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"I'm thrilled that you see that": Guiding parents to see success in interactions with children with deafness and autistic spectrum disorder

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ABSTRACT

Children with deafness who are also on the autistic spectrum are a group with complex support needs. Carers worry about their ability to communicate with them, and are often uncertain about what constitutes 'good' communication in this context. This paper analyses the use of a therapeutic intervention, Video Interaction Guidance (VIG), which originates in developmental psychology and focuses on the relational foundations of communication. We draw on a single case using an ethnomethodological/conversation analytic framework, and in particular Goodwin's (1994) work on 'professional vision', to show how the ability to see 'success' is a socially situated activity. Since what counts as success in this setting is often far removed from everyday ideas of good communication, how guiders facilitate particular 'ways of seeing' are critical for both the support of carers and the impact of the intervention. We argue that this work has implications in three areas: for the practice of VIG itself; for the role of qualitative, interactional research addressing the way in which interaction-based interventions are protocolised, enacted and assessed; and for the way in which expertise is conceptualised in professional/client interactions in health and social care.

Introduction

Children with deafness who are also on the autistic spectrum are a group with complex support needs. Carers worry about their ability to communicate with them, and are often uncertain about what constitutes 'good' communication in this context. This paper analyses the use of a therapeutic intervention, Video Interaction Guidance (VIG), which originates in developmental psychology and focuses on the relational foundations of communication (Murray & Trevarthen, 1985; Trevarthen, 1974). VIG is based on observation of real life communication, between carer and child, captured on video. Excerpts from this video are then selected by the guider and played back to the carer, to demonstrate what the guider has identified as successful communicative events and to aim to co-construct an understanding of the success of the moment. In this way it is hoped participants will perceive existing positive contingencies and be able to build upon them in future communication. Early evaluation of the intervention indicates a significant impact (Fukkink, 2008), but its success ultimately relies upon the process of co-construction, so that aspects of communication can be mutually perceived as successful. In this paper we draw on a single case using an ethnomethodological/conversation analytic framework, and in particular Goodwin's (1994) work on 'professional vision', to show how the ability to see 'success' is a socially situated activity. Since what counts as success in this setting is often far removed from everyday ideas of good communication, how guiders facilitate particular 'ways of seeing' are critical for both the support of carers and the impact of the intervention. Current UK Medical Research Council guidance on the use of interventions (MRC, 2008) states that where a 'complex' intervention such as VIG is used, researchers must consistently provide as close to the same interaction as possible in order to preserve its integrity. For this to be possible, it has been argued that integrity must be defined functionally, with an emphasis on process above other aspects (Hawe, Shiell, & Riley, 2004). Identifying and examining the interactional processes through which an intervention like VIG occurs is therefore of

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wider significance. Put another way, in order to critically explore the utility of VIG, it is necessary to first examine how it operates in practice. The analysis presented here begins such an examination.

Background

Goodwin's work on 'professional vision' sets out to show the discursive practices "used by members of a profession to shape events in the phenomenal environment they focus their attention upon, the domain of their professional scrutiny, into the objects of knowledge that become the insignia of their profession" (1994: p. 606). Through shaping in particular ways, objects of knowledge are created that are the special domain of a particular profession.

Through his analysis, Goodwin shows how participants build a particular 'professional vision', a socially organised way of seeing and understanding events that pertain to the specific interests of a particular professional group. The example that perhaps most clearly illustrates different 'ways of seeing' relating to specific interests is one that Goodwin himself uses: the trial of 4 white policemen who were initially acquitted of beating black motorist Rodney King in LA in 1992, despite the fact that the beating was filmed by a passer-by. Goodwin's analysis of footage from the trial demonstrates how lawyers for both sides were able to structure the happenings visible on the video in ways that suited their own agendas. What appeared at face value as police brutality towards an innocent motorist was, through a set of discursive practices, transformed by the defence into a reasonable police response towards a potentially dangerous man. Rather than treating the tape as a record that spoke for itself, the defence lawyers presented it as something that could be understood only by embedding the events visible on it within the work life of a profession, and by framing the ways in which these events should be so perceived.

In considering how this framing was actually achieved across this and other settings, Goodwin identified 3 specific practices. Firstly, coding schemes were used to transform the materials that were being attended to in a specific setting into objects of knowledge. Secondly, the use of highlighting; particular phenomena in a complex perceptual field were made particularly salient by marking them out in some way. Thirdly, framing was assisted by the production and articulation of graphic representations of a field, such as maps, charts, transcripts etc.

As Goodwin argues, then, the conduct of this trial provides an example of how being able to see a meaningful event is not a transparent, psychological process, but is instead a socially situated activity. Vision is lodged within communities of practice,[1] and individuals from different communities will see different things in the same object or event, just as an archaeologist and a farmer will see different things in the same patch of dirt. As we will see from the data that follow, parents/carers and professionals involved in VIG may also see very different things in a communicative exchange with a child, and so how things become agreed on as a 'moment of success' is equally socially situated. In addition, as we have alluded to earlier, not only what is taken to count as a 'moment of success' but *how* that moment is agreed upon is also of fundamental importance for the wider utility of VIG, and its integrity as an intervention.

Goodwin's concept of professional vision has previously been used to examine interaction in a variety of healthcare settings, most commonly involving situations where an experienced practitioner is in some kind of training or teaching role and needs to make a judgement about the competency of a less experienced practitioner to 'see' significant aspects of a case. As Koschmann and LeBaron (2003) note, drawing on their work in an operating theatre setting, how participants to a joint activity come to develop a shared or mutual understanding of what they are perceiving has long been of interest to researchers across the human and social sciences. In practical terms, how we detect when discrepancies in what we see have arisen, and how we try to reconcile these, is critical for safe and effective practice in a wide range of clinical settings. Hindmarsh, Reynolds, and Dunne's (2011) work on dentistry highlights how Sacks' (1992: p. 252) distinction between 'claiming' and 'exhibiting' understanding is of paramount importance in the supervisor/supervised relationship in healthcare. Supervisors draw on a range of resources when making judgements on this distinction, both verbal and non-verbal.

However, as the terminology used in the VIG intervention suggests, the 'guider' in this setting is not in a straightforward teaching or tutoring relationship with the parent/carer or professional who is involved with the intervention. This creates a potentially delicate scenario. As Pomerantz (2003) and Pomerantz, Fehr, and Ende (1997) observe, the activity of teaching defines at the outset the one being taught as not fully competent. However, the competency that is at issue here is not one that relates to a technical or professional healthcare skill (such as taking a patient history or conducting a physical examination), but one that might broadly be defined as 'interacting more effectively with your child'. Explicit teaching activity in this setting would risk being seen as inappropriate both in terms of its threat to parental competency, but also to the integrity of the intervention. Unlike the settings which Hindmarsh et al. (2011) and Pomerantz et al. (1997) describe, guiders cannot and should not explicitly teach. However, in common with these other healthcare settings, in order for the intervention to have any impact, guiders must be sure that parents or carers can 'see for themselves'.

Applying the concept of 'professional vision' to VIG

Video Interaction Guidance is becoming embedded in the UK public sector. In some Local Authority areas there is a locally funded strategic initiative to implement VIG, so that it becomes part of routine practice. In other cases individual practitioners enter training as part of their continuing professional development. There are approximately 500 practitioners of VIG in the UK including educational psychologists, speech and language therapists, teachers, social workers, family therapists and academics. As a result of this diversity, children and families are identified for participation in VIG in different ways, from routine service delivery through to specific trials and projects. The data presented in this paper come from a specific study aimed at assessing the utility of VIG with a particular client group.

VIG is designed as a family centred intervention. It begins with the parent/carer (or sometimes the professional) working with the child being asked to identify areas for improvement/issues of concern. From these areas of concern, goals for change are formulated. Video is taken by the guider at the home or school setting, following the guidelines laid down by Kennedy, Landor, and Todd

[1] The term 'community of practice' was first used by Lave and Wenger (1991) to refer to a group of people who share a craft or profession, drawing on their work on how apprentices learn. Communities of practice can evolve naturally, or they can be created specifically with the goal of gaining knowledge.