in such assessments, where practical consequences for children and families are predicated upon the professionally-sanctioned version of the 'problem' [11]. Broadly, institutional talk is typically characterized by asymmetries both in terms of interactional organization and knowledge [12]. In the examined assessment context, the fundamental institutional aim of which is to elicit information about a child's life and experiences, such asymmetry may be especially pertinent for three reasons. First, it has been broadly described that children are typically afforded only a 'half-membership' status to the group in which they are interacting with adult members, and are not considered to have full interaction rights [13]. Second, the specific children in these interactions are present in this context because there has been some level of recognized historical concern about their behaviour, emotional wellbeing, communication and/or development. A range of studies in different contexts have consistently demonstrated a number of ways in which individuals categorized as such may demonstrably not be afforded comparable interactional rights as other speakers on a moment-by-moment basis [14,15]. Third, in these initial assessments, the children (and families) are the individuals whose experiences and 'problems' are *being discussed*, and therefore it would be socially expected that they might possess primary rights to describe these themselves uncontested [16]. Given that this context brings (at least) these three sets of partially conflicting issues together, it might be predicted that complex interactional matters may arise during these sessions in relation to children's positioning to take the conversational floor, the manner in which their epistemic rights to share about their state of affairs are negotiated, and the extent to which their version of events is received as accurate and/or reliable.

Given this backdrop, we investigate how this particular group of children was treated as social agents with rights to 'know' within the context of an assessment. We explore tensions of symmetry and asymmetry between adults and children, considering how children's positioning to convey 'knowledge' about their condition was treated as fluid. Our analysis was informed by the question: What are the conversational practices that practitioners and children use to build their own and their co-participants' knowledge status, and how do these practices bear on the achievement of institutionally relevant goals?

2. Methods

The data consisted of video-recorded initial mental health assessments at a Child and Adolescent Mental Health Service (CAMHS) with 28 families and each appointment lasted approximately ninety minutes. CAMHS is a UK specialist mental health service for assessing, diagnosing, and treating childhood mental disorders. Typically, children are referred for assessment by a General Practitioner. Children in the study had been referred for a range of potential problems, including behavioural, neurodevelopmental, emotional, and psychiatric disorders. All but one family was seen by at least two practitioners. All 29 practitioners within the team participated, including consultants, staff-grade and

trainee child and adolescent psychiatrists, clinical psychologists, assistant psychologists, community psychiatric nurses (CPNs), learning disabilities nurses, occupational therapists and psycho-therapists. Some sessions included medical students (1) or student nurses (2).

The study is representative of general attendance to CAMHS, with 36% of the children being female and 64% male. The age of the children ranged from 6 to 17 years (mean = 11.21, SD = 3.10). Most children attended with their mothers (27), with seven also having fathers attend (one child attending with only their father). Six were additionally accompanied by their maternal grandmothers, and in some cases another family member and/or professional known to them.

2.1. Data analysis

Conversation analysis (CA) was utilized, as this pays close attention to the details of interaction. CA is a well-established approach to the study of talk-in-interaction, and takes naturally-occurring data as its focus [17]. The basic premise is that the researcher inspects recorded data to see how the participants in a scene display their own understandings of what they are doing and saying, as evidenced in the organization of their talk. This is facilitated through the production of a detailed transcription, conforming to the guidelines of Jefferson [18] and by the use of video-recordings so that non-verbal behaviour (such as the child nodding in confirmation) and other paralinguistic features (such as the child smiling) can be transcribed and analysed.

2.2. Ethics

Approval was granted by the National Research Ethics Service (NRES: UK). Information was posted to families with their appointment letter up to three weeks prior to attendance. At the appointment, consent/assent was taken from clinicians, parents, and children, before and after attendance. Consent forms for children were age appropriate (different forms for different age groups) and time was taken before the appointment to verbally go through the child information sheet and the consent form with each child. Parents facilitated this process where needed. Consent was also taken from all parties at the end of the appointment to ensure that they had not changed their mind after they experienced the assessment. This was a mechanism to manage any misguided expectations about the appointment prior to attendance, and was particularly important for children.

3. Results

Analysis revealed that practitioners' directed questions to children and/or parents, with these questions being designed in ways that simultaneously positioned children as 'knowledgeable' (to varying degrees) on their own state of affairs whilst in some instances challenging the children's accounts of their experiences and circumstances. Accordingly, the rights of the children to own and display their knowledge unfolded through these question-answer sequences. Analysis explored how the positioning of the child as knowledgeable functioned to frame and reframe who had the right to tell the 'true' story.

In conversational terms, particularly in relation to question and answer sequences, speakers occupy different positions on an epistemic gradient from more knowledgeable (K+) to less knowledgeable (K-) regarding the matter at hand [19]. In our data, three patterns of epistemic gradient were evident following practitioners' questions. First, some children were treated as being in a K+ position, and responded accordingly by asserting some knowledge. Second, some children were treated as being in a K+

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