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Professional Practices and Children's Social Competence in Mental Health Talk

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The World Health Organisation estimates that worldwide 10–20% of children and adolescents experience mental health problems (WHO, 2018). Beyond the boundaries of these clinically defined populations and conditions, children experience a range of ordinary and extraordinary circumstances that affect their mental health and wellbeing. Throughout their

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J. Lamerichs et al. (eds.), *Children and Mental Health Talk*,
The Language of Mental Health,
https://doi.org/10.1007/978-3-030-28426-8_1

lives, children may participate in a range of different institutional settings where emotional, behavioural and neurodevelopmental matters are attended to as relevant for the purposes of that institution. This might occur in clinical settings where mental health and wellbeing comprise a primary institutional focus. Beyond such institutions, the mental health and wellbeing of children also are of relevance in a range of other institutional settings, such as in educational or judicial systems or in the course of research. Studies in these different contexts show the differing understandings of children's interactions and a range of practices from those professionals who support children to manage their health and wellbeing. Rather than considering mental health and wellbeing issues as external forces that happen to the child, the perspective here taken is that children are directly involved in the process of talk around mental health issues in everyday contexts, positioning them as interactionally competent and capable. The undertaking of fine-grained analyses using ethnomethodological and conversation analysis approaches makes it possible to observe of the multifaceted ways that children manage and display social competence in a range of institutional settings.

From a Developmental to an Interactional Perspective on Children's Social Competence

The concept of children's competence often is framed as an assessment of children's capability. Claims of children as competent—or not—are driven by underlying paradigms that provide conceptual constructions of the child as developing competence, prominent in many sociological and psychological studies. As you read the chapters of this book, you will see that the theoretical framing of children's interactional competence is located and described as in situ competence. In this understanding,

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first recognised by the early ethnomethodologists, we describe children as 'competent interpreters in the world' (Mackay, 1991: 31). The early ethnomethodologists, including Robert Mackay (1991) and Matthew Speier (1971, 1973), were the first to write about the social competence of children. Their pioneering work investigated children's interactional competence in everyday interactions, and this theoretical framing of children's competence can be located and described as in situ competences.

A sociological perspective recognises children as collaboratively producing and making sense of their worlds through their social interactions in everyday life and involves examining how children display their social competence in situ. For example, Danby and Baker (2000) showed how first impressions of young children's interactions can suggest that they have an undeveloped idea of turn taking, an essential feature of social interaction. A study of preschool-aged boys in the classroom showed how they talked over each other, so that they did not wait until one had finished their turn before another started. The talk gave the appearance of speaker turns being unorganised and jumbled. Yet detailed analysis showed that they were not engaging in interactions that were chaotic but, rather, the talk was ordered and systematic. The specific element for being heard was to have the speaker's main message audible; recycling their initial turns of talk that overlapped with another meant that their main message was heard in its entirety. The finding showed that young children's talk was not disorderly nor chaotic but that it used the same features as adult talk. As Schegloff (1987) found in adult conversations, adults routinely talk over each other to get the floor for speaking yet, as Danby and Baker (2000) found, 3- and 4-year-old children also do this to gain the floor. In our society, the developmental perspective is so persuasive that it is easy to think that the practice of children talking over each other is there because they have not learned to take turns at talk.

It is not always possible, though, for children to engage in the conversations that are about them or involve them in some way. Children often are not afforded the opportunity to be included and, even when they are included, they elect to not contribute to the talk about them or involving them, even when asked. One way in which children can display their competence is by resisting engagement in discussions about their mental health (Hutchby, 2002; O'Reilly & Parker, 2013). One well-documented

practice that children use is to disclaim knowledge with expression such as 'I don't know' (Hutchby, 2002; Lamerichs, Alisic, & Schasfoort, 2018; O'Reilly, Lester, & Muskett, 2016; Stafford, Hutchby, Karim, & O'Reilly, 2016; Stickle, Duck, & Maynard, 2017). There is no reason, however, to assume that these knowledge disclaimers index a state of mental incompetence. For example, Hutchby (2002) considers an example from a child counselling session where a child client responds with 'don't know' to 57 of the 92 questions asked by his counsellor. The following fragment shows two of these responses:

Fragment 1 (Hutchby, 2002: 160)

```
((Referring to the child's drawing))
01    C:  Is that da:d. in Paris,
02        (2.1)
03    C:  Who's this in Paris,
04 → P:   °Don't know,°
05    C:  No who is it, an-=seriously who is it.
06 → P:   °Don't know.°
07        (.)
08    C:  Jus' people,
09        (1.6)
10    C:  °Mm.°
```

The child first disclaims knowledge at line 4. Given that what is being disclaimed is knowledge about a picture that he has just drawn, this response is treated as non-serious by the counsellor, rather than an indication of the child's actual mental state. Here and elsewhere in this session, disclaiming knowledge is employed by the child client to continue avoiding the counsellor's questions, even after his pursuit of a serious response. Disclaiming knowledge highlights the socially competent ways that children resist engaging in encounters that they may be involved in against their own volition (Hutchby, 2002).

Ethnomethodological and Conversation Analysis Approaches for Understanding Mental Health Talk with Children

Ethnomethodological and conversation analysis approaches to analysing child mental health talk make possible fine-grained analysis that displays

evidence of how children engage in these conversations. First, children can find themselves often engaging with mental health professionals due to decisions that have been made by adults rather than by themselves (Fasulo, 2015; Hutchby, 2002; O'Reilly & Parker, 2013; Stafford et al., 2016). Indeed, in some situations a child's conduct may even suggest that they are unclear about why a decision has been made to bring them to such a setting (Kiyimba, O'Reilly, & Lester, 2018). Second, in some settings, such as family therapy, the presence of other parties, such as family members, can affect the extent and way in which children participate in mental health talk (Hutchby & O'Reilly, 2010; O'Reilly & Parker, 2014). Third, children may be treated in ways that position them as more or less knowledgeable about their own mental health and wellbeing (Butler, Potter, Danby, Emmison, & Hepburn, 2010; O'Reilly et al., 2016).

Professionals who engage children in mental health talk seek to find ways of broaching this potentially delicate matter in ways that suit individual children and their circumstances. Recent years have seen a rapid increase in research exploring practices that professionals can use to pursue this objective. Although this body of research remains relatively small, it nonetheless already contributes a range of practical guidance. At a general level, the findings of this research identify a broad spectrum of practices that professionals use to promote mental health talk. Practices towards one end of this spectrum attempt to bring into direct focus matters that are relevant to a child's mental health and wellbeing, while practices towards the opposite end of this spectrum are used to discuss a child's mental health and wellbeing more indirectly. We consider practices towards either end of this spectrum in turn.

There are circumstances where it is ostensibly relevant for a professional to take, as a direct focus, a child's mental wellbeing. For example, one practical task for child counsellors to focus on matters that are relevant for counselling. This can be seen in the following fragment, where the counsellor (C) comes to directly and explicitly highlight the emotional impact of the child client's (referred to as J) circumstances:

Fragment 2 (Hutchby, 2005: 317–318)

```
01 C:  A:h 'kay so if you did what your da:d (.)
02     a::sked you or suggested, li[ke ] go an' play on the=
03 J:                              [Yeh]
04 C:  =computer, (0.5) would that happen would your mum an' dad
05     have an argument about it.
06 J:  Well they- the:y wouldn't me an' my mum would an' me an'
07     my dad would. .hh An' my mum an' dad would tell each
08     other off but they wouldn't argue.
09 C:  A::h. (.) Is that, different do [they
10 J:                                 [An' my mum would smack
11     me an' send me up t' bed. [Even-
    ((22 lines omitted))
33 C:  D'you think she'd prefer to smack dad.
34     (.)
35 J:  No:.
36     (0.8)
37 J:  Cuz dad would smack her back an' then, .h they'd have a
38     big fight on smacking.
39 C:  A big smacking fight.
40 J:  Yeah.=
41 C:  =That doesn't sound like a ver[y nice (thing)
42 J:                               [No: so I just take the
43     smack an' I don't really care (cuz) she can't- .hh well
44     she can smack really hard but it doesn't hu:rt.
45 C:  So::, so 'f she smacks you::, (.) sometimes it might feel
46     better cuz it means that mum and dad don't have a row.
47 J:  Yeh.
48 C:  A:::h. 'Ka:y.
```

In this fragment, the child client describes a circumstance in which she can come to be smacked by her mother. After some discussion of this matter (not all of which is reported here), the counsellor formulates an upshot of the discussion that focuses on the emotional impact of this circumstance upon the client (lines 45–46). This brings into direct focus an aspect of the client's mental wellbeing—her emotions—that has not been made explicit in the prior talk. Other research identifies alternative practices that therapists use to ground mental health talk in something that has already been raised by the child client (Danby & Emmison, 2014; Kiyimba & O'Reilly, 2018; O'Reilly, Kiyimba, & Karim, 2016). What is common across these practices they make discussion of mental health or wellbeing direct and explicit.

On the other hand, there are also practices that professionals use to focus on mental health and wellbeing more indirectly. For example, fictional characters (Lester & O'Reilly, 2015) and metaphors (Bradley & Butler, 2015) can work to create a social distance between a child's behaviour and their broader identity, so the child can critically discuss their behaviour without associating this with their identity more broadly. For instance, in the fragment below we see an example of how reference to the superhero character *Superflex*, who was considered capable to defeat a range of social and behavioural problems, referred to as 'unthinkables'. As we see in the fragment, 'Glassman' is used as a reference to one of the 'unthinkables' (line 4), corresponding to a situation in which the child would make a small problem into a big problem that resulted in what was called an 'earth shattering reaction' (Lester & O'Reilly, 2015: 340). These references to unthinkables and the superhero enabled the therapist to address and negotiate the boundaries of what are inappropriate and appropriate behaviours. At the same time, they position the child as capable of dealing with inappropriate behaviour. In Fragment 3, Bria is the therapist and Billy is the child.

Fragment 3 (Lester & O'Reilly, 2015: 340)

```
01 Bria:   First you pick and then I get to pick (2) kay=
02 Billy:  (Climbs on to the swing) (3)
03 Bria:   (Pushes swing) thank you for being Superflex and using a
04         nice voice (1) for a second there I thought Glassman was
05         gonna come [out
06 Billy:             [Whoa (.)
07 Bria:   You were almost being kind of rude but [then↑
08 Billy:                                         [ah (.)
09 Bria:   out comes Superflex↑
```

In instances where initial attempts to elicit mental health talk falter, there are alternative strategies that professional child counsellors and therapists can use to more indirectly foster talk on delicate matters. For example, professionals have successfully promoted discussion by asking children to

engage in drawing activities that allow them to communicate about a sensitive matter in a different way (Fogarty, Augoustinos, & Kettler, 2013). Nevertheless, as illustrated in Fragment 1 above, drawing activities do not guarantee success in promoting sensitive conversations (Hutchby, 2002). No single practice is guaranteed to be successful but, rather, professionals who interact with children draw on a repertoire of practices that are suitable for a particular child and their immediate circumstances.

There is a broader range of professionals—not only those working within clinical settings—who may find themselves in circumstances where they engage with children about matters that relate to their mental health and wellbeing. For instance, educators often are afforded opportunities to engage in particular types of encounters that incorporate discussions of mental wellbeing that may not be possible in mental health settings. For example, early childhood teachers and children can embed discussions of traumatic events within activities that routinely occur as part of early childhood education (Bateman & Danby, 2013). One effective device used by the early childhood teachers in a study around post-earthquake play in New Zealand was that of second stories, where the teacher encouraged children to produce second stories on hearing a first story about the earthquake event. In this way, talk became an interactional resource to shift accounts from the earthquake itself to the relational aspects of community support (Bateman & Danby, 2013). Nevertheless, as in the mental health settings considered earlier, children may not align with attempts to initiate such talk (Bateman, Danby, & Howard, 2013). In the following fragment (considered in detail in Chapter 4), and in contrast to the prior child counsellor fragments, here it is the child who initiates talk about his earthquake experience. In the mundane context of sitting on the grass reading books, the child (ZAC) selects a story he had written about his earthquake experience directly after the event and gives it to his teacher (LEO) to read to him:

Fragment 4 (Bateman & Danby, 2013)

```
01 ZAC:  ↑now can you read ↓mi:ne:?
02 LEO:  ar=↑sure:↓ . and that was all about the ↓earthquake
03       wasn't it >remember=when=we< had the
04       <earthqu:ake::> can you remember about the
05       earth↑quake::?
06 ZAC:  ↑yeah↑=
07 LEO:  =what can you remember about the earth↑quake¿
08 ZAC:  [ ↑ m m m m ¿ ]              [we:: (       )]
09 LEO:  [wha:t special] thing could [↑you remember¿]
10 ZAC:  on the grass?
11 LEO:  we did did↑n't we::¿ . and we all [came on to-]
12 ZAC:                                    [↑I remember] we-
13       I remember- I remember it?
14 LEO:  ↑you rem↓ember it? ↓can you remember what happened?
15       (0.9)
16 ZAC:  °mmm the dinosaurs-° the ↑di:nosaurs were dancing¿
17 LEO:  the ↑dinosaurs were dancing¿
18       (0.7)
19 LEO:  ↑real:ly:¿
```

Although this educational context is different to clinical settings, the professional practice of eliciting talk about a traumatic event from a child is still evident. What is clear is that professionals who seek to engage children in mental health talk approach this delicate matter in ways that align with children's immediate contexts. The approach taken by the professional reflects the specific professional context in which the talk is embedded.

There is a range of ways in which professional contexts can influence mental health talk with children. Some contexts involve regulation about what professionals can and cannot do. For example, Kids Helpline is an Australian helpline for children and young people, where counsellors respond to young callers and provide counselling support through telephone, online chat and email modalities. They draw on strategies that include designing the opening of the calls for callers to find their own way into their reason for calling the helpline (Danby, Baker, & Emmison, 2005) working within the institutional remit of 'We listen, we care'. In enacting this remit, the counsellors avoided giving advice, even when requested by the caller (Butler et al., 2010). Rather, they used strategic questions to afford agency to the caller to solve their own problems, and other strategies that included using address terms to build client rapport and trust (Butler, Danby, & Emmison, 2011), script proposals to

propose what a caller might say to a third party (Emmison, Butler, & Danby, 2011), compliment-giving to help callers identify their strengths (Danby, Butler, & Emmison, 2011), respecification of the clients' troubles (Cromdal, Danby, Emmison, Osvaldsson, & Cobb-Moore, 2018) and counsellor displays of active listening (Danby, Butler, & Emmison, 2009). Acknowledging children's competencies in mental health talk is imperative in ensuring that the wellbeing of the child is supported in such a sensitive context.

Beyond the specific practices that professionals use to facilitate discussions about mental health and wellbeing, establishing and maintaining good rapport with a child is an important foundation for promoting discussions about these matters. Although establishing rapport at the outset of an encounter is important (Childs & Walsh, 2017), rapport is to be actively maintained over time, especially during periods of sensitive and challenging discussions (Fogarty et al., 2013; Iversen, 2019). In multiparty settings such as family therapy, professionals must find ways to simultaneously maintain rapport with parties who are likely to hold divergent perspectives (Parker & O'Reilly, 2012). As professionals attempt to promote and sustain talk about a child's mental health and wellbeing, they work towards establishing and maintaining a relationship to facilitate such conversation.

Recent years have seen a rapid increase in exploring practices in different professional settings that pursue specific objectives. The practices range from specific practices that professionals use to directly or indirectly engage children in mental health talk, through to practices that more generally facilitate a productive relationship that appears necessary for such conversations to occur. Although this body of research remains relatively small and is restricted to only a small number of institutional contexts where mental health and wellbeing talk occurs, it nonetheless highlights a range of practices that professionals use to foster conversations about mental health and wellbeing with children.

Professional Practices and Professional Vision

Professionals at work provide the backdrop to the concept of professional vision, which underpins the work discussed in the chapters of this book. This concept was coined by Charles Goodwin (1994) and is defined as 'socially organized ways of seeing and understanding events that are answerable to the distinctive interests of a particular social group' (Goodwin, 1994: 606). This concept is one way to understand how professional groups orient to how they go about producing their professional knowledge in ways that other professionals recognise as institutional work. Professionals orient to specific features of the physical and social environment. Goodwin initially demonstrated this concept through analysis of video footage of archaeologists going about their everyday work, and then he elaborated his concept through the analysis of police officers in courtroom encounters. In both these examples, Goodwin's point was that professionals attended to some certain features of the environment, and not to others, focusing on what is important to the participants as professionals in that place and that time.

Goodwin (1994) suggests that people working in the same profession (e.g. child counsellors) speak a common language and enact being a professional as expected by other members of the profession. In this way, professional vision is interactively organised and situated as orienting to specific aspects relevant to the profession is observable within a specific profession. Not only do professionals organise their work through their own conduct, they also make noticings of others' conduct to co-produce situated practice, bringing some features into focus while not attending to others. Hutchby (2015: 541) has translated this vision to the setting of child counselling, for the purpose of which he has coined the term 'therapeutic vision' to refer broadly to 'seeing and understanding events according to occupationally relevant norms' (p. 149). For example, child counsellors routinely highlight aspects of a child's talk that can be considered relevant for addressing matters relevant to the child's feelings. Hutchby sees those 'counselling-relevant frames' laid down in the context of manuals or storybooks. This professional attention constitutes the production of an institutional approach to professional practice.

The concept of professionals having a vision to notice things relevant to their work in settings in which child mental health becomes a focus is mirrored by Peräkylä and Vehviläinen (2003). They introduced the notion of professional 'stocks of interactional knowledge' (SIKs) to refer to the 'normative models and theories or quasi-theories about interaction' that professionals draw on in their work and when they talk about what it is they do (2003: 729–730). These normative models are deeply constitutive of the relevant institutional practices that professionals rely on in their professional orientation to work practices. Peräkylä and Vehviläinen use psychotherapy as an example of an institutional setting in which the SIK that underly psychotherapy is highly constitutive of the praxis, or as the authors claim, without SIKs, there would be no psychotherapy.

A primary contribution by Peräkylä and Vehvilainen's (2003) is the articulation of how findings drawn from ethnomethodological and conversation analysis relate to professionals' theories about their interactional practices. In so doing, they identified particular directions in which these studies contribute to exemplifying SIKs that may only be described in very general terms and thus help to further explicate the professional theories and normative principles that operate in these domains. For example, Danby, Emmison, and Butler (2009) and Hutchby (2005) explored the therapeutic concept of 'active listening', highlighting the ways in which it is accomplished 'as part of the practical, contingent, and interactionally skilful work of counsellors and children as cultural members, rather than the abstract recommendations of handbooks and training manuals' (Hutchby, 2005: 309). Brought to the fore are profession-relevant concepts and strategies oriented to by the professionals in the course of their everyday work practices.

Professionals work in specific ways that are framed by their stocks of interactional knowledge (SIKs) and their professional vision to do what is required of them in their everyday work. In this sense, professional vision is observable as a universal phenomenon that frames each professionals' practice. Nevertheless, each professional's vision is enacted differently within the confines of the specific professional contexts. The chapters within this book highlight a diverse range of interactional practices that professionals use to facilitate talk with children about mental health and wellbeing.

In doing so, these chapters consider ways in which professional practices interface with children's competence.

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