THE ORGANISATION OF ACCESS IN CHILD MENTAL HEALTH ASSESSMENTS:

A CONVERSATION ANALYSIS OF INITIAL ASSESSMENT APPOINTMENTS

AT A CHILD AND ADOLESCENT MENTAL HEALTH SERVICE

Thesis submitted for the degree of

Doctor of Philosophy

at the University of Leicester

By

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December 2017
ABSTRACT

Title: The Organisation of Access in Child Mental Health Assessments: A Conversation Analysis of Initial Assessment Appointments at a Child and Adolescent Mental Service.

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Initial child mental health assessment appointments are an under researched area of interaction. Within the appointment, parents and children work to present a case to the clinicians of the child’s difficulties which situates their cause as legitimate, doctorable, and as requiring specialist services. The clinicians establish the reason for the child’s attendance, build an understanding of the difficulties the child is facing, and formulate and communicate a decision about whether there is a mental health related concern. The objective of this research was to explore the sequences of interaction between clinicians, parents, and the children in order to understand the social actions that are being accomplished through the participants talk. A conversation analytic framework was utilised to explore the interactions at a child and adolescent mental health service within 15 video recorded initial assessment appointments.

Access to mental health services is organised through the construction of each participant’s turns in the interaction. Clinician’s question design elicits certain responses from the child, which then further orient to their perceived right to knowledge. Parents work to build a case for their child’s difficulties using a variety of rhetorical devices such as extreme case formulations and contrast devices that legitimise their need for specialist intervention. Clinicians deliver their decision about the child’s difficulties in such a way that asserts their authority and accountability in the relationship, whilst parents’ responses maintains this asymmetry.

In conclusion, through their turns at talk, all parties in the interaction perform and accomplish different tasks which impact on the shape of the remainder of the appointment as well as the clinician-patient relationship and the child centeredness of the interaction. Conversation analysis proves a valuable and appropriate resource for researching child mental health appointments; a communication centred methodology for a communication based service.
ACKNOWLEDGMENTS

I would like to firstly thank my supervisors, Dr Michelle O’Reilly and Professor Ian Hutchby for their patience, guidance and support throughout this PhD; their expertise, attention to detail, and reassurance have been invaluable. I would not, and probably could not, have done it without them. I would also like to thank Dr Michelle O’Reilly and Dr Khalid Karim for employing me as their research assistant at the Greenwood Institute, trusting me with their project and data collection, and setting me on the path of this PhD.

Thank you to my family. To my parents for always believing that I could ‘set the world alight’ and passing on their unwavering faith when I needed it most. To my brothers who have always pushed and challenged me and who are always there with encouragement and support no matter how far apart we all are. To my husband. When I began this PhD I do not think either of us really knew what we were letting ourselves in for. This thesis has in many ways been the third party in our relationship and has been with us through the most significant moments of our life so far. You have always been there despite my mental, and sometimes physical, absence. Now it’s my turn! I hope I can give you the patience, support, and stability you have given me to enable me to achieve my goals.

Finally, I would like to thank all of the families and clinicians who agreed to take part in the research. At a sensitive point in their lives, the commitment of children and families enabled this research to happen.
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### Abbreviations

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<tr>
<td>ADHD</td>
<td>Attention Deficit Hyperactivity Disorder</td>
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<td>A &amp; E</td>
<td>Accident and Emergency</td>
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<td>ASD</td>
<td>Autism Spectrum Disorder</td>
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<tr>
<td>BBC</td>
<td>British Broadcasting Corporation</td>
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<tr>
<td>BPS</td>
<td>British Psychological Society</td>
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<td>CA</td>
<td>Conversation Analysis</td>
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<td>CAMHS</td>
<td>Child and Adolescent Mental Health Services</td>
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<td>CCTV</td>
<td>Closed Circuit Television</td>
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<tr>
<td>DNA</td>
<td>Did Not Attend</td>
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<tr>
<td>DSM (III/5)</td>
<td>Diagnostic and Statistical Manual of Mental Disorders</td>
</tr>
<tr>
<td>ECF</td>
<td>Extreme Case Formulation</td>
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<tr>
<td>ESRC</td>
<td>European Social Research Council</td>
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<tr>
<td>FSW</td>
<td>Family Support Worker</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<td>HRA</td>
<td>Health Research Authority</td>
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<td>NHS</td>
<td>National Health Service</td>
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<tr>
<td>NICE</td>
<td>National Institute for Clinical Excellence</td>
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<td>NRes</td>
<td>National Research Ethics Service</td>
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<td>NSPCC</td>
<td>National Society for the Prevention of Cruelty to Children</td>
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<tr>
<td>OCD</td>
<td>Obsessive Compulsive Disorder</td>
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<td>ONS</td>
<td>Office of National Statistics</td>
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<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>OT</td>
<td>Occupational Therapist</td>
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<td>PDS</td>
<td>Perspective Display Series</td>
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<td>PE</td>
<td>Physical Education</td>
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<tr>
<td>PIS</td>
<td>Participant Information Sheet</td>
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<tr>
<td>PR</td>
<td>Parental Responsibility</td>
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<tr>
<td>R &amp; D</td>
<td>Research and Development</td>
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<tr>
<td>SD</td>
<td>Standard Deviation</td>
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<tr>
<td>SEN</td>
<td>Special Educational Needs</td>
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<tr>
<td>SENCo</td>
<td>Special Educational Needs Co-ordinator</td>
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<tr>
<td>TCU</td>
<td>Turn construction unit</td>
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<tr>
<td>UK</td>
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<td>World Health Organisation</td>
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CHAPTER ONE: OVERVIEW

1.1 Background and Rationale

The research undertaken for this PhD is situated within a larger project investigating various interactional facets of initial child mental health assessment appointments, referred to as triage, in a Child and Adolescent Mental Health Service (CAMHS) (O’Reilly, Karim, Stafford & Hutchby, 2015). The data for the wider project consists of video recordings of 28 initial assessment appointments in a CAMHS service. Analysis has investigated areas of interaction such as identifying the interactional processes that occur in appointments (O’Reilly, et al., 2015), examining sequences related to establishing the reason for the appointment (Stafford, Hutchby, Karim & O’Reilly, 2014), and the use of either/or questions in assessments (Antaki & O’Reilly, 2014). The sample of 15 video recordings presented in the following chapters is taken from this larger collection of 28 video recordings. The broader project details were completed by Dr Michelle O’Reilly and Dr Khalid Karim and this included the application for ethics approval through the NHS ethics service which occurred prior to the conception of this PhD research. My own role on the wider research project began with participant recruitment, ethical implementation, data collection and transcription. It was in my capacity as a research assistant working on this wider project that I established my own interest in the data and independently developed my own set of research questions. This will be discussed further in the methodology chapter with regards to how a sample of the larger corpus of data was chosen, obtaining ethical approval for the research projects, and other procedural decisions.

Whilst observing and transcribing the triage appointments and in understanding the process of referral and treatment outcomes more clearly, I became increasingly interested in how families present themselves and their concerns, and situate their child’s difficulties. Furthermore, it became apparent that throughout these appointments, the professionals involved were working hard to unpick the accounts being presented whilst managing the families’ expectations, and to some extent, managing families’ access to future services. Newman (2000) suggests that in a clinical consultation the clinician questions whether the patient is giving an
accurate account or what they think they want to hear, whilst the patient is concerned with trying to convince the clinician their complaints are genuine and with telling them what they want to hear to receive the desired treatment. It was this dynamic that drew me to explore the data further.

The PhD (and broader project) required consultation with clinicians and reading through children’s medical referrals and histories, and from this it became apparent that most children had been through a lengthy process of appointments prior to their referral to CAMHS. This involved, but was not limited to, being seen and assessed by GPs, paediatricians, and other specialist child and family services, as well as school interventions and assessments. It was also apparent that a mental health assessment was the final option for many of them in terms of understanding their child’s difficulties. This alone makes the dynamic of these triage appointments different from many other services as families have often had to actively pursue a referral and have been living with their child’s difficulties for quite some time. In many cases families had been passed between services for some time without receiving a diagnosis or being given an explanation that they could work through.

The clinicians involved in the child mental health assessments have a role in not only trying to understand the concerns of the child and the family and formulate potential diagnoses and treatment plans, but are, at a fundamental level, gatekeepers to the services and treatments that CAMHS offers. To some extent, the triage assessments and the clinicians conducting them are assessing the suitability of a child’s difficulties to be treated by a specialist mental health team in the context of a specialist mental health service. When considering the multiple layers involved in a seemingly routine medical interaction, it became apparent that the process and interactions within it were far more complex and multi-faceted than I had originally appreciated.

1.2 Research Aims and Questions

The purpose of this research was to try and gain a better understanding of the processes involved in initial assessment appointments at CAMHS, particularly exploring the ways clinicians manage their responsibility in providing access to future treatment and services and the ways families try to ensure their concerns are
heard and responded to. To simply look at the mechanisms the clinician uses would have been short sighted as the assessment is by definition a dialogue between clinician and the family. In this respect only looking from the clinician’s objective would perhaps have failed to put their methods into context. It was thus necessary to look at the other side of the conversation to the needs of the family and the mechanisms they use to achieve what they feel is best for their child. The main research question for this project was:

How do clinicians and families in initial assessment appointments in CAMHS manage the organisation of access to services?

To answer this question, this PhD addresses three core areas of interest related to triage appointments within CAMHS. Each of these areas involves units of interaction that will affect the outcome of the appointment. Within each area, the clinicians and families are both working to achieve certain things that will assist them in either presenting their child as requiring help from a specialist service, or to determine whether the child does require help from a specialist service.

1. Organisation of access

The core objective of the clinicians in each assessment appointment is to assess the appropriateness of the CAMH service for each child they see and possibly offer a potential diagnosis. Once the child has attended the appointment, they have four options available to them with regards to the child’s treatment. Therefore, a secondary research question related to this is:

a) How do clinical professionals interactionally organise access to services?

2. The role of the child

The child and the difficulties they are experiencing are the reason for and the focus of the appointment. However, in many medical settings where both children and adults are present, the child is only afforded half membership in interactions (Hutchby & O’Reilly, 2010). CAMHS is by definition a service with child centred practice at its core so children and young people should be given an equal, if not greater, opportunity to contribute to discussions and be considered
to have the right to knowledge about their thoughts, feelings, and behaviours. Therefore, this led to the following secondary questions:

b) Where and how is the child given the opportunity to articulate their opinions about the difficulties they are facing?

c) What role does epistemics and the right to knowledge play through the triage appointments and how is this managed interactionally?

3. The role of the family

When a child is referred to CAMHS, generally the objective for the family at the end of the initial assessment is to have received an explanation for the child’s difficulties, however tentative, and to have been offered some support for them moving forward. When this appointment takes place, parents, and sometimes the child, are aware that the clinicians are often standing between them and further treatment. To this end they utilise certain discursive strategies when interacting with the clinicians to present their child’s difficulties and need for help from CAMHS as authentic.

d) What are the discursive strategies families employ to present their child’s need as genuine and the possible diagnosis as appropriate?

1.3 Thesis Overview

This section outlines the structure of the thesis and provides an overview of the content of each of the chapters. The analytic chapters are structured to mirror the structure of the appointments so as to tell the story of the appointments through the analysis; the first analytic chapter concentrates on interactions at the beginning of the appointment, the second chapter the middle, and the third chapter the conclusions presented at the end of the appointment.

1.3.1 Chapter Two – Literature Review Part 1

This chapter gives an overview of the contextual background of the thesis and situates the thesis within current issues around mental health care including prevalence, financial implications of austerity on services, and the shape of services
in the United Kingdom. This chapter gives the reader an insight not only into the current issues around mental health but also an understanding of the construction of the concepts of mental health and illness. To finish, the chapter describes the setting that the research was conducted in, the origin and purpose of triage appointments, and their structure.

1.3.2 Chapter Three – Literature Review Part 2

In the second part of the literature review, the concept of communication research is discussed. The chapter explores the aims and successes of communication research on a health care environment using examples of previous research. Epistemics plays a key role in doctor-patient communication with clinicians and patients displaying an orientation to and maintenance of the asymmetrical relationship within appointments. The concept of rights to knowledge and the significance of epistemics on interaction is also discussed and considered in relation to lay-professional interactions. Communication research is particularly scarce within a mental health setting, especially in child centred services. The importance of research in these services is discussed and the chapter will conclude with an outline of the significance of the research conducted in this thesis for mental health communication research.

1.3.3 Chapter Four – Methodology

Chapter four describes the methodological decisions and implications of the research. It begins by discussing the choice of conversation analysis as a methodology and its impact on procedural and analytic decisions. The theoretical framework for the research is situated within the philosophical underpinnings of conversation analysis specifically and qualitative analysis more generally. The majority of the chapter consists of procedural information in terms of sampling, recruitment, and data collection. This includes a discussion around the benefits and concerns of video recording as a method of data collection, as well as a discussion about transcription and practical and theoretical considerations and decisions that were made. The chapter concludes with a detailed description and review of ethical considerations for this research project including collecting informed consent and
1.3.4 Chapter Five – Problem Presentation

This is the first of the three analytic chapters. This chapter focuses on interactions that happen at the beginning of the appointments and make up the problem presentation phase. We begin by looking at the clinicians’ question “do you know why are you here?”, including the various ways that the question is phrased, who it is directed to, and the impact of the question construction on the response given. Following this, the analysis turns to cases where the child responds to being asked “why are you here?”, how they respond, and the impact this has on the interaction as a whole. Throughout the chapter, there will be a focus on the imbalance in perceived rights to knowledge and how this is evidenced through the interactions being examined.

1.3.5 Chapter Six – Building a Case

Following the explanation by the family of why they are attending CAMHS, the families move in to building a case for the problem they have presented. The content of this chapter follows this progression and focuses on how parents build a case for the child’s difficulties requiring specialist mental health intervention. The chapter is divided into two parts with part A focussing on the rhetorical devices that parents use when building a case, and part B looking at how parents formulate their account through witnessing. Within part A, the uses of two rhetorical devices are identified and discussed: extreme case formulations and contrast structures. Part B explores how parents situate themselves as witnesses to the child’s difficulties in the accounts that they give through the use of examples and comparisons made between their own child and others. Attention is focussed on the resources used by the child’s parents as opposed to the clinicians or the children themselves and the notion that parents are evidencing and legitimising the difficulties their child is experiencing.

1.3.6 Chapter Seven – Delivery of Diagnosis

The final analytic chapter explores the interactions between clinicians and families during the delivery of the diagnostic decision. The interactions are analysed through
the perspective of the epistemic asymmetry in the relationship and how this is maintained by the interactants through their talk. Initially the chapter explores the impact of the clinicians’ talk on the asymmetry through the delivery of the decision they are communicating. Epistemic asymmetry and its maintenance through the delivery of diagnostic decisions is considered in the context of the content of the decision being delivered; whether a mental health problem is present or not. Analysis will also consider the part that families play through their responses to the diagnostic decision, identifying two types of response, minimal acknowledgment tokens and extended responses; the impact the type of response has on the wider interaction; and the impact it has on the epistemic relationship between clinicians and families.

1.3.7 Chapter Eight – Discussion

The conclusion of the thesis begins with an overview of the key findings from each chapter. The secondary research questions outlined in the present chapter are then considered and addressed in order to formulate a response to the overarching research question. The implications of the research are considered in the context of the potential impact for clinicians, families, and services, as well as the importance of the research in the context of conversation analysis. Limitations are reflected upon and addressed. The chapter concludes with a reflection on the research process and the findings, including personal reflections on both the impact of the researcher on the research, and also the impact of the research on the researcher.
2 CHAPTER TWO: BACKGROUND AND CONTEXT

2.1 Mental Health and Illness

2.1.1 Defining Mental Health and Illness

Mental health is defined as a person’s capacity to manage the challenges of daily life and to interact with other people and their environment in a way that allows the individual to promote and maintain their own well-being and achievements (Black Country Partnership NHS Trust, n.d.; Department of Health Australia, 2015). In contrast, mental illness is considered to be present when an individual is unable to manage their thoughts, feelings, or behaviours and these in turn may cause distress to the individual and those around them (Department of Health Australia, 2015). The presence of symptoms consistent with a mental health difficulty does not necessarily mean that an individual can be classified as having that disorder. Rather it is the adverse effect of those symptoms on daily life and functioning that leads a group of symptoms to be classified as a mental health difficulty in a particular case (Dogra, Parkin, Gale, & Frake, 2002). Dogra et al point out that mental health is not a static state but on a continuum; whilst an individual may experience good mental health for the majority of their childhood, circumstances affecting them in teenage years, for example, may result in them experiencing a mental illness.

2.1.2 Conceptualisation of Mental Health and Mental Illness

Whilst mental health as a discipline is relatively recent in its conception, an enduring aspect has been the consideration and debate of the construction and conceptualisation of mental health and illness (Strong & Sesma-Vazquez, 2015). A biological model is common-place in psychiatry with mental health difficulties being considered as ‘mental illness’ which all have a set of symptoms, a physical aetiology, a diagnosis, and a biological treatment (Rogers & Pilgrim, 2014). Psychiatry is the leading profession within mental health services and as such dictates the framework within which professionals within mental health services work (Rogers & Pilgrim, 2014). Due to its medical grounding, many psychiatrists advocate an illness framework for contextualising and understanding mental health difficulties. However, some do so within a biopsychosocial framework,
acknowledging the importance of the social environment on health (O’Reilly & Lester, 2017; Rissimiller & Rissmiller, 2006).

Terminology such as ‘mental illness’ suggests that the symptoms an individual experiences are physical in nature and biological in cause and treatment (McCann, 2016). In employing this terminology with patients (another label that results from the biological model in psychiatry), their experiences are medicalised and a reality is created in which they view the difficulties they have been experiencing, the causes and effects, and their possible prognosis (Walker, 2006). In referring to mental illness, a connection is made between physical and mental health which can result in treatments that focus on the biological, such as medication, and do not demonstrate an appreciation of the psychological aspects of the individual’s difficulties (Adams, 1964). Evidence of this has been seen in the rapid uptake and evolution of psychopharmacological management for disorders such as Attention Deficit Hyperactivity Disorder and Autism Spectrum Disorder, both of which are considered to be incurable (Frances, 2013).

The publication of the Diagnostic and Statistical Manual version 3 (DSM-III) in 1980 illustrated the shift in thinking towards a biological, illness framework (Mayes & Horwitz, 2005). This new version introduced diagnostic criteria in the form of symptoms of each condition as well as a longer and more specific list of possible diagnoses. Due to its purpose and use as a diagnostic guideline for mental health professionals, the focus on symptoms and diagnoses promoted a biological vision of mental health for the professionals using it (Mayes & Horwitz, 2005). Alongside the revision of the DSM-III, the pharmaceutical industry grew with the need and potential for a wide range of medications to treat the various conditions, exacerbating the illness framework associated with mental health today. The DSM-5 saw a vast expansion of classifications of mental illness. Many professionals and researchers alike have been concerned by the apparent move towards labelling everything not considered to be statistically normal (Burman, 1994; Rose, 1990).

An alternative perspective of mental health and illness has been promoted by psychology and psychoanalysis. Whereas the biological framework creates a dichotomous distinction between being well and being ill, the psychological and
psychoanalytic model presents mental health as a continuum (Rogers & Pilgrim, 2014). Both frameworks, however, position mental illness as in the mind. The statistical notion of a normal distribution, advocated by psychologists, illustrates the distribution of the population’s mental health as being fluid and on a scale of wellness to illness. The psychoanalytic model promotes the notion that everyone is experiencing mental illness to some extent with it being debilitating for some but not others. However, this model still uses language associated with a biological model such as diagnosis, treatment, and symptoms (Rogers & Pilgrim, 2014).

Psychology asks questions around the individual’s experiences of mental illness. In advocating a continuum of illness and wellness, rather than distinct categories, it is able to, and does, focus on questions around causation and exacerbation of the individual’s experiences. Psychology asks ‘Why this? Why now?’ of the individual to understand why they have moved along the continuum from mental wellness to illness (Rogers & Pilgrim, 2014). While recent scientific studies have identified biological elements to the transition from mental health to illness, in restricting the explanation of mental health differences to a biological framework, treatments and care may not be sympathetic to psychological explanations (Adams, 1964).

Alongside the different approaches to conceptualising mental health and illness is the conceptualisation of the individual experiencing the difficulties. Individuals accessing mental health services are commonly conceptualised as patients or consumers (Rogers & Pilgrim, 2014). The notion of individuals as patients aligns itself with the biological framework of psychiatry. In adopting a model of symptoms and diagnoses, the psychiatrist-patient relationship follows. Being a patient is defined by the experience of illness and being treated by a doctor. Psychiatric, psychological and medical research maintains and exacerbates this rhetoric by viewing patients and their experiences as phenomena to be studied and quantified (Rogers & Pilgrim, 2014). Individuals as consumers of health services removes the medical framework and focuses instead on the individual’s use of services and implied freedom of choice over the services they engage. In removing the medical connotations from the label, the notion of individuals being consumers of health services gives them empowerment. However, the label also limits the
individual to the available services, thus limiting the idea of choice somewhat (Rogers & Pilgrim, 2014).

The terminology around mental wellness and illness is not just about the language used. The choice of terminology reflects the approaches taken to viewing mental health or illness and normality or abnormality (Rogers & Pilgrim, 2014). There is no definition of a mental disorder in the DSM-5 (Frances, 2013), and whilst the notion of mental health focusses on the experiences and behaviours of the normal child, mental illness appears to be considered to be present in any case of deviation from ‘normal’ (Strong & Sesma-Vazquez, 2015).

In this thesis the terms mental health and mental illness have been employed, and individuals accessing services have been referred to as patients or service users. Whilst there is not an orientation to a biological framework in the thesis, this terminology reflects the common vernacular around mental health both in the public domain and within the service the data was collected from. As with the majority of mental health services, the dominant profession and perspective within CAMHS is that of psychiatry. Although the service takes a multidisciplinary approach to caring for young people, the majority of the appointments discussed are led by psychiatrists of varying grades, and this dictates the approach and vernacular employed by all professionals in attendance.

2.1.3 Prevalence of Mental Health and Illness

The World Health Organisation reports that globally one in four people will experience a mental disorder in their lifetime, with 450 million people across the world experiencing mental ill health in 2001 (WHO, 2001). Depression is the most common mental disorder experienced with it accounting for 4.3% of the global burden of disease (WHO, 2013). Across the world, between 2011 and 2030, mental disorders are expected to cost US$16.3 million-million in lost economic output alone. These statistics demonstrate the impact of mental ill health on the world’s population and economy.

For children and adolescents, the prevalence of mental health disorders has been reported to be one in five young people aged 5 to 15 worldwide (World Health
In the United Kingdom, findings published by The Office of National Statistics (ONS) reported that 10% of children and young people aged 5 to 16 years had a clinically diagnosed mental health problem (The Office of National Statistics, 2005). These were made up of emotional disorders, conduct disorders, hyperkinetic disorders, and disorders such as autism spectrum disorder (ASD) and eating disorders.

2.2 The Economic Impact of Mental Ill Health

With mental ill health becoming more prevalent across the world, there is a need to improve the quality of and access to services for patients. However, alongside an increase in mental ill health is a decrease in monetary support to fund specialist services and resources (Williams & Hazell, 2011). Individual, socioeconomic and political factors such as education, poverty and political oppression all contribute to determining an individual’s risk of developing a mental disorder (WHO, 2013). In the current climate of the global financial crisis leading many countries into austerity measures, budgets have been cut across the board. This not only affects the health care provision on offer but also increases many of the risk factors involved in mental ill health. These include unemployment, poverty, substance misuse, homelessness, financial instability and social isolation. Economic instability and its effects are not the only challenges faced when considering the risks to mental health. Situations in which individuals face unusually high levels of stress and fear also impact upon future mental health (Williams & Hazell, 2011). Recently, these situations include terrorist attacks, natural disasters, and war. Alongside an impact on the mental health of the population effected, these situations also demand financial input in the aftermath. This reduces the funds available for other areas of need which reduces the capacity of the countries involved to provide adequate care (Williams & Hazell, 2011).

Specialist mental health services vary across the world. Whilst many countries have embraced and developed therapeutic, community-based services which work alongside specialist wards for acute cases, there are still countries which rely on and advocate the use of mental hospitals and institutions (WHO, 2013). Financially, the acceptance and integration of community based services provides a
more viable option due to their assimilation into other areas of healthcare (WHO, 2013). The care given is considered to be patient-centred which improves the adherence to and effectiveness of treatment (Robinson, Callister, Berry, & Dearing, 2008). Although private services are available, in the United Kingdom (UK) mental health care is incorporated within the umbrella of the National Health Service (NHS). Frontline services are community-based outpatient facilities which both work alongside and are integrated into other specialisms such as drug and alcohol services, occupational therapy services, and general medical services (NHS England, n.d.). Separate services exist for child mental health care and adult mental health care.

In the UK, the 2008 financial crisis resulted in a culture of austerity in government spending. Funding for specialist mental health services in the UK has not been disproportionately reduced in comparison to other services, but the lived experiences of patients and clinicians is of services being condensed and in some cases lost altogether (Dooher & Rye, 2013). Within the UK, there are 54 mental health trusts under the umbrella of the NHS. However, between 2010 and 2017 there were 145 fewer psychiatrists and 5,161 fewer mental health nurses within the NHS (NHS, 2017). Despite the fall in mental health care professionals, there was an 8.9% increase in the number of people detained under the mental health act in the years 2015/16 and 2016/17. This demonstrates that even though funding has not been reduced disproportionately, the resources available have decreased while the demand for services has increased. The NHS has encouraged patients to seek help and advice from voluntary agencies, but cuts to their funding mean that these services are becoming harder to access (Dooher & Rye, 2013).

Alongside funding cuts in the NHS there has been an increase in unemployment and the number of families living in persistent poverty as a result (ONS, 2017). With the clear links between poverty and poor mental health, it is unsurprising that the number of individuals seeking help for mental ill health is rising. Whilst unemployment has a direct effect on adults in society, children become victims of the associated issues arising from one or both parents losing their jobs (Williams & Hazell, 2011). This includes poverty, unstable home lives, parents suffering from mental health difficulties, and an effect on the quality of their
education. All of these issues are risk factors for poor mental health in children and young people.

Child and Adolescent Mental Health Services (CAMHS) is underfunded in comparison to adult mental health services (Williams & Hazell, 2011). In most cases, children are reliant upon their parents to identify and seek help for a mental health related difficulty (Chu & Kendall, 2004). On average, parents contacted between one and eleven agencies before they received help for their child’s difficulties (Shanley, Reid, & Evans, 2008). Parents seeking help for suspected autism wait three and a half years on average from initially contacting a health professional to receiving a diagnosis for their child (Crane, Chester, Goddard, Henry, & Hill, 2016). Whilst Autism is particularly complex to diagnose (Goin-Kochel, Mackintosh, & Myers, 2006) this reflects some of the challenges parents and children face when it comes to accessing appropriate services to address concerns surrounding the child’s mental health.

2.3 Child Mental Health Services Around the World

Mental health and its associated difficulties are experienced throughout the world. Each country has its own challenges when considering the recognition of and care for those who are struggling to maintain their mental health. The World Health Organisation has published guidelines for the effective identification and treatment of individuals which recognise the differing medical and contextual landscapes of the world’s population (WHO, 2013). Western Europe, North America, Australia and New Zealand are considered to have more developed health care systems which recognise the significance of good mental health and the increasing requirement for services to meet the needs of those experiencing mental health difficulties (Hazell, 2005). In developing nations, however, the nature of the embryonic political systems, war, and natural disaster have contributed to more rudimentary health care systems. However, whilst the advancements in medicine and mental health tend to be concentrated on the more developed nations, there are still differences in the way mental health care is accessed.

The healthcare systems across the world operate in different ways. In the United Kingdom and New Zealand healthcare does not directly cost the patient
anything, which, in theory, allows every individual to receive the care they need (Hazell, 2005). In Australia, health care costs to the individual are minimal with the majority being covered by the state (Hazell, 2005). In North America, individuals are responsible for paying for their own healthcare either directly or through health insurance (Offord, 2005). The direct cost of healthcare in North America, especially specialist services, means that many people experiencing mental health difficulties do not seek or receive the care they may need.

Psychiatry in Europe has been considered to be an independent but significant division of medicine since the 1990s (Piha, 1997). This recognition has led to training and diagnosis being standardised so that, in theory, each individual across Europe should receive a similar standard of mental health care (Hannesdottir, 1993). However, in Eastern Europe, mental health difficulties and associated learning difficulties and neurological problems have taken longer to be accepted with semi-permanent hospitalization in institutions being common-place until recently (Shooter, 2005). In Australia and New Zealand, similarly to Europe, mental health care is delivered in the community rather than being hospital-based, with value being put on communication and links between different agencies to provide the best possible care (Hazell, 2005). There are, however, differences across countries and continents in terms of the number of psychiatrists per capita and the resulting type of care that is received by individuals. In Sweden, there are approximately 12.5 child psychiatrists per 100,000 children and young people, whilst there are only 1.2 psychiatrists per 100,000 children and young people in Spain (Shooter, 2005).

In developing countries, the often turbulent histories mean that health care has focussed on the physical ailments of children (Rahman, Harrington, & Gater, 2005). Countries affected by war and natural disasters have populations in need of basic provisions such as shelter, food, and clean water. These have long been a priority for these countries and the focus of aid from foreign organisations (Shooter, 2005). However, more recently there has been a recognition of the significance of these events on children’s mental health (Thabet, Thabet, & Vostanis, 2016) and the economic effect this may have in the future (Rahman, Harrington, & Gater, 2005). Whilst meeting basic needs is still a priority, the importance and care for children’s
emotional and mental wellbeing is being increasingly recognised and acted upon (Rahman, Harrington, & Gater, 2005). As mental health care is still in its formative stages in many developing countries, there is still a lack of understanding among many people, including professionals, and a lack of specialist resources. The reality of this is that mental illness encompasses neurological and developmental disorders, learning difficulties and psychiatric disorders (Graham, 1981).

Whilst mental health care differs from country to country, there is an increasing worldwide recognition of the importance of mental health and the significance of mental illness. Global organisations such as the World Health Organisation work to ensure a baseline acknowledgment and treatment for all individuals regardless of which country they live in. The execution of their recommendations is decided upon by governments and policy makers who then filter their interpretation through to the health care systems and finally to the service users.

2.4 Child and Adolescent Mental Health Services in the United Kingdom

In the United Kingdom, publications and initiatives such as the Children’s National Service Framework (Department of Health, 2003), Every Child Matters (Department for Education, 2004), and NICE Guidelines (National Institute for Health and Clinical Excellence, 2005) have drawn increasing attention to the issue of mental health and illness in children and young people in terms of the prevalence, severity, and impact on the individual, society as a whole, and the National Health Service (NHS) as a service provider. Recent media coverage has brought mental health and illness into the spotlight. Coverage includes efforts to bring mental health and illness into everyday dialogue and increase understanding and support available, for example the British Broadcasting Corporation’s (BBC) ‘In The Mind’ series of television and radio broadcasts (BBC, 2017). In contrast, there has also been recent publicity around the treatment of patients experiencing a mental illness in the NHS (Greenwood & Buchanan, 2017) which includes arguments around the adverse effects of government austerity on mental health provision. There is a growing awareness of the issues surrounding childhood mental illness which is increasing demand for specialist services as well as for voluntary and charitable organisations.
such as MIND, Barnardo’s, and the National Society for the Protection of Cruelty to Children (NSPCC).

CAMHS is a specialist service, known as secondary care or Tier 2 services, within the NHS, providing assessment, treatment, and support for children and young people who are suffering from mental health difficulties, and their families (Partridge, Jones, & Richardson, 2003). Each region in the UK has its own CAMH service and although all are structured and function similarly, they operate independently and occasionally differ in the exact age group they incorporate or the processes they follow. The majority of CAMH services see children from 3 to 18 years of age (Department of Health, 2003). When young people under the care of CAMHS reach 18 years of age, they are generally transitioned into adult mental health services to continue their care (Bailey & Shooter, 2009).

Children and young people are referred to specialist CAMHS through their General Practitioner (GP), paediatrician, or other frontline agencies such as schools or social services (Dogra, Parkin, Gale & Frake, 2002). Depending on the severity of the difficulties the child is facing, following referral they will be put on a waiting list for an assessment (triage) appointment. CAMH services accept referrals for any child or young person who is “at risk of significant, persistent and/ or complex emotional or mental health difficulties” (East London NHS Foundation Trust, 2016). Cases are prioritised based on the potential risk of harm to the individual, gauged from the referral letter and any accompanying information, with more urgent cases being given a higher priority.

### 2.4.1 A Multidisciplinary Approach

Within CAMHS, multiple professionals from different professional backgrounds work together to assess, create, and deliver care plans for the children referred to the service. The teams include psychiatrists, clinical psychologists, psychotherapists, occupational therapists, and psychiatric nurses. This multidisciplinary model of assessing and providing treatment within a single service affords the opportunity for different perspectives and offers a range of skills to ensure the best fit for the case in question (Dogra, Parkin, Gale, & Frake, 2002; Partridge, Jones & Richardson, 2003). The diversity of skills and expertise also provides a variety of therapeutic options.
available to clinicians with possibilities including play therapy, cognitive
behavioural therapies, conventional medications, substance misuse advice and
support, and psychotherapy (Dogra, Parkin, Gale & Frake, 2002).

2.4.2 Child Centred Practice

Within the healthcare system in the UK, children are considered to have the right to
be active decision makers in their care, to be respected and have their views listened
to and considered, and to have care adapted to meet their needs (Department of
Health, 2003). Child centred practice is central to all aspects of health care in the
UK, particularly where the service being provided exists for children specifically.
The Children’s National Service Framework (Department of Health, 2003) made
children central to their own care in terms of communication, consultation,
diagnosis, and treatment. The notion of child centred practice is rooted in the United
Nations convention on the rights of the child (UNICEF, 1989). This landmark
convention puts the child at the forefront of decision making with regards to their
own life. Specifically, article 12 states that “every child has the right to express their
views, feelings and wishes in all matters affecting them, and to have their views
considered and taken seriously”.

In practice, the notion of child centred care is harder to define and
implement. From a general patient perspective, patient centred care is about respect,
courtesy, and being involved in decision making (Robin, Callister, Berry & Dearing,
2008). Children should play an active role in discussions about their care (Carter,
Bray, Dickinson, Edwards, Ford, 2014). For clinicians, child-centred care means the
child’s interests are the focal point of all thinking and practice (Carter & Ford,
2013). To provide a child centred service, healthcare professionals have a
responsibility to implement the rights of the child and make sure each child is
encouraged and helped to make their views known on issues which will affect them
(Soderback, Coyne & Harder, 2011).

Children should be active participants in decision-making about their
treatment but this is not always the case. There is some uncertainty as to the extent
that young children in particular can fully participate in their care (Day, 2008).
Despite clinicians engaging with the child in therapeutic settings and making it clear
that their opinion will be heard, appointments that include both the child and their parents do not always have a clear focus on the child’s voice, with either interactions between clinicians and parents dominating, or children agreeing with parents’ opinions when theirs are sought (Cooklin, 2001). Many professionals consider parents to be the experts on their children’s views and opinions, but what parents and professionals believe to be in the child’s best interests may not be the same as the child’s beliefs (Soderback, Coyne & Harder, 2011). In a CAMHS triage setting where both parents and children are present at the appointment, this puts more emphasis on clinicians to ensure they engage the child in a meaningful and considered way.

Involving children meaningfully in their own healthcare and creating a child centred service requires professionals and policy makers to consider what information children want and what information is meaningful to them, as well as how this can be communicated to them in the most effective and appropriate way (Day, 2008). Bensing (2000) advocates for communication being the most effective way for professionals to understand patients and their thoughts, feelings, and goals. With this in mind, Bensing (2000) promotes the need for communication research in health care that aims to understand the dynamics of the relationships and the processes involved in appointments and relationships. The realities of applying child centred practice in some interactions can be complex. The analysis of the data within this thesis must all be considered within the framework of child centred practice to fully engage with the dynamics of the interactions.

2.5 The Role of the Family in Help Seeking

Children are generally not the main initiators of seeking help, and neither do they determine attendance (Wolpert & Fredman, 1994). Families are often fundamental to the child seeking help in the first instance and also in ensuring treatment is maintained by the child, for example in the form of taking them to appointments (Hoagwood, 2005). This is especially significant when considering CAMH services treat children from the ages of 3-18; most children within this age range would not have access to other forms of transport and still rely on parents and carers to remember appointments and, in some cases, to administer medication. It is rare for
children to seek help themselves and it is often the case that it is the family who recognise difficulties before the child (Chu & Kendall, 2004). To this end it is possible that the family member(s) who identified the difficulties the child was facing and has been active in seeking support and possible diagnosis will also become more involved in attending appointments and the therapeutic process as a whole for reasons such as trust, familiarity, routine, and having a vested interest.

Unfortunately, many families report feeling frustrated by the process of seeking and receiving quality care (Kasper, Steinwachs, & Skinner, 1992). They often feel that communication by the clinician was insufficient (Rose, 1998), and that they have not been listened to or provided with adequate information (Levine & Ligenza, 2002). This may be due in part to the expectations held when entering CAMHS and the treatment process. There is often a misalignment between the opinions of the general public and health care practitioners as to what mental illness is and the forms it takes (Lauber, Nordt, Falcato, & Rossler, 2003; Jorm et al, 1997). This suggests that when families enter into the mental health care system they are often unaware or misinformed when it comes to diagnosis and treatment. When considering the potential misalignment of knowledge, it would not be surprising that when families initially seek help for a child with suspected mental health problems there may, in some cases, be disagreement between the child, the family, and the practitioner as to what, if anything, is wrong with the child as well as the suggested course of treatment. Given the research findings that suggest a successful alliance between families and clinicians is integral to successful treatment outcomes (Kazdin, Marciano, & Whitley, 2005), discrepancies over diagnosis and treatment could impact negatively upon treatment success. In this respect, it is important not only for the clinician to listen to the family’s concerns but also to establish what it is the family and child are trying to achieve by accepting the referral to CAMHS. Hutchby and O’Reilly (2010) identify that in a family therapy setting the adults in the interaction actively seek and identify problems. It may be the case that when parents enter therapy with their child they have a potential diagnosis in mind and are attempting to authenticate this claim to the clinician and seek their confirmation.
2.6 Triage

In medical settings, triage traditionally refers to the process of assessing patients prior to treatment to determine the severity of their presenting concern and the most appropriate course of action (Bower & Macdonald, 2005). Triage is commonly applied to settings with a high number of patients. The assessment process has been applied successfully to a variety of medical settings including military field hospitals, accident and emergency (A & E) departments, and mental health services.

Within CAMHS, triage was introduced in a pilot form to reduce waiting list times, to improve the allocation of cases to appropriate pathways, to decrease non-attendance, and to increase the quantity and quality of multidisciplinary working (Parkin, Frake, & Davidson, 2003). Due to the demand for mental health provision for young people, waiting times were increasing for the majority of services both in the United Kingdom (UK) and abroad (see Ching Lai, 2006; Jones, Lucey, & Wadland, 2000; Parkin, Frake, & Davidson, 2003). Long waiting times between referral to CAMHS and receiving an appointment increases the distress families experience (Ching Lai, 2006). As well as distress to families, there is the potential for the symptoms being experienced by the young person to intensify (Ching Lai, 2006; Parkin, Frake, & Davidson, 2003). While patient care is paramount, the extended waiting times for an appointment also adversely impact the relationship between referrers and specialist CAMHS (Ching Lai, 2006).

Aside from the external reasons for needing to improve waiting times for specialist mental health care, internally long waiting lists correlate with the number of patients who do not attend (DNA) their first appointment (Ching Lai, 2006; Parkin, Frake, & Davidson, 2003). Triage has been found to reduce rates of non-attendance by up to a third, with a quarter of cases that were seen being closed at the triage appointment as CAMHS intervention was not deemed appropriate (Ching Lai, 2006; Jones, Lucey, & Wadland, 2000; Parkin, Frake, & Davidson, 2003). This increase in attendance may be due to reduced waiting list times. Following the pilot trial in different trusts, families and young people, the clinicians involved, and GPs who referred to the service all reported satisfaction with the introduction of a triage format (Parkin, Frank, & Davidson, 2003).
Triage appointments in CAMHS typically last between an hour and an hour and a half in length and take the form of a semi-structured interview generally conducted by two professionals (Jones, Lucey, & Wadland, 2000). Having more than one professional conducting the assessment allows for a broader and more flexible approach and interpretation of the families’ concerns (Parkin, Frake, & Davidson, 2003). Whilst the focus of the assessment is on the patient themselves, their parents or carers are also invited and they are encouraged to bring any other people who may have insight into the difficulties being experienced. As a result of the number of people in the appointment, the interactions become more complex than general medical interactions such as those in general practice. The information being provided is being delivered in multiple forms by multiple people as well as additional information contained in the referral (Achenbach & Rescorla, 2001).

The aim of a triage assessment is not to provide a therapeutic environment or diagnosis (O’Reilly, Karim, Stafford, & Hutchby, 2015), although the very nature of families discussing their concerns with a professional can in itself be therapeutic (Hartzell, Seikkula, & von Knorring, 2010). Rather, the appointment assesses the type and severity of a patient’s symptoms alongside the risk and difficulties posed as a result of them (Ching Lai, 2006) in order to determine the need for specialist CAMHS intervention (Parkin, Frake, & Davidson, 2003). Triage appointments in CAMHS are only used in non-urgent cases. Cases deemed to be urgent or involving deliberate self-harm are assessed by the on-call team rather than being placed on a waiting list for a triage appointment (Parkin, Frake, & Davidson, 2003).

There are five possible outcomes from a CAMHS triage appointment (Parkin, Frake, & Davidson, 2003). These are:

1) The patient does not attend the appointment.
2) Following assessment, it is deemed CAMHS provision is not necessary. The case is closed.
3) The patient is placed on a waiting list for treatment.
4) Additional further assessment or observations are needed before a decision can be made regarding treatment.
5) The assessment takes place and immediate intervention is necessary.
The possible outcomes of the assessment and the form the appointment takes allows clinicians to assess patients as close to the point of referral as possible. The implication of this being the clinicians are assessing the same behaviours and concerns that have caused the referrer concern before they have either become exacerbated, evolved, or subsided. By introducing a triage clinic to specialist services, it allows clinicians to close cases that do not require CAMHS intervention and allocate follow up care to those that do need it in a more efficient manner. This initiative saves time for the service and families, and has financial implications (Parkin, Frake, & Davidson, 2003).

2.6.1.1 Structure of the Appointment

As outlined in the Introduction, although not focused on diagnostics, triage appointments at CAMHS follow a similar structure to general medical appointments and generally comprise six distinct phases. This PhD focuses on the interactions from three of those phases; establishing the problem, building a case, and decision delivery. Each of these three phases and their significance in the overall interaction will now be described in detail.

2.6.1.1.1 Establishing the problem

Establishing the problem, or problem presentation, occurs at the beginning of the assessment, following the clinician’s opening and introductions. Problem presentation in CAMHS triage appointments is similar in content to that of a general medical appointment. The clinician inquires as to the reason for attendance, and the patient responds with their formulation. Within this phase of a medical appointment, clinicians establish the reason for the patient’s attendance from the patient’s accounts of their concerns (ten Have, 2001). Whilst it is the shortest phase of medical appointments, it is also considered to be one of the most important as it is the only opportunity patients are given to account for their visit and provide a candidate diagnosis (Heritage & Robinson, 2006). As the first medically focussed phase in the appointment, it is particularly important that clinicians conduct the interaction effectively and appropriately (Heritage & Robinson, 2006).
Whilst the problem presentation phase of the appointment is designed to elicit a reason for attendance from a patient, it is both initiated and terminated by the clinician (Heritage & Robinson, 2006) and shaped by their question design and behaviour (Beckman & Frankel, 1984). Solicitation of the patient’s presenting concern is usually formulated by clinicians with a variation of the question “what can I do for you today?” (Robinson, 2006). In general practice, variations in the question formulation often correspond with whether the concern is new or enduring (Robinson, 2006). Robinson noted that whilst there have been efforts to train clinicians in the impact their question formulations can have on the patient’s responses, these predominantly focus on the importance of asking open ended questions as opposed to closed. Although this is valuable information for clinicians, there has been little research and subsequent training on the importance of the wording of questions. Whilst two questions may be similar in the information they are seeking, subtle differences in syntax and construction can alter the patients’ interpretations and the responses offered.

Following a request for information about their reason for attendance, patients have choices to make about how to structure their response and its content (Heritage & Robinson, 2006). These choices include whether to present their concerns as a narrative formulation or as a candidate diagnosis, or whether to simply describe their symptoms (Pomerantz, 2002). Each of these choices has consequences for the clinician’s response and potentially the remainder of the interaction (Stivers, 2002). Regardless of the choice patients make about how they formulate their response to the clinician, their primary concern is presenting their reason for attendance as ‘doctorable’ and being worthy of medical attention (Heritage & Robinson, 2006). Prior to making the appointment, patients will have realised their symptoms and attempted to formulate a possible explanation from their limited medical knowledge, research, and conversations with other people (Pomerantz, 2002; ten Have, 2001). As a result, many patients attending first appointments have a working hypothesis for the cause of their symptoms, for which they are seeking expert advice. These working hypotheses are the reasons given to the clinician for attending the appointment.
When presenting their concerns to the clinicians, patients’ choices about how to communicate their thoughts to the clinician are further complicated by the orientation to the doctor-patient relationship and rights to knowledge of the lay person versus professional. Patients display different reasoning processes that have been involved in their formulations depending on their choice to present their concerns from either a medical or lay perspective (Mishler, 1984). When patients choose to present a candidate diagnosis as a reason for attendance they do so in a cautious manner, orienting themselves to the clinician’s medical knowledge (Gill & Maynard, 2006; Drew, 2006). Presenting a candidate diagnosis to the clinician invites enquiries from the clinician about the patient’s right to the knowledge they are displaying and has implications for the remainder of the interaction (Heritage & Robinson, 2006). Patients manage this asymmetry by using interactional techniques to downplay their claim to knowledge, for instance by attributing candidate diagnoses to third parties (Gill, 1998).

Within triage appointments at CAMHS, there is also a choice to be made about who communicates the presenting concern to the clinician: the family members or the child. This can be dictated by the formulation of the clinician’s question and who they direct it to, but on occasions where there is ambiguity over the intended recipient or where the child struggles to answer, who presents the problem has to be interactionally managed. Stivers (2001) reported that the choice of whether the parents or child present the problem is important because it determines the knowledge state that will be attributed to the child for the remainder of the appointment. Not only this but the content of the presenting concern will differ between parent and child due to the nature of their lived experiences, and it is this content that forms the foundations of the clinician’s subsequent enquiries.

2.6.1.1.2 Building a case

Building a case refers to the phase of the appointment where patients make an argument and provide evidence for their seeking medical intervention and, in some cases, providing evidence for a previously stated candidate diagnosis. In CAMHS triage appointments, parents tend to be the ones to engage in this phase with the clinician as opposed to the child. This is in contrast to problem presentation where it
is generally the child who gives their reason for attending the appointment (O’Reilly, Karim, Stafford, & Hutchby, 2015). In a general medical encounter, the act of building a case for needing medical attention or to support a candidate diagnosis is described within the phases of problem presentation and history taking. In CAMHS triage appointments, however, this appears to be a distinct phase of the appointment in its own right with its own aims and objectives.

Similarly to when describing the presenting concern, parents and patients have to decide how they will present their opinions. This decision again includes a judgement about medical or lay presentations, but alongside this is a choice about whether they list symptoms or use a more narrative approach focussing on the personal and lived experiences (Heritage & Robinson, 2006). At the point in the appointment where the act of building a case occurs, patients and clinicians have already agreed upon the necessity of the appointment. Rather, the act of building a case is for patients or parents to put forward their reasons for why they should be there and for continued intervention (Halkowski, 2006). Whilst constructing the strongest case they can for the need for specialist medical intervention, patients and accompanying parents also work to construct themselves as rational and reasonable witnesses to the events in their lives (Halkowski, 2006). In doing so, they tend to present their case in a logical order evidencing the discovery of symptoms and subsequent concerns.

Patients, and parents in the case of CAMHS triage appointments, use a number of resources when presenting and building the case for the difficulty being discussed. Each resource performs a function within the interaction that contributes towards the overall impact of the case being presented. Resources employed when building a case include, but are not limited to, referencing third parties, offering suggestions of a diagnosis, and describing the behaviours and symptoms being experienced (O’Reilly, Karim, Stafford, & Hutchby, 2015). These resources are used to aid accounts when offering explanations for how the concerns and difficulties were realised (Heritage & Robinson, 2006) and why this has led to seeking medical attention.
The role of the clinician in this phase of the appointment is to direct the interaction through questioning. Through the questions they ask, they elicit information about the symptoms being experienced, the medical background, and the social factors that provide a context for the reason for attendance (Boyd & Heritage, 2006). This information is then collated and clinicians use it to formulate a diagnosis.

2.6.1.1.3 Decision delivery

This diagnostic phase of medical appointments commonly occurs towards the end of the session following, but separated from, the examination phase (Heritage & Stivers, 1999). Offering a diagnosis indicates that the clinician has completed their investigation with all other phases of the appointment leading to diagnosis (Heath, 1992). Byrne and Long (1976) asserted that the delivery of a diagnosis constitutes a discrete phase in the medical encounter during which a specific action is performed as part of the interaction. During the diagnostic phase in medical interactions, the clinician summarises the patient’s complaint and provides an explanation for it. This explanation identifies and categorises the reason for the difficulties or illness experienced by the patient and may also include a treatment plan (Peräkylä, 2006).

In providing an explanation for the complaint, the diagnostic phase of the appointment also legitimises the patient’s medical help seeking and claims of illness (Health, 1992). Maynard and Frankel (2006) observed that even where patients were accompanied by other people, the diagnosis was still directed at them. In triage appointments in CAMHS, the focus of the appointment is not on the decision and delivery of a diagnosis, but rather on determining whether there is a need for specialist intervention or not and the most appropriate course of action (O’Reilly, Karim, Stafford, & Hutchby, 2015). Additionally, in CAMHS triage appointments the patient is a child and is accompanied by adults. Children are often afforded half membership in medical interactions with greater emphasis being given to the views and experiences of the accompanying adults (Hutchby & O’Reilly, 2010). This may affect the dynamic of the diagnostic interaction with the decision being delivered to the parents rather than the child.
When delivering a diagnostic formulation, clinicians report these to patients in a particular style (Byrne & Long, 1976; Peräkylä, 1998). Most commonly, clinicians report their decision to patients with minimal explanation or evidence of their reasoning. There are instances where clinicians evidence their decision (Maynard & Frankel, 2006) but this appears to correspond with the temporal distance between the examination and decision delivery (Peräkylä, 1998; 2006). Interestingly, patients not only appear to accept this style of delivery but also tend to give little or no response to it (Heath, 1992). Heath (1992) noted that this was particularly surprising given the range of response choices available to participants, including simple acknowledgements of the information and agreement or disagreement. Recipients do occasionally provide extended responses where they disagree with the decision that has been made or where the clinician displays uncertainty in their delivery (Heath, 1992).

A diagnostic decision can be either good or bad news to the patient (Maynard & Frankel, 2006). In most cases a decision by the clinician that there is nothing medically concerning is perceived as good news, whereas a diagnosis of a medical condition is generally perceived as bad news. However, where good news of no medical concern is delivered, the severity of the patient’s symptoms and the legitimacy of their need to seek medical attention in the first place are bought in to question (Heath, 1992). Additionally, patients can be left with a symptom residue, whereby the clinician has evaluated their symptoms and deems they are of little or no concern but the symptoms still remain (Maynard & Frankel, 2006). Following the delivery of there being no medical concern, patients must work to justify their seeking medical attention in the first place while clinicians work to address the existence of symptoms that have no medical implication.

2.7 Child Mental Health

While specialist services for mental health are relatively recent, the concept and services for child mental health has taken even longer to come to fruition. In the nineteenth century, children were not considered to have brains developed enough for them to display or experience any form of psychopathology (Rey et al., 2015). However, over the twentieth century there was an evolution of thought regarding
child development with childhood being constructed as a distinct phase of a person’s development (O’Reilly & Lester, 2017). This led to a change in the way childhood illness was conceptualised and treated, and in turn to the recognition and understanding of the distinction between mental health and mental illness in childhood. In the latter half of the twentieth century, health care interventions specifically for children became more prevalent (Karim, 2015) as did the conception of disciplines such as educational and developmental psychology and child psychiatry. With increased understanding of child development and deviations from this arose the notion of typical development, and in turn, atypical development. (O’Reilly & Lester, 2017). Deviation from expected behaviour began to be pathologised (Strong & Sesma-Vazquez, 2015), increasing the potential for pharmacological interventions and the medicalisation of mental health in children. In recent years, child mental health has been recognised as a discipline in its own right with specialist services specifically oriented towards care and intervention for children who may be experiencing mental health difficulties, a distinct budget for child mental health, and an increase in research focussed on this area (O’Reilly & Lester, 2017).

2.7.1 Risk and Resilience

It is widely considered that there are a number or protective factors that positively affect good mental health, and in contrast, a group of risk factors that affect a young person’s propensity to develop a mental illness. Protective and risk factors are all made up of features from different areas of the child’s life, including the self, the family, education and community, and the wider world (see Table 1) (Smith, 2002; The Mental Health Foundation, 2016). Whilst these factors do not determine whether a young person will or will not suffer from a mental illness during their childhood or adolescence, they do increase or decrease their susceptibility. Many children within the sample discussed in this thesis have experienced or are experiencing one or more of the risk factors outlined below.
Table 1

A summary of protective and risk factors affecting a child's propensity to develop a mental illness

<table>
<thead>
<tr>
<th>Protective Factors</th>
<th>Risk Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological factors</td>
<td>Genetic predisposition</td>
</tr>
<tr>
<td>Being physically healthy and active</td>
<td>Having a long term physical illness.</td>
</tr>
<tr>
<td>Having a functional, inclusive, and supportive family</td>
<td>Having a close relative who struggles with their</td>
</tr>
<tr>
<td>life with secure attachments and good relationships</td>
<td>mental health</td>
</tr>
<tr>
<td>Having a supportive and inclusive social network of</td>
<td>Experiencing the death of someone close to them</td>
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<td>other young people</td>
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<td>Receiving an education in a supportive and inclusive</td>
<td>Having parents who are separated and family</td>
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<td>environment.</td>
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<td>Having a sense of belonging or a religious belief.</td>
<td>Experiencing poverty, discrimination, bullying,</td>
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<td>or abusive relationships</td>
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<td>Being a young carer or being in care</td>
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For many individuals, symptoms of mental health problems begin in childhood and develop through adolescence into adulthood, if not recognised early (Bayer, Ukoumunne, Lucas, Wake, Scalzo, Nicholson, 2011). During adolescence individuals develop a sense of self, relationships, and experience challenges, all of which develop resilience and protective factors that are drawn upon throughout life (Jackson, Hill, & Layis, 2012). This highlights the importance of children and young people having experiences which will enhance their toolkit of protective factors and enable them to better cope with situations that may otherwise contribute to poor mental health. Whilst there are risk and resilience factors which are within a child’s experiential control, there are many which are not, such as parents’ mental health, family stability, and economic security. Identifying and developing a greater awareness of the risk and resilience factors involved in mental health will enable services to better identify and monitor children and young people who may be at risk (Walsh, 2009).
The importance of exploring children and young people’s understanding of mental health and illness is being increasingly recognised despite the fact that it is still a relatively under researched area (Svirydzenka, Bone & Dogra, 2006). While significant progress has been made in educating children and young people about their physical health and wellbeing, mental health has been neglected. Recent policy initiatives however have put an increasing focus on child mental health and on children and young people’s views, opinions, and understanding of it (NICE, 2009; WHO, 2003). Emerging research has focused on what children and young people understand mental health to be, as opposed to mental illness and the distinction between the two (see for example, Bone, Dugard, Vostanis & Dogra, 2015; Svirydzenka, Bone & Dogra, 2014; Wahl, 2002).

When questioned about their understanding of mental health, Johansson, Brunnberg and Eriksson (2007) found that young people referenced the brain and thinking. They also made a distinction between being happy and unhappy, and recognised that being unhappy and having feelings of depression are associated with mental ill health. However, Singletary et al. (2015) found that when the focus of the questioning was on what makes us mentally healthy, young people gave information that related to their physical health. Despite this, children aged 10-11 years of age were able to differentiate between mental and physical health (Roose & John, 2003), even if they are unable to articulate those differences. Whereas young people have an understanding of mental health and illness, younger children appear to use terms such as mental health, mental illn
...
negative opinions of what mental illness is and of those who experience mental health related illnesses (Pinfold et al., 2003; Sessa, 2005; Sheffield, Fiorenza & Sofronoff, 2004). Age again plays a role in how children and young people understand mental health and illness. Comprehension of the concepts becomes more sophisticated as children get older with older children being able to understand that there may be underlying psychological reasons for an outward behaviour (Wahl, 2002). Older children are also more likely to understand that mental health has a temporal quality and whilst a person can be experiencing mental ill health, mental health can be improved and a person can become mentally healthy again (Bone, Dugard, Vostanis & Dogra, 2015).

Whilst children and young people can express some understanding of mental health and mental illness, young people have relatively little information and education about mental health (Bone, Dugard, Vostanis & Dogra, 2015). However, with increasing numbers of children and young people entering specialist mental health services in the UK, it is pertinent that clinicians, researchers, and policy makers listen to and understand their perspectives (O’Reilly, Ronzoni & Dogra, 2013) in order to inform decisions about education and health care.

2.8 Conclusion

Mental health and illness is a significant area of concern for governments and governing organisations throughout the world. The economic impact of mental illness is already substantial throughout both developed and developing nations. With increased prevalence of mental illness and austerity leading to ever tighter budgets for services, the need for services is increasing yet the ability of services to meet that need is not growing at the same rate. This is also the case for child mental health. Children across the world are exposed to trauma, the effects of war and natural disaster, and newer stressors such as academic pressure and unstable social and familial relationships. These factors all increase the child’s propensity to develop a mental health related problem and services need to be able to meet that need and provide effective interventions. The evolution of our understanding of mental health has led to a rise in research interest around the topic of child mental health and illness. With the need for effective and efficient services to provide the
best possible care for children and young people, research would most benefit CAMHS and the child if it began to examine the processes within services to understand the relationships and practices that lead to an efficient and successful outcome for all involved.

The following chapter will discuss the importance of communication research in health care settings, particularly child mental health services. There will be an orientation to the dynamics of the relationship between clinicians and patients as this plays a significant part in the construction of the participant’s talk-in-interaction in a health care context. Findings from research using conversation analysis in a health care settings will be discussed and their relevance explained in terms of their contribution to understanding and improving the organisation of communication within services, and thus the effectiveness of treatments and patient satisfaction.
3 CHAPTER THREE: DOCTOR – PATIENT COMMUNICATION

3.1 Communication Research in Health Care Settings

In the context of analysing interactions that occur in medical settings, conversation analysis (CA) began by exploring the encounters in primary care, for example general practice, but has progressed to incorporate specialist health care settings such as paediatrics, oncology, medical telephone helplines, and psychiatry and therapeutic appointments (Gill & Roberts, 2014). Gill and Roberts suggest that there are three types of research involving CA in health care environments. The first is doctor-patient communication in outpatient settings, which includes acute care and specialist services. The second type is interactions between patients and professionals who operate outside of conventional medicine, such as speech and language therapists, medical helpline staff, and pharmacists. The third is the examination of interactions between health care professionals including exploring how they work together in decision making, patient care, and conferences. This illustrates the scope of conversation analysis within the institution of health care and the potential for valuable contributions to both theory and practice.

Whilst CA was not originally intended as a method for studying interactions in institutional settings, over time researchers have increasingly seen the benefits of applying it to environments such as courts of law, education, and medicine (Antaki, 2011). In a health care setting, conversation analysis aims to uncover and report the ways in which doctors and patients accomplish particular social actions within the framework of the doctor-patient relationship. Since its emergence into healthcare settings, CA has made a significant contribution to our understanding of how the structure of interactions can affect the course of a consultation (Drew, 2010), and achieve actions such as opening and closing appointments, the negotiation of antibiotic prescribing, or history taking. The application of conversation analysis to health care has demonstrated that the nuances of everyday interactions remain constant and transcend the institutional context in which it occurs (Heritage & Maynard, 2006). Through examining these interactions, researchers also identify patterns that transcend participants in order to say something about how the goals of professionals and lay persons are achieved (Halkowski & Gill, 2010). The challenge
for CA research in healthcare is to emphasise the significance of communication in all aspects of care and to understand the social actions that achieve the interactional tasks necessary.

Interactions in health care encounters explore the social actions that are jointly achieved by the participants within a specific setting. In these settings, CA explores and records how participants use interactional resources to accomplish particular actions (Gill & Roberts, 2014), such as presenting their problem or delivering a diagnosis. Health care interactions differ to every day interactions as one speaker tends to ask the questions and the other responds (Jones, 2001). In every day interaction, questions and responses are more evenly distributed between speakers. Although the tasks achieved in health care interactions are co-constructed by each participant, the relationship of the participants may not be as symmetrical as in everyday interactions (Maynard & Heritage, 2005). The differing expertise of doctors and patients contributes to an asymmetry in their relationship which is realised and maintained through their turns at talk. Management of relationships between oneself and others in an interaction is fundamental to the organisation of turns at talk (Heritage & Maynard, 2006) and asymmetry is a recognisable feature of interactions within lay-professional relationships.

Health science is concentrated on outcome focused research whereas communication research uncovers the processes involved in achieving those outcomes (Drew, 2010). Within CA research, there are two possible approaches to dissemination. The first is a ground up approach whereby professionals are involved in analysis using methods such as data sessions, role play within training, and discussions of scenarios. This method encourages reflection by professionals on their practice. The second approach is top down approach whereby research is conducted with a specific research question in mind and the results are disseminated directly to the organisation in such a way as to trigger a change in communication patterns (Heritage & Robinson, 2011). Whilst both of these approaches differ, the focus for CA research in medicine remains the same: to uncover how social actions are achieved in interactions within a health care setting.
3.1.1 CA Research in General Medical Appointments

In general medicine, CA has been applied successfully to investigate the organisation of interaction. Research has explored a variety of conversational devices and aspects of appointments with some studies being catalysts for change in the way doctors phrase particular questions (for example, Heritage, Robinson, Elliott, Beckett, & Wilkes, 2007). As previously noted, CA research has crossed into many different aspects of healthcare from general medicine to more specialist services, with the areas of study being wide ranging. Some of the vast array of CA research in general medical appointments will be discussed, before honing in on the area of interest for this thesis: therapeutic and psychiatric health care settings.

One of the most prominent CA studies to come from the investigation of doctor-patient interaction was conducted by Heritage, Robinson, Elliott, Beckett, and Wilkes (2007). Patients often present with multiple concerns when attending primary acute care appointments, however patients rarely present all of their concerns resulting in them leaving the appointment with unanswered questions. The team tested an interaction based intervention to see if a change in language would alter the frequency with which patients expressed further concerns in the appointment. Having randomly assigned physicians to one of two groups and video recording the appointments, they found that a difference in vocabulary from “is there anything else you want to address in the visit today?” to “is there something else you want to address in the visit today?” increased the number of patients who reported additional concerns. This simple change in language altered the course of the appointment and the outcome for patients. Conversation analysis enabled the researchers to investigate the nuances of interaction and apply principles of preference organisation from ordinary conversation to an institutional setting. Following the study, interventions were put in place to highlight this phenomenon to other medical professionals, thus having an impact on real world medical practice across a number of disciplines.

3.1.1.1 Communication across the phases of the appointment

Research by Byrne and Long (1976) outlined the general structure of a medical appointment, describing the phases clinicians and patients journey through during...
the session. Clinicians and patients move through the phases together in a specific order to achieve the aims of the appointment (Gill & Roberts, 2014). While the organisational structure of the appointment is taught to clinicians as part of their training, patients are familiar with it through repeated exposure as users of health care services (Heritage & Maynard, 2006). In studying interactions in medical settings, CA research has found that a similar structure is adhered to through medical appointments in a variety of specialist services as well as general medicine. Research has shown that each phase of the appointment brings with it a unique set of interactional challenges that the clinicians and patients must negotiate in order to accomplish the tasks of that phase (Gill & Roberts, 2014).

One of the initial stages of the appointment involves the clinician establishing the patient’s reason for seeking medical care. Clinicians must decide how best to solicit the patient’s presenting concerns as the formulation of the request may have an effect on the patient’s response and subsequently on the rest of the appointment and possible treatment (Robinson, 2006). When exploring the interaction between clinicians and patients during this phase of the appointment, Robinson found that subtle differences in the way clinicians phrase their question altered the action the question was performing. Differences in the phrasing of the question also affected the response given by the patient. The design of the clinician’s question was also found to orient to the clinician’s understanding of the patient’s reason for attendance, thus shaping the trajectory of the remainder of the interaction. Whilst clinicians show an awareness of the design of their solicitation, patients must make a choice about how they are going to account for their visit. Patients must manage the dilemma of where and how to present their reason for attendance whilst displaying an orientation to the epistemic dynamic in the clinician-patient relationship (Gill & Roberts, 2014).

Following on from establishing the reason for attendance, patients must engage in problem presentation. This is one of the only opportunities patients have to give their opinion and understanding of the problems they have been experiencing during the consultation (Heritage & Robinson, 2006). Patients also orient to the doctorability of the problem they are presenting and show an alignment with the need to display their problem as medical and needing specialist help (Heritage &
Robinson, 2006). In doing so, patients show an awareness of the possibility that seeking medical help could reflect on the clinician’s perception of their competence and the credibility of their concerns (Halkowski, 2006). To alleviate this, patients demonstrate that they have given their problem due consideration, including whether they are able to help themselves rather than seeking medical advice. Clinicians, however, must investigate the patient’s concerns thoroughly before they offer their diagnosis and either confirm or disconfirm the patient’s explanation (Gill & Roberts, 2014).

Diagnostic decisions tend to be delivered towards the end of the medical appointment. Whereas presenting the problem is dominated by the patient’s views, the delivery of a diagnostic decision tends to be dominated by the clinician. Patients rarely respond overtly to a diagnosis (Heath, 1992; Peräkylä, 2006), instead responding with acknowledgments or, in many cases, silence. In some cases this lack of response works to maintain the progressivity of the interaction and demonstrates that the patient is aware of a diagnosis ordinarily being followed by information about treatment (Robinson, 2003). If a patient challenges the diagnosis it is treated as a challenge to the clinician’s authority and also undermines the reason for the patient seeking specialist help (Pilnick & Coleman, 2003).

Conversation analysis allows researchers to uncover and begin to understand the social process involved in medical appointments and the interactions between doctors and patients. In exploring the differing interactional patterns in the various phases of the appointment, researchers can begin to evidence the processes being accomplished and explore the resulting outcomes for both the clinician and patient. These findings can then be explored and applied across different health care services including mental health and therapeutic services.

### 3.1.2 Conversation Analytic Research in Mental Health and Therapeutic Appointments

Interaction studies in specialist health care provision are increasing. The findings from general medical encounters can be applied to specialist services, but different services approach appointments in different ways with some seeing patients with recurring difficulties and some assessing patients for the first time. As the
relationship changes between doctor and patient, so may the execution of social actions. Whilst specialist health care provision includes areas such as oncology, paediatrics and midwifery, of particular interest are interactions in mental health and therapeutic services.

Within psychiatry, communication is of particular importance (Karim, 2015). Whereas in general medicine a physical examination can generally be undertaken, psychiatry is almost solely dependent on communication between clinicians and patients to diagnose disorders. Communication is also an essential part of building a rapport, establishing the reason for attendance, and delivering therapeutic interventions (Priebe, Domic, Wildgrube, Jankovic, Cushing & McCabe, 2011). The emphasis put on effective communication in a psychiatric and therapeutic environment makes the execution and application of conversation analytic research and findings particularly pertinent (Karim, 2015).

Conversation analytic research in mental health and therapeutic environments, whilst making up a very small proportion of the overall research conducted in these settings, has crossed into multiple areas. Some of these areas include, but are not limited to, family therapy (O’Reilly), counselling (Hutchby), communication with patients with psychosis (McCabe), and Autism (O’Reilly). Conversation analysis is not concerned with therapeutic effectiveness but rather is interested in how the interaction is constructed between the participants (Streeck, 2010).

McCabe, Heath, Burns, and Priebe (2002) used conversation analysis to investigate patient engagement during outpatient appointments between psychiatrists and patients experiencing psychosis. By exploring the interaction they found that patients attempted to talk about their symptoms but psychiatrists responses closed down the sequence. In using conversation analysis to investigate the process of the appointment through interaction, McCabe and her team were able to extrapolate the findings to build on the understanding of patient satisfaction and reasons for disengagement in specialist mental health services.

More recently, conversation analysis has been used to explore the interactional dynamic in psychiatric assessments for Autism Spectrum Disorder
(Maynard & Turowetz, 2017). In their study examining ASD assessments from 1985 and 2011-2015, they focussed on the delivery of a diagnosis by the clinicians and how that diagnosis was received by families. Through analysing the decision making process undertaken by the clinicians as to whether the child is presenting with ASD or not, they noted that the telling of stories was a central part of the decision making interaction. Not only were stories used by clinicians as part of the narrative process, but they were also used by parents when receiving the diagnosis. This use of stories as a narrative transcended the time period between the appointments in 1985 and those more recently undertaken. Two types of stories were identified by the researchers: tendency stories and instantiation stories. Tendency stories were more commonly used by both parents and clinicians, with parents appearing to use stories in response to the clinician, working to align their position with that of the clinician. In using conversation analysis in this context, Maynard and Turowetz (2017) were able to reveal an element of the interactional dynamic with the appointments and how this affects the delivery and receipt of the particular diagnosis given.

Within a therapeutic environment, the use of conversation analysis can expose the dynamic between family and clinicians to make treatment and intervention more effective. Disengagement from the treatment process is a concern in a therapy environment in the same way that it is in general medicine. In general medicine, resistance to pharmacological treatments can have negative effects on a patient’s wellbeing and future prognosis (Osterberg & Blaschke, 2005). Within a therapeutic environment, a resistance and disengagement with treatment presents in the form of non-attendance at appointments, or dropping out of treatment (Kazdin, Holland & Crowley, 1997), and can have similar outcomes for the person involved as well as financial repercussions for the service. In a child service, non-compliance can take the form of a lack of cooperation within the interaction (Hutchby, 2002). O’Reilly and Parker (2013) used conversation analysis to explore interactions in family therapy appointments to identify how children disengage from therapy within the session. They identified four social process that relate to children’s disengagement in the therapy process including active or passive disengagement by children, the ways children evaded adult demands, the contributions of other family members to the interaction, and finally the role of the therapists in engaging the
child. By looking beyond the outcome data from family therapy sessions and into the processes that are occurring within the session, O'Reilly and Parker (2013) were able to identify patterns in the interaction which may have led to children’s disengagement from treatment and had adverse effects on their healthcare.

Conversation analytic research in therapeutic environments with children is less prominent than that in adult focussed therapeutic environments (Fasulo, 2015). The field is growing, however, with research covering a variety of therapeutic services for children. The chapter will now explore how the dynamic between adults and children in interactions differs to that of just adults. Whilst similar interactional rules apply to adults and children, children do not access and contribute to the therapeutic environment in the same way as adults (Fasulo, 2015). This has implications for the focus of communication research in therapeutic environments involving children.

3.2 The Doctor - Patient Relationship

The doctor-patient relationship is a complex dynamic that differs from most social relationships and is particularly important in healthcare (Hoff & Collinson, 2017). The effect of a positive relationship can influence multiple facets of the patient’s healthcare experience. As the features of relationships are difficult to quantify, research has focussed on qualitative approaches to determine those that are present in successful medical relationships. Features that contribute to a positive doctor-patient relationship include trust, empathy, communication, listening, and sharing information (Hoff & Collinson, 2017). Shipman (2010) also advocated respect, integrity, and honesty, with patients being more likely to follow their doctor’s advice and recommended treatment plan if these elements of the relationship were present. Positive relationships between doctors and patients affect the quality of care patients receive and their uptake of it (Rosenblatt et al, 2000).

One key factor in the development and maintenance of a positive doctor-patient relationship is the effectiveness of the communication between the parties (Shipman, 2010). Communication involves two parties, the doctor and the patient, but within this relationship, the doctor is responsible for initiating the interaction and creating and maintaining an open channel of communication. Patients are then more
able to ask questions of the doctor and thus receive more information, making their health care experience more informed (Shipman, 2010). Whilst a successful doctor-patient relationship contributes to improved patient satisfaction, treatment compliance, and health outcomes, it is not simple and both parties must negotiate various factors within their interactions that contribute to the relationship they share.

3.3 Rights to Knowledge and Epistemics

Participants in interactions each have their own territories of knowledge. This refers to the notion that each person will have different experiences, most of which are individual to them. That is, participant A will have experienced events known to them but not to participant B, and participant B will have experienced events known to them but not to participant A (Labov & Fanshel, 1977). Whilst each participant has their own territory of knowledge, there may be some overlap. However, this overlap will differ depending on the event or information being shared, and the participants in the interaction (Kamio, 1997). Having an understanding of what others may or may not know aids interactions and shapes the questions asked and responses given (Heritage, 2013). This understanding enables participants to successfully reference people, places, or events during the course of the interaction.

Within the structure of interactions, speakers orient to and shape their turn construction around the perceived territories of knowledge and epistemic status of the participants (Heritage, 2012a). Participants in interactions have differing expertise and knowledge of certain subjects which is reflected in the structure of their turns and responses. The composition of a speakers question reflects differing levels of expertise on the subject being discussed. In interactional relationships, epistemic authority is given precedence over the views and opinions of those without the same level of expertise (Pollner, 1975). Understanding epistemic status is integral to the analysis of interactions as it is fundamental in the production of social action through talk and managing relationships within interaction (Heritage, 2012a).

In interaction, epistemics refers to the knowledge states of the participants (Heritage, 2012a). These are carefully managed and negotiated throughout the interaction through turn construction and responses (Heritage, 2012a). An individual’s epistemic status is consistent throughout an interaction (Heritage,
2012a). Epistemic status refers to the position the individual holds in the social relationship of which the interaction is part, for example doctor-patient, parent-child, friends. Within the social relationship, the relative epistemic status of individuals varies and is dependent on the perceived access to knowledge relative to the other person or people in the interaction (Heritage, 2012a). The interactants each having experience or knowledge of something does not translate to epistemic equality, however. For example, a patient may be given a diagnosis by a doctor that the patient is familiar with, but they may not have the medical expertise to interpret the diagnosis and understand the implications and treatment options. The relative states of knowledge of participants in an interaction have been illustrated by Heritage (2010; 2012a; 2012b). Heritage (2010; 2012a; 2012b) describes epistemic status as a gradient of absolute knowledge to a complete absence of knowledge, or from knowing to unknowing. Participants who know nothing of the topic being discussed are said to be in a K- position, whereas those in possession of absolute knowledge are in a K+ position. During interactions participants may move from a K- position to a K+ position and vice versa as topics shift.

While epistemic status concerns the joint understanding by individuals in an interaction of each other’s knowledgeability and rights to knowledge, epistemic stance refers to the expression of these relationships throughout the interaction through the construction of turns at talk (Heritage, 2012a; Heritage 2012b). Heritage (2012a) uses the following example to illustrate the epistemic stance expressed through a speaker’s question design: During an interaction a speaker may enquire as to the marital status of a participant. This could be formulated in three ways depending on the epistemic status of the speaker:

1) Are you married?
2) You are married, aren’t you?
3) You are married.
The epistemic relationship of the interactants is represented in the following figure.

![Diagram showing the epistemic relationship between speaker and recipient](image)

*Figure 1. A graph showing the epistemic relationship between speaker and recipient reflected in speakers question type (from Heritage, 2012a).*

The first question indicates that the speaker is in a K- position with no knowledge on the subject, whereas the recipient is in a K+ position, holding the information the speaker is requesting. In the second request for information, the speaker’s question structure indicates that they have some knowledge but they are comparatively still in a K- position to the recipients K+. In statement three, the speaker and recipient appear to both be in a K+ position, but the recipient is still in epistemic authority as they have experiential access to the information. This figure illustrates the differing epistemic status of participants in an interaction and the resulting affect this has on their epistemic stance as expressed through the construction of turns.

Epistemic rights and responsibilities are communicated through the structure of interactions (Heritage & Raymond, 2005). In general, participants in an interaction who are in a knowing position give statements of information and knowledge, whereas the participant in the position of lesser knowledge asks questions (Heritage, 2012a). For example, in a health care interaction, the clinical professional asks questions of the patients experiences and symptoms, of which the patient is the expert. However, when it comes to diagnosis, the professional makes
assertions rather than asking questions as they are in the more knowledgeable position and have the epistemic rights to express that information (Peräkylä, 2006).

3.4 The Role of the Child in Health Care Interactions

Whilst many of the interactional tasks of health care appointments involving children are the same as appointments with adults, the interactional dynamic differs considerably. Despite the importance of input from children in health care appointments that are about them, children are often afforded half membership in the interaction (Hutchby & O’Reilly, 2010) resulting in a lack of understanding about the child’s illness experience (Stivers, 2001). They are considered to be less knowledgeable about their difficulties despite them being the ones who are experiencing them.

Children’s epistemic status is reduced not only by being a child and thus being less knowledgeable, but in a child mental health environment is further compounded by them being considered to be affected by mental ill health and thus lacking competence and capacity (Fasulo, 2015). Children’s perceived competence is also affected by the differing levels of cognitive and linguistic ability between themselves and adults (Lobatto, 2002). This difference makes the interaction more adult-led due to a potential lack of understanding by the child (O’Reilly & Parker, 2013). Resistance to responding to questions in health care settings may be misconstrued as evidence for a child’s lack of understanding and competence with regards to the matters being discussed (Hutchby, 2002). However, a claim to a lack of knowledge by the child may not be a reflection of their cognitions but rather it may be used by the child as a conversational tool to alter the course of the interaction (Hutchby, 2002). It is only through fine grained analysis of talk in interaction that these mechanisms come to light.

The presence of a third party in an appointment, such as a parent, can complicate the structure of the interaction (Stivers, 2001). Where an adult third party is present, the child can be excluded from the interaction due to the perceived competence of the adult in relation to the child. The turn by turn structure of
interactions means that once the adult has been selected as the next speaker, the child may very easily be excluded from the sequence (Stivers, 2001). During interactions that involve family, clinicians have to be mindful of including all members who may each have different opinions about their reason for attendance and motivations for seeking help (Escudero, Friedlander, & Verela, 2008). For the clinician, this involves making decisions about whom to direct questions to and what to ask (Stivers, 2001). However, even where questions are directed at the child rather than the adults, parents often interrupt the child’s answer or intervene when the child does not provide an answer (Aronsson & Rundström, 1988; Hutchby & O’Reilly, 2010).

Not only are children considered to hold a lesser right to knowledge than adults in medical interactions, but they are also talked about in the third person, often in derogatory terms, whilst still being present in the room. Parker and O’Reilly (2013) found that in family therapy sessions, parents worked to present the child as the problem in order to mitigate any responsibility they may be considered to hold for the child’s behaviour. In doing so, they took advantage of the epistemic asymmetry between adults and children and further excluded the child from the interaction. Children who do want to participate in sessions may struggle to access the interaction (Hutchby & O’Reilly, 2010). Parents often self-select to answer the clinician’s questions, or to take the conversational floor (Shakespeare, 1998), leaving the child with little interactional opportunity, space, or rights to interject.

The lack of input from children in these situations has been acknowledged to some extent, and there has been some effort to recognise the value of children’s input in their healthcare (Dogra, 2005). In research looking at how children present their experiences of their mental health to clinicians in CAMHS, O’Reilly, Lester, and Muskett (2016) noted that when clinicians directed questions towards children, the child was positioned as holding epistemic rights to the information. Children express a desire to be involved in their health care in a meaningful way and in decision making processes (Shelton, 2004). Whilst 31% of 5 to 10 year old children questioned reported that they felt they were peripheral in their assessments at a child guidance clinic, those who did feel they were involved considered it to be a positive thing (Ross & Egan, 2004). This highlights the importance of including children and young people in interactions that are focused on their wellbeing, and of research that
unpicks the interactions and is able to say something about how clinicians can and do successfully include children in their health care.

3.5 The Significance of This Research

Research in health care environments using conversation analysis has the potential to uncover the processes involved in the interactions between clinicians and patients, and to understand the social actions that are being performed through the participants talk. In understanding these processes, patterns can be identified that affect the outcomes of the appointment and the possible success or failure of the clinician-patient relationship. The identification and analysis of questioning practices and the effect these have on responses and the remainder of the interaction allows clinicians the possibility of honing their own communication skills and encounters with patients to make their interactions more effective (Gill & Roberts, 2014).

Psychiatry and therapeutic environments are dominated by talk (Karim, 2015). In a service aimed at children, it is important to understand how the actions achieved through talk are managed and achieved (Fasulo, 2015). Children do not generally attend a medical service, or therapy, as a result of their own choice, but rather as a result of the choice of the adults around them. This makes understanding how clinicians can include children in interactions in a meaningful way all the more significant (Fasulo, 2015). To do this, researchers must explore how the status of the child in therapy is realised within the interaction in contrast to the adults. The relationship between child, family, and clinician is central to the success of treatment, many of which rely on effective communication.
CHAPTER FOUR: METHODOLOGY

4.1 Introduction

This study investigates communication in the institutional setting of Child and Adolescent Mental Health Services (CAMHS). More specifically, the research looks at how access to services is managed on an interactional level between clinicians and families in triage appointments. There are several areas to which particular attention will be paid throughout the research such as epistemics and the right to knowledge of the participants in the interactions. This includes how the right to knowledge is negotiated through talk, how the children in the appointments communicate their understanding of why they are there, and how families build a case and clinicians examine this.

This chapter provides a rationale for utilising a qualitative design, specifically conversation analysis. A critical discussion is engaged with, utilising the literature regarding the theoretical framework of conversation analysis and how this affects data collection, transcription, and ethical considerations. The chapter begins with a comprehensive review of the methodology and theoretical framework. The second part of the chapter details procedural information including core methodological decisions on sampling, data collection, and the preparation of data for analysis while putting these decisions in the context of wider literature. Due to the nature of the data and participants as patients attending a medical service, the chapter concludes with a detailed discussion of the ethical considerations and practices followed in this research and issues that were encountered along the way.

4.2 Methodological Framework

This section of the chapter focuses on the theoretical underpinnings of the chosen methodological approach. First, it discusses the benefits of qualitative research in general, followed by an overview of conversation analysis (CA). The overview of CA will cover the theoretical framework of the methodology, its history and foundations, and basic assumptions. The section concludes by outlining the turn-taking sequence observed by Sacks, Schegloff, and Jefferson (1974), the basis of which forms the foundation of conversation analysis.
A qualitative paradigm was considered most appropriate to effectively explore the interactional processes involved in CAMHS appointments. Qualitative research allows for a deeper understanding of individuals experiences and perspectives (O’Reilly, Ronzoni, & Dogra, 2013), captured through means such as interviews, naturalistic observations, and textual data. It takes an inductive approach, with research questions being developed from prior observations which are then informed by theory and explored through research. Typically qualitative approaches are contrasted with quantitative research which takes a hypothetico-deductive approach to the relationship between theory and hypotheses (Langdrige, 2004). A quantitative approach generally reduces participant behaviours and responses to a numerical value and explores these using statistical methods of analysis. The purpose of qualitative research is to ask open ended questions, exploring these through the examination of naturalistic data, with the answers to these questions deepening understanding of the phenomena being studied (O’Reilly & Parker, 2014).

There is no one single theoretical position underpinning qualitative research, rather the multiple methodologies encompassed by a qualitative paradigm have differing positions. Positions include, but are not limited to, Feminism, Social Constructionism, and Interpretivism (O’Reilly & Kiyimba, 2015). Each of these positions approaches research from a different standpoint, but all advocate the importance of understanding participants’ experiences and realities and tend to oppose the reductionist, essentialist ideas typically underpinning quantitative research. A positivist position underpins quantitative research; the notion that reality is observable and researchers can test and verify this reality, drawing conclusions that are generalizable and say something about the nature of the world (Burr, 2015; O’Reilly & Kiyimba, 2015). In contrast, the observations made over the course of qualitative research and the conclusions that are drawn from these are not intended to be generalizable, but rather to be transferrable (Gobo, 2004). Further research can then build on these findings to establish whether there are similarities or differences in alternative circumstances. Qualitative research acknowledges that the very nature of the research design and analysis as reflexive processes means that findings and interpretation will inevitably be influenced by the researchers’ views and
experiences (O’Reilly & Kiyimba, 2015). This, however, does not mean that the findings are the opinions of the researchers, but rather that the researchers’ lived experiences will affect their interpretation of the data.

A qualitative research paradigm was employed for this research because of its focus on understanding phenomena and the realities and experiences of the participants involved. The research objectives required that the paradigm chosen was flexible enough to facilitate the inclusion of numerous participants with different backgrounds and experiences, as well as being sensitive to their vulnerabilities. The research questions developed demand in-depth, experience- and language-based responses as opposed to frequencies, or statistical comparisons of variables. They also require naturalistic observations to answer them, which draws the research towards a qualitative paradigm.

4.2.2 Conversation Analysis

Conversation Analysis (CA) is a research methodology that falls under the qualitative paradigm. It is described as the analysis of talk-in-interaction (Hutchby & Wooffitt, 2008) and is concerned with how language is used by individuals in interactions to express their lived experiences of their social world (Antaki, 2011). The systematic analysis of ordinary everyday talk has been the focus of CA since its inception, but latterly there has been a move to apply the same principles to institutional talk to understand how individuals convey their understanding in interactions with a different dynamic.

While CA is a language-based methodology in that analysts observe, collect, and analyse spoken interactions, it is not interested in the technical details of language such as semantics or syntax. Rather it is interested in the social actions that are performed through language as part of an interaction (Buttny, 1993). As Antaki (2011) explained, conversation is ordered and sequential with turns in interaction being designed by its participants to perform an action. With each turn comes an expectation of what would constitute an appropriate response, which can be adhered to or ignored by the next speaker. By examining the sequences in interaction, the way turns are designed and responded to, the analyst can begin to say something about what social action is being achieved and how (Antaki, 2011).
4.2.2.1 Theoretical Framework

Conversation analysis falls under the theoretical orientation of social constructionism. Social constructionism emphasises the effect of context on a person’s reality in the form of the social, historical, and cultural setting (O’Reilly & Kiyimba, 2015). It is through our interactions with other people that we share our knowledge of the world, both past and present. In turn, our concept of the world is constructed through communicating with other people, listening to their experiences and perspectives, and applying our pre-existing knowledge to develop our understanding. Through the study of the organisation of everyday interactions, CA researchers seek to understand individuals’ experiences (Wooffitt, 2006).

Social constructionism is further sub-divided into two perspectives: macro social constructionism and micro social constructionism. Macro social constructionism views language as the way the world is constructed whilst acknowledging the influence of pre-existing social structures such as relationships and institutional etiquette (Burr, 2015). Micro social constructionism, however, views knowledge as co-constructed through every day conversations with little reference to power relations in conversation: power is created through discourse as opposed to it being a product of the underlying social relationships and structures (O’Reilly & Kiyimba, 2015). Micro social constructionists view the realities expressed through interactions as equal as analysts only have access to the transcript of the interaction and not the thoughts, opinions and experiences that have shaped the realities (Burr, 2015). Specifically, CA aligns with a micro social constructionist perspective in that it views interactions as a construction of reality rather than a reflection of it; participants in the interaction are building their reality through the interaction (Burr, 2015). Conversation analysis is interested in the mechanisms by which knowledge is shared and co-constructed by the participants in the interaction. Analysts refrain from making judgments or assumptions about the truthfulness or reliability of an account, instead focussing on the observable systematic production of an interaction.
4.2.2.2 History and Origins of Conversation Analysis

Conversation Analysis was developed in the 1960’s by sociologist Harvey Sacks. This new methodology distanced itself from the notion of language and actions being disorderly. It also moved away from the perspective that language and actions are only measurable through scientific experiments analysed using statistical methods (Heritage & Clayman, 2010). Conversation Analysis developed from work by Garfinkel’s ethnomethodology, and Goffman’s conception of interaction order. Sacks was a student of Goffman and both were close followers of Garfinkel’s work.

4.2.2.2.1 Goffman’s interaction order.

In the 1950’s, Erving Goffman established a facet of sociology focusing on the structure of interactions and how participants express the concept of the self within them (Hutchby & Wooffitt, 2008). Goffman recognised that interpersonal interaction was a reflection of social organisation (Heritage & Clayman, 2010) and as such could be investigated in a structured manner (Hutchby & Wooffitt, 2008). He placed importance not on the individual but on how they interact and react with and in response to others, and relationships that are acted out through these interactions (Heritage & Clayman, 2010). This movement toward interaction as a vehicle for social order and relationships was in contrast to the perception at the time of interaction being functional, disorganised, and uninteresting. (Heritage & Clayman, 2010)

4.2.2.2.2 Garfinkel’s ethnomethodology.

Ethnomethodology is another form of sociology developed at the same time as Goffman’s interaction order, and later influencing Sacks’ conversation analysis. Garfinkel’s theory extended the idea of interaction order by proposing that in the course of social action, participants have a shared understanding of the knowledge they each possess and how this is used in interactions (Heritage & Clayman, 2010). This shared understanding of knowledge is used in everyday interactions to enable participants to have successful and meaningful conversations and to complete the social action that was intended. Sacks developed these ideas further with them
forming the basis of the CA concept of speakers using socially shared resources to achieve order and meaning in their interactions (Silverman, 1998).

4.2.2.2.3 The evolution of conversation analysis.

While showing an interest in both ethnomethodology and interaction order, Sacks developed and extended this work into conversation analysis. During his analysis of calls to a suicide prevention help line, Sacks observed that calls generally began with an exchange of names regardless of differences in call handler and caller. However, in many cases the call handler gave their name but no such response was forthcoming from the caller. Despite multiple attempts to bring the interaction back to establishing their identity, the call would end with the caller having not given their name. Sacks established that whilst there are patterns in interactions and participants work together to achieve certain social actions such as greetings, there are circumstances where these can be avoided or reworked by one or other of the participants to achieve a different goal. Whilst he did not offer the suicide prevention centre a solution to this interactional dilemma, it did lead him to question whether speakers use their utterances and turn design to achieve certain actions (Hutchby & Wooffitt, 2008).

The development and increasing availability of devices for recording meant Sacks was able to access recordings of actual interactions and repeatedly listen to them to identify commonalities, deviances, and thus practices for performing social actions (ten Have, 2007). The ability to listen to the actual recordings as opposed to reading a transcript, or an account of a conversation by an observer, enabled the identification of the hitherto unnoticed organisation of such interactions (Hutchby & Wooffitt, 2008). In analysing these cases, Sacks developed a theory about the use of language and its functionality in performing social actions within interactions (Hutchby & Wooffitt, 2008). In contrast to alternative theories on language at the time, Sacks created a method by which interactions could be analysed rigorously and methodically. Over time, and with input from other researchers and academics who took an interest in Sacks’ work, analysis has become more detailed and expanded into areas and applications other than everyday conversation such as medical
interactions, court room interactions, and help line interactions (see Antiaki, 2011 for examples of conversation analysis applied to institutional settings).

4.2.2.3 Basic Assumptions

Through the development of the conversation analytic methodology and approach to analysis, basic assumptions took shape (Heritage & Clayman, 2010). These assumptions form the foundation of conversation analysis for researchers:

1) The importance of ordinary conversation

The origins of conversation analysis began with Sacks’ observations of the interactions in a phone call to a helpline. Following this, conversation analysts concerned themselves with understanding the social actions involved in the ordinary everyday interactions of the general population. Sacks was not interested in the potential application of the findings or methodology to other, institutional, settings (Silverman, 1998). However, as mentioned above, it has developed significantly into a number of different areas. This is due to the realisation that whilst all interactions are underpinned by similar structural concepts, the actions being performed differ as do the relationships between the interactants (Heritage & Clayman, 2010).

Despite the impressive and necessary expansion of CA into other areas of communication, the significance of ordinary conversation maintains importance. As Heritage and Clayman (2010) stated, ordinary every-day conversation is the primary means of communication for individuals and is the first form of conversation that young children are exposed to, included in, and initiate. They also pointed out that ordinary conversation is relatively enduring across time whereas institutional interactions are subject to changes in policy and guidance, as well as social developments through history. Therefore, ordinary conversation is the most natural form of information exchange analysts can study.

2) A preference for naturally occurring data

Naturally occurring data in the context of CA refers to interactions which would have occurred in the context in which they were observed and with the same content regardless of the researcher’s presence (Potter, 2002). Data is collected in ordinary,
everyday settings as opposed to laboratories or pre-arranged contexts. This allows analysts to study phenomena in the context that they occur looking at actual instances as opposed to recreations or accounts post event (Silverman, 2010). At the time that Sacks was developing conversation analysis, there was a preference among communication based researchers to use either fabricated data or recreations of interactions that illustrated the evidence for the theory they were discussing (Heritage & Clayman, 2010; Hutchby & Wooffitt, 2008). Sacks, however, dismissed this practice and insisted upon the use of naturally occurring data for analysis and reporting.

The practice of using only naturally occurring data has continued with interactions being audio recorded, and, more recently, video recorded. The use of recorded interactions allows the researcher to revisit the data multiple times, familiarising themselves with it and in turn giving rise to a more detailed analysis. A further advantage of using recorded naturally occurring data is the ability to report excerpts from their transcripts alongside analysis in publications (a discussion of video recording in research can be found later in the chapter.). Being able to evidence the analysis gives greater credibility to the findings and illustrates their relationship to the real world (Heritage & Clayman, 2010). Recording naturally occurring data also allows the analyst to revisit the interactions as research questions iteratively develop, facilitating the data driven approach to analysis that the qualitative paradigm demands.

For CA specifically, as the analysis of the achievement of social actions within conversation, the use of naturally occurring data allows the analyst to understand the context in which certain acts are accomplished (Wooffitt, 2006). In understanding the context of an utterance, analysts can begin to say something about what is being achieved by the speaker at that point in the interaction. Not only this, but the analyst can begin to identify where the activity is positioned within an interaction and the impact this has on the remainder of the conversation.

3) Structural analysis of conversation

Within interactions there are not only utterances but also speakers who produce the utterances. Each of these speakers has their own thoughts, feelings, motivations, and
psychology behind the utterances they are producing. Conversation analysis dictates that the speaker’s utterances should be analysed without reference to the speaker’s position. Rather, analysis should focus on the structure of the interaction and what this is doing in the context of the conversation, as opposed to trying to relate this back to the speaker’s motivations for producing the utterances (Heritage & Clayman, 2010). Conversation analysis goes so far as to make the assumption that the organisation of conversational practices are produced and used independently of the speakers motivations. Instead, the way participants organise the sequences within their interactions is how they display their motivations and psychology (Heritage & Clayman, 2010). For example, the analyst cannot make claims about the reason why a participant is feeling a particular way, but the participant may structure and design their turn in a way that communicates how they are feeling to the other interactants. In this respect, analysts should begin not with theoretical perspectives on what they might find, or are looking for, but rather by looking at the structures present. They can then build an understanding of the action they are performing in the specific context of the interaction (Hutchby & Wooffitt, 2008).

4) Transcription

Transcription is an important phase in qualitative research, forming a part of both data collection and analysis. Data generation can be divided into three parts, with the natural interaction being the first, the recording of the interaction being the second, and the transcript being the third (Heritage & Atkinson, 1984). The process of transcribing allows the researcher to revisit the data after collection and gives the opportunity to develop an initial impression of the data as a whole as well as identifying key features that may be of particular interest (ten Have, 2007). Whilst transcription began as a basic written representation of audio data, over time it became more sophisticated thanks to the work of Gail Jefferson. She developed a system that allowed the intricacies of the interactions to be recorded in the transcript, giving a more detailed and accurate representation of the data (ten Have, 2007).

Conversation analysis is interested in the sequential order of talk-in-interaction and how speakers accomplish this. The transcripts produced from the data thus need to represent the fullness of the interactions to not only show the basic
turn-taking practices but the nuances of talk-in-interaction (Hutchby & Wooffitt, 2008; Hepburn & Bolden, 2013). Conversation analysis necessitates that the transcript is as true a representation of the interaction it is depicting as possible. The method of analysis is dependent on capturing both what was said and the details of how it was said to truly understand the data and draw conclusions from it (Hepburn & Bolden, 2013). Therefore, the transcript itself has to be detailed enough for the analyst to be able to convey the intricacies of the interaction (Hepburn & Bolden, 2013).

The use of the Jefferson system of notation for transcription (see Jefferson, 2004) was designed specifically for conversation analysis. It is a system that is evolving in response to the needs of the analysts using it and their research interests (Atkinson & Heritage, 1999). It is therefore becoming more detailed and aids in the production of more intricate and accurate transcripts. Essentially, the Jefferson system is a set of symbols that represent the intricacies of speech in written form (see Appendix 1). With Jefferson notation, a transcript gives the analyst a written record of what was said in the interaction and how it was said (Edwards & Potter, 1992) which enables them to carry out a more detailed analysis.

Transcription itself is considered to be an important part of the data collection and analysis process (Hutchby & Wooffitt, 2008). The production of a transcript for CA purposes is an active and iterative process (O’Reilly & Kiyimba, 2015) with transcribers continually revisiting and engaging the video or audio data to examine different aspects of it. The transcript itself is purely a written representation of an oral interaction which is recorded in either audio or audio-visual form. The audio or video recording is considered to be the data with the transcripts providing an additional reference point. The transcript itself is also considered to be flexible, evolving as the researcher revisits the data and adapts and changes the transcript accordingly (Mondada, 2007).

When transferring analysis into literature, transcripts are the only source of evidence for authors to refer readers to when expressing their findings (Roberts & Robinson, 2004) as audio and video footage cannot be directly conveyed on paper. This reliance on the transcript in the literature makes it all the more important to
provide readers with a clear and accurate representation of the interaction being analysed and for researchers to continually refer back to the recording when carrying out analysis. In requiring and providing clear and accurate written representations of the interaction, researchers give a transparency to their analysis making it more trustworthy, both of which are key indicators of quality in qualitative research (Peräkylä, 2004; 2011).

4.2.2.4 The Turn Taking Sequence

Conversation analysis is built upon the basic principle that conversation is made up of a series of turns taken by the speaker and recipient(s) (Drew, 2013). In their groundbreaking paper, Sacks, Schegloff, and Jefferson (1974) outlined the fundamentals of the turn-taking sequence. They drew upon their analysis of naturally occurring conversations to make observations about the properties of these sequences and the structure of conversation. Turn-taking occurs in all forms of interaction, whether it be phone calls, everyday conversations, or institutional interactions, and is fundamental to the organisation of talk in interaction (Schegloff, 2007). Turns in talk are structured independently from grammatical rules such as syntax and sentences. A turn in talk does not constitute a sentence but rather is made up of a series of component parts which may be shorter or longer than a sentence (Silverman, 1998). Each of these parts are referred to as turn construction units (TCUs), with the boundaries of a TCU offering a legitimate place for a new speaker to take the floor. These boundaries are known as transition-relevance places.

Sacks, Schegloff, and Jefferson’s (1974) premise of turn-taking as a fundamental part of interaction is founded in the notion that each turn performs an action. A turn may for example perform the action of a greeting, which the co-interactant would interpret and respond appropriately to. Turns are continually monitored by the interactants to determine the action being performed as this may have implications for the response given in the next turn (Schegloff, 2007). These actions are interpreted and responded to by the co-interactants creating an organised sequence of interaction (Schegloff, 2007) which is grounded in each speaker’s understanding of the previous speaker’s action in their turn (Drew, 2013). For this to happen effectively, for each party to show that they have interpreted and are
responding to the others action, each party needs to take turns and speak one after the other, one at a time (Schegloff, 2007).

In their paper, Sacks, Schegloff and Jefferson (1974) described 14 observations they had made when analysing the organisation of turn-taking practices. These observations can be summarised by three basic principles (Hutchby & Wooffitt, 2008):

1) Turn-taking is used in interaction;

   All spoken interactions are made up of a collection of turns in which the first speaker performs an action which is then interpreted and responded to by a fellow interactant. This pattern then repeats and creates an organised sequence of interaction.

2) There is a preference for one person to speak at a time;

   Within interactions, turns are allocated to specific speakers. When taking a turn, a speaker has the exclusive right to it (Sacks, Schegloff & Jefferson, 1974). The transfer of turns to another speaker occurs at a transition-relevance point where one speaker has completed their turn and another takes theirs.

3) Turns are produced in relatively quick succession whilst avoiding overlapping talk.

   From their observations, Sacks, Schegloff and Jefferson (1974) determined that for the most part turns occur with no, or very short, pauses between them. They suggest that this occurs as a result of turns being exchanged around organised transition-relevance places. This allows speakers to complete their turns and pass to the next speaker with minimal gaps or overlaps between speakers. Where overlaps or longer pauses do occur, interactants treat these as troublesome to the interaction and work to repair it.

   4.2.2.4.1 Turns and action sequences.

The organisation of turns goes beyond single turns in interactions with groups of turns also appearing to have an organisational structure (Schegloff, 2007). Turns are
grouped together predominantly in relation to the action that is being performed as opposed to by topic. Subsequent turns are also grouped and these groups then sit together to form a complete interaction. For example, when inviting a friend for dinner the interaction may begin with a group of turns performing a greeting, move to a group of turns performing and responding to an invitation, and conclude with a closing. Each group is made up of a series of turns that perform that action before transitioning into the next action which has its own set of turns.

In adhering to the rules of turn-taking in interaction, talk-in-interaction follows an organised structure and ensures that interactions are successful and meaningful (Schegloff, 2007). The way speakers design their turns allows them to perform the action they desire and allows co-participants in the interaction to understand the action they are performing and to respond to it appropriately (Drew, 2013). Sacks, Schegloff and Jefferson (1974) note that the structure of interactions, how turns are designed and constructed and the structure of the response, is both context-sensitive and context-free. The rules for turn construction and turn taking are universal across interactions regardless of time, place, or participants. Regardless of context, the 14 observations of conversational structure still stand. Despite the rules of turn taking being context-free, they are also sensitive to the nature of the interaction taking place and the social structures within a context.

The understanding and analysis of turn-taking forms the foundations of conversation analysis. Whilst Sacks, Schegloff, and Jefferson’s original findings were based on observations of everyday, ordinary conversation, they have since been found to apply to other specialised forms of talk (Hutchby & Wooffitt, 2008). In understanding the structure and organisation of the mechanics of conversation, we can begin to say something about the actions being performed through these turns, what the speakers and recipients are doing in the interaction, and the implications these actions and responses have on the subsequent conversation (Schegloff, 2007).

4.2.3 Quality Markers

How to assess the quality of qualitative research has been a subject of discussion amongst academics for some time (O’Reilly & Kiyimba, 2015). While quantitative research has a clear set of guidelines for conducting high quality research, it is
argued that transferring these for use in qualitative research is not appropriate (Potter, 1996). With a focus on process rather than outcomes, and broad theoretical underpinnings, the quality of qualitative research cannot be objectively judged solely on the same positivist quality markers as quantitative research of reliability, validity, and generalisability (Devers, 1999). The general consensus amongst academics in the field of qualitative research is that there should be an emphasis on producing high-quality research. To do this, quality markers for qualitative research should differ to those of quantitative (Peräkylä, 2004).

Within the qualitative paradigm however, there are also discrepancies over the most appropriate way to assess quality (Rolfe, 2006). Due to the number of methods that fall under the paradigm, each with its own epistemologies, academics have struggled to agree on a set of quality markers that encompass all qualitative research (Guba & Lincoln, 2005). Conversation analysis is one such methodology where the application of quantitative quality markers would be inappropriate, but for which there is limited guidance with regards to an explicit set of unique measures (O’Reilly & Kiyimba, 2015).

Although limited, discussions between academics have given some guidance about the form that high quality qualitative research takes. The relationship between the conversation analytic methodology and the notion of quality is one such area where academics have given some thought as to what high quality research looks like. For CA research, the focus is on the transferability of findings and the trustworthiness and transparency of the research process and conclusions (Peräkylä, 2004). These concerns constitute measures of validity for CA researchers. Throughout the analytic process there are multiple ways researchers can ensure and demonstrate that they understand and have addressed these issues (Peräkylä, 2011; Potter, 1996). Peräkylä (2011) outlined six possible issues around the validity of CA work, including: 1) Transparency of analytic claims; 2) Deviant case analysis; 3) Validation through ‘next turn’; and 4) Generalisability of findings.

1) Transparency of analytic claims

Analytic claims should be transparently connected to the data and experiences of the reader. One aspect of ensuring transparency involves creating a direct and
understandable link between the data and analysis. Analysis should be presented alongside excerpts from the transcripts of the original data, making clear the connection between these and the claims being made (Potter, 1996). In conjunction with this, both Potter (1996) and Peräkylä (2011) state the importance of readers being able to recognise the phenomenon being analysed as being ‘transparently true’. Also referred to as ‘apparent validity’ (Kirk and Miller, 1986), the premise is that when readers are presented with the analysis and excerpt illustrating the phenomena being examined, they should be convinced of its truth and existence. Conversation analysis identifies methods that are used in everyday interaction to accomplish an action and gives a name to this phenomenon. As these methods occur in and are identified from everyday interactions, they should be recognised by readers as being methods they use (Pomerantz, 1990).

2) Deviant case analysis

A deviant case is a piece, or pieces, of data that does not fit the pattern observed in the rest of the collection. Whilst deviant cases may appear problematic as they do represent cases that do not conform to the phenomenon identified by the researcher, they are a valuable resource for demonstrating the validity of claims being made (Potter, 1996). The analysis of deviant cases can demonstrate that the participants in the deviant interaction also treat the sequence as unusual or unexpected and can therefore provide support for the analyst’s original claims (Peräkylä, 2011; Potter, 1996). Deviant cases provide an opportunity for the analyst to test their claims and to reformulate them if necessary (Peräkylä, 2004). The practice of deviant case analysis should be embraced by CA researchers as a measure of the validity of their claims and therefore as an opportunity to improve the quality of their research.

3) Validation through next turn

The process of analysing data using a CA method requires that the analyst examines sequences of interaction. As discussed earlier, sequences are made up of a progression of turns between interactants. One measure of validity suggested by academics is that of examining the next turn to validate the claim being made about the turn being analysed (Peräkylä, 2004; 2011; Potter, 1996). If an analyst has identified a turn as performing the action of an invitation, for instance, the co-
interactant should respond in such a way that treats the former as that. The analyst’s interpretation of the action can be validated by examining the way in which the interactants themselves interpret the action. This ensures that the analyst is remaining objective and true to the data and not imposing their own subjectivity and preconceived theories on the analysis (Potter, 1996).

4) Generalisability of findings

For conversation analysis, sample size is not considered a relevant criterion by which to measure the quality of a study or the generalisability of findings (O’Reilly & Parker, 2012). Sample sizes themselves vary dramatically with some studies considering hundreds of cases of a phenomenon (see for example Schegloff, 1968), whereas others may draw upon a single case analysis. Instead of sample size, there is an emphasis on the richness and depth of the data set (O’Reilly & Parker, 2012). This makes the idea of the generalisability of phenomenon in the quantitative sense difficult to achieve. However, as noted previously, there are qualitative researchers who prefer the notion of findings being transferable rather than generalisable (Gobo, 2004). This notion applies internally in that a piece of research should corroborate and build upon pre-existing theories and analysis (Potter, 1996). In this respect quality is being assured through the validation of findings in the context of previous research.

The concept of generalisability or transferability also applies externally, to other people in other settings. Given the generally small data sets and depending on the research objectives, it may be appropriate to claim that there is a possibility of the findings being relevant to other settings (Peräkylä, 2011). The phenomena may not be found in an identical form in these settings, but it is possible that they are present. For research in institutional settings, the notion of transferability refers to the question of whether phenomena identified are also present in settings other than the one sampled. Peräkylä (2011) suggests that findings from institutional settings should be reflective of previous findings from other research in similar settings, for example medical interactions.

Producing high quality CA research is shaped by the requirement for naturalistic data and the analysis of interactions within this (Peräkylä, 2011). With
this in mind, to produce high quality research, analysts must make clear the links between their own and previous analysis as well as making the analytic process transparent for the reader. Analysis itself must be analytical, demonstrating the process of analysis, rather than being purely descriptive or making assumptions (Antaki, Billig, Edwards & Potter, 2003). A mindful approach to each of the above markers of quality has been taken during the course of producing this piece of research. A further, retrospective appraisal of the markers in relation to the research can be found in the discussion chapter.

4.3 Generating Data

The following sections of the chapter are concerned with procedural information. Beginning with an overview of the sampling strategy used, the section will then move on to discussing theoretical sampling. The section concludes by providing demographic information about the participants the data was collected from and a detailed overview of the recruitment process employed.

4.3.1 Sampling

A purposeful sampling method was used to select participants to take part in the research. Purposeful sampling allowed parameters to be set before beginning recruitment (Silverman, 2010). This ensured that the data collected from the sample selected would address the research questions. In this instance, the overarching parameter was the need for participants to be either clinicians working in, or patients referred into, the CAMHS triage stream in the service to which access had been granted. Further parameters were set in the form of inclusion and exclusion criteria, discussed in the following section.

4.3.2 Inclusion and Exclusion Criteria

As part of the sampling process, inclusion and exclusion criteria were developed prior to recruiting participants and carrying out the study (see Table 2 below). Having clear inclusion and exclusion criteria ensured that an appropriate sample was approached and recruited throughout the research. Whilst the inclusion criteria remained consistent throughout the process, the exclusion criteria evolved from theoretical sampling to active recruitment as patients’ individual circumstances came
to light. Criteria marked with a * indicate characteristics that may affect the individuals' capacity to consent.

Table 2

*Inclusion and exclusion criteria for families*

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Offered a triage appointment at CAMHS.</td>
<td>• Required a translator as English was not the first language.*</td>
</tr>
<tr>
<td>• Child, accompanying adults, and clinicians provided consent or assent to participate.*</td>
<td>• Acute cases.</td>
</tr>
<tr>
<td></td>
<td>• The child had learning difficulties affecting their capacity to consent.*</td>
</tr>
<tr>
<td></td>
<td>• Clinical team vetoed the families’ participation.</td>
</tr>
<tr>
<td></td>
<td>• Child did not want their parents to know about the appointment.</td>
</tr>
<tr>
<td></td>
<td>• Last minute appointments.</td>
</tr>
</tbody>
</table>

*will be discussed further in Ethics section

During the theoretical sampling process, the exclusion criterion consisted of the family requiring a translator because their first language was not English; acute cases; and the clinical team vetoing a family’s participation. Families who required a translator were excluded on the grounds that they may not be able to provide fully informed consent, and because of the practicalities of transcription and analysis of the video footage. Acute cases were discounted on the basis that these patients were more vulnerable by virtue of the difficulties they were experiencing and their need for intervention, and it was felt that it would be inappropriate to ask them to take part.

A further criterion for exclusion from the study occurred when the clinical team deemed it inappropriate for particular families to be involved based on the information they had about the child’s difficulties. This occurred in three instances during the course of the research. In each instance, the clinicians were concerned...
that the nature of the difficulties the child and family were seeking help for were such that they may not have fully disclosed during the session if they were being recorded. This could have affected the decision made by the clinicians about their future medical treatment.

During the active recruitment phase of the research it was observed that a small number of children had a note in their files stating that they did not want their parents to know about their upcoming appointment with CAMHS. Consequently, it was concluded that these children would also be excluded from the potential sample. This was decided upon due to the risk that their parents may open the invitation letter and information pack sent in the post which referred to the child’s upcoming appointment. This would breach the child’s confidentiality and potentially affect their medical treatment. Two children were excluded under this criterion.

In some instances families were given emergency or last-minute appointments, arranged just a few days before the appointment was due to take place. I was generally unaware of these new allocations and as a result some patients who arrived for a triage appointment had not received the information pack detailing the research. In these instances, the families were not approached to take part as, firstly, they had been given no prior notice of the research; and secondly, I had not had an opportunity to check their CAMHS file for potentially problematic information such as needing a translator, or confidentiality concerns.

4.3.3 Participants

Participants in the research comprised of 15 families attending triage appointments for their child (also referred to as the patient) at a National Health Service (NHS) Child and Adolescent Mental Health Service (CAMHS) in the Midlands of England. Families were included in the potential sample on the basis that they had been accepted for assessment at CAMHS through the triage process. As detailed in Chapter One, triage appointments are a screening appointment for all non-urgent cases referred to CAMHS. The purpose of these appointments is to determine whether there is a mental health concern present for the child, and if there is, what the appropriate course of action should be. Families who had been offered and had confirmed their upcoming triage appointments were invited to participate in the
research. Every child in the sample was accompanied by their mother\textsuperscript{1}, with other relatives attending on occasion including the child’s father, their maternal grandmother, siblings, and in one instance, a family support worker (FSW) (see Table 3 for details).

Table 3

*Description of who attended the appointment with the child*

<table>
<thead>
<tr>
<th>Family</th>
<th>Mum</th>
<th>Dad</th>
<th>Grandparent</th>
<th>Other Relative</th>
<th>Other Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>x</td>
<td>x</td>
<td>(grandmother)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>x*</td>
<td></td>
<td>(grandmother)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>x</td>
<td></td>
<td></td>
<td>(siblings)</td>
<td>(FSW)</td>
</tr>
<tr>
<td>8</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>x</td>
<td></td>
<td>(grandmother)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>x</td>
<td></td>
<td></td>
<td>(aunty)</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note.* The categories ‘mum’ and ‘dad’ include step-parents and cases where parental responsibility (PR) has been granted.

*Parents who are not biological parents

\textsuperscript{1} In this sample, mother or mum refers to both biological and non-biological mothers, including parents with Parental Responsibility.
The children and young people were all aged between 6 and 15 years old with a mean age of 10.93 years (SD= 2.89). Of the 15 children, 10 (67%) were male, and 5 (33%) were female (see Table 4 for a breakdown of demographic information). In their study of the effectiveness of a triage clinic in a CAMHS setting, Parkin, Frake, and Davidson (2003) reported a sample of 24 children and young people where 15 (63%) were male and 9 (37%) were female. The similarity of the demographic across samples suggests the participants in the current study were representative of patients being seen at CAMHS for triage appointments.

Table 4

*Table of children’s age and gender*

<table>
<thead>
<tr>
<th>Family</th>
<th>Age</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>13</td>
<td>F</td>
</tr>
<tr>
<td>2</td>
<td>15</td>
<td>M</td>
</tr>
<tr>
<td>3</td>
<td>13</td>
<td>M</td>
</tr>
<tr>
<td>4</td>
<td>9</td>
<td>M</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>F</td>
</tr>
<tr>
<td>6</td>
<td>9</td>
<td>F</td>
</tr>
<tr>
<td>7</td>
<td>11</td>
<td>M</td>
</tr>
<tr>
<td>8</td>
<td>8</td>
<td>F</td>
</tr>
<tr>
<td>9</td>
<td>12</td>
<td>M</td>
</tr>
<tr>
<td>10</td>
<td>9</td>
<td>M</td>
</tr>
<tr>
<td>11</td>
<td>9</td>
<td>F</td>
</tr>
<tr>
<td>12</td>
<td>13</td>
<td>M</td>
</tr>
<tr>
<td>13</td>
<td>8</td>
<td>M</td>
</tr>
<tr>
<td>14</td>
<td>16</td>
<td>M</td>
</tr>
<tr>
<td>15</td>
<td>3</td>
<td>M</td>
</tr>
</tbody>
</table>

The sample also included members of the CAMHS clinical team. The team responsible for facilitating the triage appointments consisted of 29 clinicians in total. Twenty-four different clinicians were recorded as part of the research, with six being recorded twice, and one being recorded three times (see Table 5 for details). The
range of clinical roles practiced by the sample from the clinical team included consultant, staff-grade, and training grade child and adolescent psychiatrists, clinical psychologists, assistant clinical psychologists, community psychiatric nurses (CPNs), a learning disabilities nurse, occupational therapists, psychotherapists, and trainee psychotherapists. Some appointments also included student nurses and medical students in observational roles.

Table 5

*Roles of the clinicians and appointments they were present in*

<table>
<thead>
<tr>
<th>Clinician (Pseudonym)</th>
<th>Position</th>
<th>Present in recordings</th>
<th>Number of recordings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Aadi</td>
<td>Junior Doctor (Psychiatry)</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Dr Aadesh Vernon</td>
<td>Consultant Clinical Psychologist</td>
<td>1, 9</td>
<td>2</td>
</tr>
<tr>
<td>Dr Alice Williams</td>
<td>Consultant Child Psychiatrist</td>
<td>8, 13</td>
<td>1</td>
</tr>
<tr>
<td>Alisha Webb</td>
<td>Occupational Therapist</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td>Dr Adrika Aapti</td>
<td>Consultant Child Psychiatrist</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Alison Kebble</td>
<td>Psychotherapist</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Cain Field</td>
<td>Community Psychiatric Nurse</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Erin Porter</td>
<td>Assistant Psychologist</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Heather Carter</td>
<td>Occupational Therapist</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Dr Jagadev Shan</td>
<td>Training grade Child Psychiatrist</td>
<td>10, 15</td>
<td>1</td>
</tr>
<tr>
<td>Dr Kaamil Kurup</td>
<td>Consultant Child Psychiatrist</td>
<td>12, 14</td>
<td>3</td>
</tr>
<tr>
<td>Khrystyanr Trakas</td>
<td>Training grade Psychotherapist</td>
<td>12, 15</td>
<td>2</td>
</tr>
<tr>
<td>Lou Hawley</td>
<td>Learning Disability Nurse</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Laura Richardson</td>
<td>Occupational Therapist</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Mena</td>
<td>Student nurse</td>
<td>11</td>
<td>1</td>
</tr>
<tr>
<td>Marie Maddock</td>
<td>Assistant Psychologist</td>
<td>9, 11</td>
<td>2</td>
</tr>
<tr>
<td>Dr Nina Dutta</td>
<td>Consultant Child Psychiatrist</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Dr Pasquel Renaldo</td>
<td>Training grade Child Psychiatrist</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Dr Rabani Kaur</td>
<td>Training grade Child Psychiatrist</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Sarah Bryan</td>
<td>Occupational Therapist</td>
<td>10</td>
<td>1</td>
</tr>
</tbody>
</table>
Sakhi Puri                  Community Psychiatric Nurse            14                        3
Dr Sai Raavi               Training grade Child psychiatrist           13                        2
Valda Valentine            Community Psychiatric Nurse            1, 3, 11                   3
Zara Tattesell             Community Psychiatric Nurse            6, 8                       2

4.3.4 Recruitment

A gatekeeper was used to gain initial access to the sample. As this study required access to children within an NHS service, a gatekeeper was necessary to ensure the research did not impede on the everyday practice and treatment of patients. As a member of the clinical team, the gatekeeper was also crucial in gaining the trust of the clinicians and access to patient information. They also provided practical advice on when and how best to approach participants about the research without detracting from the primary purpose of their visit to CAMHS.

Within this CAMH service, triage appointments took place twice a week with up to four families being invited for appointments which all ran in parallel. Once the appointment had been confirmed by the families, invitation letters, information sheets, and consent forms were sent to them by post explaining the research and asking whether they would be interested in taking part (See Appendices 2-11). Letters were usually sent a few weeks in advance of the arranged appointment.

On the days that triage was held, families who had been sent information about the research were approached in person and asked if they would be interested in taking part. Once the family arrived for their appointment they were asked to complete a set of forms for CAMHS and then take a seat in the waiting area before being called through for their appointment. At this point families were approached regarding participating in the research project, establishing whether they were aware of the project from the information pack that had been sent, providing basic information about the research, and answering any questions they had. If families were willing to participate then informed consent was collected. Procedures, issues, and information around informed consent are discussed later in the chapter.

For the clinical staff the procedure differed slightly (see Figure 2 for a visual representation of the recruitment strategies for families and clinicians). Each
member of the CAMHS clinical staff who was involved in the triage appointments was provided with invitation letters and information sheets by way of their internal post system. The research was also explained to them in person by the gatekeeper and myself in a group meeting so they were aware that it was being carried out. We detailed the purpose of the project and its aims and objectives, as well as outlining the basic procedure. Questions were asked and answered with regards to the details of the recruitment procedure and how the clinicians would know which families had consented to the research prior to the appointments. There was some discussion around the use of specific rooms for these appointments to ensure that the consenting families’ appointments took place in the room with the recording equipment. Reassurance was given that all involved would remain anonymous; that the clinicians’ professional opinions with regards to the suitability of certain families to take part would be taken over and above the research itself; and that any disruption would be kept to a minimum and would not interfere with the running of the triage clinic.

Before the triage appointments were due to start, the clinical team who were involved in triage that day came together to discuss the cases and to assign clinicians to each family. At this time they were made aware of which of the patients being seen that day had been invited to take part in the research. Once each family had been spoken to and consent forms had been signed, the clinicians were then informed of which families had agreed to take part in the research. In the event that more than one family provided their consent, the clinicians decided who would be recorded based on the medical and background information they had available to them about the child. In cases where only one family provided consent, the clinicians were given the opportunity to say whether they had any concerns about that particular family taking part that may lead to their exclusion from the study. At this point, consent was then taken from the clinicians who would be seeing the participating family.
Figure 2. A flowchart showing the recruitment process for clinicians and families during the research process.

Meeting conducted with all clinicians involved to explain the research and answer any questions.

- Information packs sent to all clinicians involved in triage appointments.
- Triage patient files accessed and letters and information packs were sent to all families who met the inclusion criteria.

Families who had been sent information packs were approached and given the option of participating.

Consent obtained

- Clinicians informed of the families who had consented and asked for any concerns.

Consent not given

- Clinicians informed that they would not be participating. The family's appointment continued as normal.
- Thanked for their time and appointment proceeded as normal.

Clinicians agreed the family could be filmed.

- Consent obtained from clinicians prior to the appointment.
- Appointment was conducted whilst being recorded.
- Retrospective consent was sought from the family and clinicians after the appointment.

Clinicians had concerns about the family being filmed.

- Clinicians informed the family that they would not be participating. The family's appointment continued as normal.
- Thanked for their time and appointment proceeded as normal.
4.4 Data Collection and Preparation

Following recruitment and the completion of consent forms, families and clinicians were made aware of their right to withdraw at any point from the research and a more thorough explanation of the proceedings was provided to the families. Children and parents were given the opportunity to go and see the room where they would be having their appointment to familiarise themselves with the recording equipment. Several children opted to look when the opportunity was offered.

No further contact was had by myself with the participants until consent was taken again at the end of the appointment. In instances where multiple families had consented the clinicians informed them of whether they had been ‘selected’ or not as opposed to me informing them to ensure minimal disruption to the appointments. Families had already been made aware that there was a possibility that they would not have their appointment recorded if more than one family consented to the research.

During the appointment, participating families were video recorded using in-built recording equipment. This particular CAMH service had a room specifically designed for observation of therapy sessions via either a two-way mirror, or CCTV style video recording equipment (see Figure 3 for a representation of the room). The latter was used in this research. Two cameras were installed on the ceiling at opposite corners of the consultation room. Two microphones hung above the centre of the room, again from the ceiling. The cameras and microphones were permanent, static, installations. Although the cameras were static there was the capability of switching between them to record from the most appropriate angle. All of the recording equipment was controlled from a separate observation room behind the two-way mirror ensuring minimal interference in the appointment.

At the end of the appointment the recording equipment was stopped and families were met in the waiting room and asked again to consent to their video recording being used for research (see section 3.5.2 for details). The clinicians were then asked to do the same and any further questions were answered. Both the families who participated and the clinicians were provided with a copy of the consent form they signed and were also given my contact details should they have
any questions or concerns later on. A copy of the family’s consent was also added to the patient’s CAMHS file.

![Diagram of consultation room layout with recording equipment positions](image)

**Figure 3.** A diagram showing the lay out of the consultation room used with positions of recording equipment.

### 4.4.1 Video Recording

Recording in research, and video recording specifically, has become more popular as a method of data collection across the social sciences (Bottorff, 1994; Speer & Hutchby, 2003). Video recordings are particularly valuable when conducting qualitative research due to the amount of detail captured on video as opposed to audio recordings. Within conversation analysis, the requirement for naturally occurring data also makes video recording an attractive method of data collection. Qualitative methods acknowledge that individuals’ actions and understanding are produced as a result of the contributions of others (Heath, 2004), and with a reliance on observation, qualitative research is enhanced by the use of technology such as video recording (Miles, 2006). With this in mind, video recording lends itself to this form of research given its ability to capture an unbiased view of both verbal and nonverbal interaction between individuals.
Recent advances in technology have improved the quality of video footage allowing for a clearer and more realistic representation of the observed situation and the circumstances in which it is produced (Heath, 2004). This improvement in picture quality allows for the more accurate capture of non-verbal interactions and the sound quality allows for more accurate transcription of the data. Additionally, the increased availability of video recording equipment has made it more accessible as a method of data collection (Heath, 2004). Grimshaw (1982) demonstrates that one of the many advantages of video recording is the opportunity to review the footage as often as necessary allowing for a more complete analysis. The opportunity to review the footage also allows the researcher to monitor all participants without being constrained by the sequential occurrence of real time.

4.4.1.1 Benefits of Video Recording

Video recording as a method of data collection is beneficial in the healthcare professions as there is an increasing focus on effective communication both professionally and clinically (Carroll, Iedema, & Kerridge, 2008). It is also becoming increasingly popular in research related to the health care services (Iedema, Forsyth, Georgiou, Braithwaite, & Westbrook, 2007). Investigating healthcare consultations using video recording provides an essential insight into practice that allows the development of quality service delivery (Themessl-Huber, et al., 2008). Peräkylä (2006) suggests that by using video recording we can better capture and observe the interaction between professionals and their patients. In this sense video recording allows for both the nonverbal and verbal interactions to be observed whereas audio recording only allows the verbal interaction to be listened to. Video recording provides far richer data than audio recording especially in instances where there are several participants involved in the same interaction; it records the dynamics of the interaction more successfully because of the ability to include nonverbal interaction in the analysis of the data.

As detailed earlier in the chapter, CA has a requirement for the collection and analysis of naturally occurring observational data. The use of video recording technology enables researchers to do just this. Researchers can record and review real life interactions as they occur. These recordings not only enable the collection of
audio information but also non-verbal information that forms a part of the interaction. Whilst non-verbal information is not the main focus of the analysis for the CA researcher, it provides valuable contextual information (Bottorff, 1994). The use of video recording allows the analyst to revisit the data not only in the form of a transcript but by actually observing the interaction repeatedly and fully immersing themselves in the data.

4.4.1.2 Concerns with Video Recording and Allowances Made

One of the main concerns with using video recordings in research is the effect the presence of the recording equipment may have on the interaction (Speer & Hutchby, 2003). There is the possibility that participants will be more anxious (Blaxter, Hughes, & Tight, 1996), and that being aware of being recorded may affect the language participants use and the content of the interaction (Stubbs, 1983). Through analysing recordings of family therapy sessions, O’Reilly, Parker and Hutchby (2011) found that families orient the conversation to the cameras’ presence before and during discussions of sensitive topics. This suggests that families are aware of the recording equipment during the sessions and this may have altered the content of the interaction. This was of particular concern in the current research as the content being recorded was a clinical consultation. In this respect the alteration of content on the part of both the participating family and the clinician may have impacted upon the decisions made about the child’s health and future treatment. To minimise this effect as much as possible it was decided that the static, built-in, recording equipment be used rather than a portable video camera and tri-pod set up. As Bottorff (1994) argues, one step a researcher can take is to minimise the intrusiveness of the recording equipment in order to reduce the effect of recording on the participants.

A further concern when video recording interaction is that participants will not agree to being recorded. In terms of participant recruitment, audio recording is looked upon more favourably than video recording (Themessl-Huber, et al., 2008), with participants being more likely to agree to be audio recorded than video recorded. There are, however, steps that the researcher can follow, and indeed steps that I followed, to improve the chances of participants agreeing to the research.
These include giving them time to consider the information they have been given and to think about their participation (Themessl-Huber, et al., 2008); fully informing participants of the procedure for the research; giving assurances about the protection of the recordings and their confidentiality (Bottorff, 1994); building a rapport with participants; being as transparent as possible about the research; and answering questions they have (Grant & Luxford, 2009). Despite the concerns about the effect of the camera on participants’ behaviour and the potential for causing anxiety, several studies suggest that over time participants forget the camera is there and they feel no more anxious than they otherwise would have (Bottorff, 1994; Herzmark, 1985; Martin & Martin, 1984). Indeed, when collecting consent at the end of the appointments many families remarked that “it wasn’t as bad as I thought it would be” and that they had forgotten they were being recorded. One advantage of the appointment being over an hour in length is that it gave the families an opportunity to settle in to the environment and format of the appointment, and as a result to become less aware of the recording equipment. In recent years, members of the public have become more accustomed to video recording technology with most people understanding the use and prevalence of CCTV surveillance, having access to webcams, and using technology such as video calls. This has made most people more comfortable with the notion of being videoed and caused them to take less notice of the technology (Shrum, Duque, & Brown, 2005).

### 4.4.1.3 Additional Recordings

A portable digital dictaphone was also used to provide a second audio recording of the appointment. This was done for two reasons: first, it ensured an additional audio copy was available if the original failed; and second, during some of the appointments the clinicians would make the decision to see the child or young person and the rest of the family separately. Generally in these cases one of the clinicians would leave the room with either the parents or the child and continue the consultation elsewhere. The other clinician stayed in the room with the remaining members of the family and continued the appointment. This procedure was usually followed if it was felt it would be beneficial to either the parents or the child to be able to talk about their concerns without the other being present. Having a small portable audio recording device meant that this could be taken with the clinician who
left the room resulting in a complete recording of the whole session. Clinicians were shown how to use the dictaphone and were asked to take it with them should they separate the family. In the majority of cases this system worked but on occasion the clinician who left the room forgot to take the recorder with them. The clinicians decided to separate the family and child for part of the appointment on five occasions, of which three split off sessions were recorded. Table 6 shows the families who were split by the clinicians during the appointment, and of those which had the split off session recorded.

Table 6

<table>
<thead>
<tr>
<th>Family</th>
<th>Family separated?</th>
<th>Split off session recorded?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>2</td>
<td>no</td>
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</tr>
<tr>
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<td>5</td>
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</tr>
<tr>
<td>6</td>
<td>no</td>
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<tr>
<td>7</td>
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<tr>
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<tr>
<td>13</td>
<td>no</td>
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<td>14</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>yes</td>
<td>yes</td>
</tr>
</tbody>
</table>
4.4.2 Transcription

Once the recording had been made it was then subject to a two stage transcription process. First it was transcribed verbatim to give an accurate account of the appointment, followed by a finer layer of detail known as Jefferson notation (Jefferson, 2004). The transcripts were used for analysis, alongside the video data, with excerpts being reproduced throughout the analytic chapters. A detailed description of the importance of transcription in CA research and the Jefferson notation system is provided earlier in this chapter.

4.5 Ethical Considerations

Both the British Psychological Society (BPS) and European Social Research Council (ESRC) codes of ethics were closely followed whilst undertaking the research. Full health research ethics was sought and approved from the Health Research Authority – National Research Ethics Service (HRA-NRES) as the research took place in a clinical setting using both NHS staff and current patients as participants. Full local Research and Development office (R & D) approval was granted following the completion of the NRES online application and presentation of the research proposal to the ethics committee. Following a meeting with the ethics committee amendments were made to the methodology in accordance with their requirements.

The following sections of the chapter will discuss some of the more prominent ethical considerations that accompanied the research. Of consideration were the issues surrounding the use of children in research, particularly as members of a clinical population, and the practical considerations of consent. These issues will be discussed in the context of their theoretical background and alongside some of the ethical difficulties that were faced during the research process and how these were addressed.

4.5.1 Ethics and Children

The inclusion of children as participants in research gives rise to additional ethical considerations, especially where the research takes place in a medical environment because of the assumed vulnerability of the group. Due to their age and perceived level of understanding, children are at a greater risk of being adversely affected by
any intervention during their care (Alderson, 2007). In general, they lack the life experience to be able to predict what may happen, and to fully understand the implications of consenting to take part in research (Mishna, Antle, & Regehr, 2004). An additional complication is posed when conducting research in a medical environment where medical professionals and possibly parents are promoting the research to children. In this situation, the child may defer to their perceived authority and greater knowledge and may lack the confidence to refuse to partake in the research (Duncan, Drew, Hodgson, & Sawyer, 2009).

A child’s perceived level of understanding is a crucial factor when considering the ethics of including or excluding a child from a piece of research. Children’s understanding of the concepts surrounding research and what it entails will vary depending on factors such as age, general intelligence, the presence of a learning disability, and social background (Hunter & Pierscionek, 2007). Indeed, Hunter and Pierscionek (2007) claim that many adults consent to take part in health research without having a full understanding of the implications, so researchers should be even more cautious when including children in their samples. In a medical setting, practitioners use the concept of Gillick competence to determine whether a child has the level of understanding and intelligence necessary to be able to comprehend the risks and benefits of consenting to medical interventions (Taylor, 2007). In a research setting, Gillick competence would relate to whether the child understands the nature of the research and the implications of participating. However, Hunter and Pierscionek (2007) claim that it is not appropriate to apply Gillick competence to a research setting as research tends to focus on long term benefits to the population being studied rather than the individual participant directly.

4.5.2 Consent to Participate

Providing informed consent is the act of an individual to freely agree to participate in a piece of research on the basis of adequate clear and understandable information about the process and aims of the research (BPS, 2009). As demonstrated earlier in the chapter, potential participants were provided with a Participant Information Sheet (PIS) prior to being approached about the research in person to ensure they
had adequate time to read and understand the information about the research and to consider any questions they may have had. The research was also explained in person during the consent process, reiterating the main points with regards to participation and the aims of the research.

Informed consent was sought from families and clinicians both prior to and after the filming of the appointments. Obtaining consent again at the end of the appointment gave families the opportunity to reflect on what had been talked about and withdraw their participation if they felt they did not want their footage to be added to the data set. All families who had consented prior to their appointment also gave their consent after the appointment.

Although families were asked to complete consent forms and send them back by post prior to the appointment, in every case participants completed the consent forms on the day of the appointment in person. None of the families returned their forms by post. If, once a family had been approached in person, they declined to participate, they were thanked for their time and cooperation and their experience with CAMHS continued without intervention.

4.5.2.1 Assent

In response to concerns regarding children’s level of understanding and how this affects their competence to consent to research, seeking parental consent and assent from the child have become the ethical requirements for including children as participants (Field & Behrman, 2004). By doing this, researchers are not assuming a level of competence on the child, but rather they are acknowledging the child’s possible level of understanding and allowing individuals who know the child best to make a judgment on the potential risks and benefits to them.

While consent was sought from all adults present for the appointment, assent was sought from all children under 16 years of age. As Field and Behrman (2004) recommend, children were talked through the research at a level that they would understand and were given the opportunity to ask questions throughout the process and after the appointment was finished. If a child gave their assent but their parent or
carer did not consent to their taking part then the family were withdrawn from the sample.

4.5.2.2 Concerns Surrounding Consent

The informed consent process allows not only the participants to enter into the research with adequate information about their involvement, but also allows the researcher to review the appropriateness of the individual’s participation. The BPS Code of Human Research Ethics (2014) states that researchers have a responsibility to keep participants safe and act responsibly in their role. This encompasses not only protection from physical harm but extends to the potential for psychological harm through deception or a lack of understanding. In the context of the recruitment process for this research project, this was particularly pertinent given the vulnerability of the population being sampled as children, children with possible mental health difficulties, and as anxious families seeking support. Two issues that affected the validity of informed consent were differing opinions about participation between parents and children, and a lack of understanding about the research.

4.5.2.2.1 Disagreements.

One dilemma faced was circumstances where the parents agreed to the research but the child did not, or vice versa. One of the main concerns as a researcher was that, if the parents agreed but the child did not want to take part, the parent may pressure the child to consent. On occasions where a difference of opinion between members of the family occurred as to whether to take part or not, the decision was made not to include them in the research. As the appointment was about and for the benefit of the child’s health and wellbeing, it was important that they were comfortable with the research taking place due to the effect it could have on the care they received if, for example, knowing they were being recorded affected how open they were in the appointment.

4.5.2.2.2 Perceived lack of understanding.

The premise behind informed consent is to ensure that when participants are agreeing to take part in research, they know exactly what they are agreeing to, what the study is about, what is expected of them, and what will happen to their data. The
nature of CAMH services in the UK is that it sees individuals from a diverse range of backgrounds and cultures. Explaining the research in an accessible format to many different types of people was paramount when obtaining consent to ensure participants understood fully what they were consenting to.

One family were excluded from the study during the consent process as a result of a perceived lack of understanding about the research. The family initially consented to participate, but, when given the opportunity to ask questions, it was clear that they had not understood what the research entailed or that this was a research project taking place independently of the care they were going to receive from CAMHS. Consequently, and compounded by the fact that they were anxious about their appointment, a joint decision between the research team and the clinicians was made that they should not participate in the research in this instance.

4.5.2.3 Where Consent Was Not Given

During the recruitment process, approximately 60% of families approached about the research and invited to take part, declined. Where families chose not to participate, the most common reason given centred around anxiety relating to the appointment itself. Families, both parents and children, felt this anxiety would be exacerbated by the added pressure of being video recorded. For many families, both parents and children alike, it was their first experience of a specialist mental health service. Many families were anxious about the outcome of the appointment as well as managing the social stigma of the possibility of a mental health concern affecting themselves or their child. Other reasons given for not wishing to participate included parents being concerned their child would not be as honest with clinicians if they knew they were being video recorded; children and parents alike being open to the research but averse to being video recorded; and children not wanting other people to know about the difficulties they were having.

4.5.3 Anonymity and Confidentiality

When explaining the research to participants, it was made clear that any data collected would be anonymised both for names of participants and any identifying features. Participant information sheets stated that:
“Data will be collected through the use of video-recording equipment. Your normal triage session will be recorded and the tape passed to the research team. VHS copies will be transferred to DVD for ease of storage and quality. Care will be taken during this process. This tape will be transcribed and then securely stored in a locked, reinforced cupboard at (place name omitted). The transcripts will be anonymous and all identifying features removed from them. If the research team show any clips from the video to professionals outside of the research team, faces will be obscured with pixels and names removed. For example if used for other research or meetings.”

Transcripts produced from the data had all names anonymised and any identifying features removed. For example, place names, school names, and addresses were all removed from the transcripts and replaced with (name omitted). Pseudonyms were used in all transcripts for all participants, including clinicians. Through anonymising the data, every effort was made to maintain participants’ confidentiality both within the research setting and externally when presenting or publishing analysis.

Ethical guidelines state that data must be “stored in a manner that avoids inadvertent disclosure” (British Psychological Society, 2009). All raw data, transcripts, and records of consent were stored in a locked box in a secure cupboard in a university building. Any digital information such as participant databases and digital copies of transcripts were password protected and stored on a secure, encrypted, hard drive. The database of participant information was also anonymised with the participants’ pseudonyms rather than using their real names.

Whilst every step was taken to ensure confidentiality and anonymity were maintained from a research perspective, CAHMS, as an NHS service, also had its own approach to and policies on confidentiality. As medical professionals, clinicians were able to discuss cases within the service and wider medical profession where referrals or further assessment was concerned, or where there was a disclosure of immediate harm to the child or family. However, clinicians were required to maintain patients’ confidentiality outside of these circumstances, refraining from discussing patients in an inappropriate context (NHS England, 2016).
4.5.4 Right to Withdraw

At several points through the consent process families and clinicians were informed of their right to withdraw from the research at any point up to publication of the findings. Procedures were put in place during the appointment to ensure that the recording was stopped should the participants no longer wish to continue. Clinicians were made aware of where I would be during the recording so, should they or the family no longer wish to take part or feel it was inappropriate to continue, they were able to inform me as soon as was appropriate so I could stop the recording. Families were told during the consent process that should they wish to withdraw from the study and stop the recording, they could inform the clinician in their appointment and the recording would be stopped and the data destroyed should they wish. Asking for retrospective consent when the appointment was over also gave the participants the opportunity to withdraw if they had not felt comfortable doing so during the appointment. Throughout the duration of the research there was not an instance of families or clinicians withdrawing having given consent. This included during the appointment, when retrospective consent was sought, and since the data was collected.

4.6 Summary

This research project examines the interactions between clinicians and 15 families in initial assessment appointments in CAMH Service in the UK. Data collected takes the form of 15 video recorded appointments that have all been transcribed using the Jefferson system of transcription notation. With its micro social constructionist underpinnings, conversation analysis has been employed to analyse the data collected. Producing high quality research was a priority throughout the process, regularly referring back to the quality markers of transparency and transferability. Throughout the process, maintaining ethical integrity was paramount especially given the nature of the research setting and participants sampled, and ethical procedures were stringently followed.
CHAPTER FIVE: ESTABLISHING THE PROBLEM

The Negotiation of Rights to Knowledge

5.1 Introduction

This chapter will explore the ways the epistemic rights of the child are managed through the question-answer sequence between the clinicians and children in the problem presentation phases of the appointments. Whilst the notion of asking a patient why they have sought medical help or attended a medical appointment is information-seeking in function, it is also a question of epistemics as it is directly questioning the knowledge of the person it is directed to. The chapter is split into two sections. The first explores the question asked by clinicians to elicit the presenting concern from the children, which, in these appointments, generally takes the form of “do you know why you are here?”. This will be discussed in relation to the underlying epistemic positioning of the question and the implications of this. The structure of the problem presentation sequence will also be discussed. Whereas part one focusses on the clinicians’ questioning, the second part of the chapter orients to the responses elicited from the children and how they account for their symptoms and referral, if at all.

As demonstrated in early research, medical appointments occur over several phases. A core element of a medical interaction is where the patient presents the main reason for attending the appointment; that is, they describe or present the problem to the doctor. Problem presentation occurs in the majority of medical appointments. It is the point in the interaction where the clinician seeks the patient’s perspective on their reason for requesting medical input (Robinson, 2006). In the context of the appointment as a whole, it is one of the only occasions where the patient is given the opportunity to account for their visit and to offer their perspective on the difficulties they are experiencing (Heritage & Robinson, 2006). Problem presentation is co-constructed by the clinician and the patient (Heritage & Clayman, 2010) as it is comprised of a question by the clinician which is then responded to by the patient.
Across medical interactions, this phase of the appointment tends to be both initiated and concluded by the clinician (Heritage & Robinson, 2006). Clinicians ask questions such as ‘what can I do for you?’ or ‘how can I help you’ to the patients to elicit their reason for attendance and, more specifically, their ‘presenting concern’ (Robinson, 2006). Questions are designed to elicit information (Heritage, 2002), but the way they are constructed has implications for the responses they receive. The design of the clinician’s question soliciting the presenting concern from the patient has implications for the way the patient understands and responds to the question (Robinson, 2006; Heritage & Clayman, 2010). Robinson (2006) points out that, while the general advice to clinicians is to ask open-ended questions to elicit more informative responses, the distinction between open and closed questions is not sufficient when considering the effect the clinician’s question structure has on the patient’s response.

When responding to the clinician’s question with their presenting concern, patients have choices to make about the structure and content of their account. Whilst patients are predominantly concerned with ensuring they are presenting their concern as a doctorable problem (Bloor & Horobin, 1975), they also work to present their concern with a candidate diagnosis or a lay account of the symptoms (Heritage & Clayman, 2010).

Within the clinician-patient relationship there is a complex epistemic dynamic. Whilst the patients are seen as knowledgeable about their experiences of their symptoms, the clinician is considered to be the expert in the interaction due to their medical training. Where the patient’s experiences are the focus of a discussion, they are considered to be the epistemic authority on those particular matters (Heritage, 2013). The epistemic dynamic between clinician and patient is reflected in the responses patients give when asked to give their presenting concern. Where patients offer a candidate diagnosis, this tends to be offered in a guarded fashion, downgrading the certainty of their presentation (Gill, 1998). This downgrading reflects their discomfort at encroaching into the area of medical expertise (Ruuusvuori, 2001). The alternative option is to present their concerns as a narrative explanation of symptoms. This enables patients to account for their concerns and
explain them in a way that is within the boundaries of their knowledge (Heritage & Clayman, 2010).

When considering the epistemic relationship between a clinician and patient where the patient is a child, the dynamics alter. Children are typically afforded half-membership in interactions (Hutchby & O’Reilly, 2010), possibly due to the differences in cognitive ability and linguistic skills in comparison to adults (Lobatto, 2002). However, O’Reilly, Lester, and Muskett (2016) found that clinicians did treat children as the knowledgeable party with regards to information about their lives. In a child mental health setting, a service oriented to child-centred care, it is particularly important to involve children in the interaction as it is about their health and experiences, but this may be affected by the construction of the clinician’s questions.

5.2 ‘Do You Know Why You Are Here?’

A notable and often discrete aspect of the initial assessment is when the clinicians begin to seek out the reasons for the family’s attendance in a general way, from their perspective. A common way of opening this up for discussion is with a variation of the question ‘why are you here?’. Within the sample of 15 families, the families are asked by the clinician why they have come to the appointment and sought help from CAMHS in 11 cases. In these 11 cases, this question-answer sequence serves the purpose of ‘getting down to business’ and indicates a shift from rapport-building to the main business of the appointment. The question of why a family has come to the appointment is not a simple one however, nor without variation. Within the 11 cases where the sequence is present, the clinicians direct their question to the child or young person in 9 cases and to the parent(s) in the remaining two cases.

Establishing the reason for the visit takes a similar structure to a perspective display sequence (PDS) (Maynard, 1989). Perspective display sequences were identified by Maynard (1989) as a means by which speakers offer their opinions with a more guarded manner, orienting first to the opinion of the recipient before offering their own. They typically follow the structure of:
Turn 1 – the speaker makes an enquiry about the recipient’s opinion;
Turn 2 – the recipient offers their opinion;
Turn 3 – the original speaker provides their own opinion about the topic.

These sequences have been identified in ordinary conversation (Maynard, 1989) as well as clinical settings. During the delivery of particularly difficult diagnoses the sequence functions to soften the impact of the diagnosis for families whilst making it appear as a collaborative diagnostic decision (Maynard, 1991). In the data to be discussed, the sequence of establishing the reason for the visit follows a similar structure. However, in most cases instead of clinicians providing their own opinion or understanding for the child’s attendance, they acknowledge the response given and use it as a platform to progress the interaction and information seeking.

The most common way for the clinician to ask families the reason for the appointment tended to be articulated as “Do you know why you are here today?”, or a variation thereof, as illustrated in the following excerpt from Family 1.

1  C Clin Psy °all right°
2     (1.29)
3     er- (0.39) †do you kno:w (0.31) why you've
4     c†ome here toda:y

Typically, \textit{wh}- questions have been found to be used as a way of speakers challenging a position, leading to the recipient providing an account (Koshik, 2003; Egbert & Vöge, 2008; Bolden & Robinson, 2011). In particular, ‘\textit{why}’ interrogatives have been found to solicit accounts, communicating that the opinion or event being accounted for is incongruous and requires explanation (Bolden & Robinson, 2011). ‘Why’ questions are often found in interactions involving complaints, criticism, or blame (Bolden & Robinson, 2011) and are heard as challenging due to their position in an interaction (Koshik, 2003).

As well as being oriented to as a challenge, there is also evidence for ‘\textit{why}’ interrogatives being used as, and responded to as, information seeking (Egbert & Vöge, 2008; Bolden & Robinson, 2011). Bolden and Robinson (2011) argue that prefacing a question with a ‘\textit{why}’ interrogative gives the opportunity to access
knowledge not held by the speaker. In using ‘why’ interrogatives in an information seeking capacity, differences in epistemic status between the speaker and recipient are highlighted with the speaker requesting knowledge from the recipient (Bolden & Robinson, 2011).

5.2.1 Analysis

In the context of the current data, the wh- question posed by the clinicians is treated as information seeking by the recipient. This is illustrated in the response given to the question as seen in the following excerpts. In addition to the question of the reason for attendance being posed as a ‘why’ interrogative, it is prefaced with ‘do you know’. The use of ‘do you know + wh- question’ is information seeking with the information being sought being a reflection of the recipient’s knowledge (Schegloff, 1988). The following two excerpts illustrate the information seeking nature of the ‘do you know + why interrogative’ and the structure of the interaction as a variation of a perspective display sequence.

Excerpt 1: Family 1

1 C Clin Psy "all right"
2 (1.29)
3 er- (0.39) ↑do you know (0.31) why you’ve
4 c↑ome here toda↓y
5 Child erm because (0.39) I- keep (0.94) doin my-
6 (0.41) I thi↑nk it’s ↓O- C- D-
7 C Clin Psy ri:ght (0.78) ↓ok: (0.92) um (0.52) "that is
8 a (. ) important word you use" (. ) mea↓ning
9 when you say O- C- D-

The first excerpt begins with the clinician following the question sequence of do you know + why interrogative in their first turn "↑do you know (0.31) why you’ve c↑ome here toda↓y" (lines 3-4). As noted previously, the preface ‘do you know’ and ‘why’ interrogatives demonstrate an epistemic difference between the speaker and recipient (Bolden & Robinson, 2011) with the speaker being in a K- position and the recipient being in a K+ position (Heritage, 2012a) (see chapter 3 for an explanation of rights to knowledge). However, in the context of the triage appointments being considered,
the clinician is not in a true K-position of a complete lack of knowledge. Prior to the appointment, clinicians will have accessed the child’s medical notes and referral information giving them information about the reason for attendance. In this respect, the initial question of “↑do you know (0.31) why you’ve come here today↓” (lines 3-4) is a perspective seeking enquiry as much as, if not more than, a knowledge seeking enquiry. The clinician is checking what the child’s understanding is of their reason for attendance as much as they are gathering knowledge about why they have been referred.

The notion of the question being perspective seeking is evidenced in the clinician’s reaction to the child’s response. The child gives a medicalised reason for attendance in lines 5-6, following which the clinician responds with the acknowledgment tokens “right” and “↑okay↓” (line 7). The acknowledgments ‘right’ and ‘okay’ signal a shift in topic from the one being responded to (Beach, 1993). Following the acknowledgments, the clinician moves on to question the child’s understanding of the terminology she has used (lines 8-9) using this as a platform to begin unpicking the difficulties the child is experiencing. The following excerpt adheres to the same PDS structure as the previous excerpt with the clinician enquiring about the child’s knowledge of their reason for attendance, the child responding with their perspective, and the clinician following this with an acknowledgment and a question seeking further information.

Excerpt 2: Family 2

1 (Therapist) um ↑do you ↑know (0.88) why you’re here
2 ↑today (0.83) can you ↑tell me a bit about
3 that
4 Child (er) it’s about self-harming
5 Therapist about self-harm (0.63) okay
6 (1.77)
7 i- and what do you mean by ↑that Callum °in
8 what ↑way°

The initial question follows a similar format to that in Excerpt 1, with a do you know + why interrogative. Unlike Excerpt 1 however, the question is then followed by an
additional turn construction unit of “can you tell me a bit about that” (lines 2-3) which works to elicit further information. It also works to display an expectation that the child has access to that knowledge. In this respect, the clinician has communicated her assumption that the child has the knowledge to be able to respond to her question with a confirmation and expansion. The child’s response is treated as answering the clinician’s initial question of “do you know why you’re here today” (lines 1-2), but not as answering the subsequent tag question. Following her confirmation of the child’s response, the clinician pauses and then asks an information seeking question: “what do you mean by Callum in what way” (lines 7-8). This works to rephrase the request for further information and to check the child’s understanding of the difficulties he has been experiencing.

The why interrogative in the question why are you here is information seeking and suggests an exchange of knowledge from the child to the clinician. However, the preface of do you know appears to soften the epistemic difference and allow for the possibility that the child does not know the reason for the referral and attendance at CAMHS. In the following excerpt, the clinician seeks information from the child using the same ‘do you know + why interrogative’ format discussed previously. In this instance however, the child claims not to know.

Excerpt 3: Family 16

1  Doctor   Koloman do you know why (0.39) you’ve come (0.75) to today
2  Child     [no]
3  Doctor   you don’t (.) okay

Following being asked “do you know why (0.39) you’ve come (0.75) to today” (lines 1-2), the child in this excerpt responds by saying no, rather than by giving information about the reason for referral as in the previous excerpts. The child’s response of “no” (line 3) demonstrates the significance of prefacing the why interrogative with do you know. If the clinician had phrased her request for information as ‘why have you come here today?’ there would be a clear assumption of knowledge with the why interrogative being used to request an account for
attendance (Bolden & Robinson, 2011). Instead, the addition of do you know allows the child to respond by claiming a lack of knowledge.

In response to the child’s reply, the clinician follows by rephrasing the child’s response and giving an acknowledgment token: “you ↓don’t (.) ok” (line 4). The clinician’s acceptance of the response and distinct lack of additional questioning demonstrates the epistemic relationship discussed previously. Whilst the clinician is requesting information in their first turn, they are not in an absolute K-position and the child is not always in an absolute K+ position. If the clinician was unaware of the reason for referral and the child also claimed to be unaware, as in this excerpt, one would expect interactional trouble to be indicated in the turns that followed while they both attempted to glean some information from the other. However, the clinician simply acknowledges the child’s answer and proceeds with the appointment. This notion becomes more evident in the following two excerpts where the clinicians expand their responses.

Excerpt 4: Family 3

1 Doctor ↓ok alright I will ↑ask ↓Mum and ↓Dad ↓a
2 little bit ↓as well do you know ↓why you
3 are< why you- why you are ↓here
4 Child ↓(shakes head)) ↑uhum
5 Doctor oh (0.59) ↓well the the were they were a bit
6 ↓of concern ab↓out you that you are a little
7 ↓bit an↓xious

Initially, the interaction appears to follow a similar sequence to those previously discussed with the clinician asking the child “do you know ↓why you are< why you- why you are ↓here” (lines 2-3) and the child responding (line 4). Prior to the initial question, the clinician states that he “will ↑ask ↓Mum and ↓Dad ↓a little bit ↓as well” (lines 1-2) which suggests a fostering of collaboration across the accounts of the child and parents. This lessens the importance placed on the perspective given by the child as the clinician will also seek his parents’ views. Again, the child responds by indicating that he does not know the reason for his referral and attendance, placing him in a K- position. The clinician’s response to the child’s claim of a lack
of knowledge initially indicates trouble in the preface “oh” (line 5) suggesting the child’s response was unexpected. In contrast to Excerpt 3, the clinician continues by providing the child with an account of why he has been referred. This evidences the notion that whilst the clinicians are asking the children why they are there, they are not enquiring because they are in a K- position themselves, but rather because they are using the child’s response as a platform to continue the appointment. The addition of ‘do you know’ as a preface to the ‘why interrogative’ again gives the child the opportunity to respond with ‘no’.

The following excerpt follows a similar pattern with the clinician explaining the reason for the appointment following the child’s claim to a lack of knowledge.

Excerpt 5: Family 17

1 Doctor °:\alright° (0.74) ok do \YOU know why you’re
2 here to\day
3 Child urm: (0.21) no not really (0.41) something
4 ‘bout difficulties or ;some’ing like that
5 Doctor about your difficulties
6 Child ye:ah (. ) some’ing like th[at]
7 Doctor [al r]ight (0.53)
8 erm: (0.77) what it is I’m a you you were
9 seeing Doctor Grothenhuijs weren’t you the
10 neu;rologist
11 Child um
12 Doctor and what thats happened is he’s \<no lo:nger
13 working> but there are still some of concerns
14 (0.55) regarding (0.52) um: <some of your
15 be:haviours and why you behave in particular
16 ways> ( . ) you’ve \got a diagnosis of ADH\D
17 haven’t you
18 Child um
19 Doctor and they’re wondering what else you may \have
20 (0.77) as \well if there’s anything else going
21 on as well
Within the initial question of “do YOU know why you’re here today” (lines 1-2), the clinician emphasises the words do and you. The emphasis on you focusses the question on the child and seeks the child’s knowledge of the subject. The epistemic relationship is also managed through the placement of emphasis with the implication from the clinician being ‘I and your parents know why you are here, but do you?’. Instead of responding with ‘no’ as the child in Excerpt 3, the child in this excerpt hedges his response tentatively negotiating the epistemic grounding set by the initial question. There is a suggestion in the question that he should have an understanding as everyone else present does, however he does not.

Part of the child’s response is repeated by the clinician in line 5 who then goes on to expand on the reasons for the referral. The clinician accounts for the child’s attendance at the appointment in some detail, emphasising that the epistemic balance is actually in the clinician’s favour. Instead of asking ‘why are you here?’ implying the child’s epistemic advantage, the clinician’s growing emphasis on “do YOU” (line 1) and his subsequent account given to the child clearly demonstrates that the child is in a K- position and the clinician is in a strong K+ position.

Throughout the account offered to the child, the clinician punctuates his turns with questions directed to the child. These questions are all statements about the child’s medical history that have been adapted into interrogatives and is all information that the child should have epistemic access to: “you were seeing Doctor Grotenhuijs weren’t you” (lines 8-9) and “you’ve got a diagnosis of ADH haven’t you” (lines 16-17). The interrogatives “weren’t you” and “haven’t you” (lines 9 and 17) are tag questions that require an affirmative response. Whilst the question is being asked of the child, the phrasing of the tag puts the clinician in a K+ position (see Figure 1 in chapter 3) (Heritage, 2012a). The account given by the clinician establishes his epistemic position over the child in terms of the reason for the child’s referral and knowledge about the child’s medical history. In the following excerpt, the clinician again places the emphasis on ‘you’ in the initial turn, with underlying implications about the epistemic balance between the people present at the appointment.
Excerpt 6: Family 12

1  Nurse  I’d _like it if you could tell me:_ (0.21) why
2     you think you’ve _come here to-day_  
3  Child  “um: well because I’ve got a_
4      _phobia but_” ((looks at mum))
5  Mum    just explain you _you say K[ohm]_
6  Child  °[what (d)o you me)
7  Nurse  you said you just _said_ that you’ve _come here_
8  Child  because of your _phobia (0.27) _okay can you
9  Nurse  _tell me a little bit more about ↑that_

When asking for the child’s perspective, the clinician in this excerpt does not use the interrogative preface ‘do you know...’. Instead, she makes an assumption that the child does know and instead asks her to “tell me: (0.21) why you think you’ve _come here to-day_” (lines 1-2). There is still an orientation to the child’s cognitive state of knowledge in the ‘why’ interrogative phrase “why _you think_” (lines 1-2), requesting the child’s perception and understanding rather than asking ‘why have you come here today’. The emphasis placed by the clinician on “you” in lines 1 and 2 when asking for the child’s perspective both directs the question to the child and highlights the fact that the clinician and the child’s mum already have an understanding of the reason for referral, but pursues the child’s understanding. As per the previous excerpts, the child responds, in this instance offering her perception. The perspective display sequence is then interrupted by the child turning to her mother for help in answering. This has an epistemic implication indicating that the child perceives her mother’s understanding of the question to be greater than her own.

In the following turns, the child’s mother provides guidance and the clinician reports what the child has already said with the addition of the question “can you _tell me a little bit more about ↑that_” (lines 9-10). This question was also used by the clinician in Excerpt 2 to request an expansion on the child’s answer but as a tag in the initial question position (“do you know why you’re here today, can you tell me a _bit about that_” lines 1-2). The insertion of the interaction between the child and Mum in lines 4-7 is similar to Maynard’s (1989) observation of prompt questions
inserted in to the perspective display sequence. Prompt questions allow for extra information to be exchanged before the sequence resumes with the original speaker giving their subsequent report. Here however, the resumption of the sequence by the clinician (the original speaker) is used as a platform to begin asking more information seeking questions as seen in previous excerpts.

The final excerpt again contains a series of additional prompt questions within the overall perspective display sequence. The prompt questions are all posed by the clinician, with the child’s response having an implication on their epistemic status for the remainder of the interaction.

Excerpt 7: Family 8

1 (Doctor) erm: 
2 (1.74) 
3 do ↑you (0.37) d- do you ↑know why ↑you’re 
4 ↑here by the way ((child shakes head)) no (.) 
5 not a not a cl↑ue ((child shakes head)) 
6 (1.04) 
7 has mum not ↑told you ↑why ((child shakes 
8 head)) 
9 (1.13) 
10 ↑n↑o” 
11 (1.47) 
12 shall ↑we ask your ↑mum (.) what she thinks 
13 (0.90) why- ↑why you are ↑here 
14 Mum (they said) it’s bec↓ause of the problems 
15 he’s ↓having at school an (0.65) ↓everything 
16 Doctor right 
17 (3.47) 
18 could you ↑tell me a ↓little bit more ab↓out 
19 that 

Similarly to the preceding excerpts, the clinician begins the sequence by asking the child “do you ↑know why ↑you’re ↓here” (lines 3-4). In this instance however it is immediately followed with the additional “by the way” (line 4) indicating that the
The clinician is inserting the sequence into a previous interaction sequence. The addition of this phrase also implies that it is not necessary for the clinician to ask this of the child, but they are choosing to. The epistemic implication of this is that the clinician already possesses the information the child may give him.

Following the initial question, the child indicates that they do not know why they have been referred resulting in the clinician beginning the embedded prompt sequence. Within this, the clinician asks “has mum not ↑told you ↓why” (line 7). The function of this question is to prompt the child to remember why he is there with the implication that his mum would have told him about it. However, the question also works to make a statement about the states of knowledge of the participants in the interaction: the child does not know why they are there, but his mother does and it is his mother’s responsibility to impart this knowledge to her child. This acts as a platform to ask the child’s mother for her perspective, allowing the sequence to be repaired and to continue.

When indirectly asking the child’s mum for her perspective, the clinician uses a similar format to the one used to request the child’s perspective. The phrasing “wh↓at she thinks... ↓why you are ↑here” (lines 12-13) comprises of similar elements as ‘do you know why you are here today’. The initial part indicates a cognitive element to the request “wh↓at she thinks” (line 12), followed by a ‘why’ interrogative. Mum responds by attributing the information to a third party: “(they said) it’s bec↓ause of the problems he’s ↓having at sch↑ool” (line 14-15). In attributing this knowledge to a third party, Mum is making a claim about her lack of knowledge about the referral: The clinician stated he was going to ask Mum “wh↓at she thinks” (line 12), but she responds with information from a third party. Following Mum’s response to the request for information, the clinician concludes the PDS with an acknowledgment token. Similarly to previous excerpts, this is then proceeded by a request for further information initiating the beginning of the next phase in the appointment.

5.2.2 Summary

Whilst the act of establishing the reason for the child’s attendance is an interaction between two, although sometimes more, parties, this section of the chapter has
orientated to the clinicians’ questions and responses. In particular there has been a focus on the structure of the question designed to elicit the reason for attendance from the child and the epistemic implications of it. Additionally, observations were made regarding the turn structure of the sequence and the similarities to Maynard’s (1989) perspective display sequences.

The structure of the clinician’s initial interrogative generally took the form of ‘do you know + why interrogative’. In prefacing the question with ‘do you know’, the clinician is both establishing the child’s knowledge whilst allowing for a yes or no response (Schegloff, 1988). ‘Why’ interrogatives are used either to challenge a position or to elicit information. In the excerpts analysed, the ‘why interrogative’ was used to elicit information from the child about the reason for their referral. When combined, the ‘do you know + why interrogative’ format does not just elicit information, rather it elicits the child’s understanding of their reason for referral to CAMHS. The addition of ‘do you know’, or an alternative cognitively oriented preface such as ‘why do you think’, to the clinician’s question has an epistemic implication for the answer. In addition to this, the epistemic relationship between the participants in the interaction is managed through the structure of the question. Within the structure of the question there is an implication that the clinician is not truly in a K-position and this is evidenced through the subsequent turns in the sequence and in cases where the child was unable to provide information about their referral.

The overarching sequence of the interaction takes a similar form to that of a perspective display sequence (Maynard, 1989). However, the aim of the sequence is not for the clinician to elicit the child’s opinion in order to report their own; rather, it is to elicit the child’s perspective on the reason for their referral and to use this as a platform into the rest of the appointment. The sequence in this instance follows the following structure:

Turn 1 - Clinician enquires about the child’s knowledge of their referral
Turn 2 - Child responds with their perspective
Turn 3 - Clinician acknowledges child’s perspective and makes a follow up enquiry about the details of the perspective given.
In some instances, the sequence included a question answer series embedded into the original sequence. This looked very similar to the notion of additional prompt questions observed and described by Maynard (1989). These questions and answers enable the child to provide an answer to the original question, work to repair any trouble and allow the sequence to continue its original course.

5.3 Children’s Responses

Children and parents respond to clinicians asking why they have come to the appointment in different ways. This section will focus specifically on how children respond, the types of response they give, and how they are responded to in turn by the clinician (see also Stafford, Hutchby, Karim & O’Reilly, 2014). Of the 11 cases where the clinician asks the family the reason for the appointment, the children respond on 9 occasions. Within these 9 cases, the children respond in three distinct ways:

1) With a candida diagnosis
2) With a lay explanation
3) With a claim to insufficient knowledge, through both verbal and nonverbal means.

These strategies for responding to the clinician’s enquiry are explored in the analysis below.

Each type of response and its delivery demonstrates an orientation by the child to the epistemic balance within the clinician-patient relationship. Children choose to respond to the clinician’s question in one of the three ways outlined above, however their choice of response has an implication for their perceived knowledge and understanding for the remainder of the appointment. The children in these excerpts appear to show an orientation to the epistemic balance within the interaction through different means within their responses.

5.3.1 Candidate Diagnoses

The children in three of the families respond to the clinicians question with a candidate diagnosis. Two of the three responses use technical medical terminology to account for their reason for attendance, whereas the third uses terminology that
transcends the divide between medical and lay accounts. Following the responses
given by the children, the clinicians in each instance probe the child’s meaning and
understanding of the terminology they have used. In two of the cases the children
offer accounts of their behaviour that are consistent with appropriate use of the
diagnostic term used. In the third instance the child struggles to account for her
explanation or for the terminology she uses. Instead, she refers to a third party as
having given her that information.

Excerpt 8: Family 2

1 (Therapist)um ↑do you ↑know (0.88) why you’re here
2 ↑tod↑ay (0.83) can you tell me a bit about
3 that
4 Child (er) it’s about self-harming
5 Therapist about self-harm (0.63) ok↓ay
6 (1.77)
7 i- and what do you mean by ↑that Call↓um ‘in
8 what ↑way’
9 Child what (0.42) em: (0.38) it’s (mainly) ↑I self-
10 harm
11 Therapist you self-harm
12 (1.03)
13 ↑ok’ (. ) c- can you say something about that
14 ↑is it i- ↑do you cut yourself ↑or hurt
15 yourself in a ↑different way
16 Child cut

The child’s initial explanation for his attendance is prefaced with “er” (line 4) which
marks his transition into the role of speaker from the clinician (Hutchby, 1999). The
buffer device (Hutchby, 1999) ’er’ works to mark the fact that the clinician has
asked the child to make a claim to knowledge in an environment where his expertise
is not validated as the clinician’s is. In this appointment the child is alone with two
clinicians for the initial stages with his family waiting elsewhere and joining later as
the child is in his late teenage years. As a result, there is a perceived imbalance in
rights to knowledge about the difficulties that have brought him to the appointment.
Although he is old enough to be considered medically competent (Taylor, 2007) and is the expert about the day to day difficulties he faces, the other people in the room have the expertise to agree or disagree with his medical response to their question.

The term “self-harming” (line 4) could be construed as both a lay term and a technical medical term; ‘self-harm’ is both a description of any behaviour that results in harm to the person carrying out the act, and a diagnostic term used to label a collection of behaviours that usually occur in response to an emotional or psychological state. ‘Self-harm’ is also both a symptom of wider health concerns and a medical concept. In this excerpt, the child’s response “(er) it’s about self-harming” (line 3) is treated by the clinician as a technical diagnostic term in her response by asking him to expand on what he means by the term and also how he self-harms (lines 6 and 10-11). The clinician’s request for an explanation is also a way of aligning their knowledge for the remainder of the appointment, ensuring that all parties have the same understanding of the terms being used and the difficulties being faced by the child. This is particularly important as all subsequent treatment is based on the clinician’s understanding of the problems.

Not only is self-harm a term that transcends medical-lay boundaries, there are an increasing number of terms being used in lay parlance that also do this. The term ‘phobia’ is one that is traditionally a diagnostic term but is being used increasingly to describe fears or a general dislike for something specific, for example spiders.

Excerpt 9: Family 12

1 (Nurse) I’d like it if you could tell me: (0.21) why
2 you think you’ve come today
3 Child um: well because I’ve got a phobia but*
4 ((looks at mum))
5 Mum just explain you say K[ohm]
6 Child °[what (d)o you me]*
7 I don’t know what she me:ans°
8 Nurse you said you just said that you’ve come here
9 because of your phobia (0.27) okay can you
10 tell me a little bit more about that
11 Child °er:::**
Similar to the child in Family 2, the child in this excerpt prefaces her response, this time with “um” (line 2): “um: well because I’ve got a phobia but” (line 2). In prefacing her response with ‘um well’, the child appears to be introducing distance between herself and the knowledge claim she is making, positioning herself as being a lay person in the interaction as opposed to an expert. The child’s use of ‘but’ and the simultaneous look to mum works to mitigate the knowledge claim she has made, suggesting this knowledge may not be sufficient in the context. The child here is younger than the child in Family 2 and her mum is present for this part of the appointment. Following on from her response, the child also looks to her mum for help with her answer. In line 6 the clinician again seeks clarification for the child’s understanding of the term she has used to which the child gives a response describing symptoms that correspond with the use of the term ‘phobia’. The account the child gives of her experiences of a phobia are not everyday fears but describe physiological reactions to everyday objects which aligns with medical use of the term ‘phobia’.

Despite using medical language, the children were not always able to demonstrate an understanding of the terms they used. The following excerpt is an example of this. While many of the features are similar to those in the previous two excerpts, for example a prefaced response and pursuit by the clinician, the child is unable to demonstrate appropriate understanding of the term ‘OCD’ (Obsessive Compulsive Disorder).

Excerpt 10: Family 1
The child prefaces her response with “erm” (line 5) and also hedges her claim with pauses and the phrase “I think” (line 6). The hedge “I think” allows for the possibility of correction. The child is not presenting her response as fact but rather is making a personalised claim that is sensitive to the epistemic asymmetry operating in the interaction. The clinician begins his turn with the acknowledgment tokens “right (0.78) ok:” (line 7). When the child attempts to provide an explanation for the terminology she has used, she suggests that the term is one that she has experienced other people using in relation to the behaviours she displays and that she does not have an independent understanding of it: “Ah: can’t remember what the teacher told me-” (line 16). The act of attributing the term to another person not present in the appointment also serves to mitigate the child from any errors in her understanding and lay the responsibility with another party. The fact that the third party is labelled as a teacher, another professional, further serves to add credibility to her claim to knowledge and the accuracy of that information.

In line 5 the clinician emphasises the significance of the terminology the child is using and the gravity that medicalised terms hold in interactions such as these: “that is a (. ) important word you use°”. This again highlights the assumptions around the rights to knowledge of the children by medical professionals in these appointments. While the children have ownership of and are the experts in
the difficulties they are experiencing, it is not always treated as appropriate that they may hold more medicalised and technical knowledge around their difficulties.

5.3.2 Lay Responses

Children also responded by giving a lay reason for being at the appointment. Where the children in the previous excerpts used medical terminology to account for their reason for attendance, the child in this next excerpt accounts for his attendance using a lay conceptualisation of the difficulties they faced. This account is more descriptive in nature than the medicalised responses, which are more specific.

Excerpt 11: Family 17

```
1  Doctor °alright° (0.74) ok do YOU know why you’re
2      here today
3  Child urm: (0.21) no not really (0.41) something
4      ‘bout difficulties or ↓some’ing like that
5  Doctor about your difficulties
6  Child ye:ah (.) some’ing like th[at]
7  Doctor       [al r]ight
```

Similarly to the previous excerpts, the child’s response begins with the preface “urm:” (line 3). Given the pause that follows, this may be serving to maintain his position in the interaction while he composes a response to the clinician’s question. The response continues with a claim to insufficient knowledge “no not really” (line 3), however by adding “not really” to “no”, the child is suggesting that they do have some idea. By prefacing the response with “no”, he is saving face if his subsequent suggestion is treated as incorrect or insufficient by the clinician. The child then quickly goes on to offer a possible explanation for his attendance “something ‘bout difficulties or ↓some’ing like that” (lines 3-4). Although this response is vague, it does acknowledge the presence of a concern that may warrant specialist intervention. The clinician then probes further with a repetition of the child’s statement (“about your difficulties” line 4) but the child responds simply by confirming the statement and repeating the subsequent part of his original answer (“some’ing like th[at]” line 5).
5.3.3 Claims to Insufficient Knowledge

Where the child in the previous excerpt offers a claim to insufficient knowledge as a preface for a lay response, many children did not offer any explanation to account for their attendance and simply claimed they did not know why they were there and in some cases performed this action non verbally. A claim to insufficient knowledge was the most common way for children to respond when asked why they had come to the appointment, or whether they knew why they were at the appointment. They happened in one of three ways in this data:

1) Responding with ‘I don’t know’ when asked ‘why are you here?’.
2) Responding ‘no’ when asked whether they knew why they were at the appointment.
3) Responding non-verbally with a shake of the head when asked whether they knew why they were at the appointment.

Excerpt 12: Family 6

1 (Doctor) what did you th↓ink you’d come here f↓or w¬
2 what was your un↓der↓standing of why you’d
3 ↓come here today
4 Child to check if ↓I had
5 Doctor ↓huh
6 Child um ((child looking to nanny))
7 Nanny ( )
8 Child to check if ↓I had six ↓ears and ( ) ((mum
9 laughs))
10 Nanny that was me sor↓ry we were mucking ab¬
11 ↓before we came out
12 Doctor what ↓do you think ↓you’re- what ↓do you think
13 you’ve come for ↓here tod↓ay w¬ what ↓do you
14 ↓think (.) why ↓do you ↓think ↓your: mum and
15 ↓nana bought ↓you here tod↓ay
16 Child ↓don’t know
17 Doctor don’t ↓know (0.40) do ↓you ↓think ↓it’s to ↓do
18 with your behav↓ior
The clinician begins by asking the child what her understanding is of the reason for the appointment. Unusually, the child responds by repeating a humorous answer that we subsequently discover was a tease made by the child’s grandma on the way to the appointment. This response deflects the attention from the child’s understanding.

The clinician continues to pursue her original line of questioning by ignoring the child’s humorous response and rephrasing the question. The phrasing of the question itself: “why do you think your mum and nana bought you here today” (lines 10-11), has undertones of epistemic assumptions, suggesting that the child was not the instigator of the appointment; she had not asked to or chosen to go, rather her mum and nana had taken her. Following this, the child responds with her first claim to a lack of knowledge: “don’t know” (line 12). In the following excerpts it appears to be common practice for the clinician to then transition in to another line of questioning or to another family member, however the clinician in this appointment pursues her original line of enquiry thus treating the child’s response not as a genuine lack of knowledge, but as resistance to answering the question (Hutchby, 2002). The clinician’s comment in line 19 of “that makes me think you do kind of know but not saying” illustrates the notion that she believes the child does know why she is there and that the responses of ‘don’t know’ demonstrate an unwillingness to answer the questions.

In the following excerpts, the clinician phrases the initial question slightly differently only allowing for a yes or no response.
Excerpt 13: Family 18

1 (Doctor) you’ve come here to: (0.25) see us today do you know what this appointment’s about
2 Child °(no) not really° ((hand over mouth when speaking))
3 Doctor not really

The clinician’s question is direct and simply asks whether the child knows what the appointment is about. In response, the child answers by claiming that they do not know: “°(no) not really°” (line 3). Similarly to Extract 11, the child adds ‘not really’ to his initial response of ‘no’. In this instance however, he does not continue on to give a lay response, instead the clinician immediately repeats his answer and moves on to an alternative line of questioning. A similar sequence can be found in the following excerpt.

Excerpt 14: Family 16

1 Doctor Kolomban do you know why (0.39) you’ve come (0.75) today
2 Child [no]
3 Doctor you don’t (.). okay (0.30) who have you brought with you today
4 Child um mum and nan

Later in the appointment:

5 Mum Kolomban does know why he’s come today
6 Doctor right
7 Mum he does know what the process is all about
8 but we’re a little bit silly this morning
9 Doctor [yeah]
10 Doctor right

Although the initial question by the clinician is phrased slightly differently, the child here also claims they do not know why they have come to the appointment. In this excerpt however, the child’s response comes in overlap of the question. This may be due to the pause before the final word “to/today” (line 2) which may have led the
child to believe that the clinician’s turn had finished. There is no additional information provided in the child’s response and the doctor moves straight on with the appointment by keeping the child engaged and asking a question he is able to answer, and does: “who have you brought ↓with you today” (lines 3-4).

In the second half of this excerpt, which occurs a few minutes later, the child’s mum interjects and refers back to the previous line of questioning. She contradicts the child’s claim to a lack of knowledge and maintains that the child does know why he is at the appointment and as such affords him lesser membership in the interaction and positions herself as more knowledgeable than him: “Kolomban does know why he’s ↓come today” (line 5). In addition to this, she explains why he has responded in the way he did, stating that it is because “we’re a little bit ↓silly this morning” (line 7). This serves to redefine the child’s epistemic position in the interaction and undermines his previous and future responses in that particular appointment.

The third way for the child to claim insufficient knowledge was to use a non-verbal cue. In the following excerpts, the child uses a shake of the head to signify that they do not know why they are at the appointment.

Excerpt 15: Family 3

1  Doctor  o↓k alright I will ↑ask ↓Mum and Dad ↓a
2  little bit ↓as well do you know ↓why you
3  are < why you- why you are ↓here
4  Child  ((shakes head)) "no"
5  Doctor  oh (0.59) ↓w:ell the the were they were a bit
6  ↓of concern ab↓o:ut you that you are a little
7  ↓bit anxio↓us (0.80) so we will ask ↓Mum and
8  Dad ab↓o:ut that and then ↓we will get ba I
9  if you want to tell me any↓thing in in in in
10  between (.↓) ↓just let me kn↓ow ↓alr↓ight

Accompanying the child’s shake of the head is a verbal “"no"” said very quietly (line 3). This is treated as unexpected by the clinician with the change of state token “oh” (Heritage, 1984). This suggests that the clinician expected the child to hold a
knowledgeable epistemic position and to have an understanding of his reason for being there. Instead, the clinician informs the child about his reason for being there, thus aligning knowledge and putting the child back on a level footing so the appointment can continue. Despite the work done by the clinician to make the child a knowledgeable member of the interaction, he then shifts focus to the child’s parents and in doing so informs the child that “if you want to tell me anything in between (.) just let me know right” (line 6-7). The clinician has simultaneously realigned the child’s knowledge with that of the other members of the interaction and afforded him half membership in the interaction in the same conversational turn. The child’s answer has been treated as not being sufficient and the clinician has sought an alternative way to move the interaction forward (Stivers & Robinson, 2006).

Excerpt 16: Family 8

1 (Doctor) erm:
2 (1.74)
3 do ↑ you (0.37) do you ↑ know why ↑ you’re
4 ↓ here by the way ((child shakes head)) no (.)
5 not a not a clue ((child shakes head))
6 (1.04)
7 has mum not ↑ told you ↑ why ((child shakes head))

The child in this excerpt uses purely non-verbal responses to the clinician’s questioning. Similarly to Family 6, the clinician pursues a response from the child by rephrasing the question and providing prompts despite repeated indications of a lack of knowledge. The clinician references the mum’s knowledge in line 6 (“has mum not ↑ told you ↓ why”), and in doing so places the child’s mum is an epistemically higher position than the child. There is an assumption that the child’s mum knows the information the clinician is asking the child for, and it is the mum’s responsibility to pass on this information to the child, despite the appointment being centred on the child and the difficulties they are facing.
5.3.4 Summary

When asked by the clinician if they knew why they had gone to the appointment, children responded in one of three ways. The children either responded with a candidate diagnosis, a lay explanation, or with a claim to insufficient knowledge. While qualitatively different, each of these responses made orientations to the epistemic relationship in the interaction and the child’s perceived right to knowledge compared to the clinician’s. Each response was also treated in this way by the clinician. Where children gave a candidate diagnosis or a lay explanation for their reasons for attendance, they downgraded their certainty with prefaces such as ‘*erm*’ or ‘*um*’. These downgrades reflect the delicate action of encroaching on knowledge to which they are not perceived to be entitled (Gill, 1998). Where children made a claim to insufficient knowledge, they did this either with a ‘*no*’ response, a ‘*don’t know*’ response, or a non-verbal response such as shaking the head. Claims to insufficient knowledge were treated either as genuine or as an insufficient response that requires the information to be sought from another party in the interaction.

5.4 Conclusions

Establishing the reason for attendance is one of the shortest, yet most significant phases of the medical appointment for the patient as it is one of the only opportunities they have to give their perspective on the problems they are experiencing (Heritage & Clayman, 2010). The epistemic dynamics of the clinician-patient relationship are clearly visible in the excerpts presented, with both clinicians and children orienting to the perceived rights to knowledge of each participant in the interaction.

When asking the children why they are at the appointment, the most common formatting of the question was ‘*do you know* + *why interrogative*’. From exploring the data, the preface ‘*do you know*’ appears to serve two functions, both establishing the child’s knowledge and indicating that the clinician already has this knowledge. The ‘*why interrogative*’ works to request knowledge from the recipient and as such establishes the differences in epistemic status between the clinician and child. The structure of the problem presentation sequence orients itself to a perspective display sequence (Maynard, 1989). In the excerpts looked at, the sequence is used by the
speaker to establish the recipient’s knowledge and then use the response as a platform to unpick that response and begin to take a history from the child.

In response to the clinician’s question, children also appear to orient to the epistemic dynamic in the interaction. Where children gave accounts of their reason for referral, whether as a candidate diagnosis or a lay explanation, they treated their responses with caution. Where explanations were provided by the child, the clinician used their next turn to probe the child’s understanding of the explanation they had given. This further demonstrates the orientation to rights of access to knowledge with children not being afforded the same epistemic status as the clinician or, in some cases, the parents. Where children responded with a claim to insufficient knowledge, the clinician in some cases attempted to prompt a response and in other cases oriented the interaction to the child’s parents. Again, this demonstrates the fragility of the child’s epistemic position in the interaction and the impact it can have on the remainder of the appointment.

This chapter has endeavoured to explore the sequence of interaction around problem presentation. It has explored the cases where the clinician initiates a problem presentation sequence with the child, but there are instances in the collection of 15 families where the sequence does not exist at all. In the majority of these cases, the clinician informs the family of the reason for their referral and from there proceeds into history-taking with the remainder of the appointment continuing as normal. Whilst it is worth noting that these deviant cases exist, they have not been discussed further as the focus was on what happened where the sequence did occur and the implications of this.
6 CHAPTER SIX: BUILDING A CASE

The Use of Rhetorical Devices and Account Building

6.1 Introduction

This chapter presents the ways families build a case around the concerns they have about their child’s mental wellbeing and their need for specialist intervention. In the context of this thesis, building a case refers to the presentation of evidence, both fact and opinion, intended to demonstrate and gather support for the family’s interpretation of the problem their child is experiencing. In the appointments recorded, parents spend time and effort providing information about the difficulties the child is displaying. The information is imparted in multiple forms including first-hand experiences, reports from third parties, and listing symptoms.

Building a case occurs across the phases of the appointment designed to discover the reason for the patient’s attendance and the clinician’s verbal examination (Byrne & Long, 1976). This phase of a medical appointment is one of the only defined opportunities that patients and their families have to present their account of the symptoms and difficulties (Heritage & Robinson, 2006). Within medical appointments, it is the phase that has the most time dedicated to it (O’Reilly, Karim, Stafford & Hutchby, 2015).

The act of building a case is co-constructed by the clinicians and patients (Heritage & Robinson, 2006). Clinicians initiate and conclude the phase of interaction (Beckman & Frankel, 1984) and pose prompting questions, while patients and attending family provide detailed accounts that form the content. Within CAMHS triage appointments specifically, the interaction within this phase appears to be weighted towards the family in terms of the quantity of content produced. However, building a case remains a co-constructed and progressive interaction between clinicians and families (O’Reilly et al., 2015).

When building a case, attendees at medical appointments are attempting to convince the clinician both of the diagnosis they may suspect, and of the legitimacy of their needing help from the service they are attending (Halkowski, 2006). Being offered a diagnosis by a clinician can provide an opportunity to access additional
services and treatments (Avdi, Griffin & Brough, 2000). Additionally, in child services, it provides parents with an explanation for their child’s symptoms and behaviours (Avdi, Griffin & Brough, 2000). With this in mind, parents must construct the most convincing account that they can, outlining not only the difficulties their child is displaying but also utilising additional information and resources to strengthen both their argument and rhetoric.

The chapter is divided into two parts; Part A explores how parents build a case through their use of rhetorical devices including the use of extreme case formulations and contrast structures. Part B focuses on how parents present an account by witnessing using examples and comparisons to other children. The analysis focuses on the strategies and devices used by families when building a case. Whilst it is important to acknowledge that there are two parties involved in the interaction, and that in this context interactions are composed of statements or questions and responses, the clinicians’ responses are noted but are not given the same attention as the families’ turns.

A range of conversational devices are used by families throughout this phase in the appointment to assist them in building and presenting an effective case for the difficulties their child is facing. The devices discussed in this chapter represent only a small selection of these. This chapter focuses on devices that were selected not only because of the work they do in the interaction, but also on the basis of their prevalence across the appointments in the sample, with each of these being employed in the interactions of at least 10 of the families. It was noted during the course of their selection that these appeared to fall within two main categories, that of rhetorical devices, and of witnessing. These categories form the basis for the structure of the chapter and will be described in more detail as the chapter progresses and each feature is examined.

The data analysed in this chapter comes from the middle section of the appointment which generally occurs alongside the clinicians taking a family and medical history. Prior to this phase of the appointment, the clinician has established the reason for the referral, with the child and/or the parents presenting the summary of the problems they are experiencing (see chapter 5). The family now spend time
expanding on their concerns, giving anecdotal evidence of the difficulties they are facing as a result of the concerns surrounding their child, providing developmental and medical information relating to the child, and presenting information received from professionals who have seen the child previously. Within the data presented, the work of building a case is always conducted by the parents of the child and other family members where present. The child occasionally interjects but generally listens to what was going on. In some instances the child has been taken to a separate room by the second clinician at this point in the appointment.

6.2 Part A: The Use of Rhetorical Devices

Rhetorical devices are used by all families while building a case. The devices used include, but are not limited to, extreme case formulations (ECFs) (Pomerantz, 1986) and contrast devices (Hutchby, 1992), both when referring to third party opinions and when describing the child’s behaviours. Rhetorical devices are elements of speech which are used in everyday interaction to enhance the speaker’s discourse, for example metaphors and description are basic rhetorical devices used by speakers to provide greater detail to a persuasive argument. The following rhetorical devices of ECFs and contrast devices are used by families to contribute to the persuasive nature of the case they are building for the difficulties their child is experiencing and why they are in need of specialist intervention from a mental health team.

6.2.1 Extreme Case Formulations

When building accounts, speakers have a range of descriptive practices such as extreme case formulations (ECFs) available to them to legitimise their claims and provide a version of their account that is most convincing (Pomerantz, 1986). As Edwards (2000) points out, ECFs cannot be defined by a grammatical rule but rather they appear in interactions in a variety of settings and contexts and include formulations such as ‘never’, ‘always’, ‘most’, ‘nothing’, ‘brand new’, and ‘forever’. In using ECFs, the speaker is hearably presenting the most extreme version of events enabling them to semantically dispute any other version presented by other interactants. Although the focus is on the way the family (speaker) uses ECFs when building a case and not the way this is responded to by the clinicians, it is worth noting here that in most instances ECFs are rarely challenged in interactions despite
them being semantically extreme and an exaggerated version of the truth (Pomerantz, 1986; Edwards, 2000).

The following two excerpts come from two different families, both of whom use ‘never’ as a contrast device to demonstrate the differences between reports of behaviour received from school and their own experiences, but for different purposes. Contrast devices occur during the course of interactions and are designed to introduce doubt to a previously stated position (Hutchby, 1992); they are discussed in greater depth later in the chapter (see section 6.2.2). In the first excerpt, Mum is working to demonstrate that although the school have reported that her child has been attempting to self-harm, she does not have any experience of it at home. In the second excerpt, the parents again use the ECF ‘never’ to demonstrate emphatically the differences between behaviour reported from school and that observed at home. In this instance however, the school have not observed any difficulties, but Mum and Dad have at home.

Excerpt 17: Family 8

1 Mum (.hhh) ↓well he’s never he’s never ↑done
2 (nought) like this n- (0.38) what I can’t
3 understand he’s never (0.44) done anything
4 like ↓this before never
5 Doctor umhm
6 Mum never ↓since (0.36) ↓he’s been ↓born (0.44)
7 he’s ↓never done ↓owt like this

In this excerpt, Mum and the Doctor are discussing a report made by school of an attempt by the child to self-harm, with possible suicidal ideation. Mum repeatedly uses the ECF ‘never’ to legitimise her claim about her experience of her child’s previous behaviour. In repeating and emphasising the ECF, she calls in to question the accuracy of the school’s report; the ECF calls in to question the legitimacy of the school’s account, as Mum had not witnessed the behaviours herself. In adding the softener “he’s never done anything like ↓this before” (lines 3-4), Mum anticipates and redirects the possibility of the Doctor undermining the ECF ‘never’ (Pomerantz, 1986). The reference to a time frame, “before” (line 4), allows for the possibility
that the child may have carried out the acts reported by the school, but he has never done anything like that prior that event. There is a possibility that the legitimacy of the ECF ‘never’ could be called in to question both because of its extreme nature, but also because Mum would not have been witness to the events reported as they occurred at school. The use of the softener acknowledges this possibility and makes the utterance interactionally stronger (Edwards, 2000).

Mum begins her next turn at line 6 by repeating the ECF, mirroring the emphasis used at the end of her previous turn. She adds an additional qualifier in this instance, making her definition of ‘never’ explicit in stating “never ↓since (0.36) ↓he’s been ↑born” (line 6), alluding to the maximum possible amount of time that ‘never’ could be defined as for any person. This addition makes her exclamation more extreme than simply using ‘never’. The use of the ECF emphasises the extreme nature of the behaviour and builds a case for it being unusual and out of the ordinary and questions the school’s reports.

The Doctor responds to the initial turn with the acknowledgment token “umhm” (line 5), but does not question the accuracy of the account provided. It is unusual for ECFs to be challenged despite generally being semantically inaccurate (Pomerantz, 1986; Edwards, 2000). If the Doctor were to challenge the ECF, he could do this by questioning the use of ‘never’ as an accurate representation of the frequency of the behaviour, “What, never?”. Alternatively, he could place a restriction around the claim, for instance “So he has never done this before that you are aware of?”. Both of these possibilities would undermine the ECF and Mum’s account by displaying the Doctor’s uncertainty at its legitimacy.

Excerpt 18: Family 3

1 Doctor i- is it specifics er ↑people he is ↑angry
2 with ↓or i- i is he angr↓y also at ↑sch↓oo↓l
3 ↓or a-
4 Dad NO he’s [fine at school]
5 Mum [NEVER at sch↓oo↓l]
6 Dad Never at sch[oo↓l]
7 Mum [never] at school
For both Mum in excerpt 17 and for the parents in the current excerpt, the use of ECFs is to provide contrast between the children’s behaviour at school and their own experiences of their behaviour in a family environment. In both cases, the behaviour at school differs from the experiences of the parents at home which could bring the legitimacy of the parents’ accounts into question. In employing the ECF as part of a contrast device they provide their version of events and in so doing, perform the social action of building a case.

Both Mum and Dad work collaboratively to demonstrate the disparity in their child’s behaviour across different environments by upgrading and confirming each other’s assessments. The ECF ‘never’ is first presented by Mum in overlap with Dad (line 5) and is an upgraded assessment of Dad’s response “NO he’s [fine at school]” (line 4). The emphasis on Dad’s “no” (line 4) and the two subsequent responses of “never” from both Mum and Dad (line 5 and 6) highlight the disparity they are describing between behaviour at school and elsewhere, and also the commitment to their ECF. By repeating each other’s ECF in their original form, Mum and Dad confirm each other’s assessments of the situation and form a united front in describing the severity of their child’s behaviour.

The following excerpt occurs just a few minutes later as part of the same interaction regarding the child’s behaviour. The content of the interaction has progressed to how the behaviour is responded to and the child’s subsequent reactions. Immediately prior to this excerpt, the parents have listed strategies that they have employed to manage their child’s extreme behaviour. Here, Mum uses the same ECF in two consecutive turns to legitimise the act of help seeking.
Excerpt 19: Family 3

1 Mum  not[hing ↓h]elps
2 Dad  [no]
3 Mum  (.) nothing nothing ↓does it be[cause]
4 Dad  [coz he now]
5  he ↓knows the next ↓time he’ll just carry
6  ↓o[n as]
7 Mum  [he’ll]
8 Dad  (.) the same th[inking he’ll ↓get away with
9  ↓it]
10 Mum  ↓nothing stops it ↓don’t
11  ↓matter ↓wha]t ↓you do:
12 Doctor  uhh

A further ECF is employed by Mum in this excerpt – ‘nothing’. In claiming that “not[hing ↓h]elps” (line 1), Mum is implying that as parents they have tried every behaviour strategy and explored every possibility. This cannot be the case however, as if it were the act of seeking additional help would be futile. Instead, the repeated ECF of ‘nothing’ works to legitimise their need for additional support as they have reached the limits of their knowledge and resources. In line 10 and 11, Mum upgrades the ECF of “nothing stops” with the formulation “↓don’t matter ↓wha]t ↓you do:”. This highlights the original implied message that they have tried everything to control the child’s behaviour. The ECF contributes to the act of building a case for the extreme nature of the child’s undesirable behaviour by portraying him as uncontrollable. The implication that his behaviour is beyond their control also pathologises the behaviour, presenting it as psychologically abnormal. This is the overarching case the parents are attempting to build and present to the clinician and the ECF serves to emphasise the point.

As in excerpt 17, the Doctor’s response comes in the form of an acknowledgment token, in this instance “uhuh” (line 12). Acknowledgment tokens enable the listener to display their understanding of the speaker’s point without displaying agreement or disagreement with it (Schegloff, 1982; Bercelli, Rossano & Viaro, 2008). The use of an acknowledgment token by the listener allows the
speaker to continue their turn without interruption (Jefferson, 1984). As previously noted, ECFs are rarely challenged which is evident in excerpt 17 and 18. The parents in this data are making ECF claims as part of an account of their experiences. This makes it more difficult for the Doctor to challenge the ECFs as it would involve challenging the parent’s personal experience and they do not have the epistemic foundations to be able to achieve this interactionally.

Different ECFs can achieve a similar message in the course of different interactions. The parents in the previous excerpt used the ECF ‘nothing’ to make the claim that they have tried everything but the child’s behaviour is unaffected. In the following excerpt taken from a different family, Mum uses the ECF ‘everything’ to make the claim that nothing has helped her child’s behaviour. In both instances, the parents are building a case for their need of help and the use of the ECFs legitimises their accounts of the extreme behaviour their child is displaying.

Excerpt 20: Family 6

1 Mum ↑just that I’ve tried ↑everything (hhh) and
2 I am ↑strict but ↑they just don’t
3 (1.04)
4 seem to ↑listen or anything (0.37) everything
5 I ↑say (0.78) ↑just like even (0.56) at
6 bedtime ↑if I tell her to go in her ↑bed
7 (0.41) she ↑won’t
8 Doctor um

Prior to this excerpt, Mum has become tearful and the doctor has enquired as to the reasons for the distress. Mum begins her response by employing the ECF ‘everything’ followed closely by ‘anything’. She claims that she has “tried ↑everything” (line 1) to manage the behaviour of the child and the child’s sibling but “↑they just don’t (1.04) seem to ↑listen or anything” (line 4). In using these ECFs, Mum is working to demonstrate the extremes of the child’s behaviour and their need for help to manage it; she is suggesting that the typical and usual parenting strategies that generally work with children are not having any effect with this child. The implication of this suggestion is that there is something wrong with the child. Mum
continues her turn by illustrating her point and legitimising her use of the ECF with an example. She chooses a simple, everyday instruction, “to go in her bed” (line 6), but she says the child does not do what she asks. In using an example of an ordinary instruction, she is highlighting the extent of the problem she is having with the child not listening and validating the use of the phrase “everything I say” (line 3).

The ECFs in the following excerpt are not employed in reference to the child’s behaviour or difficulties, but rather to the parent’s experiences of the support they have received thus far.

Excerpt 21: Family 5

1 Mum ( ) \an it was like I mean it is Mrs Cooper
2 \the SENCO at the school is b you kn ow
3 basically (0.38) been pushing us push (0.62)
4 you know she’s felt Mandy’s autistic for
5 quite a while now
6 (1.34)
7 \but it’s just getting (0.27) the educational
8 psychologist (0.28) who’s just \not
9 Dad \it’s just getting
10 Mum \well we feel like we’re fighting a losing
11 battle to be \ho[nest]
12 Dad \[\one one say]s it’s \this
13 \one says it’s \that one says it’s the \other
14 and it’s like nob o[d[y’s \they’re all]
15 \fighting to \make a decision \is my op i nion

Similarly to excerpt 19, Mum and Dad work together to build a case for their help seeking. The family report that they have been seeking help for their child for some time and have had several professionals involved in the process. Here, they present a possible diagnosis that has been sought by the school special educational needs co-ordinator (SENCO) and put forward to the educational psychologist. In stating that “it’s just getting (0.27) the educational psychologist” (line 7-8) they imply that the
suggestion of autism offered by the SENCO is one that they agree with but the educational psychologist is reluctant to corroborate.

When stating “they’re all fighting to make a decision” (lines 14-15), the ECF ‘all’ legitimises the notion that they have yet to receive a diagnosis of Autism for their child because the professionals involved have struggled to reach a consensus. The ECF ‘all’ lies in direct contrast to the shortened utterance of “it’s like nobody’s” (line 14) which occurs immediately prior to it. Dad switches his phrasing from ‘nobody’ to ‘all’ (everybody involved) to reframe the point he is trying to make. The semantics of the possible phrase “nobody’s making a decision” lies in contrast to the actual phrase used: “they’re all fighting to make a decision” (line 15). The former implies that the professionals involved do not have a possible diagnosis, while the latter implies that they each have a different suggestion and cannot reach a consensus. This highlights the importance of the selection of the ECF as a device for legitimising a claim. Whilst the metaphor of the professionals fighting to make a decision is not an ECF, it does add an extreme element to the statement. It makes the statement more dramatic and emphasises the level of disagreement between the professionals. Following this statement, the softener “is my opinion” (line 15) is added. This lessens the possibility of the Doctor challenging the idea that ‘nobody’ is making a decision as it is no longer being presented as fact but opinion.

6.2.1.1 Summary

The data and analysis have shown that ECFs are used by parents to legitimise the claims they make regarding the difficulties their child is experiencing and, furthermore, contribute to the case of pathology being built by parents around their child. Parents use devices such as repetition of the ECF and collaboratively using the same ECF in a way that strengthens its impact and emphasises both their distress and the case for the child’s pathology. Pomerantz (1986) observed that the extreme case is formulated in some interactions so as to legitimise a speaker’s distress where there is the possibility that it may be trivialised. In excerpt 19, for instance, the use of ‘nothing’ in the utterance “nothing helps” (line 1) enables Mum to present one of her concerns to the Doctor in the worst case scenario to ensure that the extent of the
difficulties are heard by the Doctor and understood as being legitimate. As previously noted, the EFCs are not questioned in this data set. The Doctor hears them but does not challenge their legitimacy or accuracy, or the accuracy of the following claims that the ECF is working to legitimise, which makes them a valuable resource for parents when building a case of pathology around their child.

6.2.2 Contrast Structures: ‘They said X but Y’

In the course of building a case, parents often referenced third parties’ opinions or provided evidence both for and against perspectives on their child’s difficulties. Inconsistencies appeared between accounts provided by others and the case the parents were working to build. These inconsistencies were generally acknowledged by parents during the course of the interaction and alternative accounts, facts, or opinions provided to establish an alternative explanation congruent with the case they were building. The inconsistencies presented and the subsequent alternative explanations took the form of contrast structures. Contrast structures are rhetorical devices commonly found in interactions involving differences in opinion or arguments (Hutchby, 1992). They have been identified in various settings including talk radio interviews (Hutchby, 1992), courtroom interactions (Drew, 1990), and when legitimising accounts (Smith, 1978).

It was common for parents in the course of presenting evidence for the case they were working to legitimise, to present opinions from third parties that both supported and contradicted the case they were building. In this section, the focus is on one of the ways parents present contradictory evidence and opinions from third parties, and how they then work to undermine these in the structure of the interaction; using a ‘they said X but Y’ structure. Within this structure, the parents first report the opinion to be disputed; ‘they said X’. The second part of the turn, ‘but Y’, uses their own experience and opinion, or that of an alternative professional whose opinions are congruent with the parents, to highlight the inconsistencies in the account and undermine the previous reported opinion. Hutchby (1992) found a similar structure was employed by talk radio hosts when discussing items with callers, using a ‘you said X but what about Y’ format to undermine the caller’s opinions and present an alternative account.
The Mum in the first excerpt is seeking specialist intervention under the guidance of other agencies for her child’s behavioural difficulties. She has come to the appointment accompanied by her family support worker (FSW). Despite attending the appointment at CAMHS for the challenging behaviour, she disputes some of the more extreme behaviour reported by the child’s school. She uses a very clear contrast structure to illustrate this discrepancy in the following excerpt.

Excerpt 22: Family 8 (FSW – Family Support Worker)

1 Mum an he went to school with ↑Velcro ↓on [and
2 they ↓says] he tried to strangle his ↓self
3 with laces
4 FSW [um:]
5 um:
6 Mum ↓but he got velcro trainers ↓on

The school had raised concerns because the child had attempted to make a ligature out of shoe laces and harm himself with it. Mum begins the contrast structure by initially stating why the school report is inaccurate and then reports the position of the school: “they ↓says] he tried to strangle his ↓self with laces” (lines 2-3). She then provides an account as evidence for why the school report is inaccurate and the child could not have done this: “↓but he got velcro trainers ↓on” (line 6). In producing this contrast, she creates doubt around the accuracy of the behaviour reported by school. Mum highlights the incongruence between the account given by school and the facts as she knows them, leaving the Doctor conducting the appointment with the dilemma of which account is most accurate. There is the possibility that the child used someone else’s laces, but regardless of that, Mum’s account casts doubt on the legitimacy of the schools account. As Edwards (1990) describes in relation to courtroom interactions, the inference that is drawn from a contrast such as this, that the report by school is inaccurate, is implicit and based entirely on the doubt created by Mum’s account.

In the following excerpt, Dad follows a very clear ‘they said X but Y’ formulation. Following a question from the Doctor regarding the child’s friendships, Dad reports the schools opinion and follows this with his own contrasting experiences.
Excerpt 23: Family 5

1  (Dad)  she can’t mAKE ↓friends
2  (2.68) ((child talking to herself and
3       playing))
4       um she kno- sh↓e knows
5  (1.04)
6       the ↓children’s names (0.40) but (0.91) I
7       mean we’ve ↓been to meetings at the school
8  (0.90) um: obviously we attend IEP ↓meetings
9       etcetera (0.93) and they ↓say oh ↓she’s got
10       lots of friends ↓and when we come out we see
11       her in the play↓ground and she stands there
12       ↓doing this ((flaps hands to demonstrate what
13       child does))
14  Doctor  ↓but the ↓school ↓thinks she has many friends
15  Dad    ↓the school thinks she’s got ↓many friends
16       and the school keeps on (checking) (0.85) do
17       lots of ↓things ((child sighs)) but she
18       [(can’t ↓have)]

The excerpt begins with dad making a claim about one aspect of social interaction that the child struggles with: “she can’t mAKE ↓friends” (line 1). He then continues by making reference to an inconsistent opinion from the school with regards to making friends, which is where the ‘they said X but Y’ sequence begins. The first part of the sequence is given in lines 9-10: “they ↓say oh ↓she’s got lots of friends”. The reported position that the child has many friends is attributed to the school using the pronoun ‘they’. The second part of the sequence is given in lines 10-12: “↑and when we come out we see her in the play↓ground and she stands there ↓doing this”. It is in the second part of the sequence that the inconsistency is expressed between the two accounts. The account given by Dad of the child’s behaviour in the playground does not directly contradict that which he reports in the first part from school as he does not say that when they saw her in the playground she was alone or had no friends. However, the structure of the sequence works to make a direct contrast between two parts allowing the hearer to imply that in standing in the
playground flapping, she is also standing alone. Dad’s response is treated as a contrast by the Doctor who responds with “↓but the ↑school ↓thinks she has many friends” (line 14), with ‘but’ displaying a contrast between what dad has reported and the following summary of the schools opinion. The contrast presented by Dad projects doubt on the accuracy of the current and subsequent accounts provided by the school claiming that the concerns around child’s social difficulties are unfounded, thus building the case for the possibility of a pathology.

The following excerpt is also referencing social difficulties the child is experiencing. Again, Mum uses a ‘they said X but Y’ contrast structure to dispute the claim made by school.

Excerpt 24: Family 4

1 Mum an: (0.90) they just kept ↓saying to me oh
2 it’s better to be like ↓that than you know
3 ↓have lots of different
4 Doctor hum
5 Mum but I find ↓that he’s not got ↓any particular
6 ↓friends and he finds it hard
7 Doctor um
8 Mum an- his TA said to ↓me only a ↓few (0.22) few
9 (0.25) weeks (0.27) ago ↓(hhh) ↓she says the
10 trouble ↓with him is (0.26) if a new child
11 ↓comes in the school ↓he’s that desperate to
12 ↓get his own friend that he’s grabbing ↓them
13 ↓and come with [me ↓an]↓d he’s too
14 overpowering ↓↓↓with em because he’s so
15 ↓desperate to ↓have his own fri[end]

The initial turn presents the position that is being refuted as being attributed to a third party (school). In beginning the account of the school’s position with “they just kept ↓saying” (line 1), Mum is treating the subsequent reported account about the child’s social difficulties as insufficient and undesirable. This is followed by the second turn which begins with the contrastive ‘but’, setting up the information that follows as a direct contrast to the school’s position. Mum frames the contrasting
information as a personal experience: “I find that” (line 5), with additional information that references the effect that the social difficulties the child is experiencing is having on his life “he finds it hard” (line 6). In this instance, the personal experience is being treated as a stronger account than that of the school’s opinion. The addition of the effect on the child’s life adds impact to both the case for the child experiencing social difficulties outside of those which are considered normal for a young person, and for specialist intervention.

An additional third party is referenced towards the end of the excerpt as part of the ‘...but Y’ element of the contrast structure (lines 8-15). The third party is referenced directly and Mum specifies that they are “his TA” (line 8) rather than a general classroom assistant. This places the third party’s subsequent reported opinion as more informed and knowledgeable of the child’s difficulties as they work directly with the child. Mum also places emphasis on the time frame for the comments as being “only a few weeks ago” (lines 8-9) thus making them recent and relevant, whereas no time frame is specified for the opinion of the school.

The addition of a third party’s opinion to the ‘...but Y’ part of the sequence is also employed in the following excerpt. The initial contrast is between Mum’s opinion and the opinion of the school, however this inconsistency is then legitimised further by the reporting of an additional opinion of a doctor that corresponds with that of the parent.

Excerpt 25: Family 16

1 Mum erm (.) school had noticed things were a
2 little bit unusual however they
3 challenged me when I said I wanted to push it further
4 Doctor um
5 Mum there’s nothing wrong with him he hasn’t got an ADH↓D we’re not prepared to support you I
6 said well don’t support me then I’ll do it solo

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10 Doctor  um
11 Mum  hence the reason why I went an um (0.94) I
12 went to see Doctor Aisha Jenks
13 Doctor  "um"  
14 Mum  um: (0.37) and within twenty minutes of
15 ↓ being in the room with him he he came to the
16 same conclusion that I did that he had ↓ ADHD↓

The position attributed to the school in the initial part of the sequence (they said X) is one of apathy and hostility; although they acknowledge there is something unusual, they do not believe it warrants specialist intervention. Mum uses a three part list (Jefferson, 1991) to report the interactions she had with the school in lines 6-7: “there’s nothing wrong with him”, “he hasn’t got an ADHD”, “we’re not prepared to support you”. The use of a three part list adds impact to Mum’s account of the events. The use of reported speech to relay the interaction serves to present the account as accurate and factual to the listener, validating the claim made. The contrast in this sequence is not demonstrated with an explicit contrast device such as ‘but’, rather the contrast is implied by the following account of a consultation with a medical professional and the account of the visit Mum reports. Mum uses both the title and full name to refer to the medical professional “Doctor Aisha Jenks” (line 12) and in doing so highlights the contrast between the knowledge base of school and the Doctor, legitimising the Doctor’s account and casting doubt on that of the school. The emphasis placed on “I” (line 10) highlights the fact that the doctor’s opinion was the same as her own. The use of the contrast in reporting the opinion of a third party presented as a knowledgeable source legitimises Mum’s account of the reasons why her child is experiencing difficulties in his everyday life, and her reasons for seeking additional specialist intervention and a diagnosis.

6.2.2.1 Summary

The ‘they said X but Y’ contrast structure appears to be employed regularly by parents as a tool for highlighting inconsistencies in accounts and creating doubt around a third party’s account whilst legitimising their own. This enables those parents to create a stronger case for their experiences and opinions surrounding the difficulties their child experiences and works to discredit accounts that may bring
doubt to theirs. In some cases parents appear to use an additional third party to strengthen their case. These third parties are presented as supporting the parents’ accounts and as being more knowledgeable than those responsible for the account being discredited. This serves to give credence to accounts which would otherwise be based on the credibility of the parents as witnesses alone.

6.3 Part B: The Construction of an Account

During the course of building a case, parents construct an account of their child’s difficulties from their experiences. Aside from rhetorical devices, parents draw upon a range of discursive resources when describing and explaining the difficulties their child faces and their journey to finally being given the opportunity of specialist advice and possible intervention. The resources available to them include anecdotal accounts of specific events to which they were witnesses, and their observations of the elements of the child’s life that makes them different from other children. Part B of the chapter first explores the notion of parents as witnesses of their child’s difficulties and how they use this standpoint to evidence their account and strengthen the case they are building. The second half of this section looks at the ways parents use comparisons with other children to make a case for a pathology around their child. Smith (1978) notes that in making a direct comparison to behaviour that is deemed to be ‘typical’, the alternative behaviours described appear atypical. Both of these resources draw upon their knowledge and experiences as parents of the child and as witnesses to their child’s difficulties. As such they are in strong epistemic position which further adds to the rhetorical devices discussed in Part A to build a coherent and convincing case for the child’s struggles and need for specialist intervention.

6.3.1 Witnessing

In their accounts of their child’s behaviour, parents regularly use examples of events they have witnessed to evidence their claims about the normality or pathology of their child. Accounts such as those in the data below provide experiential evidence of the difficulties the child is demonstrating and the effect these have on daily life, and add an additional layer of information to the case being built and presented by parents. Hutchby (2001) notes that by presenting information as having been
witnessed by the speaker, speakers add authenticity to the experiences and emotions being reported. In reality, it is possible that the actual events reported by the parents occurred slightly differently than the way they are presented in the appointment, were richer in context, or are presented in a more orderly fashion (Smith, 1978). In this respect, the parents have chosen how to work the examples used in specific ways to elicit a certain response from the clinician and to add evidence to their case that their child has a legitimate difficulty requiring specialist help. The following excerpts and analysis will explore the ways in which parents utilise examples and present themselves as witnesses to the events to legitimise the claims they are making about their child’s difficulties.

Excerpt 26: Family 5

<table>
<thead>
<tr>
<th>Line</th>
<th>Speaker</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Dad</td>
<td><strong>everything she does she needs assistance</strong></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td><strong>with</strong></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td>(1.20)</td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>er:: (0.87) <strong>she doesn’t use apparatus</strong></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td>(0.41) <strong>er we’ll arrive at the school and</strong></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td><strong>she’s has to have somebody to hold her</strong></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td><strong>h[and]</strong></td>
</tr>
<tr>
<td>8</td>
<td>Mum</td>
<td><strong>[hates]</strong></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>PE <strong>terribly</strong></td>
</tr>
<tr>
<td>10</td>
<td>Dad</td>
<td><strong>just to walk along a little beam on the floor</strong></td>
</tr>
</tbody>
</table>

Dad begins by making a statement about the extent of the child’s difficulties on a day to day basis. This initial statement provides the hearer with a premise under which they should interpret the examples that follow. Following a significant pause, Dad continues his turn by giving examples of the activities the child needs assistance with such as not using apparatus and requiring “**some body to hold her hand** ... **just to walk along a little beam on the floor**” (lines 6 & 9-10). Physical Education (PE) lessons are not usually an event that a parent would be privy to as they occur during school lesson time, but Dad places both himself and Mum there as observers in stating that “**we’ll arrive at the school**” (line 5). In placing themselves there, they establish themselves as first-hand witnesses to the events and thus legitimise the
claims they are making about their child’s ability to use the apparatus in PE lessons. Emphasis is placed on “just” (line 9) when describing the action of walking across the “little beam” (line 9). This works to make a claim about the simplicity of the task the child is completing and therefore how unnecessary it should be for someone to have to give her assistance to complete it. It is reported in a way to suggest the abnormality of the behaviour and implicitly contrasts the child’s ability with that of the ‘normal child’.

The following excerpt is taken from the same family but later in the appointment. Again, the parents are providing evidence for the difficulties they and their child face on a daily basis, carrying out routine tasks, contrasting their child’s behaviours with that which would normally be expected in that environment.

Excerpt 27: Family 5

1 Mum and I th[ink cos] in the supermarket you
2 know like certain places we go
3 Doctor [“ok”]
4 Dad there’s [so many people so busy and so any
5 people]
6 Mum [certain places we go (.) if we go
down the fridges she’s not [very] keen I
don’t know whether it’s the humming or
whatever I don’t know (0.93) so we sort of
like
11 (1.27)
12 cos she’s gonna [run off so she’ll run
13 Child [( ) up]
14 Mum [or she’ll get very]
15 Child [an run off]
16 Mum stressed [out she’s get out of my way] get
17 out of my way
18 Dad [( )]
19 Dad they’re looking at me (0.45) that sort of
20 th[ing they’re looking he’s looking at me
21 (0.53) and then she’ll
The excerpt begins with Mum and Dad collaboratively describing the difficulties their child experiences in specific contexts. From lines 1 to 27, they draw on numerous examples of unusual reactions by the child to things in her environment, in this case the supermarket. The reactions are treated as unusual by Mum in lines 8 and 9 in repeatedly stating “I don’t know” in reference to the cause of the behaviour. Both parents are working hard to convey the information to the Doctor which is evidenced by the numerous overlaps in turns. For example, in lines 4 to 5 Dad is part way through his turn when Mum begins her own, despite the lack of an appropriate transition point.

A specific example of behaviour the parents have witnessed is offered in lines 25 to 27: “she hit a little boy in Asda twice the other week because he was looking at her”. Following a sustained pause of 1.04 seconds, Dad offers this example of the type of unusual and extreme behaviour that results from the child’s concern that people are looking at her. The emphasis placed on “hit” (line 25) highlights the child’s reaction. He provides details about the child and the event as a whole, specifying that it was a “little boy” (line 25), and that it happened in “Asda” (line 25) “twice” (line 26). Factual details such as these add credibility to an example and offer an element of reliability and authenticity to an account (Hutchby, 2001). Emphasis is placed on the fact that the boy was “little” (line 25) and that she hit him “twice” (line 26) which works to frame the behaviour as extreme. Dad completes the example by stating the reason for the reaction: “because he was looking at her” (lines 26-27). The emphasis on “looking” highlights the trivial nature of the causal event, while completing the example with this fact makes it relevant to the previous discussion about the difficulties she experiences. Dad gives this information in a lowered tone of voice, marking it as information that a parent would not typically want to admit with regards to their
child’s behaviour. This feature of his talk gives the witnessed event more significance as he is now recalling the event as part of building a case.

Factual information is worked into examples by a number of parents. The use of factual information distinguishes the account being given as first-hand knowledge as opposed to relaying second hand information from a third party. Presenting examples as having been witnessed first-hand allows them to be heard as problems parents are personally experiencing with regards to their child’s behaviour (Hutchby, 2001).

Excerpt 28: Family 3

Mum [erm] (.) he won’t wear anything new if we buy anything new for him
Doctor right
Mum he’s (0.26) when he was little we used to have to put it on him while he was asleep
Dad [sleep]
Mum coz if you bought anything new and tried to get it on him you’d got no chance< (.) so while he was asleep (0.21) we used to put his new stuff on him (0.25) and then he’d get up and run around and he wouldn’t realise (.) and then he’d look down and see them and think oh (0.36) ah you know (hhh) and he wouldn’t bother he’s the same now something has to be in his wardrobes probably about three months before he’ll wear it (0.72) still I’ve got things in there that I bought him just after Christmas and he’s not even took the labels off

Mum uses examples in this instance to illustrate the case she is building about her child being unusually particular about certain sensory experiences, such as food and clothing. Mum places herself as a direct participant in the examples she uses emphasising her active role and first-hand experience in the events she is describing,
for example “↓we used to put his new stuff ↓on him” (lines 9-10). In placing herself as not only a witness but an active participant in the events, she is legitimising her account and the case she is building around the child’s difficulties. Active participation in a reported event makes it harder for the hearer to refute or undermine the authenticity of the claim (Hutchby, 2001). Mum begins her example by describing the child’s behaviours when he was younger, working to highlight the longevity of the particular behaviours being evidenced. Towards the end of the excerpt, she moves to the present day and makes connections to the behaviour he still displays: “he’s the same now” (line 14), making explicit the continuity in behaviour across his childhood and the current need for specialist intervention.

Similarly to the previous excerpt, Mum used information positioned as factual to emphasise her claims about the child’s unusual behaviour. In lines 14 to 16 Mum makes the claim that “↓something has to be in his wardrobes probably about three months ↓before he’ll wear it”. The claim she is making, that he will not wear brand new clothes that he does not recognise, is presented as a generalisation of his behaviour in the use of “probably” (line 15). However, she then uses a specific example with factual information such as a time frame to legitimise this claim: “still ↓I’ve got things in there that I bought him just after Christ↓mas and he’s not even took the labels ↓off”. Again, the reference to factual information establishes the account as authentic and Mum as a legitimate witness to events. In some cases however, parents’ attempts to use factual information to legitimise their accounts when building a case are not as successful. In the following excerpt, Mum attempts to relay factual information within the example she is presenting, but struggles to recall the specific details with accuracy.

Excerpt 29: Family 2

1 Mum ↓but it’s too late by the time he’s ↓cutting
2 (with a kn↓ife)
3 (2.49)
4 it’s like he ↓had a disagreement with (0.50)
5 which ↓one was it yester↓day was it
6 ↓yesterday (or when~) what day we ↓on
7 (1.01)
The excerpt begins with a summary of the point that Mum is making about the erratic nature of the child’s self-harming. She has previously given an account of the circumstances that typically occur around the child’s self-harming behaviour in response to a request from the clinician. Following the brief summary, Mum evidences this with a recent example of the events and behaviour she is trying to describe. The example Mum provides is comparatively short with the majority being taken up by her attempt to recall facts associated with the event. Similarly to the previous excerpt, she uses a time related fact to position the example relative to the current interaction. However, unlike the previous excerpt, she struggles to recall and relay this information with accuracy: “was it yester\_day was it ↑yesterday (or when-\_) what day we ↓on (1.01) what day we ↓on” (lines 5-6). Whereas in the previous excerpts, foregrounding recalled events with facts served to legitimise a speaker’s account, inaccurate information can also place the speaker’s position as a witness in a vulnerable position with regards to the acceptance of the account by the other interactants (Hutchby, 2001). In her final turn in this excerpt, Mum pulls the information together to provide a coherent and hearably accurate account of events as she witnessed them: “he ↓had a disagreement with his brother on ↑Tue\:_s↓day and then ↓he ↓ran off and cut hims↑elf” (lines 10-12). The confirmation of the time frame by the child in line 9 works to corroborate Mum’s account and legitimise her position as an accurate witness to events.

**6.3.1.1 Summary**

Evidencing claims with first-hand accounts works to legitimise and authenticate the claims being made. In the case of the excerpts above, each set of parents is making a claim about the difficulties their child experiences which, when accompanied by witnessed examples, adds a secondary layer of credibility to the case they are building. When presenting an example, parents first deliver a generalised overview
of the claim being made which instructs the clinician to hear the example that follows in a particular light. The examples are then accompanied by references that place the speaker at the scene making it evident that it is a first-hand account, and factual information such as time references that legitimise the example being given. By accompanying claims about the child with these additional examples and witnessed accounts, parents add authenticity when building a case.

6.3.2 Construction of Pathology Through Comparison

During the course of building a case for their child’s difficulties and need for intervention, parents are tasked with constructing their child’s behaviours as unusual or atypical. Much of this construction happens through talk and through the comparison of their child and a ‘typical’ child to accentuate the differences they observe. As O’Dell and Brownlow (2015) state, child development is illustrated by a trajectory of what is ‘normal’. Parents are encouraged by professionals and society to keep track of their child’s development in relation to this ‘normal’ trajectory throughout childhood. This results in parents taking note of the ways their child may be developing or behaving atypically over the course of their childhood, which then becomes a part of the history they relay to professionals in environments such as CAMHS. In constructing the behaviour and development of one person as normal, parents, professionals, and society assumes that deviance from this should be read as not normal (Smith, 1978). The following excerpts all illustrate how the frequency and effect of comparing the child’s behaviour and development to that of another serves to build the case for a pathology or ‘atypical’ behaviours.

Excerpt 30: Family 10

1 Dad sister is more communicative you know she’s
2 ( ) (0.69) she talk with (0.27) everyone
3 and tried to learn languages
4 C Clin Psy ok:
5 Dad she’s younger than him but she
6 more soc= ciable

The comparison in this excerpt is being made between the child at the appointment and his younger sister. Dad lists the social skills that the sister excels at and in so
doing implies that these are skills that are ‘normal’ for children to have. Before Dad specifies the first skill the sister has, he sets up the utterances that are to follow as a comparison between the two children with the sister being constructed as ‘normal’: “sister is more” (line 1). The direct comparison comes in lines 5 and 6: “she’s younger than ↓ him but er (0.31) she more sociable”. Particularly significant in the comparison is the presented fact that the sister is younger. In constructing the child’s sister as having these particular social skills, and at a younger age, Dad not only implies that the child does not, but that it is not normal that he cannot and does not do these things listed. Any fellow interactants could construe Dad’s description of his daughter as her being particularly gifted in these areas, possibly beyond her years, and that the child he is seeking help for is of average ability but following a normal pattern of behaviour. However, the specialist clinical environment they are in and the fact that they are attending the appointment because they are concerned about the child’s behaviour and development set up the comparison in such a way that it is heard as the child not only having atypical social skills for his age, but also being below the ability of his younger sibling. This dynamic between environmental information and the comparison being made contributes to the case of pathology being built by the parents.

Similarly to the previous excerpt, the following excerpt also relies on environmental information to interpret the child’s behaviour as unusual when compared to his siblings. The child being discussed in this excerpt already has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD), but Mum is pursuing a joint diagnosis of Autism Spectrum Disorder (ASD).

Excerpt 31: Family 16

1 Mum he w[as ne]ver a child to watch ↓ television
2 wouldn’t wa[tch ↓ tele]vision (.) at all]
3 Doctor [um]
4 Nan [would never (even) DV]D’s
5 Mum no way
6 Child [NOW I ALWAYS] watch t[ELEV]ISION
7 Mum [where as my other two]
The initial behaviours being presented by Mum and Nan (the child’s maternal grandmother) of not being “a child to watch television” (line 1), or “(even) DVD’s” (line 4) could be taken as positive in any other context. Many children spend a great deal of time watching television instead of being outside playing, and various views on parenting see this as a negative behaviour. Therefore, the fact that the child in this excerpt does not display an interest in those things could, at face value, be heard as a healthy characteristic. However, the addition of “even” (line 4) by Nan when contributing information about DVDs leads the listener to understand that this is being framed as extreme behaviour. Following these observations, Mum presents a direct comparison with her other children who would “quite happily watch the children’s programmes” (lines 9-10). This behaviour is presented as ‘normal’ with the addition of information referring to the positive way in which they watched “they’d sit and relax” (line 11), but the child being discussed was “never like that” (lines 11-12). This repeated ECF, accompanied by the fact that the sibling’s behaviour is being presented as positive, provides a benchmark for what is being considered to be ‘normal’ behaviour, contrasted with the child’s unusual attitude to watching television. When the observation that the other children would “sit and relax” (line 11) but he was “NEver like that” (lines 11-12) is combined with knowledge of his existing diagnosis of ADHD that was being discussed, the implication is that the child’s behaviour is not typical. This construction of atypical behaviour contributes to the picture being built of the child’s difficulties.

Comparisons with sibling behaviour appear in several parents’ accounts when building a case for the pathology of their child. The following excerpt differs to the ones previously discussed as, although there is a reference to comparing their children, the direct comparison in behaviour is constructed through developmental milestones.
Mum begins by giving contextual information about the relationship between the child and her older siblings. Dad then uses this information to begin making a comparison between the children which forms part of their case for the child’s behaviour as being atypical. Whilst he does not directly compare the behaviour or characteristics of the children like for like, he makes comparisons by employing the notion of ‘normal’ developmental milestones: “we could see the difference in her development” (lines 15-16). As O’Dell and Brownlow (2015) discuss, the construction of ‘normal’ development implies that any deviation from the trajectory is not normal. The Doctor encourages Dad to make a comparison and evidence his claim. It is Mum who then gives an example of the late age at which the child started walking: “she didn’t walk til [probably about eighteen months]” (lines 22-23). Walking is one of the many milestones children’s development is measured.
against to determine whether they are growing and maturing at a ‘normal’ rate. Mum’s reference to this milestone and the fact that she prefices it with “she didn’t” (line 22) constructs the child’s development as delayed or unusual in comparison to the norm.

Parents do not only compare their child to other siblings to make a case for their behaviour being unusual or atypical. In the following excerpt, Mum makes a comparison between the child and his peers at school. This comparison differs to the ones previously discussed as when comparing to peers, Mum is comparing to children of the same age as her child, and the expectation that follows is that they should behave and be able to regulate their behaviour similarly.

Excerpt 33: Family 16

1 (mum) he used to stand out like a sore thumb in the classroom against the other children
2 Doctor >right in what way<
3 Mum um: he was very hyperactive (0.85) you’d stand all the children in line (.) all the children’d be stood still like soldiers
4 Kolomban would be there pulling his faces
5 pulling his hair you know (0.75) an in assembly he’d be the only child that
6 wouldn’t be sat

The comparison begins with an instruction to the listener as to how they should interpret the information that follows. In stating “he used to stand out like a sore thumb... against the other children” (lines 1-2) the premise is that the description of behaviour that follows should be heard as a deviation from what is expected. This is then continued into the next turn, at the beginning of which Mum states “he was very hyperactive” (line 4). Again, the following description and comparison is to be heard in the context of the child being hyperactive. The term ‘hyperactive’ carries implications for behaviour such as being fidgety, constantly active, and disruptive (Oxford English Dictionary) and is associated with atypical or pathologised behaviours. Mum makes the comparisons very explicit, first describing the behaviour of the other children and then directly contrasting this with the way the
child was behaving. The simile “stood still like soldiers” (line 6) is used to describe the behaviour of the other children. In reality, it is unlikely that all of the children in the child’s class would be stood as still as this, but it serves to emphasise the contrast between their behaviour and the child who was “pulling his faces pulling his ↓hair” (lines 7-8). In stating that he was the “only child that ↓wouldn’t be sat” (lines 9-10) and emphasising “only”, Mum makes the distinction between the child and his peers explicit; every child in the school was sat down in assembly, apart from him, therefore his behaviour is unusual.

6.3.2.1 Summary

Comparisons to the ‘normal’ behaviour and development of siblings and peers construct the child’s behaviour and development as unusual or atypical. The premise of the case parents are building around their child’s difficulties is that their behaviour deviates from the norm in such a way that they require specialist intervention from medical professionals. Parents’ reference contextual information both explicitly and implicitly to instruct listeners to hear the comparisons that follow in a particular light. Smith (1978) noted a similar phenomenon when accounts were provided about behaviours that were to be construed by the listener as pathological. The concepts of ‘normality’, of ‘usual’ childhood behaviours, and of ‘typical’ developmental trajectories are referenced by parents to concurrently construct an account of their child as ‘not normal’, of displaying ‘unusual’ childhood behaviours, and of following an ‘atypical’ developmental trajectory.

6.4 Conclusions

Within this chapter the analysis has focussed on the rhetorical devices used by families when building a case for their child needing intervention from specialist mental health services. The chapter highlighted and explored four devices:

1) Extreme case formulations;
2) ‘They said X but Y’ contrast structure;
3) Witnessing
4) Comparisons to others
While not all devices were used by every parent, many parents used two or three in conjunction with each other, demonstrating their flexibility. Families work hard to build their case and the use of the rhetorical devices discussed strengthens their formulations and information they are presenting to the clinician. In using rhetorical devices in their descriptions of their child’s behaviour, parents present the strongest case they can when describing behaviours, differences, and abnormal behaviour.

Extreme case formulations help parents to describe the most extreme form of their child’s behaviour. Parents used formulations such as ‘never’ to legitimise the claims they are making about the difficulties their child is experiencing. In doing so, they are contributing to the case of pathology being built around the child and the need for specialist intervention. Following the parents’ use of an ECF, clinicians do not attempt to challenge the accuracy of the parents’ accounts or their extreme nature. This suggests that it is a valuable resource for parents to use when building a case around the pathology of their child’s behaviour.

Parents use contrast structures within their descriptions and accounts which take the form of ‘they said X but Y’. These particular contrast structures appear to be used where evidence or opinions from third parties has been raised. The contrast structure is used by parents to highlight inconsistencies in accounts and create doubt around a third party’s evidence, all the while legitimising their own account. This enables parents to discredit accounts that may otherwise bring doubt to their own and therefore give their account credence where this would otherwise be based purely on the credibility of the parents as witnesses.

Witnessing was also used as an interactional device to accomplish the action of legitimising the accounts of parents. Parents used first hand evidence and their position as witnesses to the events being described to legitimise and authenticate the claims being made. First hand evidence is harder for clinician’s to dispute and thus, this proves a valuable resource for parents when describing their child’s behaviours. In addition, parents used comparisons to normal to highlight the abnormality in their child’s behaviour or thinking. Comparisons are made to siblings, friends, and peers and include comparisons of current behaviour as well as developmental milestones.
In utilising concepts of ‘normality’, or ‘typical’ behaviours or developmental trajectories, parents are able to construct their child as ‘abnormal’ or ‘atypical’.
CHAPTER SEVEN: DECISION DELIVERY

The Maintenance of Epistemic Asymmetry during the Decision Delivery Sequence

7.1 Introduction

The focus of this chapter is on exploring the ways in which epistemic asymmetry is maintained in the relationship between the clinicians and families through the delivery and receipt of a diagnostic decision or treatment plan. The analysis identifies three ways epistemic asymmetry is maintained:

1) Through the clinician’s use of pronoun when delivering a decision;
2) Whether the clinician delivers the diagnosis in a plain assertions format or evidences their decision;
3) The parents’ lack of response to the clinician’s decision.

Each feature is discussed in relation to the data and then situated in the context of the epistemic relationship between clinician and family in the appointment.

The chapter is organised to manage two main issues. In the first part, the delivery and receipt of the clinician’s decision is explored firstly in cases where a decision is made that the child’s difficulties are related to their mental health, and secondly where they are not. The second part of the chapter explores in depth the two examples in the sample of parents giving extended responses to the clinician’s decision and how this is managed epistemically by both parties.

7.1.1 Epistemic Asymmetry

Medical interactions are characterised by an exchange of information and expertise, with the speaker giving the recipient access to their knowledge. The epistemic status of each participant in the interaction changes depending on whether they are giving or receiving information. During the discussion and examination of symptoms, the families move to a K+ position as they have first-hand experience of the difficulties the child is experiencing and the effect on their lives. During the delivery of the decision and projection of diagnosis, the clinician moves back to a stronger K+ position and the family returns to K- (see Heritage, 2012a and chapter 3 for a
The clinician possesses the knowledge and expertise to formulate a diagnosis from symptomatic information provided by the family and their own prior medical expertise. Although epistemic status is a relatively static and enduring aspect of the interaction, epistemic stance does evolve and change (Heritage, 2012a).

7.1.2 Decision Delivery in CAMHS Assessment Appointments

In the CAMHS triage appointments that are the data for this study, there is a distinct phase of decision delivery similar to that observed by Byrne and Long (1976). Within this phase in these triage appointments the clinicians summarise their decisions about whether the child’s difficulty is one that can be categorised as a mental health difficulty and thus warrants intervention from specialist CAMHS, or not. The purpose of the diagnostic phase of general practice appointments is to provide a label or explanation for the symptoms the patient is experiencing and determine the necessary course of treatment. In contrast, however, the purpose of the triage appointments is not to give a diagnosis in the traditional sense but rather to communicate a decision as to whether the difficulties the child is experiencing warrant intervention from specialist mental health services. In this respect, they are not diagnostic appointments but they do still contain a phase in which the clinicians deliver their decisions about treatment and do occasionally provide a diagnosis either explicitly or implicitly.

The data presented in this chapter explore the ways in which clinicians deliver their decisions or diagnoses, and the ways these are responded to by the family. This is done in the context of the epistemic status of the two parties involved and the maintenance of asymmetry observed in previous research (see Heath, 1992; Heritage & Stivers, 1999; Peräkylä, 1998; 2006). As Heath (1992) states, to effectively study and make observations about the asymmetry underlying the interaction during the diagnostic phase of appointments, both the delivery of a decision by clinicians and its receipt by patients must be explored.
7.2 Decision Delivery and Receipt

In the data being analysed, delivery of a diagnostic projection occurs alongside providing information about treatment. Clinicians have a variety of options available to them when making a decision about the child’s symptoms with their recommendations falling into one of the following categories:

1) Diagnosis given of a mental health related problem with clinicians naming the probable or possible diagnosis (for example, anxiety disorder or phobia).
2) Diagnosis given of a mental health related problem without clinicians naming the diagnosis.
3) Diagnosis given of no mental health related problem.
4) No diagnostic decision is made or given, with clinicians either arranging a follow up appointment or further observations.

In this section, the data is taken from categories 1 and 2, where a decision is made and delivered that the child’s symptoms are related to their mental health. This is then contrasted with category 3, where a decision is made that the child’s symptoms are not related to any mental health problem.

7.2.1 Diagnosis or Treatment Plan Given

One of the options available to clinicians when delivering a decision during assessment appointments at CAMHS is to present families with a route to diagnosis or a treatment plan, if appropriate. As stated previously, the purpose of the appointments is not to necessarily give a medical diagnosis if there is one to give, but to determine and communicate whether CAMHS is the appropriate service to be treating the child’s difficulties. In place of a formal diagnosis, clinicians tend to give confirmation that they are satisfied there is a mental health difficulty that requires intervention.

The act of delivering a diagnosis, or in this case confirming the cause of the difficulties the child is experiencing, places the clinician in the role of expert and reinforces their authority in this phase of the appointment. Peräkylä (1998; 2006) observed that when delivering a diagnosis, clinicians most frequently use a plain
assertion; that is, they state the diagnosis with no reference to evidence or explanation. However, he also observed that this occurs where the diagnosis is in close interational proximity to the examination phase of the appointment, making explicit the link between the diagnosis and the evidence for it. In the following data from CAMHS assessment appointments, the clinicians use a plain assertion format to confirm the presence of a condition that warrants CAMHS intervention but, unlike in Peräkylä’s (1998; 2006) observations, there is temporal distance between this and the ‘examination’ phase, sometimes consisting of the family leaving the room whilst the clinicians discuss the case. The following two excerpts exemplify the pattern of clinicians delivering their decision in a plain assertion format. In each example, the families’ responses take the form of minimal acknowledgments which further maintain the established asymmetry in the interaction.

Both excerpts occur following a break in the appointment, creating a temporal distance between the examination phases and the delivery of the clinician’s decision. In the first excerpt the young person, Callum, has just returned to the consultation room having been invited back by the clinicians following their private discussion about their decisions. Callum has returned alone whilst his Mum and Nan wait in the waiting area for him. In the second excerpt, the clinicians have returned to the family following their discussion elsewhere.

Excerpt 34: Family 2

1    Therapist  o↓k (.) sorry (.) to have ↓kept you Callum we  
2        just wanted to ↓really think about what  
3        you’ve been ↓saying and (0.49) you ↓know this  
4        ↓like d↓ifferent view ↓of and your mum °and  
5        nana° as w↓ell  
6        (0.93)  
7        what we w↓ere (0.57) I- I guess we’re ↓quite  
8        impressed ↓with was the fact that you were  
9        saying that you wanted some things to ↓change  
10       and that you wanted (.) some ↓help (0.75)  
11       ↓and that we ↓thought (0.34) you ↓know ya-
12 you are in the right (0.40) place you
13 know you’ve come to the right service
14 (0.92)
15 guess there was a um (. a variety of
16 thoughts we ‘had’ (0.48) one was about some
17 (.) effective
18 (1.11)
19 er drug and alcohol (. work for you
20 (0.95) I don’t know if there’s anything (.)
21 other than (0.26) redirect:tion but we can
22 find out about that
23 Child um

Excerpt 35: Family 11

1 OT °ok°
2 Psychiatrist °ok°
3 (1.11)
4 right we’ve had a: (0.37) discussion
5 amongst ourselves (. er: (0.31) about
6 what’s is the best way forward (0.30)
7 (so yes) (0.35) we: understand the
8 difficulties (0.28) that you’ve told us
9 about Mahadev happening at night (0.49)
10 so: we think that um: we have got a
11 service called erm CEIPS (0.23) um
12 please don’t ask me what it stands for
13 we’ve been struggling ourselves ( )
14 it’s a psychology service (0.49) and
15 it’s erm: not (. I mean it’s it’s a
16 level below ours (0.59) (er) of
17 specialist service (0.46) so what we
18 will be doing is we will be: referring
19 you to them
20 Mum okay
21 Psychiatrist and they will make contact with you for
22 a short piece of work (0.71)
In both excerpts, the clinicians follow the pattern of referencing their discussion before communicating their decision. Neither clinician provides a diagnosis, instead confirming that the child requires specialist intervention (Excerpt 34, line 13; Excerpt 35, line 11 and 18) but without evidencing their decisions. Peräkylä (1998; 2006) observed that plain assertions occur when diagnosis closely follows an examination which acts as evidence for their decision. However, in each of these excerpts there is both time and physical distance between the ‘examination’ phase of the appointment and the delivery of a decision by the clinicians. The lack of an explanation reinforces the asymmetry between the clinicians and families at this point in the interaction (Peräkylä, 1998; 2006). Clinicians in both excerpts make reference to the fact that the children and families do not possess the expertise or strategies to be able to help themselves: “you wanted some things to change and that you wanted (.) some ↓help” (Excerpt 34, lines 9-10) and “to help (0.40) Mahadev overcome (.) his fears and difficulties” (Excerpt 35, lines 23-24). The families are therefore not only placed in a K- position in terms of their knowledge but also in terms of their ability to help themselves, while the clinicians are able to identify and provide access to this.

The clinicians’ choices of pronouns also emphasises the asymmetry in the interaction. During the decision delivery in Excerpt 34, the clinician refers to the young person as ‘you’, for example, “you were saying that you wanted some things to change and that you wanted (.) some ↓help” (lines 8-10). In contrast to this, the clinician uses ‘I’ and ‘we’ when referring to herself and the second clinician in the appointment, for example, “I guess we’re ↓quite impressed” (lines 7-8) and “we ↓thought...” (line 11). In Excerpt 35, the clinician states “we’ve had a: (0.37) discussion amongst our↓selves (.) erm: (0.31) about what’s is the ↓best way forward” (lines 4-6). He refers to himself and the second clinician, the occupational therapist (OT), collectively using the pronoun ‘we’. In these excerpts, ‘we’ is used inclusively, combining all clinicians attending the appointment and when used in the
context of diagnosis or treatment delivery where decisions are being communicated, represents the authoritative voice (Silverman, 1987). When used in conjunction with ‘you’ to refer to the patient, there is an implication of the authority of the ‘we’ who are making and communicating their decisions about the difficulties that the ‘you’ had described (Maynard, 1991).

In both instances, the young person in Excerpt 34, and the mum in Excerpt 35, respond to the clinicians’ decisions and treatment suggestions with minimal acknowledgment tokens (“um”, “okay” and “yeah”). In Excerpt 35, mum’s acknowledgment token of “okay” (line 20) serves to indicate that she has understood what has been said so far but allows for the clinician to continue explaining the treatment plan in more detail. While patients provide sometimes extensive accounts of their concerns while building a case, their responses to diagnoses tend to be minimal (Heath, 1992). Across medical settings, patients have been observed to be passive in response to diagnostic information (Heath, 1992; Peräkylä, 1998; 2006). Minimal acknowledgment tokens such as those used in the excerpts above indicate an understanding of, and agreement with, the information the previous speaker has imparted (Gardner, 2001). In these excerpts, their function as a response to the clinician’s communication of their decisions maintains the epistemic asymmetry with the clinician in a K+ position.

Excerpt 36: Family 12

```
1 Nurse   brilliant (.) ;ok
2 (1.52)
3 what we know ;Kohemi (.) with phobias (.)
4 ;is: the only way we get over them (0.28)
5 ;okay and this is not (.) just for ;you this
6 is for everybody that’s got a ;phobia (0.22)
7 is (0.23) if we’re fa- if we’re gradually
8 (0.22) we call it exposed if we gradually
9 exposed to it or gradually have to face it
10 (0.37) okay
11 (1.05)
```
that’s the only way we get over it
otherwise our brain just thinks oh no blood
or with me oh no spiders (.) so the only way is to kind of work up to (0.88) being
(1.63)
you know less
(1.39)
fearful of it
(2.39)
does that make sense to you
(1.71) ((child nods))
good (0.78) so what happens now is
(1.49)
we have: something called (.) a treatment waiting list okay and we’ll put your name on the treatment waiting list (0.45) and (.) a therapist (.) will (.) be allocated to your case (0.60) it’ll only take
(1.11)
a couple o weeks
Mum right

Similarly to the previous two excerpts, there is no explanation of the evidence linking the symptoms to the diagnosis; instead, the clinician states the diagnosis within an explanation about an intervention. Stating the diagnosis with no explanation or specific turn dedicated to delivering the diagnosis demonstrates the authority of the clinicians to determine and communicate a reason for the child’s difficulties. The child responds to the information with non-verbal acknowledgment of the information in the form of a nod of her head. At the end of the excerpt, mum demonstrates her understanding with “right” (line 31). This response token indicates that she has understood the information given by the clinician and has connected this information with that provided earlier in the excerpt (Gardner, 2001).

Within this excerpt, the pronoun ‘we’ is used in two different ways: to represent the clinical team in the service and to represent the medical profession, of which the team in the appointment are a part. Each of these categories represents a
professional grouping with possession of a body of knowledge and expertise. In her initial turn, the clinician begins by explaining the rationale for the treatment decision, stating “what we know Kohemi with phobias is” (line 3). The clinician uses ‘we’ to refer to medical professionals, a category of persons who possess knowledge about conditions including phobias. The clinician places herself in this category and, by stating the child’s name after the use of ‘we’, excludes her from that category. The use of ‘we’ to categorise the clinicians as experts continues through the excerpt. This is particularly prominent in the explanation of the most effective intervention for a phobia: “if we’re gradually (0.22) we call it exposed” (line 8). An assumption is being made about the knowledge and understanding of the child as opposed to that of the clinician, that the child does not possess the knowledge of the intervention to adequately understand the clinician’s explanation.

The clinician also uses ‘we’ to categorise the clinical team in the service. Towards the end of the excerpt, the clinician explains that “we have something called a treatment waiting list” (lines 24-25) “and we’ll put your name on the treatment waiting list” (lines 25-26). The ‘we’ here still excludes the child and family but represents a more local category and one which exists within the CAMH service they have attended. The use of ‘we’ in these turns highlights the distinction between the clinicians, their knowledge and expertise, and therefore their ability to gate-keep and allow access to treatments, therapies, or alternative specialist services, and the families who attend the appointments who are lay people and need the clinicians help to progress forward within the service.

Whilst the following excerpt also uses the plain assertion format for delivering the clinicians decision, it differs as it is the only example of the clinician giving a clear decision about their diagnostic impression. The clinician again uses ‘we’ during the process of delivering the decision, but refers only to the team present in the service.

Excerpt 37: Family 3

1 (Doctor) w w w we h↓ave (.) a (0.44) bit of a
2 discussion [{ }] (0.33) er is there
3 ↓anything you want to tell ↓us or anyth[ing]
A plain assertion is used when communicating the diagnosis to the family with the action being completed in a single statement: “we find out there is an an anxiety...problem” (lines 10-13). No explanation is provided to evidence the link between the symptoms presented by the family and the diagnosis that has been reached by the clinicians. The inferential gap between building a case and delivery of a diagnosis was increased by the fact that the family and clinicians split so the clinicians could discuss the case between themselves. Contrary to Peräkylä’s (1998; 2006) observations, the clinician makes no attempt to close this knowledge gap during diagnosis delivery. The clinician follows on from the diagnosis delivery by making an evaluation about the appropriateness of the CAMH service to treat the child considering the stated diagnosis: “here it’s might be the right place... to that to be to that to be treated” (lines 14-18). In comparison to the previous excerpt where the clinician spends time explaining the way phobias are treated and the structure of the therapy involved, the clinician in the current excerpt gives no such explanation.

Throughout the excerpt, the clinician uses ‘we’ to represent the clinical team in the appointment: “we have (.) a (0.44) bit of a discussion” (lines 1-2), “what we find ↓out” (line 10), “we th↓ink” (line 14). Whilst he is evidencing the collaborative decision-making process, the use of ‘we’ demonstrates the agreement between the
clinicians and therefore the strength of their decision. Dad uses ‘we’ in a similar way in lines 6-8: ‘I think ↓we’ve we’ve discussed I think we’ve (0.28) poured it all ↓out in’t ↓we’. This is a third category of the use of ‘we’ within the excerpts described above and represents the category of the family in the appointment. Dad is referring to himself and the child’s mum and, similarly to the clinician’s use, it demonstrates the unity of the couple.

7.2.1.1 Summary

In all of the excerpts explored so far, the clinician has either proposed a diagnosis and a treatment plan, or confirmed that the cause of the child’s difficulties are associated to mental health and that CAMHS is the right service to address these. In each case, the choice to present the information as a plain assertion with no reference to the evidence for their decision exemplifies the asymmetry in knowledge and authority between the family and the clinicians present. Families also orient to and maintain this asymmetry by responding to the clinicians’ decisions with minimal responses. Within the excerpts presented, three different forms of ‘we’ were identified: medical professionals, CAMHS team, and parents. The use of this pronoun presents the information as coming from different categories of person, each of whom has different levels of knowledge and expertise.

This first section of analysis has focussed on excerpts where a decision is made by the clinicians that there is a mental health concern. The following section will explore the how the epistemic relationship is managed and maintained where a decision is made that there is no mental health concern.

7.2.2 No Mental Health Concern

The following excerpts illustrate how the clinicians maintain the asymmetry in the interaction where a decision has been made that the child’s difficulties do not have a mental health element and, as such, CAMHS is not the appropriate service to be treating them. In contrast to a diagnosis of a mental health related difficulty, the clinicians in the following excerpts reference and summarise the evidence obtained in the appointment thus far to substantiate their decision to discharge the child from the service. Whereas the clinicians in the previous excerpts have used a plain
assertion format for decision delivery, the clinicians in the following excerpts use a *plain assertion + [evidence]* format. It appears that, whilst there is an element of asymmetry that is maintained in the interaction, the clinician works hard to reduce this and works to align the family in the decision making process.

Similarly to the excerpts previously discussed, the diagnostic decision in the following excerpt is delivered following a discussion between the clinicians which the family are not privy to. This again creates a temporal distance between the examination phase of the appointment and the delivery of a diagnostic decision by the clinicians.

Excerpt 38: Family 18

1. Doctor  we’ve had a discussion amongst ourselves
2.          because (the wider team) ( ) see you so we
3.          [just w]anted to
4.   Mum  [umhm]
5. Doctor  (0.30) "I er: (. ) get a better understanding
6.          of what we thought the issues were" (0.51) um
7.          (0.58) from our discussion you know (. ) >we
8.          we< we do understand that there are
9.          significant behavioural issues: (0.23) that
10.         Nathan’s having and th: the question for us
11.         was is there any explanation in terms of
12.         any: (0.32) underlying mental health (.)
13.         disorder (0.33) um >at the moment we don’t
14.         think there is any underlying mental h[alth
15.          ]condition which is driving these< but there
16.          are significant factors and themes that we
17.          have picked up (0.50) as going through the
18.          history (0.29) to probably explain why
19.          (0.25) >you know some of the behaviours are
20.          there< (0.51) >um is it ok to just talk about
21.          what we dis\c\ussed ;yeah<
22.   Mum  [(no)]
23. Child  um
Doctor um (.) >when I’s speaking to Nathan (0.37) the common thing that (.) came out was that there’s < (0.36) um (0.83) a lot of resentment about dad not being there dad going off the picture:

Mum umhmm
(omitted lines 30-37)

Doctor (0.54) um (0.31) and also (0.35) erm: about his behaviour at school (0.46) how he’s behaving getting into trouble with the police
(omitted lines 41-47)

Doctor generally h how he struggles to control his anger when he > when he < when he gets in: his lack of (0.50) er (0.21) > you know < (0.35) to keeping to boundaries or to authority
(omitted lines 52-63)

Doctor ¡so um (0.46) but um (.) yeah THAT’S WHAT that’s what (.) what the main things th th [there are] problems > there are behavioural issues [an (.) the] se are probly the some of the explanations<

Mum [um]

[right]

um

Doctor of why that’s hap happening

The clinician initially offers an explanation for their discussion. As in previous excerpts, he uses the pronoun ‘we’ to refer to himself and the other clinician in the appointment. The use of ‘we’ continues throughout the feedback. In lines 6 and 7, he states that the discussion between the clinicians was to get a better understanding of “what we thought the issues were” from “our discussion”. An epistemic distinction is made between the family and the clinician’s expertise: ‘we’ the clinicians have spoken about and made a decision based on the discussion had with yourselves, a discussion the family are not participants in. This distinction continues through the
following statements of “we do understand that there are significant behavioural issues:” (lines 8-9) and “the question for us was is there any... underlying mental health disorder... we don’t think there is” (lines 10-14). In lines 10-14, the clinician structures his statement to perform the social action of delivering his decision as the expert. Not only this, but the decision made is presented as being in collaboration with another clinician making the epistemic asymmetry in the interaction more pronounced.

In the previous excerpts, the clinicians use a plain assertion format to deliver their decision that CAMHS is the appropriate service for the child. Here however, the clinician works to evidence the decision that CAMHS is not appropriate and the behaviour does not have a mental health element (lines 24-72). In evidencing the decision from the information provided during the appointment, the clinician makes some of their reasoning accessible to the family whilst also treating themselves as accountable for the decision (Peräkylä, 1998).

Despite the references to evidence and reasoning, mum responds in the same way as the parents in the previous excerpts: with minimal acknowledgements of “um” (line 69) and “umhum” (line 29). In responding by withholding talk, she is maintaining the asymmetry in the doctor-patient relationship through a lack of challenge to the clinician’s decision. In being told that the child’s difficulties do not reflect a mental health concern, mum and child are effectively being sent away from the service with a symptom residue (Maynard & Frankel, 2006): they are leaving with same set of symptoms but no conclusive explanation or plan of action other than the knowledge that they can rule out a mental health explanation.

In the following excerpt the child’s mum is again being informed that the clinicians have decided there is no mental health related concern. However, in contrast to the previous excerpt, this is the decision that the mum and child were aligned with. The referral had been instigated by the child’s dad who is not present at the appointment and was refuted by the child’s mum earlier in the appointment. Despite the difference in parental opinions in the previous and following excerpts, the strategies for acknowledging and maintaining asymmetry in the interaction remain the same.
Excerpt 39: Family 15

1 Therapist and I guess that is the: the bit bit that we
2 are thinking about that there has been a lot
3 of changes an um: (.) you know (.) schools
4 changes in (.) you know (.) living with (.)
5 mum (.) living with dad and living with mum
6 again you know it’s (0.38) it’s kind of like
7 uh things that are quite upsetting (0.43)
8 and um (.) also kind of like thinking about
9 changes in the family’s what you were
talking about dad having new (0.26) wife
10 Child “yeah”
11 Therapist and uh (.) also mum of course has a (.) a
12 new (.) husband you know but (0.27) I guess
13 those are (.) things that are (.) quite
difficult to get your (0.40) head around and
14 kind of like find eh (0.39) how things are
15 (0.30) at the moment (0.87) em: (0.36) but
16 (.) on the other hand what we were (0.32)
17 actually (.) getting the impression from
18 listening to you (0.64) is that there’re not
19 (0.56) any: (0.99) mental health issues
20 really that we were really concerned from
21 hearing you and we don’t think really that
22 that there is (0.49) mental health difficulty
23 (0.31) as such (.) that would worry us (0.27)
24 um er: th- and would in a way (0.51) mean
25 that (0.82) we would be the best service for
26 you to be involved (0.58) and that is our
27 initial impression (0.57) and clearly you are
28 saying that your experience of actually
29 looking after Bentley in the past (0.45)
30 th[ree m]onths
31 Mum [yeah]

(Omitted lines 33-56)
The decision that the child’s difficulties are not related to his mental health is stated explicitly in lines 20-25. The clinician makes the assertion that “we don’t think really that that there is mental health difficulty” (lines 22-24). He uses the authoritative ‘we’ throughout the diagnostic sequence and marks its significance with ‘actually’: “we were actually getting the impression from listening to you is that there’re not any mental health issues” (lines 18-21). By prefacing the diagnostic decision with ‘actually’, the clinician is displaying the diagnosis in contrast to the suggested problem presented by the family (Heath, 1992). In this instance, the child’s mum was not responsible for the referral and does not agree with his father’s opinion that the child has a mental health related difficulty. Despite the agreement with the decision, mum again responds by withholding talk and instead produces the minimal acknowledgment token “yeah” in lines 32 and 60. Whilst the mum in the previous excerpt also responded in this way, this suggests that regardless of the parent’s agreement or disagreement with the clinician’s decision, their priority in the interaction is to maintain the asymmetrical epistemic relationship.

The clinician reduces the inferential distance between building a case and their decision by making reference to the evidence that has been gathered from “listening to you” (line 19). Following the decision delivery, the clinicians continue to provide evidence illustrating why they have come to the conclusions they have and also discounting contradictory information that potentially undermines their diagnosis. Similarly to the previous excerpt, the clinician is making himself and his colleague accountable for the decision. Following the orientation to the evidence from the therapist, the Doctor present in the appointment continues to add additional
information confirming the legitimacy and competence of their decision. Despite the child only having lived with Mum for three months, he legitimises Mum’s opinion stating that “he’s had a good chunk of time with you” (lines 57 & 59). He continues his turn by asserting his position as the medical authority in the interaction and not only reinforces the decision of no mental health problem, but directly refutes the diagnosis of bipolar that had been proposed by the child’s father in the referral: “in bipolar you would notice a variation in mood and you’re not noticing anything really” (lines 62-64). The clinician in the following excerpt also directly refutes the opinion of a third party and their management of the situation.

Excerpt 40: Family 8

1. Doctor they the (0.39) concerns of |school about the
   self-hast (.) urm
2. (0.99)
3. obviously they are worried |and (0.32) an th-
   th- that’s a fact [but I think]
4. FSW [yeah]
5. Doctor one of the |things that |we’ve been dis=
6. discussing is
7. (1.03)
8. perhaps
9. (1.63)
10. >they’ve been using |it in not the right
11. |way< (0.48) and (. ) |in a way have |been
12. re-enforcing |that
13. FSW °yeah°
14. Doctor so the way that (0.23) he he wants to |get
15. get away [from s]chool
16. FSW [yeah]
17. Doctor (. ) is by doing |that [because it]
18. Mum [yeah]
19. Doctor works [|that’s what hap]pens
20. FSW [yeah]
21. Doctor [he does] |that and he goes home
22. Mum [yeah]
The doctor cites the reason for the child’s referral prior to delivering their diagnostic decision. He demonstrates understanding for the school’s position and legitimises the referral based on the concerns they have: “they the concerns of school about the self-harm urm obviously they are worried and an th- th- that’s a fact” (lines 1-5). However, he then continues to explain that, whilst the school have legitimate concerns, they are not managing the child’s behaviour in the right way, and instead are “in a way have been reinforcing that” (lines 13-14). The doctor is making a claim about the incorrect handling of the child’s behaviour and how that may be exacerbating the problem. In doing so, he is asserting that he has the expertise to be able to make a judgment about the impact of the school’s reaction and to also advise on best practice in the situation. These assertions provide a platform to deliver the decision that the child “is not mentally ill... this is all about behaviour” (lines 44 & 46). As the referral was based on the school’s concerns, and the doctor has acknowledged and refuted them, the diagnosis of no mental health concern becomes evidenced, understandable and credible.

Heritage and Stivers (1999) suggested that where a clinician’s diagnosis is that there is no problem warranting medical intervention, during the interaction they must ensure that this is clearly conveyed to the patient so there is no misunderstanding. The repetition of the diagnostic decision makes clear to the child and their family that the difficulties they are experiencing are not a result of their mental health. In this excerpt, the clinician addresses the potential symptom residue of the self-harming behaviour by offering an explanation outside of mental illness: “this is all about behaviour” (line 6). The emphasis on ‘all’ again reinforces the fact
that there is no mental health problem and asserts the clinician’s authority as the person knowledgeable enough to recognise that.

Although the family spent time during the appointment building a case suggesting a need for specialist mental health intervention, consistent with other families, there was a lack of response to the clinician’s decision. In every excerpt thus far, the parents have given minimal responses to the clinician’s decisions whether these have been of a mental health related concern or not, or whether the parents have agreed with the decision or not. Through their lack of response, parents show an orientation towards and uphold the epistemic asymmetry in the interactions.

7.2.2.1 Summary

When delivering a diagnosis of no mental health concern, clinicians link their decisions to the evidential basis established during the course of the appointment. They maintain their epistemic authority in the interaction by demonstrating their accountability for the decisions made. They also continue to use the pronoun ‘we’ to refer to the members of the clinical team in the appointment. This distinguishes them from the family present and further contributes to the maintenance of asymmetry in the interaction. Asymmetry in the interaction is maintained through this style of delivery by explicating the decision-making process and demonstrating the clinician’s accountability as well as the specialist knowledge required to make an informed decision.

During the course of decision delivery where there is no mental health concern, parents and children alike continue to respond with minimal acknowledgments to the news. Regardless of whether the family agrees or disagrees with the decision given, they withhold talk and appear to defer to the clinician’s expertise. In responding in this way, the asymmetry in the interaction is maintained with the clinician informing the family of the decision and the family acknowledging the information provided.

7.3 Extended Responses to Decision Delivery

As illustrated in the analysis above, families maintain the asymmetry in the interaction with the clinician during decision delivery by providing a minimal
response to the decision. The following analysis, however, will consider cases where extended responses are given by patients, how these are achieved epistemically, what occurs between the clinician and patient in terms of the dynamics of the interaction, and the effect this has on the nature of the relationships within the interaction.

While, in most cases, responses by families to the delivery of a diagnostic decision are relatively limited, there are occasions when the response is extended. Peräkylä (2006) observes that following a diagnosis, extended responses tend to be more likely when the clinician accompanies the diagnosis with an explanation of their reasoning behind the decision. Whilst an extended response, or commentary on the diagnosis, may at first glance appear to reduce the asymmetry in the interaction, even when refuting the diagnosis families still maintain the imbalanced epistemic relationship through their choice of utterances. The following excerpts are taken from two different families, both of whom receive a diagnostic decision of no mental health related problem. The families in both instances receive the diagnosis with a different reaction: one accepts and agrees with the decision, and the other disagrees with the decision. In both instances, they eventually give extended responses which maintain the asymmetry in the interaction despite the responses differing in nature and content. Within the sample of 15 families, there were only two cases where the parents gave extended responses to the clinician’s diagnostic decision, demonstrating their potentially difficult interactional nature.

The following excerpt is a continuation from Excerpt 40, discussed previously in the chapter. Mum has been informed that the child’s behavioural difficulties are not deemed to be related to his mental health and do not require specialist CAMHS intervention. She gives an extended response following the clinician’s decision delivery but continues to maintain the asymmetry in the interaction through the information she provides. The interaction continues in a similar vein until its close (see Appendix 12 for a continuation of the excerpt).

Excerpt 41: Family 8

1 Doctor (0.37) em (0.36) so we're quite quite
2 confident in that respect (0.64) um
I think as well with you you seem to be growing in confidence as a mum (0.52) ((mum nods)) you had a lot of (0.33) you know difficult times (0.38) ((mum nods)) your growing more confident as you know as (0.55) more comfortable with being [( )] doing stuff

see: at first I weren’t (0.29) I wouldn’t go out me ’ouse or a[nything] you know cause of what was happening to me

yeah

I wouldn’t go out me ’ouse (0.35) but then I got to the stage where I thought well (0.86) I can’t ‘ide anymore I’ve gota (..) go out in the [open] world an

[yeah]

(0.43)

face people and that an

and that makes a big difference when you’re feeling more comfortable an c[onfident]

The extended response by Mum is elicited by the clinician’s observation that her parenting is improving and she is becoming more confident (lines 3-9). This is an area in which mum holds the expertise and is in K+ as the clinician is passing comment on her own lived skills and experiences. Mum provides evidence and an explanation for the “growing in confidence” (line 4) and “difficult times” (line 6) the clinician has made her observations about. The implication of the clinicians deciding the child’s challenging behaviour is not a result of an organic problem is that it has an environmental cause, and by passing comment on the Mum’s parenting there is a suggestion that this may be a possible contributor to the behaviour; Mum is being made accountable for the child’s behavioural pattern. The content of Mum’s response is therefore an account of the reasons why her parenting may not have been
as good as it could have been: “I wouldn’t go out me ouse or anyth[ing] you know cause of what was happening to me” (lines 11-13). It also takes the form of a defence of her parenting including evidencing its improvement and her change in mind-set: “I got to the stage where I thought we’ll (0.86) I can’t ide any more I’ve gotta (.) go out in the [open] world an (0.43) face people” (lines 16-23). Despite Mum being the expert in terms of communicating her own experiences, the act of explaining the challenges she has faced positions her behaviour as accountable to the clinician and potentially places her in a negative context.

Although Mum is offering an extended response rather than minimal acknowledgement, she continues to maintain the epistemic asymmetry in the interaction. She does not comment on the clinician’s decision or on the implication of her child’s behaviour being linked to her own. Instead, she focuses her responses on her own experiences where she holds an epistemic advantage. She begins her extended response with “see:” (line 11) which marks it as interactionally difficult, before qualifying the clinician’s comment with her experience. At the end of the excerpt, the clinician re-takes control of the interaction and reasserts his authority as an expert through his evaluation of the positive impact the changes will make on parenting and the child’s behaviour: “that makes a big difference when you’re feeling more comfortable an [confident]” (lines 24-25).

The following excerpt differs in that the extended response is formulated as a direct disagreement with the clinician’s diagnostic decision. Cases where patients challenge a clinician’s diagnosis are uncommon (Pilnick & Dingwall, 2011), and within the data set this is the only instance in which direct disagreement occurs. This demonstrates the interactional difficulty families have in disagreeing with the clinicians’ decisions in the context of the appointment. Where disagreements around diagnoses occur, a balancing act is played out in the interaction; the patient or their family are communicating a disagreement with the clinician but still defer to the clinician’s authority in the context of the medical appointment. Mum uses a variety of interactional techniques to maintain the asymmetry in the interaction in the clinician’s favour whilst still imparting her opinion. Immediately prior to the excerpt beginning, the clinicians have presented the diagnostic decision they have come to.
Rather than stating her disagreement, Mum hedges her difference of opinion as a “concern” (line 1), demonstrating a patient’s need to avoid disagreements (Heath, 1992). Mum continues to hedge her preface, deferring to the clinician’s position as expert and stating her position as a lay person who does not “profess to know (. ) (have) the knowledge because (. ) e I don’t” (lines 1-3). In contrast to her positioning, she is about to present information contrary to the clinician’s decision and potentially undermine his expertise. The use of her status as “his mum” (line 6) immediately puts the information she has in to a context that the clinicians cannot access; they cannot take on the role of the child’s mother and therefore can only disagree with her opinion as medical experts. The emphasis placed on ‘mum’ also reinforces the significance of the role and expertise that accompanies it. By invoking the category of ‘mum’, she is making a claim to knowledge and to have access to a different expertise to the clinician. Peräkylä (2006) observed that one of the primary resources patients utilise when disagreeing with clinician about a diagnosis is to reference evidence only they have access to, thus protecting their account from disagreement and being undermined. Mum also cites “research I’ve been doing myself” (lines 6-7), which introduces third party evidence that, through being referenced as ‘research’, is creditable and puts Mum in a knowledgeable position for the remainder of her disagreement. However, she prefaces the research she has done by stating “I can only go on...” (line 5) placing her knowledge as still being inferior
to the clinical knowledgeable position. The research she is citing could be as much
discreditable as creditable. The following excerpt is a continuation of mum’s
disagreement. Here, she moves away from the task of prefacing her disagreement
and begins presenting her evidence.

Excerpt 43: Family 18 (continued)

13 Mum even when Nathan: (0.76) good
14 (1.64)
15 <he’s ↓hard to manage>
16 Therapist UM
17 Mum and this is not (. ) just my own perception
18 Therapist [um:]
19 Mum (0.40) erm this is (. ) from a ↓person that
deals with children’s difficult behaviour
every day in her profession
20 Therapist [um]
21 Mum (0.59) um: she actually had ↓Nathan for about
ten days (0.48) and she said that (. )
22 Therapist [um]
23 [lit]erally had to be on ‘im (. ) <ALL THE
24 [TI]ME>
25 (Omitted lines 29- 37)
26
27 Therapist [um]
28 [um]
29 (Omitted lines 38- 45)
30 this is why: (. ) when I (. ) wrote my letter
31 (0.87)
32 In (0.24) response to the:
33 Therapist ye:[s]
34 Mum [doct]or’s um: (. ) referral
35 (0.92)
36 he does fit in to a (0.26) nearly EVERY
37 ↓aspect and characteristics of what I (0.41)
38 asked you to look into
39 Therapist [um] ((nods))

Mum continues by evidencing her disagreement with an account of the child’s
behaviour from a third party, referencing evidence that had not previously been
presented to the clinician delivering the diagnosis (it had been mentioned to the second clinician during the part of the appointment where the Mum and Child separated). She indirectly acknowledges her weaker epistemic position in the interaction by referencing the credentials of the third party, stating that the person “deals with children’s difficult be[hav]iour every day in her profession” (lines 19-21). In detailing the experience of the third party, Mum is maintaining the asymmetry in the present interaction by indirectly admitting that she does not have the expertise to negotiate with the clinician’s medical perspective. However, Mum has evidence from someone who does have experience and expertise in the area her child is struggling with. In referencing the third parties evidence, mum is making a much stronger claim than her reference to ‘research’ in the previous extract. It is more difficult for an alternative claim to professional knowledge by the clinicians to discredit a witnessing claim (Hutchby, 2001). Mum also uses an extreme case formulation in a stronger tone of voice when constructing her claim from the third parties evidence: “a:nd she said that (. ) [lit]erally had to be on ‘im (. ) <ALL THE TIME>” (lines 24-26). As detailed when exploring how families build a case, extreme case formulations enable speakers to provide the most extreme and convincing version of their account (Pomerantz, 1986). Mum is building a case for her disagreement with the clinician’s decision, similarly to the clinician’s evidencing their decision of no mental health concern.

A common feature of patients’ responses in interactions where the clinician’s diagnosis is of no problem, or a lesser problem than was originally anticipated, is for the patient to use the opportunity to justify their having sought specialist medical help in the first place (Heath, 1992). When attending a medical appointment, patients orientate to presenting their concerns and reason for attendance as ‘doctorable’ (Heritage & Robinson, 2006). In lines 38-42, Mum states that the reason she sought the referral was because of the experience of the third party when looking after her son. In justifying her help seeking, she is deferring to the clinician’s knowledge as the expert in the current situation. However, it is interesting to note that mum asserts her own authority on lines 44-46 where she states that “he does fit in to a (0.26) nearly EVERY aspect and characteristics of what I (0.41) asked you to look into”. She takes the authority away from the clinicians by stating that she has
asked them to look in to a specific condition as opposed to them making their own judgment about the child’s behaviour. She then also undermines their accountability by informing them that her son does fit the diagnostic specification for the particular condition.

The final section of the response is presented in the following excerpt. Mum rounds off her case and the clinicians respond. While continually showing an orientation to the clinicians as experts, mum’s claims to epistemic advantage peaked in the previous excerpt with her presentation of evidence. In the following excerpt, she begins to reorient herself and her claim becomes weaker.

Excerpt 44: Family 18 (continued)

48 Mum (0.71)
49 I know >that you do have to look in to the past and (know it’s) got a lot to do with it<
50 Therapist um
51 Mum but (0.33) PERsonally (. ) I don’t think it is all that (0.39) I really don’t
   (Omitted lines 54- 60)
52 Doctor >okay th the feedback that we (have) given obviously< doesn’t answer your question so
53 Mum um
54 Doctor what do we do from ;here
55 Mum ye[ah]
56 Doctor [ ;ye]ah (0.32) so: >what we’re gona do from ;here< we we after you ;leave we’ve got a team meeting ;here s[o (we’ll b]e ;saying)
57 Mum [um hum]
58 Doctor (0.38) you know we’ve seen you today and (0.23) [this is] the: an off you go
59 Mum [YEah]
60 Doctor (0.57) so we we (.) >wana discuss it< (.) get more heads so we’ve got two heads
61 Mum ye[p]
77 Doctor: [an]d we’ll get another four heads in this room.
78 Mum: yep.
79 Doctor: [com]ing here (right) (.) >so what we’re gonna do: is we’ll ave a discussion with [them (.)
80 see what people sug]est.
81 Mum: [umhm]
82 Mum: umhm

Following Mum’s challenge to the clinician’s authority and accountability, she reverts to appealing to the clinician as the expert by stating that she “PERsonally” (line 52) does not think the child’s behaviour is all to do with past events in his life. Her use of ‘personally’ and the emphasis at the beginning of the word accentuates the notion that what she has been expressing is her opinion as a lay person with little or no medical expertise. The following utterance in the turn is hedged with an epistemic downgrade (Heritage, 2013) “I don’t think” (line 52) which lies in stark contrast to the certainty with which she asserted her view in the previous excerpt that the child fits the diagnosis she had requested CAMHS explore. In softening her disagreement, Mum re-establishes the asymmetry in the interaction to favour the clinicians. Although such challenges do not always lead clinicians to reconsider their diagnoses (Heath, 1992), in this instance it does appear to. The clinicians manage the confrontation by deferring the final decision to the wider CAMHS team with whom they will meet after the appointment. The clinicians have regained control of the interaction and are able to assert both their authority in reviewing the diagnosis and their accountability in ensuring the right diagnosis is given. However, they also defer their expertise to others within the CAMHS team: “so we we (.) >wana discuss it< (.) get more heads so we’ve got two heads ...[an]d we’ll get another four heads in this ↓room ... ↓coming here (right) (.) >so what we’re gonna ↓do: is we’ll ave a discussion with ↓them (.) see what people sug↓gest” (lines 73-81). The clinicians have acknowledged mum’s disagreement with their decision and that she feels her questions have not been answered sufficiently in the appointment. In response, they have proposed a subsequent phase of discussion with the extended clinical team, all of whom possess medical expertise that mum does not. Their notion that they will have a discussion and “see what people sug↓gest” (line 81) may produce a new
proposal that would satisfy mum’s questions and align with her opinion, however it may not. Regardless of the outcome of the additional clinical discussion, there will have been “more heads” involved in the decision, thus weakening mum’s position to object.

7.3.1.1 Summary

Extended responses to diagnostic statements are rare within the data set and are restricted to a ‘no mental health problem’ decision. They appear both as a disagreement to the diagnosis presented and as an explanation of seeking medical advice. When considered alongside the effort families put in to building a case (see chapter 6), a diagnosis of ‘no mental health problem’ undermines the accounts given and the need for specialist intervention. During the extended responses, parents represent information provided when building a case, suggesting an attempt to legitimise their seeking help from specialist services. When giving an extended response, families hedge their turns, demonstrating an orientation to the asymmetry in the interaction, with the clinician as expert. Families also use accounts of their own experiences, information which only they have access to, to evidence their claims. The use of evidence in reacting to a diagnosis of no mental health difficulty again legitimises the case for seeking medical intervention, but also elevates their position within the interaction as experts about their child.

7.4 Conclusions

Through analysis of the delivery of diagnosis, the chapter explored how both clinicians and families established and maintained epistemic asymmetry through their interactions. The chapter began by examining how the asymmetry is maintained in the clinician’s delivery of the diagnosis. From the data, it appears that where a diagnosis is delivered which either includes or alludes to the presence of a mental health problem that can be treated within CAMHS, the clinicians use a plain assertion format to communicate their conclusions; clinicians delivered the diagnosis with minimal reference to the evidential reasoning that led them to the decision. Contrary to research by Peräkylä (1998; 2006), the positioning of the delivery of a diagnosis relative to the presentation of the evidence by families in the building a case phase does not appear to influence the method of diagnosis delivery. For some
families in the current data set there was both an interactional and physical break between building a case and diagnosis delivery yet clinicians still used a plain assertion format to communicate their decision. This demonstrates the orientation to authority by the clinicians in the delivery of a positive diagnosis.

The clinician’s choice of pronouns also maintains the asymmetry in the interaction where a diagnosis of a mental health problem is proposed. Clinicians appear to use ‘we’ when referring to themselves as opposed to ‘you’ to refer to the patient. The use of ‘we’ occurs where clinicians are delivering their decision and is used to encompass both clinicians present in the appointment and, occasionally, the wider CAMHS team. In contrast to ‘you’, the pronoun ‘we’ highlights the inclusive authority of the clinician’s decision and the segregation between the clinical team and the families attending the appointments.

Where clinicians deliver a decision that the child’s symptoms cannot be attributed to a mental health problem, the style of diagnosis delivery differs considerably from that of confirmation of a mental health problem. The delivery is interactionally longer than that of a confirmatory diagnosis, due predominantly to the clinicians evidencing their decision. In contrast to the plain assertion format used when there was a mental health related problem, the clinicians spend time explicating the evidence that led them to their decision. Referencing the evidence demonstrates the accountability of clinicians for the decisions they are making and suggests they have to work harder in the interaction to prove their diagnosis where they decide there is no problem. In demonstrating their accountability, they are also re-establishing their authority through asserting their position as the experts making a judgment about whether the child is experiencing a mental health problem.

The data presented also shows the part played by the families’ receipt of the diagnosis in maintaining the asymmetry in the interaction. Within this data set, the most common response within the diagnostic phase was the use of minimal acknowledgments to the clinicians’ utterances. Minimal responses not only allow the progressivity of the interaction (Peräkylä, 2006; Robinson, 2003), they also appear to play in to the epistemic asymmetry. Acknowledging the clinician’s decisions without an agreement or disagreement allows the families to avoid appearing to imply that
their knowledge is of equal status to that of the clinician (Heath, 1992). Minimal acknowledgments were used regardless of the clinician’s diagnosis. As Heath (1992) notes, it is rare for patients to respond in a way that may challenge or disagree with the clinician’s opinion. The lack of response by patients, however, contributes to a lack of information received which then exacerbates the asymmetry not just in the current interaction but in future interactions regarding the same set of symptoms.

In the data set of 15 families’ appointments, only two families gave extended responses to their diagnoses. In both instances, the diagnoses were of no mental health related concern, but in one appointment the diagnosis was welcomed, and in the other it was not. When giving extended responses either agreeing or disagreeing with the clinician’s decision, the parents in the interactions show an orientation to and awareness of the clinician’s authority. In both instances they hedge their responses and, in Family 18 where the parent disagrees emphatically with the decision, she defers to the clinician’s authority before she begins her retort. Interestingly, in both instances the lack of a diagnosis of a mental health related problem within the child leaves parenting- and nurture-related explanations for the problem behaviour. Although the responses to the diagnoses look quite different, each contains a defence of parenting in some form. The Mums in both cases show an awareness of the clinicians’ medical authority in the decision by using evidence that only they, as parents, would have access to.
8  CHAPTER EIGHT: DISCUSSION

8.1  Introduction

The focus of this thesis has been on using conversation analysis to explore the interactions that occur within initial assessment appointments at a child and adolescent mental health service. Within this broad aim, analysis has honed in on features of clinician’s, children’s and parents’ contributions to the interactions and explored the function they serve within the wider appointment and doctor-patient dynamic. Conversation analysis enables interactions to be explored in fine detail in order to understand how social actions are performed by the participants (Antaki, 2011). Specifically, this thesis has focused on the interactions between clinicians and families, uncovering the intricacies of their communication and the impact their interactional choices have on the structure and content of the appointment. The thesis has detailed the evidence for, and maintenance of, epistemic asymmetry in the interactions, as well as the way clinicians ask questions, the effect this has on the families responses, and the devices used by families when presenting information to the clinicians; actions performed by both parties through their talk-in-interaction shape the processes and outcomes of the appointment.

The appointments followed a similar structure to that of general medical appointments, outlined by Byrne and Long (1976) and ten Have (2001). Whilst clinicians tended to ask questions with families responding, families were active participants in the interaction, especially when presenting the case for their child needing specialist intervention. Within institutional interactions, there is a tendency for one party to ask questions and the other to respond (Jones, 2001) and this was found throughout the analysis. The epistemic asymmetry shifted between interactants over the course of the appointment with rights to knowledge being relatively equal in most cases when establishing the reason for attendance (although this question answer sequence did alter the epistemic balance in some cases). During the middle phase of the appointment where parents built a case for their child’s difficulties, parents held the epistemic advantage as experts on their experiences and the child’s difficulties. This then shifted again at the end of the appointment where
the clinicians reasserted their epistemic authority when delivering a decision about the child’s difficulties and future mental health care needs.

This final chapter will summarise the key findings from each of the chapters and then address the research questions outlined at the end of Chapter 1. The findings will be discussed in terms of their contribution to the wider field of communication research in health care and their application to the context from which they were derived. Recommendations for future research will be outlined, and the limitations of the study considered. The final section of the chapter will focus on reflexivity, considering the effect of researcher involvement on the data collection and analytic process.

8.2 Analytic Interpretations

8.2.1 Main Findings

The following section summarises the main findings from each of the chapters, giving an overview of the analysis and situating it within the wider context of mental health assessment appointments.

8.2.1.1 Establishing the reason for attendance

One of the main assumptions underlying conversation analysis is the notion that interaction is created through turn taking, sometimes in the form of question-answer sequences (Drew, 2013). A feature of turn taking is that each turn is shaped by the preceding turn; participants in an interaction interpret the action that is being performed by the speaker in their turn and respond accordingly (Schegloff, 2007). In health care interactions, this is no different. Clinicians and patients undertake the activities of a medical appointment through the medium of talk, with each participant performing social actions with their questions and responses. When clinicians attempted to establish a reason for attendance, they requested the information with variations of the question ‘do you know why you have come here today?’. Within the data set, the question was posed with a ‘do you know + why interrogative’ formulation. In prefacing the question with ‘do you know’, the clinicians put an epistemic focus on the child and their response, querying their knowledge.
In some cases, the sequence of establishing the reason for the visit did not occur. Where this sequence did occur, however, it was always initially directed at the child. Given the child-centred perspective of child and adolescent mental health services, this is an important sequence of interaction. The clinician is initiating the appointment with a request for information directed to the child about their understanding and reasons for being referred to CAMHS. Not only does this recognise the child as being central to the appointment, but it also allows the clinician to gauge the child’s knowledge.

Children responded to the clinician’s request for knowledge in three different ways:

1) Giving a candidate diagnosis;
2) Giving a lay explanation;
3) Claiming insufficient knowledge.

Where children responded with a lay explanation or a candidate diagnosis, they treated their responses with caution, orienting to the asymmetry of the doctor-patient relationship and the epistemic dynamic. Where children responded with a claim to insufficient knowledge, their replies were not always treated by the clinicians as reflections of their cognition. Clinicians tended to probe a child’s response of ‘I don’t know’, either rephrasing the question or probing with responses such as ‘has mum not told you why’. In probing with phrases such as ‘has mum not told you why’ the clinician made a statement about the child’s level of knowledge in relation to the other people in the appointment.

There were occasions within the data where the clinician did not engage in establishing the reason for attendance. In these instances, the clinician tended to tell the child and family what the referral had said and why they had been referred. This again has implications for the epistemic balance in the appointment with the clinician holding the relevant information and informing the family of the facts. Not only this, but they are informing the family of the difficulties they have a lived experience of and have actively sought help for. In future research it would be interesting to explore these deviant cases in more detail, looking at how the clinician presenting the information to the family is responded to and whether it affects the way parents subsequently build a case for their child’s difficulties.
8.2.1.2 Building a case

Following the clinicians establishing the reason for the referral, in acute medical appointments patients go on to problem presentation. Whilst this phase was still present in these CAMHS initial assessment appointments, it is referred to here as building a case. This is because, unlike in acute medical appointments, this was the opportunity families took to not only present the problem, but to explain their experiences to the clinician. There was not an examination phase in these appointments as, physically, there is very little to examine unlike in general, physical, medicine. Instead, the examination phase occurred verbally with families attempting to present their case for the need for specialist mental health intervention. Building a case was an activity which almost exclusively involved the clinicians and parents. Clinicians asked questions that directed the interaction but parents held the majority of the interactional space. The child was rarely addressed directly and had little opportunity to interject in the interaction.

When parents engaged in building a case for their child’s difficulties, they employed numerous interactional strategies to strengthen their point and ensure the clinicians understood the roots of their concerns. In this thesis, four different strategies were identified and discussed that were all used by parents to perform particular actions during their presentation of the child’s difficulties. These strategies were:

1) The use of extreme case formulations;
2) Using a ‘they said X but Y’ contrast structure;
3) Witnessing;
4) Making comparisons to others.

Parents used these strategies both independently and in conjunction with each other. Each strategy was used with the same purpose, but each worked to perform a slightly different social action. When used in the context of persuasive communication when building a case, they worked to demonstrate to the clinicians the extreme and unusual nature of the child’s behaviour, portraying this as abnormal and thus requiring specialist intervention.
8.2.1.3 Decision Delivery

When delivering a decision to families regarding their child’s difficulties, clinicians varied their delivery style depending on the decision that had been made. Where a decision was made that the child’s difficulties were related to their mental health, clinicians used a plain assertion delivery style. They informed the family of their decision and their plan for treatment without evidencing their decision or referencing the information given during the appointment. When delivering the decision that a child’s difficulties were not related to their mental health, clinicians prefaced their decision delivery by giving evidence from what they had heard in the appointment and the discussions they had between themselves. The lack of evidence given when the decision was in favour of a mental health related problem asserted and maintained the clinician’s authority in the relationship and their right to knowledge. In evidencing their decision where there was not deemed to be a mental health related problem the clinicians presented themselves as being accountable for the decision they had made.

Regardless of the decision made by the clinicians, or the way in which the decision was presented, families gave little in terms of a response to the clinicians. No response was given by the child or young person unless the decision was directed at them or their parents were not present. In the majority of cases, the child’s parents were the ones who responded to the decision. Responses generally took the form of a minimal acknowledgment of the information. In two cases the parents engaged in an extended response to the clinician’s decision of no mental health problem. In both of these cases, parents still worked to maintain the epistemic asymmetry despite, in one case, disagreement with the clinician’s decision.

Throughout the decision delivery, the clinicians’ use of pronouns also asserted and maintained the epistemic relationship between themselves and the patients and family. They used ‘we’ to refer to themselves as clinicians in the appointment but also to refer to themselves as a part of the medical community; a community which holds certain rights to knowledge that the lay community does not. This was then contrasted with the use of ‘you’ to refer to the family which created a distinction between the clinicians as experts and the family as lay people.
8.2.2 Addressing the Research Question

The original research question, outlined in Chapter 1, was to examine and understand how clinicians and families in initial assessment appointments in CAMHS managed the organisation of access to services. In order to answer this question, it was broken down into four smaller questions. Each of these will now be discussed in the context of the findings from the analysis.

a) How do clinical professionals interactionally organise access to services?

The objective of clinicians during the initial assessment appointment is to assess the appropriateness of CAMHS for the child and deliver a decision and possible treatment plan, depending on the result of their assessment. They have a number of options available to them in terms of the decision that can be made. During the course of the appointment and when making and delivering their decision, the clinician acts as a gatekeeper for access to the service. They must manage the interaction, expectations, and their contribution to the decision delivery in such a way as to ensure families understand the decision and the process that has been completed. This was achieved through the orientation and management by both the clinician and the family to the epistemic relationship between the two parties. Through each phase of the appointment analysed, epistemics and rights to knowledge played an integral role in the formation of questions and responses, and thus the interaction as a whole. This will be discussed further in the following sections.

Additionally, clinicians interactionally managed the patients’ access to services through the delivery of the decisions they made about the cause of the child’s problems and the most appropriate course of action. This decision was generally made during a separate discussion away from the family before reconvening with the family and child and communicating the information to them. Their options included:

5) Diagnosis given of a mental health related problem with clinicians naming the probable or possible diagnosis (for example, anxiety disorder or phobia).
6) Diagnosis given of a mental health related problem without clinicians naming the diagnosis.
7) Diagnosis given of no mental health related problem.
8) No diagnostic decision is made or given, with clinicians either arranging a follow up appointment or further observations.

Clinicians followed a plain assertion format when delivering a decision of a mental health related concern, despite a temporal distance between the end of the main body of the appointment and the delivery of their decision. Clinicians used a plain assertion format whether they gave a diagnostic label or informed the family that the difficulties were related to the child’s mental health. In communicating the decision in this way, clinicians simply gave their conclusion without linking it to the evidence that led them to it. Whilst this format may be considered in practice to provide a clear and concise conclusion for the family, the analysis demonstrated that it also worked to establish and maintain the clinicians’ epistemic status as the expert in the interaction.

When the child’s difficulties were considered to have a cause other than mental health, the clinicians deviated from the plain assertion format. In their turns prior to the decision delivery, clinicians worked to evidence their decision by referring back to the information given by the family and linking this to their knowledge of what constitutes a mental health difficulty. On occasions where a diagnosis had been suggested by the family earlier in the appointment, the clinician often made reference to this in the context of informing parents of the behaviours and difficulties they would expect to see from a child presenting with the diagnosis suggested. Clinicians then referred back to the evidence provided by the family and their own observations of the child during the appointment to dispute the diagnosis. In evidencing their decision where it was considered that there was no mental health related problem, clinicians made themselves accountable for their decision. Referencing medical knowledge that their professional status gave them access to also maintained their position as expert even though they could not provide the family with a definitive explanation.
The decision made by clinicians regarding the child’s mental health and possible interventions either gave the family access to the service and expertise it holds, or closed the service to them for the problems the child was presenting with. Clinicians showed an awareness of their role in this and occasionally made direct reference to the importance of having more than one clinician to make a collaborative decision. Additionally, in each case analysed, the clinician used the pronoun ‘we’ when describing the decision making and reasoning process and when delivering the decision. Interactionally, the use of ‘we’ worked to reinforce the clinician’s authority and was used in contrast to ‘you’ to refer to the family. Whilst clinicians may not have given much thought to the pronouns they used during this phase of the appointment, the analysis showed that they worked to position the clinicians as separate from the family, and in some cases as members of a wider group of medical professionals with access and rights to specific knowledge; a group the family was not a part of.

b) Where and how is the child given the opportunity to articulate their opinions about the difficulties they are facing?

Child centred practice is an integral aspect of the way CAHMS is structured and is the philosophy behind the majority of communication that happens within the service. Child centred care means that the child is put at the centre of interactions be they assessments or therapeutic, decision making, and treatment plans and their opinions should be sought, listened to, and considered throughout the process (Robin, Callister, Berry & Dearing, 2008). However, children are often afforded half membership in interactions where their parents are also present (Hutchby & O’Reilly, 2010). Parents tend to self-select as the next speaker if a child appears to be in interactional difficulty, and once this happens it can be very difficult for a child to re-enter the conversation (Shakespeare, 1998).

Over the course of the analysis, each of the participants in the interaction has been considered. Whilst the appointment centred on their behaviours, their history, their home life, the difficulties they were having, children themselves were actively involved in very little of the interactions analysed. Of the three phases of the appointment analysed in this thesis, children’s views were only actively sought when
establishing the reason for attendance. Whilst decision delivery was aimed at the child in two instances, the nature of decision delivery meant that the clinician directed their talk to the child rather than making the child an active member of the interaction. When parents built a case for their child’s difficulties, the interaction became solely focussed on the parents and clinician. In some instances, the child had been removed from the room and taken elsewhere to speak to another clinician to gauge their views and opinions. However, there were cases where the child was still present in the appointment and the clinician and parents talked around them.

The children were given the opportunity to articulate their opinions about the difficulties they were facing during the initial phase of the appointment. Clinicians directed their questioning to the child and allowed the child interactional space to respond. Where no response or a claim to insufficient knowledge was provided by the child, the clinician generally pursued the child’s opinion for a few turns before then turning their attention to the child’s parents. Where children were able to respond comprehensively to the request, the interaction remained focussed on them until the phases of the appointment transitioned.

After contributing their understanding of why they were attending the appointment, and the epistemic dynamic being reasserted, children did not generally contribute to the remainder of the main appointment unless addressed directly by their parents or the clinicians. This reinforces the notion that once children have been interactionally excluded, it is particularly difficult for them to re-enter the interaction unless directly invited (Shakespeare, 1998). This finding has implications for the way clinicians interact with children and young people within CAMHS assessment appointments; appointments which are theoretically child-centred.

The positioning of the child within the interaction was particularly interesting. The appointment itself was made for the child, was focussed on the child and their difficulties and its outcome made a statement about the child’s mental health. However, within the phases of the appointment analysed, the child contributed, and was invited to contribute, very little. As noted in previous research in therapeutic environments involving children, they are not given the same interactional or epistemic status as adults in the appointment (Hutchby and O’Reilly,
2010; Shakespeare, 1998). The limited involvement of the child in the main appointment follows a similar pattern to other therapeutic environments (see for example Hutchby & O’Reilly, 2010; Parker & O’Reilly, 2012), suggesting that the interactional phenomenon is apparent across multiple settings.

c) What role does epistemics and the right to knowledge play through the triage appointments and how is this managed interactionally?

Throughout the analysis, the role of epistemics and the management of rights to knowledge in the interaction was a prominent and unavoidable theme. The relationship between clinicians and patients is one in which the epistemic balance is considered to be asymmetrical in favour of the clinician. In appointments at CAMHS, this dynamic is further complicated and the asymmetry exaggerated by the fact that the patient is a child. Not only this but additional adults accompanied the child to the appointment and were encouraged to play an active role. Therefore, the relationship in this interaction is not purely dyadic between clinician and patient. Rather, the relationship can be considered to be triadic between the clinician, parents, and child (see Figure 4).

![Figure 4](attachment://figure4.png)

**Figure 4.** Flowchart of the triadic relationship between participants in a CAMHS appointment.

With this additional element to the relationship came further epistemic negotiations. Within the data set, parents, children, and clinicians all took turns to speak or were selected to respond to questions. However, parents and children engaged in maintaining the epistemic asymmetry in their turns. For example, when children had been selected to present the reason for attendance, depending on the response type given, they used strategies within their talk to maintain their position
as a lay member of the interaction despite being the subject of the appointment. When clinicians delivered a decision about the mental health basis of the child’s difficulties, they asserted themselves as experts whilst parents maintained this through their lack of response to the decision.

Whilst the lack of child involvement in the data follows similar patterns to that of other therapeutic environments, the data analysed in this thesis exposed some of the interactional strategies used by adults in the appointment to maintain the child’s epistemic status. This was achieved by clinicians through the use of a ‘do you know + why interrogative’ when asking the child for their reason for attendance. Where children were unable or unwilling to provide an explanation for their attendance, clinicians either deferred the question to the child’s parents, or provided an explanation themselves. In some cases, the child was not asked for their own explanation and the clinician either asked the parents directly or used the referral notes to give the family an explanation for their attendance. Some parents undermined the child’s responses by rephrasing the clinician’s questions, rephrasing the child’s responses, or making a claim about the child’s cognitive or behavioural state.

Epistemic asymmetry was also established and maintained by both clinicians and parents during decision delivery. In delivering a decision of a mental health related concern in a plain assertion format, clinicians asserted their rights to knowledge and epistemic status as the expert in the interaction by not evidencing or explaining their decision. When delivering a decision of no mental health related concern, clinicians presented themselves as accountable for the decision made by explaining their reasons and giving evidence from previous stages of the appointment. The lack of response by families further served to maintain this epistemic status. In neither agreeing nor disagreeing with the clinicians’ assertions, the parents avoided either presenting themselves as more knowledgeable than, or as knowledgeable as the clinician.
d) What are the discursive strategies families employ to present their child’s need as genuine and the possible diagnosis as appropriate?

Families had generally been passed through several services and been placed on a waiting list before receiving an assessment appointment at CAMHS. As a result, parents appeared to be keen to present the problems the child was experiencing as legitimate and the accounts as accurate in order to receive the help they felt they needed. From the phases of the appointment analysed, parents predominantly engaged in the interactional activities of legitimising help seeking and exemplifying their accounts when building a case. As previously outlined, the analysis identified four strategies used by parents to reinforce and legitimise their accounts: extreme case formulations, contrast structures, witnessing, and comparisons to others.

Extreme case formulations have been identified in multiple settings as an interactional strategy used by speakers to legitimise claims when performing actions such as justifying, convincing, or defending (Pomerantz, 1986). To assist in presenting their child’s need for help as genuine and relevant, parents used ECFs in their descriptions. When describing the child’s behaviour, parents often used ‘never’ as an indication of time. For example, parents stated that ‘never since he’s been born’ had their child attempted to hurt himself before. Additionally, ‘nothing’ was also used widely by parents to describe the severity of the child’s difficulties, for example, ‘nothing helps’. Extreme case formulations are rarely challenged, and this appeared to be the case when parents used them in this context. Clinicians did not question their use or their extreme nature. In using ECFs, parents presented the most extreme version of events whilst ensuring that their claims would not be questioned or dismissed. As such, ECFs appeared to be a reliable and effective strategy for parents in legitimising their claims about their child’s difficulties.

When building a case for their child’s difficulties, parents referenced opinions from third parties both in support of their claim and opinions that disputed their claim. When referencing third parties opinions that countered the extremity or the legitimacy of the claim they were making, parents invoked a ‘they said X but Y’ contrast structure. A similar structure was identified by Hutchby (1992) when exploring the interactions on talk radio programs. Hutchby (1992) recognised that
this structure was used by the host to undermine the legitimacy of the caller’s claim or opinion. In the context of the data analysed here, parents appear to use the contrast structure to undermine the opinion of the third party, despite them not being present, and to therefore remove the third parties position from the discussion. Contrast structures have also been identified in court room interactions where lawyers work to undermine the accounts provided by witnesses during cross examination (Drew, 1990). Contrast structures such as those used by parents in CAMHS appointments are not significant purely because they present an alternative, allegedly more accurate, version, but rather because doubt is cast over the reported version. The doubt cast did not give the parents account of events greater accuracy or legitimacy, but it did appear to project uncertainty on to the legitimacy of the third parties account.

Parents presented themselves as witnesses to their child’s behaviours and difficulties. In doing so, they legitimised the accounts they were giving by presenting themselves as having been there and seen it happen, rather than having heard through a third party. Evidence that has been witnessed first-hand is treated as more authentic than second or third hand evidence (Hutchby, 2001). Parents chose how to present the evidence they witnessed, with the reality being unknown to the clinician (Smith, 1978). Parents framed their evidence with a general context or overview of the claim being made, and then followed this with the specific example witnessed. They accompanied the examples with references to additional factual information, such as the time, location, or details about the event, which added authenticity to the account being given. By giving first-hand accounts of behaviour, parents presented events as genuine and in turn strengthened their case for the child’s difficulties.

When presenting their child’s difficulties, parents often compared their behaviour, development, or ability to that of their peers or siblings. The foundation of the parent’s case was that their child was presenting with behaviours or difficulties that are unusual with the premise that the foundations of those may lie in a mental health related problem. In presenting the child in contrast to peers who were considered to be typical or normal, the child was presented as being atypical or abnormal. Parents premised their comparisons with contextual information in which the clinician should hear the contrast that was being presented. In highlighting the
 differences between the child and their typical, or normal, peers, parents worked to
build a case for the pathology of the child’s behaviour and the resulting need for
intervention from specialist services.

The resources analysed in the data were not used in isolation but
collaboratively with each other. This added to the impact of the parent’s account of
their child’s difficulties. For example, parents used extreme case formulations when
comparing their child to their peers: “only child that ↓wouldn’t be sat”. These
interactional resources have all been found to be present in settings other than
CAMHS initial assessment appointments, including court room interactions between
lawyers and witnesses, talk radio call in shows between the host and callers, and
other medical contexts. The presence of the resources across a variety of
circumstances, each with very different social focuses demonstrates their versatility
and power. Whilst each of the contexts may differ and their social expectations, the
interactional aims are similar: to legitimise accounts and present them as authentic.

8.3 Application and Relevance of Findings

This thesis is comprised of two main strands: communication research, and child
mental health. The implications of this thesis on each of these areas will be discussed
in the following sections. Conversation analysis has a social constructionist
philosophy which emphasises the idea that we develop and share our knowledge of
the world through interactions with other people. This stands in contrast to the
medical models proposed by psychiatry that advocate for biological explanations for
illness and wellness (Rogers & Pilgrim, 2014). These medical models carry with
them a reality for both the patient and clinicians, that the difficulties a person is
experiencing have a physiological aetiology and will have a pharmacological
treatment (Adams, 1964). Conversation analysis advocates that through studying the
organisation of interactions, we can begin to understand individuals’ experiences
(Wooffitt, 2006). The use of conversation analysis in child mental health service
interactions encourages clinicians and researchers to reorient back to a language
based approach to the construction of mental health and illness (O’Reilly & Lester,
2015). Child mental health services are dominated by psychiatry and the medical
model of mental health and illness (Karim, 2015). The integration of CA research to
mental health settings makes language relevant and encourages the consideration of symptoms and experiences of typical and atypical behaviour as being socially constructed (O’Reilly & Lester, 2015).

8.3.1 Communication Research in Child Mental Health Services

Health care research is a broad and comprehensive area of study, incorporating both quantitative and qualitative methodologies such as randomised control trials, surveys and questionnaires, and interviews and focus groups. It also encompasses care and outcomes in a wide range of medical settings from general medical care delivered by GPs to medical helplines, specialist inpatient and outpatient services, and therapeutic services. Whilst research focusing on communication has been conducted in a variety of health care settings, in relation to the quantity of research generated from the health care sector, communication research forms just a small part of it (O’Reilly & Lester, 2017) with virtually none conducted in initial assessments at child mental health services (Mash & Hunsley, 2005). This thesis focussed on communication between clinicians and families in an outpatient mental health service for children. The nature of CAMHS as a service for children, their vulnerability and the sensitivity of their presenting concerns means that qualitative process research within these services is rare (O’Reilly & Lester, 2017). Psychiatry and therapeutic services however are communication based disciplines (Karim, 2015). Not only this, but communication is considered to be a central factor in establishing a successful relationship between clinician and patient (Hoff & Collinson, 2017) with implications for treatment adherence and success (Rosenblatt et al, 2000). Therefore there is a place for qualitative communication research in these settings (Fasulo, 2015), particularly conversation analysis.

For psychiatric services, studies aiming to understand the nuances of interaction give an opportunity to explore the effects of communication on patients and clinicians, and their relationship. The relationship between doctor and patient is complex and differs to social relationships (Hoff & Collinson, 2017). This was evident throughout the analysis in this thesis. The epistemic asymmetry was oriented to by clinicians, parents, and children in the interaction through the structure and content of their turns and responses. Unlike ordinary conversation, the interaction
was structured with clear question-response sequences, with the clinician asking questions and the parents or child responding. The exception to this was during decision delivery where clinicians imparted information to parents rather than asking questions, and parents gave minimal responses. The relationship between clinicians and families was established, maintained, and reflected through their talk highlighting the importance of clinicians understanding of communication practices. During their training, clinicians receive advice and support on communication practices. These however generally extend to broad topics such as the impact and use of open and closed questions (Robinson, 2006). The use of conversation analysis to examine the interaction of clinicians and patients in health care environments uncovers the subtleties of communication. In turn, these findings can then be explored and relayed to practicing clinicians and students. The use of conversation analysis in training for clinicians would emphasise and demonstrate the collaborative nature of interaction and encourage trainees to look at the contribution of all participants (Maynard & Heritage, 2005).

8.3.1.1 Specific interactions within the appointments

This PhD has analysed naturally occurring data of interactions that would have taken place regardless of the researcher’s involvement. This has given an insight into the structures and content of initial assessment appointments at CAMHS that would only normally be experienced by CAMHS clinicians and the families attending the appointments. Through analysing these interactions, observations can be made about the structures involved and in turn, these observations can be interpreted and applied to real world phenomena. Two of these phenomena are discussed below in relation to implications for clinical practice.

8.3.1.1.1 Child-centred interaction.

Given the child centred nature of the service the research took place in, of interest through the analysis was the role of the child in the interactions. Medical guidelines state that a child centred service puts an emphasis on the child in decision making communication (Department of Health, 2003). Whilst children were engaged in the interaction to an extent in the phases of the appointments analysed, they were not exclusively given the conversational floor. It is important to note that large parts of
the appointment were not analysed, including split off sessions that involved the child alone with the clinician. Without analysing these phases it is impossible to draw fully informed conclusions about the child centeredness of the interactions, however observations can be made about the phases that were.

Central to the notion of child-centred care is the focus on asking for, listening to, and valuing the child’s thoughts and opinions about their experiences and health care (Department of Health, 2003). In paediatric health care, if the parent presents the problem then this negatively effects the competence attributed to the child, and their involvement in the remainder of the appointment (Stivers, 2001). In the initial assessment appointment analysed, even when the child was actively involved in problem presentation, the child’s parents still ended up in a dominant role in the interaction. This follows observations by Hutchby and O’Reilly (2010) that children are often not afforded the same interactional rights as other members of an interaction, and Parker and O’Reilly’s (2012) observations that parents dominate the interaction and talk about their child despite them being present. Stivers (2001) notes the importance of the child’s interactional engagement in their medical care. However, where individuals are considered to have cognitive difficulties, or to struggle with their communication, they are often not given the same interactional rights as other members of the interaction (Shakespeare, 1998). A lack of engagement in communication results in clinicians not understanding the child’s illness experience which may result in inappropriate decision making and disengagement from interventions.

Within the analysis presented, where children’s accounts of their experiences were sought, they were treated as being less accurate than or dependent upon the parent’s knowledge and opinions. For example, when a child made a claim to insufficient knowledge regarding their reason for being at CAMHS, the clinician responded by saying “has mum not told you why?”. When a child gave a candidate diagnosis of OCD, the clinician’s response was that of “that’s an important word... what does it mean?”. Furthermore, children’s interactional rights were also undermined by their parents, for example “((child’s name)) does know why he’s here today, we are just being a bit silly”. Engaging the child in health care interactions that involve them and actively affording them rights to knowledge about their illness
experience is crucial for a successful experience and clinician-patient relationship (Bensing, 2000). In this respect, being able to understand how to effectively engage a child through interactions and the propensity for parental involvement should be a priority for clinicians working with children and young people. The positioning of children in the interaction and the effects this has on the appointment can be examined through the use of conversation analytic research (Fasulo, 2015).

8.3.1.1.2 Decision delivery

Delivery of a decision, whether it be that there is or is not a mental health related concern, is a crucial phase in the appointment for both clinicians and patients. For families, it provides confirmation, one way or another, of the possibility of an underlying mental health concern and is what the focus of the appointment has been, as well as the sometimes lengthy referral process. Peräkylä (1998; 2006) observed that in general medical appointments a plain assertion format is adopted by clinicians delivering a diagnostic decision where the decision is that there is a medical reason for the symptoms described and where the diagnosis is delivered in close temporal proximity to the examination phase of the appointment. In the decision delivery phase of initial assessment appointments at CAMHS, clinicians followed a similar pattern of a decision of a mental health basis for the symptoms being delivered in a plain assertion format. However, the findings differed to those of Peräkylä (1998; 2006) as there was not only temporal proximity before the decision delivery, but also a physical proximity. In the cases analysed, the clinicians separated from the family to discuss their observations in private before feeding back their decision. Given the length of time some families wait for an assessment appointment families, and the child in particular, may be better equipped to understand their difficulties and the treatment plan that follows if clinicians were to provide an explanation for their decision.

The lack of response by parents to the clinician’s decision is particularly important for clinicians to understand. This pattern of communication during diagnosis has been observed in numerous health care settings (Heath, 1992; Peräkylä, 1998; 2006). It would be easy for clinicians to mistake a lack of response or questioning as an acceptance and understanding of the decision made. Whilst it
appears that it is a part of communication and works to perform a specific action within the interaction, clinicians should be made aware of the reasons why children and families do not give extended responses and provide specific interactional spaces and opportunities for them to voice their opinions or ask questions.

8.3.1.2 Implications for child mental health services

Communication is considered to be central to a successful doctor-patient relationship (Shipman, 2010). It is only through analysing the nuances of the interactions that happen within appointments that researchers, health care professionals, and policy makers will truly understand the complexities of communication. In understanding these complexities, the relationships that are formed and maintained, and the actions that are performed through talk-in-interaction, clinicians can begin to make their practice more effective. In child mental health, demand for services is increasing to the point where it is outstripping availability, and funding cuts are still being made. Research aiming to analyse and understand the intricacies of the interactions within the appointments has the potential to make the processes more efficient, help to understand child engagement in services and treatment, and therefore improve outcomes.

8.3.2 Methodological Relevance

8.3.2.1 Patterns of communication

Conversation analysis as a methodology has been used to analyse talk in interactions in a variety of settings. Across these settings, patterns have emerged of similar types of questions eliciting similar types of responses, or rhetorical devices being used in similar ways across contexts (Heritage & Maynard, 2006). The data presented in this thesis shows similar patterns to studies using conversation analysis in other environments, not just medical. For example, the devices parents use to legitimise their accounts when building a case for their child having a mental health related difficulty have been found in the analysis of talk radio shows (Hutchby, 1992), the construction of accounts in everyday talk (Smith, 1978), and in court room interactions (Drew, 1991). Whilst CA research does not claim to be generalizable across contexts, there is considerable value in the identification of similar patterns
across settings. These patterns enable researchers to see interaction more broadly and as an organised phenomenon rather than random and chaotic as was once thought (Silverman, 1998).

8.3.2.2 Conversation analysis in institutional settings

Originally, Harvey Sacks was uninterested in the application of CA to institutional settings, preferring to see its relevance in the context of everyday interactions. However, over time it has been used across institutional settings with great success both in an applied form and a theoretical form. This research is an example of a further area to which CA can be applied: that of child and adolescent mental health services. Conversation analysis has been used to research interactions in paediatric settings (for example, Stivers, 2001; 2002), psychiatric settings (for example McCabe, 2002), and with individuals with communication difficulties (for example, Finlay, Antaki, & Walton, 2008; Wilkinson, 2015). This thesis, along with the original research by O’Reilly, Karim, Stafford, and Hutchby (2015), introduces conversation analysis to a multidisciplinary child mental health setting, a setting where there has been little communication research, particularly in initial assessment appointments (O’Reilly & Lester, 2017).

8.3.2.3 Implications for conversation analysis research

The intention of this research was not to solve a problem within the institutional setting in which it was carried out. Rather, it was to explore and identify the interactional processes at play that cause and enable it to work in the way it does. Within different institutions there are different social rules and responsibilities at play; differing from each other and from those of ordinary conversation (Antaki, 2011). The analysis of the interactions within institutional settings enables analysts to identify how these rules and responsibilities are constructed and enacted through talk.

8.4 Future Research

With such a rich data set, the logical progression would be to explore the interactions further, particularly the phases of the appointment not considered in this thesis such as history taking, openings and closings, and the split off sessions between the child
and clinician. Whilst analysing small segments of the data has given an understanding of the interactional mechanisms at play in the appointments, having an all-embracing perspective would be beneficial for a greater understanding of the data. With analysis of children’s accounts for their visit (Stafford, Hutchby, Karim, & O’Reilly, 2016; Stafford & Karim, 2015) and the interactional structure of the appointment (O’Reilly, Karim, Stafford, & Hutchby, 2015) already published, there is scope to utilise the data to a larger extent and explore the interactions further.

In addition to the continued analysis of the current data set, it would be beneficial to explore similar appointments in other child and adolescent mental health services across the United Kingdom. Whilst medical training and standardised appointment structures should be consistent across services, the exploration of similar interactions would give a greater understanding of the commonalities and differences in the structure of talk in interaction. Within medicine there is an emphasis on outcome focussed research that is replicable and generalizable (Leung, 2015). Qualitative research tends to be process focussed and its observations are not intended to be generalizable in the first instance (Gobo, 2004). Additional research can then take the findings and build upon them, establishing similarities and differences, and possibly generalisability.

8.5 Limitations

Every piece of research has its limitations, and this thesis is no different. The study was designed to explore the communication practices of clinicians, families, and patients in a mental health service and the implications these have on access to specialist services. The study has value due to the distinct lack of process driven research that happens within child mental health services (O’Reilly, Karim, Stafford, & Hutchby, 2015). Access to the particular CAMH service the data was collected from in this research was enabled through a gatekeeper who worked both within the service and for the university.

One limitation of the research is that the data was only collected from one service thus potentially giving only a snapshot of clinician practice and participant variation. However, across the United Kingdom, training for medics and therapists follows a standard core curriculum to ensure an equal baseline of knowledge and
practice within the healthcare system (General Medical Council, n.d.). Whilst services across the NHS are managed by different trusts and commissioning groups depending on their location, they are all regulated by central government and the same services across trusts and commissioning groups follow similar guidelines and structures. Numerous qualitative studies have found structural and interactional similarities across types of medical appointments in multiple settings, in multiple countries (for example: Byrne & Long, 1976; ten Have, 2001). With this in mind, the structure of interactions within initial assessment appointments at CAMHS should take a very similar form in all services within the United Kingdom under NHS jurisdiction.

Additionally, some conversational structures identified in this thesis are similar to those identified by other research not only in medical settings but also in other non-medical environments. The strategies identified in chapter 6 that parents use when building a case for a mental health related cause for their child’s difficulties have been identified in general conversation as well as institutional settings. Extreme case formulations are used by speakers in general conversation to emphasise the significance of points they are making, as well as institutional settings. Contrast structures have also been found in court room interactions (Drew, 1990) and in discussions on talk radio programs (Hutchby, 1992). Features of clinician decision delivery and patient response identified in chapter 7 are similar to those identified in diagnosis delivery in general medical appointments (Peräkylä, 1998; 2006). The overlap of identified features in the interactions analysed with previous interactional research in a variety of settings demonstrates the possibility of transferability of current findings to other professional-lay interactional environments.

A further perceived limitation of this study is the lack of quantifiable, outcome related data. Conversation analysis concentrates on investigating the processes involved in interactions as opposed to the outcome (O’Reilly & Lester, 2015). In engaging in a process oriented research methodology, it is possible to examine the phenomenon that are involved in constructing an interaction, rather than simply quantifying the interaction as being successful or not, or achieving certain aims. Whilst the outcome of medical appointments is important to understand, for
example in relation to adherence to treatment or engagement with services, it does not unpick the possible interactional reasons why a relationship might break down between clinician and patient, or why families do not adhere to suggested treatment plans. Process driven research examines how a problem is identified, constructed and managed through the interaction. This allows findings to be applied in formal training or informal feedback and enables clinicians to adapt the ways they interact with patients in order to achieve a more favourable outcome for both parties.

Lastly is the potential limitation of the age of the data. The majority of the video footage was collected between 2011 and 2012, with transcription being completed in 2014. Since collecting the data, the CAMHS service involved has undergone structural changes as well as funding restrictions and alterations. Within triage, appointments are now attended by one clinician rather than two, as was the case when the data was collected. This was introduced as a way of cost cutting and increasing staff productivity. As a result of career progression and general staff turnover, some of the clinicians sampled are no longer practicing in the service, especially the training grade psychiatrists. The majority of children and families sampled have been discharged from the service either due to successful intervention and effective management of their symptoms, or because they have been transitioned in to adult services. Whilst the structures within the services have altered, the findings of the research are still valid. As has been previously noted, elements of the analysis have been seen in other health care settings, and the general structure of medical appointments (Byrne & Long, 1976) has been seen to be consistent across both time and context. In this respect, the significance and application of the findings remain as relevant to the CAMH service and its clinicians and patients now as they were when the data was collected. This is evidenced by the fact that findings from analysis of the wider data set have continued to be published from the data in the intervening years (see for example, Kiyimba & O’Reilly, in press; O’Reilly, Karim, Stafford & Hutchby, 2014; Stafford, Hutchby, Karim, O’Reilly, 2016).

8.6 Reflexivity

The following sections will discuss the personal impact of the research and the effect of personal experience on the analysis, interpretation, and reporting of the data. I will
start by outlining the effect of my experiences as a researcher on the data and will end by discussing the impact of my personal experiences.

8.6.1 The Research Process

The nature of qualitative research means that the researcher’s part in the process must be acknowledged (O’Reilly & Kiyimba, 2015). This includes the part in data collection, transcription, analysis, and reporting. It is important to acknowledge that my experiences and part in the research will have influenced my analysis and reporting. Whilst not involved in the planning or design of the research, my contribution began with data collection. As part of this process I met personally with the clinicians and families who took part in the research within the CAMHS setting but outside of the appointment. Despite the meetings being brief and void of the opportunity to build connections or relationships, the future handling of the data, transcription, and analysis became more personal for having met and spoken to these individuals.

As well as having met the participants, part of the recording process involved observing the appointments ‘live’ on a screen in an adjoining room. Through directly observing the appointment it became harder to analyse the interactions as standalone units of turns and responses. As a result I was often told by my supervisors to be less psychological when analysing, to avoid making assumptions about thoughts, feelings, and motivations, and to see the turns for what they are doing within the interaction. Having received my undergraduate and Master’s Degrees in psychology, this did not come naturally and throughout the analysis and writing up process I have had to keep this advice at the forefront of my mind, sometimes with success, other times not.

8.6.2 Personal Reflection

My interest in clinical psychology and child mental health and illness spurred my curiosity in the interactions I had witnessed during data collection. Reciprocally, these interactions enabled me to apply real life experiences and understanding to my own theoretical and academically based opinions and knowledge gained through my previous degree. This enabled me to develop a greater understanding of the
difficulties facing children with potential mental illness, and their families, and the system in which they and their clinicians were operating.

Whilst studying for my PhD I became a learning support assistant in a mainstream school, working with junior aged children with special educational needs and learning disabilities. Through relationships built with the children and their families, colleagues in school, and specialists who came in to work with the children, I became increasingly aware that my PhD research had very real life implications for many families, and that I was now a part of the system that I had been studying. By virtue of my occupation, I was now one of the people giving one to one support to children, listening to families’ experiences and journeys with their children, and offering advice to them; all of whom were themselves accessing specialist services, and in some cases, mental health services. When I began this PhD, I gained a working knowledge of how CAMHS and triage worked from the perspective of those working within it, but I have since gained an understanding of the work that goes in to a referral by parents and schools, and have also seen first-hand some of the difficulties children who enter into the CAMH system present with on a day to day basis. This has undoubtedly changed my interpretation of the data as I have become far more empathetic of the families in the appointments. Their accounts of their children’s behaviour in school and the barriers many of them have faced in the process of getting a CAMHS appointment align with my personal experiences of many children I have encountered in the education environment: I can imagine each of them as a member of my class and the impact certain behaviours would have on other children and the teaching staff. Whilst I do not think this has filtered through to the analysis and reporting of the interactions, it is important to acknowledge the personal drivers and impact of the data along the way. After all, the interactions are not just words on a page of transcription, they are peoples lived experiences and a snapshot of a potentially stressful and sensitive point in their lives.

8.7 Conclusion

This research has contributed to the areas of child mental health, health care research, and conversation analysis. Using conversation analysis and a social constructionist perspective, it has shown how clinicians, parents, and children
organise their talk in interaction to perform social actions within initial assessment appointments at CAMHS. Throughout the thesis emphasis was placed on the epistemic asymmetry that was established and maintained through the interactions of the clinician and families, as well as the child centeredness of communication within the appointment. The findings of this research will help both researchers and clinicians to understand the intricacies of the interactions that happen both from the perspective of the clinician and of the families involved. The analysis and conclusions contribute to an understanding of how interaction is organised in initial assessment appointments at CAMHS, and how this affects access to services for families.

For clinicians, this research has hopefully demonstrated the robustness, importance, and effectiveness of carrying out communication research in health care settings. The insights that are gleaned from this type of research not only improve our understanding of the processes involved in health care, but can also contribute towards training for clinicians. These implications have the potential to improve access to services and the success of relationships between clinicians and families, leading to improvements in outcomes for all parties. Not only can this research expand research opportunities, but it can also improve clinical practice by making clinicians aware of the importance of good communication, and what constitutes good communication practices.

For conversation analysis, this research has demonstrated the application of the methodology to a new and complex institutional setting. The findings have brought to light some differences in communication from general practice, but on the whole have demonstrated the robustness and transferability of the findings of studies in other institutional settings. Whilst NHS services in general, and mental health and child services particularly are hard to reach settings in terms of accessibility for research, the interactions are rich and varied and provide endless opportunities for communication research. Hopefully, further communication research in similar settings will follow as conversation analysis has the potential to play an important role in shaping services for the future and improving patient access, satisfaction, and ultimately their mental health.
## APPENDICES

Appendix 1: Jefferson notation symbols chart

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Name</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>[text]</td>
<td>Square brackets</td>
<td>Indicates the start and end points of overlapping speech.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Indicates the break and subsequent</td>
</tr>
<tr>
<td>=</td>
<td>Equal sign</td>
<td>continuation of a single interrupted utterance.</td>
</tr>
<tr>
<td>(# of seconds)</td>
<td>Timed pause</td>
<td>The time, in seconds, of a pause in speech.</td>
</tr>
<tr>
<td>.</td>
<td>Micropause</td>
<td>A brief pause, usually less than 0.2 seconds.</td>
</tr>
<tr>
<td>↓</td>
<td>Down arrow</td>
<td>Indicates falling pitch.</td>
</tr>
<tr>
<td>↑</td>
<td>Up arrow</td>
<td>Indicates rising pitch.</td>
</tr>
<tr>
<td>-</td>
<td>Hyphen</td>
<td>Indicates an abrupt halt in utterance.</td>
</tr>
<tr>
<td>&gt;text&lt;</td>
<td>Greater than/ less than symbols</td>
<td>Enclosed speech was delivered more rapidly than usual for the speaker.</td>
</tr>
<tr>
<td>&lt;text&gt;</td>
<td>Greater than/ less than symbols</td>
<td>Enclosed speech was delivered more slowly than usual for the speaker.</td>
</tr>
<tr>
<td>°text°</td>
<td>Degree symbols</td>
<td>Indicates a whisper or reduced volume.</td>
</tr>
<tr>
<td>ALL CAPS</td>
<td>Capitalised text</td>
<td>Indicates shouting or increased volume.</td>
</tr>
<tr>
<td>underlined</td>
<td>Underlined text</td>
<td>Indicates the speaker is emphasising speech.</td>
</tr>
<tr>
<td>:</td>
<td>Colon</td>
<td>Indicates prolongation of an utterance.</td>
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<td></td>
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<td>---</td>
</tr>
<tr>
<td>(hhh)</td>
<td>Audible exhalation.</td>
<td></td>
</tr>
<tr>
<td>(.hhh)</td>
<td>Audible inhalation.</td>
<td></td>
</tr>
<tr>
<td>(text)</td>
<td>Parentheses</td>
<td>Speech was unclear or in doubt.</td>
</tr>
<tr>
<td>((italic text))</td>
<td>Double parentheses</td>
<td>Annotation of non-verbal activity.</td>
</tr>
</tbody>
</table>
Appendix 2: Invitation letter to clinicians

University of Leicester
School of Medicine
Greenwood Institute of Child Health
University of Leicester
Westcotes Drive
Leicester
LE5 0GU

Decision-making in child mental health assessments:
Analysis of triage appointments in a child mental health service

Victoria Stafford (Research Assistant)

Invitation letter version 1 - 12/10/2010 - clinicians

RE: Research on your service

Dear

We are writing to you to invite you to participate in a research study. We work for the
health research at the Child and Adolescent Mental Health Service (CAMHS).

The research is a study looking at the interactions between families and clinicians at the first
appointment with CAMHS. We recognise that the relationship between families and the
professionals they see is an important one and we want to look in greater detail at the
development of this relationship from the first appointment. It is essential, therefore, that we
can record these sessions to analyse at a later date to explore these details.

We hope that our research will lead to improvements in service delivery and the
communication in this important setting.

Please find attached the patient information sheets which will provide greater detail
regarding the study. Please also find attached copies of consent forms. If you have any
queries please feel free to contact the research team using the above contact details.
Members of the research team will also be available on the day of your triage clinics to
answer any queries so this will not be your responsibility.

Yours sincerely
Appendix 3: Invitation letter to families

Invitation letter version 1 · 12/10/2010 · families

University of Leicester
School of Medicine
Greenwood Institute of Child Health
University of Leicester
Westcotes Drive
Leicester
LE3 9QU

Decision-making in child mental health assessments:
Analysis of triage appointments in a child mental health service

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can record these sessions to analyse at a later date to explore these details.

We hope that our research will lead to improvements in service delivery and the
communication in this important setting.

Please find attached the patient information sheets which will provide greater detail
regarding the study. Please also find attached copies of consent forms family members. If
you have any queries please feel free to contact the research team using the above contact
details. Members of the research team will also be available on the day to answer any of
your questions. Please note that due to limited recording facilities on site, your participation
may not be required on the day of the appointment.

Yours sincerely
Appendix 4: Participant information sheet for clinicians

Participant Information Sheet

Decision-making in child mental health assessments:
Analysis of triage appointments in a child mental health service

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. We’d suggest this should take about 10 minutes. Talk to others about the study if you wish. (Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study). Ask us if there is anything that is not clear.

Part 1

Purpose of the study

The purpose of this study is to analyse the interactions between families and clinical professionals at the screening appointment at a Child and Adolescent Mental Health Service. Within the NHS it is considered important that families and young people feel recognised and engaged in a therapeutic process, patient centred care. While there is some evidence that services are working towards ensuring that this happens in practice, family interactions are complex and engaging young people in services is difficult. Young people particularly can feel excluded from participating in the outpatient environment and their contributions may not be valued. It is essential, therefore, to explore the processes that occur in actual clinical practice. This will provide the evidence for recommendations for improving services. We intend to look at a number of aspects of the interaction in the screening appointment process. For this reason we will need to video the appointment and analyse this in detail at a later point for research. This will not be used for clinical practice.

Why have I been invited?

We are asking you to take part in this study because you are a professional working with families whom attend triage appointments. We are asking for your help by participating in research and helping with the recruitment of families.

Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

This research is taking place over the course of one triage session and you will be required to participate for the full duration of this single session of triage. In your professional
capacity you will participate in the triage session and you are not expected to take any further time than this for research purposes.

What is different about this research than your normal clinical practice is that for the purposes of the research the session will be recorded on videotape for later analysis. These video-tapes will be transcribed for a language-based analysis (conversation analysis) to take part. Video-tapes will be protected and transcripts will have identifying features removed.

If you agree to take part you may be asked to help with the consent process of families and help them to fill in their consent forms.

What will I have to do?

For this research you will be expected to carry out your clinical practice as normal. Attend the session as you would anyway and provide the normal standard of care that you would normally provide in your professional capacity. This will be recorded for research purposes. You will have the contact details of the research team and you may need to assist the family in the consent process.

What are the possible disadvantages of taking part?

This study has been designed to ensure that the possible disadvantages and risks to you from taking part in this study are minimal. This study has also been designed to cause minimal inconvenience to you in relation to time and travel.

What are the possible benefits of taking part?

We cannot promise that taking part in this research will help you or your patients. The information that you share with us will help us to better understand the training needs of mental health staff which in turn will have an impact on the quality of services received by families going through Triage.

What happens when the research study stops?

When the triage session has ended arrangements will be made for a researcher to collect the tape from you. This will be transcribed and subjected to analysis. You continue your normal professional practice as usual.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.
If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with the study?

Data is being collected from one triage session and if you decide that you no longer wish to participate or any of the family members you are talking to no longer wish to participate please stop the recording device. If all members are happy please provide the recording to the point you withdrew. If members are not happy please destroy the tape and withdraw fully from the study.

What if there is a problem?

Complaints:
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions. Alternatively, if you remain unhappy and wish to complain formally, you can do this. Details can be obtained from Insert info here.

In the event that something does go wrong and you are harmed during the research and this is due to someone’s negligence then you may have grounds for a legal action for compensation against Insert info here but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

Will my taking part in the study be kept confidential?

Data will be collected through the use of video-recording equipment. Your normal triage session will be recorded and the tape passed to the research team. VHS copies will be transferred to DVD for ease of storage and quality. Care will be taken during this process. This tape will be transcribed and then securely stored in a locked, reinforced cupboard at the Greenwood Institute. The transcripts will be anonymous and all identifying features removed from them. If the research team show any clips from the video to professionals outside of the research team, faces will be obscured with pixels and names removed. For example if used for other research or meetings.

What will happen to the results of the research study?

The data provided will be subjected to language-based analyses and disseminated through research reports and published academic papers. In this process all of your identifying features will be removed from your quotations to maintain confidentiality and anonymity.

Who is organising and funding the research?

This research is being organised by a research team within the University of Leicester. Funding is being sought from the Economic and Social Research Council, success is pending.
Information sheet for clinicians – version 2 – 12/10/2010

Who has reviewed this study?

All research in the NHS is looked at by independent groups of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Derby Research Ethics Committee.

Further information and contact details

If you would like more information about the following please contact the appropriate member of the research team for more detail:

General information about research:
Specific information about this research project:
Advice as to whether they should participate:
Who they should approach if unhappy with the study:

What should I do next if I want to take part?

Simply read and sign both copies of the enclosed consent form and then return one copy of the consent form to us through the internal post (or directly) and keep the second copy of the consent form along with this information sheet for future reference.

We thank you for taking the time to read this information sheet and hope that you will be willing to help us with our data collection.

Yours Faithfully

Contact details appear at the top of this Participant Information Sheet
Appendix 5: Participant information sheet for children aged 6 to 10

Information sheet for younger children—version 2—12/10/2010

Participant Information Sheet
Decision-making in child mental health assessments:
Analysis of triage appointments in a child mental health service

University of Leicester
School of Medicine
Greenwood Institute of Child Health
University of Leicester
Westcotts Drive
Leicester
LE3 0QU

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

One of our team will go through the information sheet with you and answer any questions you have.

We’d suggest this should take about 10 minutes Talk to others about the study if you wish. (Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study).

Ask us if there is anything that is not clear.

Part 1

Contact details appear at the top of this Participant Information Sheet

Study Title
To see how people talk to each other at a first appointment at a child mental health service.

What is research?
Research is a way in which we try to find answers to questions. We want to see what way is the best way to treat children and their families.

Why is this project being done?
We want to see what the best way is for people like doctors and nurses to talk to children and their families and make the right choices about treatment.

The best way to do this is to video the first appointment you are attending. The video and microphone are in the room and the appointment will be recorded and looked at by researchers at another time. If you want to someone will show you where the video and microphones are.
**Why have I been asked to take part?**

We are asking all children and their families who attend the first appointment to take part. Every family is being asked if they would like to take part in the research project.

**Did anyone else check the study is OK to do?**

Before the research is allowed to happen, it has to be checked by a group of people called a Research Ethics Committee. They make sure the research is fair. Your project has been checked by the Derby Research Ethics Committee.

**Do I have to take part?**

Taking part in the research is up to you.

We will ask you and your parents/carers if you want to take part but it is your choice if you want to.

If you do not, the appointment will not be videoed but everything else will remain the same.

**What will happen to me if I take part in the research?**

If you do take part in the research there will be nothing different from a normal appointment except the meeting will be videoed so researchers can look at it at a later time.

Only the first time you come will be videoed. If you come for further appointments we will not have to video them.

**Will joining in with the study help me?**

We cannot promise the study will help you but the information we gain might help treat other young people in the future.

**Will my details be kept private if I take part?**

What you say at the appointment will be kept private by the research team and the clinical staff. Other people will not be allowed to look at the tape unless it is necessary to help with your problems.
What if I don’t want to take part in the research during the first meeting?

If at any time you don’t want to do the research anymore, just tell your parents or the clinical staff. They will not be cross with you.

We thank you for taking the time to read this information sheet and hope that you will be willing to help us with our study.

Yours Faithfully
Appendix 6: Participant information sheet for children aged 11 to 18

Information sheet for young people (11+) – version 2 – 12/10/2010

School of Medicine
Greenwood Institute of Child Health
University of Leicester
Welford Road
Leicester
LE3 9GU

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you.

One of our team will go through the information sheet with you and answer any questions you have.

We’d suggest this should take about 10 minutes Talk to others about the study if you wish. (Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study). Ask us if there is anything that is not clear.

Part 1

Contact details appear at the top of this Participant Information Sheet

The research

A research project to look at how clinical staff and families communicate (talk) at the first outpatient appointment in a Child and Adolescent Mental Health Service.

We are asking you to join in a research project to find the answer to a number of questions. We want to know how families and clinical staff in a Child and Adolescent Mental Health Service (CAMS) discuss the difficulties that the families bring with them and how decisions are made in what ways they can be helped.

Before you decide if you want to join in, it’s important to understand why the research is being done and what it will involve for you. So please consider this leaflet carefully. Talk to your friends, family or the clinical staff if you want to.

Why are we doing this research?

The first time that families and young people meet with clinical staff from the Child and Adolescent Mental Health Service is the most important.

The families are given the opportunity to describe what the problems are and it provides information to help the clinicians start to find ways to help. It is therefore important that during the meeting everybody including the young person feels they have been included and listened to.
This is why we want to video these first interviews with families to look at how everybody interacts and whether it could have been done differently. We want to look at how clinicians acquire the information which helps them to advise families on how things can be helped.

We also want to see how much different people including yourself are asked about their problems and how the clinical staff make their decisions.

**Why have I been invited to take part?**

You have been invited to join the study as we are approaching all families who have been referred to CAMHS for a first triage appointment to see if they want to participate. We are hoping to involve approximately 25 families.

**Do I have to take part?**

No, it is up to you. We will ask you for your assent and then ask if you will sign a form. We will give you a copy of this information leaflet and your signed form to keep.

You are free to stop taking part at any time during the research without giving a reason. If you decide to stop, this will not affect the care you and your family will receive.

**What will happen to me if I take part?**

We will be videoing and recording the first appointment but everything else will be as normal. There will be no changes made to how the appointment is carried out or any decisions made.

We will only be recording the first appointment which is usually 1 ½ hours. If you want to see where we are recording please ask a member of staff who will be happy to show you.

**Is there anything else to be worried about taking part?**

No, but if you have any questions please feel free to talk to a member of staff from the CAMHS service or ask to speak to a researcher.

**What are the possible benefits to taking part?**

We cannot promise the study will help you but the information we get might help with the treatment of other young people who come to a Child and Adolescent Mental Health Service.

**Further information and contact details**

If you would like more information about the following please contact the appropriate member of the research team for more detail:

General information about research:  [Contact Information]
Specific information about this research project:

Advice as to whether they should participate:

Who they should approach if unhappy with the study

What should I do next if I want to take part?

Simply read and sign both copies of the enclosed consent form and then return one copy of the consent form along with this information sheet for future reference.

We thank you for taking the time to read this information sheet and hope that you will be willing to help us with our data collection.
Appendix 7: Participant information sheet for parents

Information sheet for parents – version 2 – 12/10/2010

Participant Information Sheet

School of Medicine
Greenwood Institute of Child Health
University of Leicester
Westcotes Drive
Leicester
LE3 0QU

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. One of our team will go through the information sheet with you and answer any questions you have. We’d suggest this should take about 10 minutes. Talk to others about the study if you wish. (Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study). Ask us if there is anything that is not clear.

Part 1

Purpose of the study

The purpose of this study is to analyse the interactions between families and clinical professionals at the screening appointment at a Child and Adolescent Mental Health Service. Within the NHS it is considered important that families and young people feel recognised and engaged in a therapeutic process; patient centred care. While there is some evidence that services are working towards ensuring that this happens in practice, family interactions are complex and engaging young people in services is difficult. Young people particularly can feel excluded from participating in the outpatient environment and their contributions may not be valued. It is essential, therefore, to explore the processes that occur in actual clinical practice. This will provide the evidence for recommendations for improving services. We intend to look at a number of aspects of the interaction in the screening appointment process. For this reason we will need to video the appointment and analyse this in detail at a later point for research. This will not be used for clinical practice.

Why have I been invited?

We are asking you to take part in this study because you are a family who has been referred to the triage service. We are asking for your help by participating in research and the evaluation of this service.

Do I have to take part?

It is up to you to decide to join the study. We will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason.

What will happen to me if I take part?

This research is taking place over the course of one triage session and you will be required to participate for the full duration of this single session of triage. The clinician taking your
Information sheet for parents – version 2–12/10/2010

Triage session will go through the consent form with you and you can contact a member of the research team if you want to.

What is different about this research than a usual attendance to triage is that for the purposes of the research the session will be recorded on videotape for later analysis. These video-tapes will be transcribed for a language-based analysis (conversation analysis) to take part. Video-tapes will be protect ed and transcripts will have identifying features removed. You will not be identified in any reports or papers that result from this study.

What will I have to do?

For this research you will be expected to attend your triage appointment as normal. This will be recorded for research purposes if you give consent. You have the contact details of the research team (above) and you can ask them or your clinician questions that you may have.

What are the possible disadvantages of taking part?

We do not anticipate any disadvantages to taking part as video-taping the appointment will not affect any aspect of your clinical care. This study has been designed to ensure that the possible disadvantages and risks to you from taking part in this study are minimal. This study has also been designed to cause minimal inconvenience to you in relation to time and travel.

What are the possible benefits of taking part?

We cannot promise that taking part in this research will help you or your family. The information that you share with us will help us to better understand the training needs of mental health staff which in turn will have an impact on the quality of services received by families going through Triage.

What happens when the research study stops?

When the triage session has ended arrangements will be made for a researcher to collect the tape from your clinician. This will be transcribed and subjected to analysis. The research data collection part ends here and any recommendations, referrals or closings will happen as normal part of the service by your clinician. They will explain what happens for your family as part of the NHS service next.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will my taking part in the study be kept confidential?

Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.
Information sheet for parents – version 2 – 12/10/2010

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2

What will happen if I don’t want to carry on with the study?

Data is being collected from one triage session and if you decide that you no longer wish to participate or any of your family members no longer wish to participate please ask the clinician to stop the recording device. If all members are happy please provide the recording to the point you withdrew. If members are not happy please ask your clinician to destroy the tape and withdraw fully from the study.

What if there is a problem?

Complaints:
If you have a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to answer your questions or, if you remain unhappy and wish to complain formally, you can do this. Details can be obtained from the Research and Development Office, Leicestershire Partnership Trust.

In the event that something does go wrong and you are harmed during the research and this is due to someone’s negligence then you may have grounds for a legal action for compensation against: [blank], but you may have to pay your legal costs. The normal National Health Service complaints mechanisms will still be available to you (if appropriate).

Will my taking part in the study be kept confidential?

Data will be collected through the use of video-recording equipment. Your normal triage session will be recorded and the tape passed to the research team. VHS copies will be transferred to DVD for ease of storage and quality. Care will be taken during this process. This tape will be transcribed and then securely stored in a locked, reinforced cupboard at the Greenwood Institute. The transcripts will be anonymous and all identifying features removed from them. If the research team show any clips from the video to professionals outside of the research team, faces will be obscured with pixels and names removed. For example if used for other research or meetings.

What will happen to the results of the research study?

The data provided will be subjected to language-based analyses and disseminated through research reports and published academic papers. In this process all of your identifying features will be removed from your quotations to maintain confidentiality and anonymity.

Who is organising and funding the research?

This research is being organised by a research team within the University of Leicester. Funding is being sought from the Economic and Social Research Council; success is pending.
Who has reviewed this study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the Derby Research Ethics Committee.

Further information and contact details

If you would like more information about the following please contact the appropriate member of the research team for more detail:

General information about research:
Specific information about this research project:
Advice as to whether they should participate:
Who they should approach if unhappy with the study

What should I do next if I want to take part?

Simply read copies of the enclosed consent form and bring them with you to the triage appointment (copies will be available should you forget). On the day of your appointment (if you are willing) you will be asked to sign three copies of the consent form. Return two copies of the consent form to us (one for our records and one for your clinical file). Keep the third copy of the consent form along with this information sheet for future reference.

We thank you for taking the time to read this information sheet and hope that you will be willing to help us with our data collection.

Yours Faithfully

Contact details appear at the top of this Participant Information Sheet
Appendix 8: Consent form for clinicians

Consent form for clinicians

Decision-making in child mental health assessments: Analysis of triage appointments in a child mental health service

Please enter your initials in the boxes to confirm

1. I confirm that I have read and understand the information sheet dated 12/10/2010 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my working relationships being affected.

3. I understand that relevant sections of the video data collected during the study, may be looked at by individuals from the University of Leicester where it is relevant to my taking part in this research. I give permission for those individuals to view this data.

4. I agree to take part in the above study.

5. TO BE INITIALED AT THE END OF THE CONSULTATION

I agree that the video recorded material can be released to the research team

_________________________  ______________________  ______________________
Name of clinician              Date               Signature

_________________________  ______________________  ______________________
Name of person taking consent  Date               Signature

When completed: 1 for participant; 1 for researcher site file;
Appendix 9: Assent form for children up to and including the age of 15

Assent form for young people
(To be completed by the child and their parent/guardian)

Decision-making in child mental health assessments:
Analysis of triage appointments in a child mental health service

Child (or if unable, parent on their behalf) young person to circle all they agree with:

1. Has somebody explained this project to you? Yes / No
2. Have you asked all the questions you want? Yes / No
3. Do you understand it's OK to stop taking part at any time? Yes / No
4. Are you happy to take part? Yes / No

If any answers are 'no' or you do not want to take part, do not sign your name!

If you do want to take part, you can write your name below

Your name __________________________

Date __________________________

The doctor who explained this project to you needs to sign too:

Print Name __________________________

Sign __________________________

Date __________________________ Thank you

When completed: 1 for participant, 1 for researcher site file, 1 (original) to be kept in medical notes
Appendix 10: Consent form for young people aged 16 to 18

Decision-making in child mental health assessments: Analysis of triage appointments in a child mental health service

Please enter your initials in the boxes to confirm

1. I confirm that I have read and understand the information sheet dated 12/10/2010 version 1 for the above study. I have had the opportunity to consider the information, ask questions and have had those answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections video data collected during the study may be looked at by individuals from the University of Leicester, where it is relevant to my taking part in this research.

4. I agree to take part in the above study.

5. TO BE INITIALED AT THE END OF THE CONSULTATION
   I agree that the video recorded material can be released to the research team

_________________________________________  _______________  ________________________
Name of young person  Date  Signature (s)

_________________________________________  _______________
Name of person taking consent  Date  Signature  Thank you

When completed: 1 for participant, 1 for researcher sits file; 1 (original) to be kept in medical notes.
Appendix 11: Consent form for parents and accompanying adults

Consent form for parents

Please enter your initials in the boxes to confirm

1. I confirm that I have read and understand the information sheet dated 12/10/2010 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

3. I understand that relevant sections video data collected during the study may be looked at by individuals from the University of Leicester, where it is relevant to my taking part in this research.

4. I agree to take part in the above study.

5. *TO BE TICKED AT THE END OF THE CONSULTATION*
   I agree that the video recorded material can be released to the research team

<table>
<thead>
<tr>
<th>Name of parent(s)</th>
<th>Date</th>
<th>Signature(s)</th>
</tr>
</thead>
</table>

| Name of person taking consent | Date | Signature | Thank you |

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.
Appendix 12: Continuation of excerpt from Family 8 response to decision delivery (Chapter 7)

1 Mum  [coz I kept it inside me so many times
2 an(0.24) then I (0.49) talked to [people you
3 know like (. ) outside an like me mom an me
4 dad an (0.88) and (0.33) I just (0.52) got on
5 with I had to get on with it n[ow an]d
6 FSW  [um]
7 Mum  (0.66) just remind me self to give them the
8 (0.69) you know
9 Doctor and I guess this is really important for for
10 kids because when you as as a parent (0.82)
11 you’re very clEAr (. ) of what things are
12 allUed and what things are not allowed
13 (0.44) they feel (. ) [better (. ) they [feel
14 more] content
15 Mum  [yeah]
16 MHN (0.50) and that that is imp ortant so th- the
17 more you can (. ) build up on that the better
18 ( . ) your kids are going to going to feel and
19 you’re going to feel more confident
Appendix 13: Full excerpt from Family 18 response to decision delivery (Chapter 7)

1 Mum [my c]oncern i:s uhm: (. ) again (. ) I I
don’t profess to know (. ) (have) the
knowledge because (. ) e I don’t
4 Therapist [um]
5 Mum (0.45) erm I can only go on what I know as
as his mum (. ) an what research I’ve been
doing m[yself]
8 Therapist [um] yeah
9 Mum erm:
10 (1.41)
even when Nathan (. ) and I apologise if I’m
being negative !to (. ) towards ya (0.30) even
when Nathan: (0.76) good
14 (1.64)
<he’s !hard to manage>
16 Therapist UM
17 Mum and this is not (. ) just my own per↓cep[tion]
18 Therapist [um:]
19 Mum (0.40) erm this is (. ) from a ↓person that
deals with children’s difficult be[hav]iour
every ↓day in her profession
22 Therapist [um]
23 Mum (0.59) um: she actually had ↓Nathan for about
ten ↓days (0.48) an↓d she said that (. )
25 [lit]erally had to be on ‘im (. ) <ALL THE
26 [TI]ME>
27 Therapist [↓um]
28 [↓um]
29 Mum (0.37) and
30 (0.92)
some of the ↓things: coz he couldn’t annoy
32 her (0.46) ↓or: her ↓husband (0.25) >he was
33 an↓noying the dog<
34 Doctor um
Mum ( ) you know just ( ) trying to get the dog
Doctor um
Mum to get a reaction out of the dog (0.40) and this is why: ( ) when I ( ) wrote my letter (0.87)
In (0.24) response to the:
Therapist ye:[s]
Mum [doct]or’s urm ( . ) referral (0.92)
he does fit in to a (0.26) nearly EVERY aspect and characteristics of what I (0.41) asked you to look int[o]
Therapist [um] ((nods))
Mum (0.71)
I know >that you ;do have to look in to the past and (know it’s) got a lot to do with it<
Therapist um
Mum but (0.33) PERsonally ( . ) I don’t think it is all that (0.39) I really don’t >right<
Doctor >[that’s ∴fine]<
Mum (0.23) because of everything that’s go[ing o]n
Doctor [°sure°]
°sure°
Mum at home
Doctor >okay th the feedback that we (have) ∪given obviously< doesn’t answer your question so
Mum um
Doctor what do we do from ∪here
Mum ye[ah]
Doctor ∪[ye]ah (0.32) so: >what we’re gona do from ∪here< we we after you ∪leave we’ve got a
team meeting here so we’ll be saying that
Mum [um hum]
Doctor (0.38) you know we’ve seen you today and
(0.23) [this is] the off you go
Mum [YEAh]
Doctor (0.57) so we we (. >wana discuss it< (. get
more heads so we’ve got two heads
Mum ye[p]
Doctor [an]d we’ll get another four heads in this
room
Mum yep
Doctor coming here (right) (. >so what we’re gonna
>do is we’ll ave a discussion with them (.)
see what people suggest
Mum [umhm]
umhm
Doctor o’kay (. if something comes out then we will
obviously (0.36) erm (. Khrystyanr will (.)
give you a call and (0.33) we’ll discuss (it)
(. what what we’ve (.) had a chat about and
[see] what we can offer
Therapist [um]
Mum right okay
Doctor [wh]
Therapist >[I guess it’s] a bit like trying to work out
what will be the best<
Doctor best option
Therapist input that (. [we could of]fer [or whether]
it is that actually this is the (. the best
[service to offer that input

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