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Testing Children's Degrees and Domains of Social Competence in Child Mental Health Assessments

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Introduction

In the UK, when there are concerns about a child's mental health, General Practitioners (GPs) make referrals to community mental health teams for specialist psychiatric assessments. The focus for this chapter is on exploring social competence of children within these initial child mental health assessments. The data analysed were video-recorded clinical conversations

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between mental health practitioners, children, young people and their families. We utilised conversation analysis (CA) to interrogate sequences of talk and investigate displays of category-bound developmental expectations. The analysis demonstrated how practitioners oriented to children's epistemic rights to knowing about their own mental state and motives for their behaviour. However, in terms of interactional competence, practitioners treated them as having degrees of competence in relation to understanding and appropriately articulating their mental state. When children and young people presented candidate diagnoses, such as 'self-harm', 'phobia' and 'OCD', practitioners did not overtly challenge their competence to understand these medical concepts, but did pursue further elaboration and ultimately confirmed or disconfirmed their proposition. The implications and applications of the analysis are therefore discussed later in the chapter.

The Literature

Conversation analysis (CA) has adopted a certain perspective on the question of children's participation both in everyday social life and in the institutional contexts that promote facilitation and mediation between adults and children. Broadly speaking, CA addresses children's talk in much the same way as it addresses adults' talk; that is, in terms of how it evidences the competent management of resources-at-hand to engage in social interaction that is meaningful, and displayed as such, for the participants in their local (social, temporal, interpersonal) circumstances (Hutchby & Wooffitt, 2008; Sacks, 1995). CA thus has affinities with the 'competence paradigm' in the sociology of childhood (James & Prout, 1990; Hutchby & Moran-Ellis, 1998).

In the competence paradigm, the question of children's social competence has often been contrasted with the focus on cognitive and social development that tends to characterise research in child psychology. A key argument has been that rather than being treated merely as bearers of developmental mechanisms, children need to be seen as social agents and active participants in their own social worlds. Indeed, sociological

perspectives of childhood have challenged the views of children *developing* competence (see, e.g., Mackay, 1991; Prout & James, 1997), as this encourages a view of children as 'incomplete versions of adults' (Danby, 2002: 25). A resulting picture, therefore, emerges of childhood and adolescence as a 'dynamic arena of social activity involving struggles for power, contested meanings and negotiated relationships, rather than the linear picture of development and maturation made popular by traditional sociology and developmental psychology' (Hutchby & Moran-Ellis, 1998: 9). Thus, the competencies of children can be considered an interactional achievement in situ, within the local social setting, as opposed to an adult imposed assessment of capability (Theobald, 2016). For example, in relation to language competence it can be shown that children, even as young as 3–4 years old have a grasp of communication rules (Danby, 2002).

In many areas of their everyday lives, children and young people find themselves managing the contingencies of adult-controlled institutions, including not just the family home, but also school classrooms (Danby & Baker, 1998; Mayall, 1994), medical settings (Silverman, 1987; Stivers, 2002), and occasionally, for some, services such as counselling and mediation (Hutchby, 2007; Hutchby & O'Reilly, 2010). These settings involve practitioners and other organisational representatives who engage in task-oriented interaction with children and young people. One key theme often drawn out in relation to such settings is the way that differing epistemic perspectives can inform the participation of adults and children. Institutional forms of talk bring into play distinctive factors associated with the specific activities oriented to as relevant by different actors in the setting.

There is a twofold relevance to studying these differences. First, they can reveal how children and young people exercise their situated social competencies in orienting to those institutional agendas. Second, they can illuminate the ways in which practitioners, other professionals and policymakers themselves understand (or fail to understand) the social competencies of children and young people.

The Project

Children's competence is navigated, negotiated and displayed in a variety of mundane and institutional settings. In institutional environments, where children and young people are central to the institutional task, the importance of accurately determining competence has greater consequences as generally there is more at stake. One setting where the child's cognitive, social and emotional competence is frequently highlighted is during mental health assessments whereby mental health status relies heavily on self-report and family narratives about their thoughts, feelings and intentions. In that sense, competence is intrinsically bound to this in that clinical practitioners are faced with the task of deciphering whether the child or young person has sufficient competence to accurately report on matters that affect them. Thus, clinical practitioners tend to question and verify children's responses against adult versions to establish their accuracy in relation to the institutional task.

Context and Setting

Typically, in the UK, when families (or educators) have concerns about a child's mental health, parents usually attend an appointment with a General Practitioner (GP) to discuss their needs. The GP is thus usually the first point of contact for mental health problems and serves a gatekeeping function to making decisions regarding whether a referral to specialist services might be required or whether the problem can be managed in primary care. If a GP feels that the child or young person may have needs that warrant specialist mental health intervention, he or she will make a referral to the local Child and Adolescent Mental Health Service (CAMHS) requesting an initial assessment (Karim, 2015). In cases where there is enough information in the referral and grounds to do so, CAMHS will invite the family to attend an assessment appointment.

This assessment has many functions, including the assessment of symptoms and behaviours, evaluation of social circumstances and risk assessment (Sands, 2004). Practitioners also seek to ascertain some context about the child or young person's life (Mash & Hunsley, 2005), and this

environment requires a great many questions to be asked of the family (O'Reilly, Karim, & Kiyimba, 2015). The questioning generally follows a similar pattern. Initial assessments tend to follow the trajectory of introductions, establishing reasons for attendance, ascertaining the nature of the problem (which includes establishing risk), reaching a decision and closing the session (O'Reilly, Karim, Stafford, & Hutchby, 2015).

Our chapter focuses on analysis of 28 mental health assessments, collected though a UK CAMH service. All families attending for initial assessments within the research time-frame of 6 months were approached, and consenting families were video-recorded for research purposes. Urgent referral and acute cases were excluded for clinical reasons. These assessments were multi-disciplinary in nature, and thus the format they took was not informed by a specific disciplinary framework. These practitioners included consultant, staff-grade and trainee child and adolescent psychiatrists, clinical psychologists, assistant psychologists, occupational therapists, community psychiatric nurses (CPNs) and psychotherapists. The children and young people were assessed by a minimum of two mental health practitioners (apart from in one case), and all 29 members of the clinical team participated.

The assessments generally lasted 90 minutes and the data corpus consisted of 2240 minutes in total. The demographics of the participants in the sample were 64% boys and 36% girls. The mean age was 11 years, ranging from 6 to 17 years. Usually children and young people attended with one or both of their parents (legal guardians), but in some cases also attended with siblings, members of the extended family and/or other professionals.

Analytic Approach

Understanding the nuances and subtleties of how children's competence is negotiated, navigated and treated, requires an analytic approach that explores how this is intersubjectively achieved through social interaction rather than objectively agreed. As noted earlier, for our interrogation of the data we utilised CA. This approach has been used extensively for analysing

medical settings exploring interactions occurring between patients and their doctors in physical health settings (Robinson & Heritage, 2006; Stivers, 2002). Furthermore, CA has proven popular in mental health interactions because of its focus on the sequential order of talk and the social actions achieved by the range of parties (Heritage & Maynard, 2006; O'Reilly & Lester, 2017).

CA focuses on talk-in-interaction by examining the ways that talk is ordered and performs social actions (Hutchby & Wooffitt, 2008) and is an observational science in the sense that analysis is based on directly observable features in the data, showing that conversations are patterned, organised and stable (Drew, Chatwin, & Collins, 2001). This is particularly useful for the examination of mental health interactions because of its use of data that is yielded from real-world institutional interactions (Kiyimba, Lester, & O'Reilly, 2019). The use of naturally occurring data is favoured as it enables the analyst to capture what actually happens in real-world practice rather than retrospective reports, typically generated from interviews or focus groups (Kiyimba et al., 2019; Potter, 2002). This use of naturally occurring data is helpful for those practising CA, as analysts identify interactional practices in situ, so that recurrent and systematic patterns might be extracted (Drew et al., 2001). By focusing on these institutional interactions, a corpus of fragments can be generated to identify the recurrent sequential patterns within the talk and these are evidenced through the data and via co-analysis from multiple members which promotes rigour and objectivity (O'Reilly, Kiyimba, & Karim, 2016). Thus, our approach in this chapter is that of a collaborative partnership between academics and clinical-academics to promote translation of applied research into practice (O'Reilly & Kiyimba, 2015). The team-based approach to analysis, and input from the clinical author, ensures that the application of the CA to the clinical environment is meaningful and understandable to those practising in the field. In this way, a team-based approach to CA facilitates the translation of research to practise ensuring its impact.

For appropriate representation of the interactions within the initial mental health assessments, the Jefferson technique of transcription was utilised. This approach to transcription is a detailed technique that includes representing intonation, pauses and volume (Hepburn & Bolden, 2017; Jefferson, 2004).

Ethics

The sensitivity of the data, the nature of its collection and the potential vulnerability of the population meant that a stringent approach to ethics was utilised by the team. As the data were collected through the National Health Service (NHS), it was mandatory to undergo the standardised ethics process through the National Research Ethics Service and approval to undertake the project was provided. Mental health practitioners provided consent and facilitated approaching families. Families and children provided informed consent/assent together both before and after the assessment, and at both times were assured of their right to withdraw. Children and young people were provided with age-appropriate information sheets and had an opportunity to ask questions about the process. During the process of transcription pseudonyms were utilised to maintain anonymity and data were protected through encryption software.

An Analysis of Children and Young People's Social Competence

Children and young people's competence in mental health settings is a co-constructed endeavour, with each party having different degrees of access to specific epistemic domains. Broadly, these kinds of epistemic domains consist of adult–child, practitioner-lay and practitioner-personal expertise. In other words, the child and family are acknowledged to have access to an arena of knowledge situated within the personal domain of experiences, feelings, thoughts, behaviours and so on. However, practitioners are recognised as having a domain of knowledge situated within training, expertise, qualifications and clinical experience. Specifically, in the context of work with populations typically constructed by society as having less than full competence (e.g. children, the elderly, those with severe mental illness), the concept of 'half-membership' has been proposed as an explanatory framework for the differential rights to interactional involvement (Shakespeare, 1998).

The notion of half membership is a term that relates to the ways in which certain speakers are regarded as having full rights to speaking at any point in the interaction (full membership), whereas other speakers are restricted to having lesser rights to contribute (half membership). For example, children are frequently treated as having lesser rights to contribute to adult–child interactions than their adult counterparts (Hutchby & O'Reilly, 2010). It is acknowledged that there has been a conscious shift in policies and practices, with the advent of children's rights (UNCRC, 1989), and a drive for healthcare practices to be more child centred (Sőderback, Coyne, & Hardy, 2011). This reflects a new polemic of the sociology of children and childhood, constructing them as agents in their own lives (Corsaro, 2011). However, it is arguably still the case that in some healthcare interactions there have been cases whereby children in the conversation were treated by adults as having less competence to contribute than other adult speakers. The disparity between members' competences is additionally polarised in mental health adult and child interactions, whereby the adult has a specific domain of expertise and the child is more vulnerable by virtue of their potential mental health difficulty.

One arena of action where this additional polarisation of the disparity between members' competencies is identified, is within the mental health assessment. Compared to other arenas of actions where children and young people socially interact, such as in family groups or with peers, the institutional arena of action presents certain constraints on how their social competence is situated (Hutchby & Moran-Ellis, 1998). Within the institutional agenda of mental health assessments, competence is situated within a framework where interlocutors are provided with certain types of conversational opportunities or spaces, but not others. Often these opportunities to engage in the conversation for children and young people are restricted to answering specific questions by the mental health practitioner and only when addressed directly. Such interactional rights afforded to the child or young person are additionally imbued with institutional parameters of both the setting and the kinds of answers that are positioned as acceptable (Kiyimba, O'Reilly, & Lester, 2019). As such, the institutional space constrains the kinds of social competencies that can be displayed.

Previous research on problem presentation in mental health demonstrates that this phase of the appointment is a substantial part of the

assessment process (O'Reilly et al., 2015). Understanding of the problem and history taking of family and developmental history are just some of the components that are fundamental to problem elicitation. Previous research has focused on children's understanding of their attendance at a mental health assessment, using this same data corpus, to specifically identify responses to a question asking, 'do you know why you are here?'. Notably, while some provided a possible mental health reason, most initially claimed insufficient knowledge with phrases such as 'I don't know'; although further analysis of the problem presentation phase indicated most children and young people were able to provide some account, whether pseudo-technical or lay, when the issue was further explored (Stafford, Hutchby, Karim, & O'Reilly, 2016).

The Core Sequence

The negotiation and testing of children and young people's social competence in the data analysed were constrained by the institutional setting and the assessment agenda. What was observed, however, were some regularities in the turn-taking structure of these sessions. Specifically, there was a recurring sequence of phases of interaction within the 'problem presentation' stage of the appointment:

- Phase one: Practitioner display of anticipated competence—typically the practitioner asked a question. The question focused on either the child/young person's understanding of why they were attending the assessment or their understanding of the reported problem.
- Phase two: The child or young person provided a candidate diagnosis in pseudo-technical language—often offering an immediate diagnostic label but in other cases, there was some hesitancy in explaining attendance at the assessment.
- Phase three: The practitioner 'tested' their competence in using the diagnostic label—this was done through a series of follow-up questions serving to elicit additional detail about behaviour and/or symptoms.
- Phase four: Demonstration by the practitioner of acceptance/rejection of the competence of the child/young person's response.

To illustrate the analytic focus, we present four detailed fragments of data. In the following first fragment, the young person was asked early in the session for a displayed understanding of his reasons for attending the assessment.

Fragment 1: Family 2

In this fragment, a 15-year-old male young person (YP) attended the assessment with his mother. Three clinical practitioners were present, although one was taking notes rather than participating. The outcome of the assessment was that the clinical team would seek out drug and alcohol services for the young person and some support work for the family if needed. We identify the phases of the sequence on the left side of the fragment with an arrow and corresponding phase number and embolden the text within the fragment to illuminate the key part of the turn.

1	Therapist	Um ↑do you ↑know (0.9) why you're here ↓tod↑ay?
2		((looks at the YP))
3		(0.8)
4	**→1**	**Can you tell me a bit ab↓out that?**
5	**→2** YP	(Er) **it's ab↓out self-↓harmin'**.
6	Therapist	Ab↑out self-↓harm.
7		(0.6)
8		Ok↓a:y
9		(1.8)
10	**→3**	i- and **what do you mean by ↓that Call↑um °in what**
11		**way**°
12	YP	What (0.4) em:(0.4) it's (mainly) ↓I self-harm
13	Therapist	You self-↓harm
14		(1.0)
15		°okay° (.) c- can you say s↑omething about that ↓is
16		it i- **↓do you cut yourself ↓or hurt yourself in a**
17		**↑different way?**
18	YP	Cut
19	Therapist	↑You ↓cut yourself?
20		(1.1)
21		**Is it on your ↑ar↓ms?**
22	YP	((*YP nods*))
23	Therapist	°Okay,°
24		(0.7)
25		and **do you (0.3) need (0.6) stitches for that?**
26	YP	((*YP shakes head*))
27	**→4** Therapist	°Okay°.
28		(2.6)
29		**I'm gonna ↑ask you a bit about ↓that how ↑how long**
30		**have you been doing ↓that ↑fo:r**?
31	YP	About s↓even months.

This fragment is a straightforward example of how competence in using pseudo-technical language to describe the problem was, first, tested and then accepted by the mental health practitioner. The four phases of the

sequence are evident here, as the social competence of the young person was negotiated. The practitioner opened the problem presentation part of the assessment with the commonly used question '↑*do you* ↑*know (0.88) why you're here* ↓*tod*↑*ay?*', followed by '*Can you tell me a bit ab*↓*out that*'. This demonstrated a display of anticipated competence (phase one of our sequence), first by presupposing that the young person may or may not know why they were there, but also by addressing him directly, rather than turning to the accompanying adult for information. By selecting the young person as the next speaker using 'you' and through eye gaze (Sacks, Schegloff, & Jefferson, 1974), the therapist treated him as potentially in possession of relevant knowledge to answer the question.

The young person's response '*it's ab*↓*out self-*↓*harming*' was presented in pseudo-technical language, thus forming the second phase of the sequence. He presented a candidate diagnosis in a factual way rather than a list of symptoms or characteristics consistent with the possible condition. In adult medical interactions, a more typical response to questions like 'why are you here?' is for the adult patient to describe several symptoms and provide space for the medical expert to develop a diagnosis (Ten Have, 1991). It may therefore be that the way in which young people present candidate diagnoses in factual ways, explains why practitioners test out the validity of this through a subsequent series of questions about symptoms and behaviours.

In presenting the candidate diagnosis the young person provided both a direct answer to the question, as well as recognising the institutional framework within which the question was asked, and also oriented to the kinds of language appropriate to that setting. In this way, the response indicates competence in several ways: first, that they can articulate the nature of the problem; second, they orient to the situated nature of the question, i.e. the person asking the question and the setting in which it was asked; third, that they can use the kind of institutional language relevant to the setting. The competence of the young person to attend to all of those facets of the interaction is quite a sophisticated communicative accomplishment.

The third phase of the sequence (the practitioner's displayed 'test' of competence) occurred over a series of turns:

what do you mean by ↓that Call↑um °in what way° (line 10)
↓do you cut yourself↓or hurt yourself in a ↑different way? (line 16/17)
Is it on your ↑ar↓ms (line 21)
do you (0.3) need (0.6) stitches for ↓that? (line 25)

Each of these incremental questions probed the young person's understanding of the meanings they ascribed to their initial response. This functioned to ascertain the behaviours the young person was engaged in that might fit with the clinical definition, in this case self-harming. The practitioner offered category-bound descriptors of behaviours (see Potter, 1996) that are congruent with the definition of self-harming. These questions worked as prompts regarding the types of answers being sought. The practitioner appears to be seeking confirmation or disconfirmation that the young person is competent to use the phrase self-harm in a clinically appropriate way. The minimal responses following each question are affirmative that their definition of the behaviours consistent with self-harm is the same as the practitioner's understanding.

The acknowledgement token '*okay.*' with a unit final intonation served as a transition point from the series of questions regarding the behaviours constituting self-harm, to signal a topic shift. Thus, the fourth phase of the sequence (demonstrated acceptance/rejection) in this instance is a degree of acceptance of the sufficiency of the young person's use of the phrase self-harm in what we are arguing to be a clinically sufficient way to indicate to the practitioner that the young person has competence to use the diagnostic category appropriately. Therefore, at this point there appears to be no requirement for the practitioner to pursue further information to clarify the young person's competent use of the diagnostic term. Additionally, there was a presupposition within the question '*↑how long have you been doing ↓that ↑f o:r?*' whereby the '*that*' indexically related back to the self-harming behaviour as having been interactionally agreed and provided a shared platform for further exploration.

Fragment 2: Family 12

In this fragment, the child is a 9-year-old female who attended the assessment with her mother. Three clinical practitioners were present during the assessment although again, one was only taking notes. The outcome of the assessment was that the child required treatment for anxiety and was referred for cognitive behaviour therapy.

Fragment 2

1	→**1**	Nurse	**I'd like it if you could tell me:(0.2) why you think**
2			**you've come here to↓day?**
3	→**2**	Child	°Um: well **because I've got a phobia** but°
4			((*child looks at mum*))
5		Mother	Just explain you you say K[ohm]
6		Child	° [what (d]o you me-) I
7			don't know what she me:ans°
8		Nurse	You said you just said that you've come here because
9			of your ↓phobia,
10			(0.3)
11	→**3**		Okay **can you tell me a little bit more about**
12			↑**that?**
13		Child	°Er:::°
14			(2.0)
15			°<We:ll I faint or I be sick when I see ↓needles
16			or: blood or,>°
17		Nurse	Okay,
18			(0.6)
19			so (0.3) **you feel quite** ↓**faint (0.5) and sometimes**
20			**you're sick** (0.3) if you see:(0.3) needles or blood
21		Mother	And she has actually ↓fainted
22		Nurse	**And you've actually** ↓**fainted**
23		Mother	Yeah
24	→**4**	Nurse	Okay.
25			(1.4)
26			↑**how long's this been going on for?**
27		Child	Er::m: since I's about (0.7) three.

This fragment consists of the same four phases of the identified sequence, in a way that demonstrates that the child's competence to adequately define the proposed problem was treated as sufficient. Here, the practitioner displayed an anticipation of competence from the child (phase one), by asking the question '*I'd like it if you could tell me: (0.2) why you think you've come here to↓day?*' This anticipated competence was displayed first, by directly addressing the child despite the mother's presence and the child's relatively young age. Second, by framing the question in terms of what 'you think', it projected the possibility of a range of potentially appropriate responses from the child's perspective. Subsequently, the child provided a pseudo-technical response '*because I've got a phobia*', which relates to phase two of the presented sequence. Like Fragment 1, this response was apparently then tested by the practitioner through a series of questions (phase three), such as '*can you tell me a little bit more about ↑that*' and reflections on the child's descriptions of phobia-congruent behaviour, '*so (0.3) you feel quite ↓faint*'. During these pursuit sequences in both fragments, the use of the token 'okay' (Fragment 1, line 23; Fragment 2, line

17), with continuing intonation and the short pause, signals that the pursuit is incomplete. In contrast, the sufficiency of the child's description (phase four) was signalled with the acknowledgement token '*okay.*' delivered with unit final intonation and a subsequent topic shift (Fragment 1, lines 27 and 29; Fragment 2, lines 25 and 27). The topic shift pursued detail, thus displaying a validation of the appropriateness of the child's answer.

Although the child in this fragment was considerably younger than the young person in the previous fragment, the practitioner directed their questions to the child, using speaker selection strategies to do so. This is especially notable, as the mother in this sequence was part of the conversation. There are two key points in the sequence where the mother jointly produced an explanation of the problem with the child. The first instance was a response to an invitation by the child, evidenced by the incomplete turn '*but...*' (line 3) and the child's eye gaze in the mother's direction, where the mother encouraged the child with a shortened version of her (pseudonym) name Kohemi (Kohm). The second instance was a self-initiated turn insertion by the mother '*she has actually ↓fainted*' (line 21) into a sequence between the practitioner and the child. Notably, despite interjection by the mother the practitioner still oriented their questions towards the child.

The social competence of the child in this sequence was oriented to by both the practitioner and the mother. The practitioner maintained her focus on the child using 'next-speaker selection' techniques, consequently treating the child as an agent competent to provide answers to specific questions. Furthermore, a degree of social competence was afforded to the child by the mother, as the mother actively agreed with the child's responses. She also gave space for the child to answer, even where there was a transition relevance place (Sacks et al., 1974) where she could speak, (i.e. the 2.0 pause). However, at the point where the practitioner downgraded the child's description of phobia-congruent behaviour from a clear action '*I faint or I be sick when I see ↓needles or: blood*', to a feeling state '*you feel quite ↓faint (0.5) and sometimes you're sick*', the mother interjected with a repair. In this case, she upgraded the practitioner's downgrade back to a behaviour rather than a feeling, using the discursive resource 'actually', '*she has actually ↓fainted*'. This may be indicative of the point at which the mother deemed the child's competence within the interaction not to be

sufficiently developed to be able to challenge an adult who is in a position of authority. Thus, the mother did not allow enough floor space for the child to provide further detail. Compared to her previous demonstration of presumed competence of the child to answer questions about their own mental state directly, this interaction may be an assertion of her full membership as an adult in the interaction (Hutchby & O'Reilly, 2010).

Evidently therefore this fragment demonstrates a subtle difference from Fragment 1 in terms of membership status of the child. Here, the turns of the mother served an important role in the construction of the competence of the child. This was achieved by projecting anticipated competence for the child to answer the practitioner questions for herself at certain points and interjecting at other points where she treated the child as not competent to challenge the practitioner. This demonstrates that the notion of competence is not a binary construct but is something that is collaboratively, dynamically and situationally achieved.

Challenging and Testing Children's Competence

The fragments analysed thus far were straightforward examples of the ways in which competence was displayed with regard to why the child and the young person were attending the assessment appointment. In both cases, the practitioner displayed an anticipation of competence of the child/young person to answer questions about their mental health and a candidate diagnosis was provided. Although this understanding of the proposed diagnosis was apparently 'tested' and pursued by the practitioner, in both cases it was quite quickly confirmed and accepted. However, this is not always so straightforward, and we turn now to cases where the challenging and testing were more protracted and the confirmation not as readily forthcoming.

Fragment 3: Family 1

In this fragment, a 13-year-old female (YP) attended the assessment with her mother. Two clinical practitioners were present during the assessment. The outcome of the assessment was that further diagnostic work was required, to confirm a probable combination of anxiety disorder and Obsessive-Compulsive Disorder (OCD), and the team thus recommended a referral for diagnosis and treatment through CAMHS.

1	→**1** Clin Psy	**↑Do you kno:w (0.3) why you've c↑ome here**
2		**toda↓y**?
3	YP	Erm because (0.4) I- keep (0.9) doin’ my-(0.4)
4	→**2**	**I thi↑nk it's ↓O- C- D-.**
5	Clin Psy	Ri:ght
6		(0.8)
7		↑Okay:
8		(0.9)
9		Um (0.5) °that is a (.) important word you use° (.)
10		m↑eaning when you say O- C- D-,
11	YP	°Pard[on-]°
12	→**3** Clin Psy	[ah] wh- **when you say o- c- d- what does**
13		**it me:an?**
14	Mother	Wha’ d'ya think it me:ans when you say o- c- d-?
15	YP	Um-
16		(1.1)
17		Ah: can't remember what the teacher to↑ld me=
18	Mother	=obsessive [compuls]ive disord[er
19	Clin Psy	[don’t worry]
20	YP	[yeah that’s it-
21	Clin Psy	er- right so you're ↑teacher told you that you
22		may ↓ha:ve (.) obsessive c- compulsive disorder
	Lines omitted	
23	Clin psy	**D↑o you mi↑nd just telling us a little mo:re** (0.5)
24		**er- w↑hat made the teacher sa:y that you ha↓ve (0.4)**
25		**o- c- d**?
26	YP	Because when I explained to her what I been doing
27		she thought that that means li:ke (0.8) you get in
28		like- a-(0.7) repe:ating the method and to keep
29		do↑in’ i↓t
30	Clin Psy	R:igh[t.
31	YP	[A::h
32	Mother	No but how did she notice that you got it?
33		(0.5)
34		coz you kept (0.4) cr[yin’
35	YP	[DOing it in no I's doin it in
36		cla- when I's speaking to her I kept doing it (0.4)
37		like (.) with the letters an’ I'll do ‘em.
38	Clin Psy	Ye:ah (0.5) °ehh° (0.6) **do you mind just telling**
39		**me what what do you [do you do**
40	YP	[ah- every lette:r (.) thi:s is
41		(.) going a bit now this one but- now [another
42		on]e’s coming
43	Clin Psy	[uh hum]
44	YP	↑This one (0.5) the ↑one befo:r↓e was l↑ike (0.81)
45		>goin’ on about< (0.7) letters that are for my
46		fami>ly< (0.3) S for my mum L for my sister (0.5) K
47		for my brother (0.4) D for my d↑ad
48	Clin Psy	Ri:ght,
49	YP	No M for my dad so[rry
50	Clin Psy	[Yea[h
51	YP	[then D for me (.) but I
52		thought *((clears throat))* (0.8) now its c↓omin’ I
53		say ME at everythin’
54	Clin Psy	Ri::g[ht,
55	YP	[so if any I think things bad are g↓onna
56		happen to my f↑amily so I'd r↓ather it happened to
57		me-
58	→**4** Clin Psy	**°Oka:y.°**
59		**(1.2)**
60		**↑I'm so↓rry to h↑ear tha↓t**

In this fragment, the young person offered up a candidate diagnosis of OCD (phase two of the proposed sequence) in response to the practitioner's display of anticipated competence (phase one of the proposed sequence). In the same way, as the previous two fragments, she offered a fairly direct response to the question, although this was hedged with '*I think*' which softened the projected factuality of the claim. The initial responses from the young person and mother to the practitioner's questioning about what OCD means, '*when you say o- c- d- what does it me:an?*' related to the specifics of the abbreviation, rather than the meaning of the condition itself.

```
14   Mother      Wha' d'ya think it me:ans when you say o- c- d-?
15   YP          um-
16               (1.1)
17               Ah: can't remember what the teacher to↑ld me=
18   Mother      =obsessiv[e compuls]ive disord[er
19   Clin Psy             [dont worry]
```

Here, the mother reframed the question from the practitioner in a way that allowed for a greater range of possible answers and positioned the knowledge in the domain of the young person, '*what d'ya think*'. In this way, the mother constructed the child as a 'competent conversational member', by providing conversational floor space, and presenting the question in a child-centred way, thus allowing for a forthcoming response (see Leiminer & Baker, 2000). When the young person was unable to recall the teacher's explanation of the abbreviation, the mother offered up the correct name of the condition. The '*don't worry*' response from the practitioner was indicative that central concern was not with the abbreviation, but the symptoms and behaviours associated with the condition.

What we see here is a range of potential competencies negotiated in the interaction; these are both projections from the practitioner and mother of anticipated competence in the young person, and displays of the young person's competence. As previously stated, competence is dynamically accomplished turn-by-turn throughout these data. In Fragment 3, there are several:

- Projected competence of the young person to comment appropriately on her reasons for attendance from the practitioner *↑Do you kno:w (0.3) why you've c↑ome here toda↓y?* (lines 1–2).
- A display of competence from the young person to provide an institutionally appropriate response, in this case in the form of a pseudo-technical construct *I thi↑nk it's ↓O- C- D-* (line 4).
- A projected competence that the young person will be able to unpack the meaning of OCD from both the practitioner and the mother *Wha' d'ya think it me:ans when you say o- c- d-?* (line 14).
- A projected competence of the young person to articulate the reasons why the teacher attributed behaviours to OCD *w↑hat made the teacher sa:y that you ha↓ve (0.4) o- c- d-* (lines 24/25).
- A (partial) competence displayed by the young person in providing an explanation of this, though pursued by further questioning from the practitioner *Because when I explained to her what I been doing* (line 26).
- A (fuller) competence was displayed by the young person in the provision of descriptions of the behaviours and cognitions that are congruent with OCD *every lette:r .... S for my mum L for my sister* (lines 40–51).
- The practitioner treated the young person as having competently answered the question fully *°oka:y.°(1.2)↑I'm so↓rry to h↑ear tha↓t* (lines 58–60).

What is demonstrated here is that the acceptance of the young person's competence to express the behaviours and symptoms that map onto their initial candidate diagnosis was accomplished over a protracted series of turns. Thus, the young person was able to sustain a consistent narrative overextended turns of talk, which further evidences their competence in providing a more holistic overview of the issues, as well as attending to the practitioner's request for more information (*D↑o you mi↑nd just telling us a little mo:re;* and *do you mind just telling me what what do you do you do*). In institutional terms, the practitioner who is in an epistemic position to officially either accept or reject the candidate diagnosis requires a certain kind of information to inform that decision. The kinds of information required by the practitioner are: details about the type of problem, the recency and longevity of the symptoms and the seriousness of those symptoms and related behaviours. It appears that conversations about

potentially problematic behaviours have already been engaged in prior to the assessment consultation between the young person, parents and third parties such as teachers. This fragment indicates that these conversations about behaviour have resulted in a lay-diagnosis of OCD being proposed prior to the assessment appointment. Therefore, when the young person presented a summation of these conversations at the outset of the assessment by stating a candidate diagnosis of OCD, the practitioner 'unpacked' the meaning of this label by questioning her further about her behaviour.

Fragment 4: Family 6

In this fragment, the child was a 9-year-old female who attended the assessment with her adoptive mother. Two clinical practitioners were present during the assessment. The outcome from this appointment was that the child did not have a mental health condition, and therefore, CAMHS was not the appropriate service. The team recommended parenting support for the mother.

1	Doctor	So when you ↓said that you were going to take a
2		↓knife to yourself
3		(1.0)
4		Yeah
5		(1.2)
6	**→1**	**What were you ↓hoping would happen?**
7	Child	Erm
8		(2.5)
9	**→2**	**f::or me to ↓actually kill my↓self**
10	Doctor	Mummy w↑ould
11	Child	No me ↓to kill ↓myself
12	Doctor	Say that ↓again mummy would
13	Mum	↓No for her to kill her↓self
14	**→3** Doctor	**Ri:ght you're ↑smiling as you ↓say that which makes**
15		**me ↓think that (.) was that really ↓some- ↓what you**
16		**wanted to ↓do was kill yours↓elf?**
17	Child	When I'm ang↓ry
18		(1.7)
19		I ↓do.
20	**→4** Doctor	**And how long does that ↓last for ↓wanting to kill**
21		**yourself?**
22	Child	Five m↓inutes.
23	Doctor	Umhm,
24		(1.0)
25		**It's quite a g- good way of up↓setting ↑mum as ↑well**
26		**isn't ↓it?**
27		(1.1)
28	Doctor	So if you're cross with ↓mum (.) and you say you're
29		gonna kill your↓self (1.06) quite a way of ↓getting
30		mum to kind of stop doing whatever she was doing
31		that makes you ↑cross ↑isn't it?
32		(1.6)
33	Child	((*nods head*))

34	Doctor	↑um (1.0) and then what ↓happens?
35	Child	°just g↓ive up°
36	Doctor	But I guess one of the ↓things it does ↓Carla is it
37		kind of makes things ↑difficult for you and ↓mum
38		because mum then ↓doesn't know what to ↑do with ↓you
39		does ↓she?
40		(0.9)
41	Doctor	Cuz you're not really what you're ↓saying to me is
42		you're really kill ↓wanting to kill >your↓self<
43		cause your cross
44		(0.5)
45		Yeah?
46		(0.5)
47	Doctor	and you're cross with other people (0.5) but you're
48		not really ↓wanting to di:e ↓if it only lasts five
49		minutes ↑see what I'm getting ↓at
50		(0.8)
51		↑Okay
52	Child	((*nods head*))
53		(1.0)
54	Doctor	**↑What do you ↑think might be a ↑different ↓way of**
55		**managing your feel↓ings cause (.) you're not it**
56		**sounds to ↓me like you get ↓cross** (0.5) yeah?
57		(0.9)
58		and you're not very ↓good at handling being
59		↓cross

The four phases of the sequence are again clearly identified in this example. Of importance here, however, is that the fourth phase, namely accepting or rejecting the competence of the child, is more protracted and developed than in our previous fragments.

This fragment opens with the practitioner using the 'you said x' marker to introduce a prior topic using 'reflected speech' (see Kiyimba & O'Reilly, 2018). This device was shown to be effective in reintroducing sensitive topics with children (ibid.); in this case, the child's claim to '*take a ↓knife*' to herself. Significantly, however, it has also been shown to presage scepticism regarding the claims of an interlocutor (Hutchby, 1992). Once the receipt token 'yeah' had been received, the practitioner continued with the follow-up question, '*What were you ↓hoping would happen?*'. In this instance, the child's response was to emphatically assert that her hoped-for outcome would be '*f::or me to ↓actually kill my↓self*'. Interestingly, the child utilised the modal subjunctive 'actually' which has as one linguistic function, that of reinforcing the 'truth value' of the clause in which it appears (Clift, 2001; Quirk, Sidney, Leech, & Svartvik, 1985). It may be, therefore, that in projecting the need for such a definitive assertion about what she was *hoping* to happen, the child displayed interactional as well

as linguistic competence in orienting to the potential scepticism in the practitioner's question.

The practitioner seemed to experience difficulty in hearing this assertion, despite its emphatic production; instead of attributing an outcome of the action with the knife upon the child herself, the turns '*Mummy w↑ould*' and '*Say that ↓again mummy would*' display an orientation to its intended effect upon the mother. Following repair of this mishearing, phase four of the sequence can be clearly seen, but in terms of both accepting and simultaneously rejecting aspects of the competence of the child, which was complex and subtly played out.

There is some evidence of partial acceptance through the practitioner's acknowledgement token, 'right'. There was a clear challenge from the practitioner questioning the validity of the child's answer in '*was that really ↓some- ↓what you wanted to ↓do*', which may also have been a challenge to the child's competence to 'correctly' identify their motivation. The addition of the word 'wanted' in the practitioner's challenge also reformulated the question from one focused on outcome to motivation. In terms of anticipated competence, several interrelated and nuanced aspects of the child's competence were presumed in this question:

1. Epistemically it was presumed that only the child herself could access her feelings and motivations.
2. To present this description of her feelings in response to a question, there was a competence required for the child to recognise her own internal state.
3. In recognising her internal state, a competence was needed to articulate and report on it to the practitioner.

The child's response was equally as emphatic in its assertion, '*I ↓do*' even though it was presented with the caveat, '*when I'm ang↓ry*'. In producing this account, what was demonstrated by the child was a competence regarding the recognition and reporting of her feelings and motivations for her actions. This competence was not challenged directly by the practitioner. Instead, and in line with the potential scepticism encoded in the earlier 'you said x' formulation, there was a suggestion that there may be additional functions to the described behaviour, such as '*up↓setting*

↑*mum*' and '↓*getting mum to kind of stop doing whatever she was doing that makes you* ↑*cross*'. Although the practitioner did not afford the child much opportunity to provide full or alternative responses, acknowledgement was indicated by the child with non-verbal agreement that provided the practitioner the opportunity to pursue this line of reasoning. In so doing, there was a scaffolding of the child's original claim against the practitioner's reconstruction of the motivation for it, which cumulated in '*you're not really* ↓*wanting to di:e*'. Once agreement from the child was acquired, the practitioner moved to propose an alternative solution to how the child manages her anger, suggesting the child had insufficient competence to do so currently: '*you're not very* ↓*good at handling being* ↓*cross*'.

Summary and Discussion

In this chapter, we explored the social interactions between children and young people and mental health practitioners, in the context of initial mental health assessments. Using naturally occurring data in the form of video-recordings, we focused on the social competencies of the children and young people in these assessments. In response to a presupposition of competence to communicate issues and experiences of mental health, children and young people (in these examples) offered a candidate diagnosis. The focus of this chapter was to gauge the ways in which children and young people display and were treated as needing to display, competence in using institutionally relevant mental health discourses in problem presentation sequences.

Following the principles of unmotivated looking in CA (Sacks, 1984), the use of medicalised terminology and use of candidate diagnosis stood out as unusual. With closer attention paid to the broader literature and the fragments of data, it was observed that the adult interlocutors in these assessment interactions treated these responses as insufficient in their own right and as requiring further exploration. These pursuits typically took the form of seeking information about symptom and behaviour frequency and severity. Previous research examining paediatric clinics involving parents and children has shown that when parents offer a candidate diagnosis,

they are treated by the doctor as taking a stance that seeks confirmation as the preferred response (Stivers, 2002: 308).

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Doc:  Al:ri:ght, well what can I do [for you today.
Mom:                               [(°hm=hm=hm=hm.°)
Mom         .hhh Uhm (.) Uh- We're- thinking she might have an ear
            infection? [in thuh left ear?
Doc:                   [Okay,
```

Stivers reported that the offering of candidate diagnoses in these paediatric clinics tended to be tentative and heavily mitigated. In the fragment above, the use of words '*thinking*' and '*might*' from the mom, together with strong questioning intonation, served to highlight that the diagnosis was offered up for confirmation or disconfirmation. In our data, in contrast, when offering a candidate diagnosis, the children/young people did not engage in the same hedging or tentative proposals. Instead, they tended simply to present the candidate diagnosis with minimal or no mitigation.

We noted that the negotiation of competence was sequentially accomplished through a typical four-phase configuration. To summarise, this was, first a practitioner display of anticipated competence of the child or young person to respond to the question; second, the provision of a candidate diagnosis in pseudo-technical language by the child or young person; third, the testing of competence in terms of the congruence between the proposed label and the symptoms and behaviour reported; and fourth, an eventual display of accepting or rejecting the competence of that proposal. The ways in which this linguistic trajectory was built incrementally over a series of turns are important because the institutional task of these initial mental health assessments is primarily to determine whether the child or young person has an identifiable mental health problem that warrants an intervention from specialist CAMH services. Part of this determination involves an evaluation of the longevity and extremity of the symptoms and/or behaviours.

Rather than taking the child or young person's assertion of a diagnosis at face value during the problem presentation phase of the appointment, practitioners displayed further questioning sequences to establish what behaviours and symptoms had precipitated the asserted diagnosis.

This implies that the practitioner required more information to accept their competence to appropriately label the condition. Although this may project a rather binary conceptualisation of the notion of competence, our investigation of the data highlighted the more subtle and nuanced aspects of anticipated and displayed competence. Specifically, for an utterance to be treated as sufficiently competent, the preceding question had to be positioned as seeking an answer which would be within the child or young person's epistemic domain. In these cases, questions about the nature of the problem or reasons for attendance were treated as within their domain to answer. The answers provided were treated as displaying competence with regard to using appropriate language for the institutional setting, but not necessarily in the format that adults would typically present their responses in this context.

The child or young person's epistemic domain was treated as one of intrapersonal thoughts, feelings and motivation, while the practitioner's epistemic domain was in clinical knowledge, expertise and understanding of how behaviours and symptoms relate to diagnostic labels or mental ill health symptom clusters. Predominantly, the data indicate that the practitioners were not challenging the epistemics of the child/young person in terms of their feelings, thoughts and behaviours, but instead were testing the boundaries of that domain at the place where it intersected with the practitioner's epistemic domain of knowledge about mental health.

The practitioner cannot be expected to know about the child/young person's feelings or thoughts, and neither can they be expected to know about their life at home; however, the practitioner is an expert in a different area, that is, the clinical one. While the child/young person's thoughts and feelings may be treated by practitioners as personal knowledge, where there is an overlap between the child's and practitioner's epistemic domain (i.e. to determine 'correct labelling' of problematic behaviours, thoughts and feelings within a medicalised language), it is this area that is more likely to be treated as needing to be negotiated.

Conclusions

Evident from the analysis is the sophisticated and competent ways in which the children and young people attended to the institutional environment and the clinical encounter. Our analysis demonstrated that the practitioners oriented to the anticipated competence of the child or young person to provide satisfactory answers to questions about their attendance and the nature of the problem. These children and young people subsequently demonstrated interactional competence in many ways, such as answering questions in an appropriate and accepted manner, being able to articulate their thoughts, feelings and behaviours, and orienting to the institutional boundaries of the assessment interaction. As we have acknowledged, competence is not binary, and they were treated as having unquestioned competence in articulating certain aspects of knowledge, whereas more subtle competencies, such as their ability to use medical terminology 'correctly' were tested and explored. In effect, social competence can only be understood as something that is situated, contextualised and collaboratively achieved.

Professional Reflection

Nikki Kiyimba

Abstract

Nikki Kiyimba is a contributing author to the chapter and a Chartered Clinical Psychologist. She offers a clinical reflection on the value of using conversation analysis to inform practice and the core messages learned for child mental health practitioners from this chapter. In her reflection, she addresses the bidirectional influence of coming to a set of data as both a researcher and clinical practitioner. Trained as a conversational analyst, she is able to separate what the interactants might be 'intending' in a cognitive reductionist way and focus on the social actions in the data. As a practitioner, she is also able to step away from the transcripts and the

analysis to see what the interactants are accomplishing in their talk and how they achieve it, and to think about what the implications might be to feed back into clinical work.

As a co-author on this project, it has been a really interesting experience to consider the bidirectional influence of coming to a set of data as both a researcher and clinical practitioner. When analysing the data, I still hold onto my roots as a discursive psychologist and my conversational analytic training that separates me from imagining what the interactants might be 'intending' or 'trying to do' in some kind of cognitive reductionist way. This allows me, along with my co-authors, to really see what the social actions are in the interaction and how they are developed turn-by-turn in a sequential order. Then as a practitioner, I can also step back from what the text shows that the interactants are accomplishing in their talk and how they achieve it, and to think about what the implications might be to feed back into clinical work. When I think particularly about children and young people's competence, the development of this chapter has been a real journey from a rather clunky binary perception of 'competent versus non-competent', when we first approached the data. It has developed into a far more meaningful appreciation for the sophisticated and nuanced nature of children's social competence, and a realisation that competence is displayed and co-constructed in a multitude of layers and subtle inflections.

What has been most inspiring, is to see in detail how a single turn of talk from a practitioner can contain within it several presuppositions about the different kinds of competencies that a child or young person would need to have in order to respond appropriately or adequately. Digging into the detail of the data and discussing it with my co-authors have unearthed interesting aspects that otherwise may not have been discovered. This is one of the great joys of academic collaboration, as new insights are borne through collaborative inquiry. The idea that there are actually a range of potential competencies that are negotiated within the interaction is one such enlightenment that emerged from these discussions. When working with children, as with adults, we all have degrees of competence in different areas and may be competent in one thing but totally incompetent in another. The exciting thing about conversation analysis is that we can see the moments in a dynamic, in-action conversation where particular kinds

of competencies are projected and displayed. Not only are these dynamic, situated accomplishments, they are also fascinatingly co-constructed.

One example of this co-construction of competence was in Fragment 2 where the mother stepped in after having been taking a rather 'back stage' position in the exchange between the practitioner and the child. She quite assertively intervened with an interjection to upgrade the practitioner's comment, and in so doing backed up what the child had said, protecting the child's statement from being minimised by the practitioner. Where competence is assumed, unquestioned and is displayed fairly unproblematically, it can sometimes be more difficult to see than in those moments where something happens to disrupt the flow. This was one of those moments, where the mother displayed a moment of treating the child as having insufficient competence *in that moment, with that practitioner, in that setting*, to engage in a *particular kind* of competence. In this instance, the particular kind and degree of competence inferred as not yet developed might be something like the competence to assert herself in challenging the downgrade of the adult authority figure of the practitioner.

As with all research, I find that one of the outcomes of this kind of detailed inquiry is that it raises even more questions and other avenues for potential research. Another area that came to light was that the children in these data usually presented their candidate diagnosis quite directly and plainly stated. In our discussions as co-authors, we pondered on why this seemed different from our anecdotal experiences and understandings of adult interactions in similar kinds of medical situations. We started to muse on the fact that as adults, our experience tells us that when presented with a medical expert, we are more likely to present a series of symptoms and generally allow the 'expert' to come to a conclusion about what the sum of these parts might indicate. In effect, we as adults are more likely to offer the pieces of the jigsaw, but then (even if we have an idea of what we think the answer might be) defer to the medical practitioner to provide a definitive answer or 'diagnosis'. Might it be that the children and young people in these data just hadn't developed that level of social competence or familiarity with the script or schema for attending a medical appointment? Or might something else be at play? Conversation analysis has its roots in sociological enquiry and the work of Harvey Sacks, an academic interested in how people create their social world through words and interactions

with others. These are just the kinds of questions that CA asks about how people talk to one another and accomplish social actions through their words.

As a practitioner, what I take away from this particular foray into the world of mental health assessments is a far greater appreciation and insight into the kinds of presuppositions embedded in any question that I may be asking a client. By asking any question of a client, I am on some level assuming various degrees and arenas of competence; be that the ability to think, to remember what I have said long enough to answer, to hear what I have said, to be able to understand the words I am speaking, to access their own thoughts or feelings, to be able to put some kind of linguistic label on those inner experiences and to have the confidence and will to speak to me and to articulate those experiences in a way that I can understand. Perhaps it does us all good from time to time to examine our own presuppositions about others' competencies and not assume too much … or too little.

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