AN INSTITUTIONAL ETHNOGRAPHY OF YOUNG CHILDREN'S 'COMMUNICATION/DIFFICULTIES' IN TWO SPECIALIST SETTINGS

by

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ABSTRACT

This thesis is an ethnographic study of two specialist settings in England, where young children’s communication and ‘communication difficulties’ were objects of expert intervention. It describes the intertwining of institutional discourses and practices, which both construct and sustain current, dominant understandings of good and normal communication.

Instead of delineating ‘communication difficulty’ as a matter of disability or individual tragedy, this thesis focuses on the ‘socialness’ of face-to-face communication. It deconstructs the discourse of communication as a skill, right and need in disability childhood contexts, and the somewhat taken-for-granted importance of communication skills in today’s everyday life. On the basis of my findings, this thesis promotes an understanding of communication as a complex, contextual phenomenon, and aspects of ‘communication difficulties’ as social constructions.
The names of people and places in this thesis are fictional in order to protect confidentiality.
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PART 1: INTRODUCTION AND LITERATURE REVIEW

This thesis is divided in four parts. Part I outlines the research design, and situates the research project in the child welfare practice context, as well as in the landscape of sociological literature on communication, childhood and disability. Chapter 1 introduces the thesis, including how it developed from the original research proposal to its current form. The following Chapters begin to illustrate the complexity of discourses that surround children’s communication. Chapters 2 and 3 look at hegemonic notions of ‘good’ and ‘normal’ communication, which emerge from both practice and social scientific literature. Chapter 4 points out ambiguities within discourses on children as communicators and socially constructed aspects of ‘Childhood’ and ‘Disability’.
Chapter 1.

INTRODUCTION

1.1 Introduction to the research problem

"Speech, language and indeed all manifestations of communication, play a central role in the psychological well being of the child and the family. A child who experiences difficulties in developing communication skills is vulnerable because such difficulties have the potential to interfere with that well being. Consequently it is the responsibility of both health and educational services to identify children with such difficulties and provide intervention in the most appropriate manner" (Law et al., 2000, p. ix).

To date, children’s ‘communication difficulties’ have been exclusively the business of developmentally based professions, including child Health, Education and Welfare services. Dominant discourses within these arenas perceive ‘communication difficulties’ as a barrier to a ‘good life’. Professional intervention has the legal, moral and pragmatic aim of removing those barriers, or at least alleviating the societal and individual problems that they are seen as contributing to. In recent years, these discourses have increasingly emphasised the vulnerability of young children with little or no speech, who are seen as being particularly in need of additional, specialist support.

This thesis, however, takes a social constructionist approach to the phenomenon in question. It is a sociological account of two specialist settings where multidisciplinary professionals routinely dealt with young children’s ‘communication difficulties’. Instead of delineating ‘communication difficulty’ as a matter of disability or individual tragedy, this thesis focuses on the ‘socialness’ of face-to-face communication. It describes the intertwining of discourses and practices, which both construct and sustain current, dominant understandings of good and normal communication. Up to now, this particular focus has not been addressed in this manner either in the sociology of childhood, Disability Studies or Communication Theory (Cobley, 1996).
My sociological approach destabilises both taken-for-granted understandings of 'communication/difficulties'¹ who can, and has the right to, 'know' aspects of young (disabled) children’s lives. My purpose is to develop a wider understanding of how constructions of ‘good’ and ‘normal’ and communication play a significant part in contemporary western discourses and practices that surround these children. This inevitably includes a critical appraisal of both specialist and sociological ways of ‘knowing’ about children. In addition, this thesis deconstructs the discourse of communication as a skill, right and need in disability childhood contexts, and the somewhat taken-for-granted importance of communication skills in today’s everyday life. In this way, I wish to contribute not only to sociological theory but also to child welfare practice.

1.1.1 Introduction to the research settings

This research project was carried out in England between 2000 and 2002. It involved two settings, where I observed interaction among and between young children and adult professionals. In the first one, (the ‘Team Service’), a multidisciplinary team of practitioners assessed children’s communication and other health, welfare or educational needs. The second setting was a day nursery (the ‘Children’s Centre’), where disabled children were receiving additional support and education in a therapeutic environment.

Throughout this thesis, I will refer to the two settings generically as ‘clinical/therapeutic’ settings. Although entirely different settings, the practices in both were based on clinical and therapeutic knowledges of children with special needs, typically including communication needs. The two settings operated in the framework of current legal and ethical guidelines for good practice, which aimed to maximise the child’s potential through early intervention (e.g. Dockrell & Messer, 1999; Friel, 1997). In addition, both settings shared the idea that working in a team was an important element of good practice. The key difference between the settings in

¹ Throughout the thesis, I will use the term ‘communication/difficulties’, because I regard both notions of ‘good communication’ and ‘communication difficulties’ as two different sides of the same socially constructed phenomenon.
the context of this research was that in the ‘Children’s Centre’, the children had already been diagnosed with a disability, whereas within the ‘Team Service’, the children did not always come to be diagnosed as disabled (see Figure 3, p. 23).

The following descriptions of the two research settings summarise the public versions of the kind of services were being provided. They are adapted from promotional leaflets for parents (illustrations of the settings will be provided in Chapter 5).

Setting 1: The ‘Team Service’

“The ‘Team Service’ provides a multidisciplinary assessment for children under 8 years who have complex needs and sometimes disabilities. Children may have been referred to the ‘Team Service’ by either Health, Social Services or Education. The assessment team may consist of paediatric consultant, coordinator of the service, speech therapist, physiotherapist and occupational therapist, nursery nurse, clinical psychiatrist/psychologist, social worker or primary school teacher.

The assessment procedure typically involves a home visit or a visit to school, a planning meeting, observation/assessment in designated spaces (therapy rooms and observation room), concluding meeting and reviews. The purpose of the service is to ensure that a multidisciplinary assessment will be provided and that it adopts a coordinated approach for identification and planning provision or intervention to meet each child’s assumed needs. The time required for an assessment can range from one session to several sessions over a six-week period, concluding with a report and meeting. There is an emphasis on working ‘in partnership with parents and children’.”

Setting 2: The ‘Children’s Centre’

“The ‘Children’s Centre’ - day nursery - offers physiotherapy, occupational therapy, speech therapy and hydrotherapy to children aged 2-5 years. Many children visit the centre as outpatients over a period of several years. Around 20 children currently attend the nursery.

In the ‘Children’s Centre’ it is believed that children will benefit most if all professionals work together with parents and carers as a team. For example, mobility can be practiced through play as well as during physiotherapy sessions, and therapy involves other aspects of education. Speech therapists assist children in the
development of communication skills, either through speech or by non-verbal methods such as picture communication symbols.

It is believed that the sooner children begin to attend, the sooner they can begin to develop and practice their skills – there is a broad curriculum within which goals are set for each child and their progress is regularly monitored. The aim of teaching and therapy in the early years is to prepare children for school. It is also believed that each child benefits both from individual attention and learning to function as a group member. Interaction with other children and staff, as well as facilitation and positioning to enable participation, achievement and play is seen as promoting learning development."

However tempting it might be, the purpose of my analysis is not to compare, contrast or evaluate the quality of practice in the two settings. Instead, I treat the two settings as different ‘arenas for action’ (Hutchby & Moran-Ellis, 1998), where certain notions of good communication and ‘communication difficulties’ were objects of intervention.

1.1.2 The evolution of the research questions

This research project has departed from the original research design in some important ways, which I will now address. In the original research proposal for the CASE studentship (see Appendix 1), there was an exploratory aim to research the place of the child’s ‘voice’ in a multidisciplinary assessment of needs. This initial research problem mainly arose from child protection concerns, as well as from recent sociological writings on children’s communicative competencies (e.g. Hutchby & Moran-Ellis, 1998). The idea was to explore aspects of listening to and hearing what children say and/or indicate, and how constructions of ‘communication difficulties’ may affect the process of listening.

The original research concerns sought after more in-depth sociological, rather than merely developmental or medical, understanding of disability communication issues. The need for this research project was based on two main arguments. First, statistically, disabled children with little or no speech are more vulnerable to abuse than their able-bodied counterparts, because their communication needs are not understood and they do not have the means to tell of abuse. Second, even though the
children had speech, adults may not take their accounts or indications of abuse seriously (Morris, 1999). This is against the idea of ‘listening to children’, which is a current legal duty and ethical recommendation for ‘good practice’ in many countries (see Chapter 2), including England.

The ‘Team Service’ was envisaged as an epistemologically appropriate setting for the research, because the ways in which health professionals assess and deal with children’s communication and child protection needs could be observed there. However, as part of the pilot phase of the research, it was also suggested that before starting the main fieldwork with the ‘Team Service’, I should spend some time familiarising myself with the everyday life of disabled children in a day nursery (‘Children’s Centre’). The idea was to gain further ethnographic understanding of ‘what was going on’ in general: how did children and workers ordinarily communicate, for example, with the use of visual communication aids, in care settings? What was communication like in general between adults and children and among children? In addition, did the communication aids allow them to express their ideas on, for example, child abuse?

The original research proposal suggested using ethnographic methodology. This stemmed from an approach in the so-called ‘new paradigm for childhood sociology, which promotes the recognition of children as ‘beings in their own right’ (e.g. James & Prout, 1997). At the same time, the aim was to understand the meanings that all the actors in the two settings applied to their co-actors and interactions. There was the expectation that a ‘fuller picture’ about children’s ‘communication/difficulties’ would emerge from intensive observation and a prolonged stay in the field.

Unexpectedly, the observations in the nursery became crucial to the direction of the research. They started to generate some other questions about the phenomenon of ‘communication’ and meaning making. Does non-verbal communication follow the same logic as verbal communication? What kinds of theoretical models may underlie the use of augmentative communication? How may this be manifested in practical contexts? For example, does the provision of picture symbols representing body parts necessarily enable the children to express their experiences of abuse? These questions
have so far been marginal in child protection related literature that discusses disabled children’s communication.

Further sociological questions in the nursery arose about the ethos of care. What kind of institutional discourses framed the principles according to which the adults communicated with children? What kind of communication did these principles allow and/or encourage? These frameworks might not have derived directly from, for example, child protection concerns, but could most certainly be seen as having implications for those concerns, and for the understanding of disabled children's lives in general. For these reasons, it was decided that the original focus of the research should be broadened.

The original questions concerning the ‘Team Service’ setting were modified as well after the pilot observations in both settings. There was a shift away from child protection concerns to a narrower exploration of the minutiae of the diagnostic processes: how did health professionals come up with definitions of ‘communication difficulties’ in multidisciplinary interaction? A practical reason for this shift was that child protection issues did not arise to the extent that the original research proposal expected, whereas ‘communication difficulties’ were a frequent concern in the referrals. The focus of attention of my study thus moved to giving accounts of interactional events where clinical notions of ‘communication’ and ‘disability’ met.

Furthermore, once I had spent some time in the field, I found out that the ‘voice’ of the child was not built into the needs assessments. On the other hand, I regarded it as analytically necessary to search for the meaning of the ‘voice’ - that of the children, adult actors in the two settings, and my own as a researcher - in a more general way: What underlying assumptions did the idea of an individual’s ‘voice’ entail in the two settings, if and when it was an object or feature of interaction?

Another significant change to the original proposal was that I did not carry out formal interviews with parents or professionals. I did, at one point, prepare self-completed questionnaires for the ‘Team Service’ practitioners to complement my observations; however, the response rate was very low. Consequently, one of the potential research questions was abandoned: How did health professionals view their own practices vis-
à-vis ‘communication/difficulty’? Therefore, in this thesis, I will remain the sole ‘speaking subject’ (Lee, 2000).

1.2 Developing an epistemological stance

My sociological approach is fundamentally different from practice orientation in clinical/therapeutic settings, where the child is typically treated as a ‘case’, or as an individual with specific needs. Instead of looking at the child, I have concentrated on ‘communication’ and ‘communication difficulties’ as objects of human interaction. For this purpose, I have adopted an interpretivist, constructionist approach (Schwandt, 1994) in two different senses. First, in terms of the ‘realities’ in the research settings, I see the meanings of (inter)actions, ‘texts’ and objects as socially constructed. Second, my approach constructs accounts of those realities, oscillating between sociological and clinical/therapeutic worlds.

At the same time, my attitude, to an extent, resembles the following quotation by Hacking. Here I conceptually replace Hacking’s focus on ‘psychiatric disorders’ with ‘communication difficulties’:

“"My position here is rather curious. I have already made amply plain that I do not, myself, favour the language of social construction. I am discussing it in connection with psychopathologies because many deeply committed critics of psychiatric establishments find social construction talk helpful. It enables them to begin with a critique of practices about which they are deeply sceptical. I respect their concerns, and I have, I hope, represented them fairly, if cautiously. On the other hand, I also respect the biological program of research into the most troubling of psychiatric disorders. That creates a dilemma" (Hacking, 1999, p.122).

Indeed, my personal wavering between the so-called foundationalism and anti-foundationalism (e.g. Prout, 2000) in relation to both notions of ‘Childhood’ and ‘Disability’, as well as between extreme and more benign versions of ‘realism’ and ‘anti-realism’ in sociological thought (Williams & May, 1996) has affected this research process to the extent that a great deal of this thesis will describe and reflect on it. This is because, as I see it, there is no doubt that ‘communication difficulties’ are real to the children, their families and professionals, whose duties are to intervene.
in these children’s lives. For these reasons, between the lines and beyond, this thesis is an account of my personal journey through the trials and tribulations of doing a PhD research project.

Ironically, albeit having been keen to deconstruct social norms for ‘good communication’, I have nevertheless felt the need to conform to them. Hence this thesis follows established academic norms for writing and presenting results of social scientific enquiry. It sets the scene, outlines the empirical evidence and draws conclusions based on sociological theory. Yet I want to stress that a PhD thesis, as an ethnographic text, is a somewhat abstract and reduced encapsulation of something complex, fluid and multifaceted that took place within social interactions in the field. It is, like ‘communication difficulties’, an outcome of a social construction process.

1.3 Conclusion

The crafting of this thesis has involved various practical hurdles, one of which has been the delineation of its scope. As for Barnes:

“Every book, unless it is carefully controlled in the making, tends to grow into a prolegomenon to a complete history of the universe” (Barnes, 1979, p.9).

Instead of trying to explain absolutely everything about human communication, I have focused on dimensions of its ‘socialness’ in the two research settings. This thesis talks about face-to-face communication in specific contexts, and generates sociological analyses of my observations in the field. At the same time, I believe that, on a discursive level, my findings have significance beyond the research settings in question.

Another headache for me has been the ethical obligation to somehow incorporate the child’s ‘voice’ into the research. Indeed in academic and practice discourses about research on/with children, a current trend stresses that children should not be treated merely as objects of adult purposes (Beresford, 1997). On the other hand, in this research, I have done something else that is equally valuable: I have described observable action that has significant consequences to the lives of young (disabled)
children. In fact, the notion of the ‘voice’ of the child, as I will explain several times later on in this thesis, has become subject to deconstruction in the course of this research process. This finding, I argue, has important implications for both sociological theorising of communication, and for child welfare and social research practices.

A further obstacle arose out of my verbal encounters with adult non-sociologists, with whom I had to tackle my own ‘communication difficulties’. This included attempts to translate sociology into plain English, with the added edge of English not being my first language. However, I regard this as a finding in itself in that adults, as well as children, do not remain unaffected by dominant discourses on communication.

1.4 Overview of the chapters

Chapter 2

In child Health, Education and Welfare practice, ‘normal communication’ and ‘communication difficulties’ are understood in certain ways. Chapter 2 provides an overview of the practice context of this research, as well as describes currently recommended procedures for identification of and intervention into ‘communication difficulties’.

Chapter 3

Chapter 3 delineates a sociological challenge to the dominant understandings of human communication (and thereby also those of ‘communication difficulties’). I will introduce and deconstruct some influential and taken-for-granted verbalist, cognition-based and ‘engineering’ models of communication. This questions the primacy of abstract thought and symbolic understanding in ‘normal’ child development, as well as the understanding of communication as a key skill for a good life. Instead, it is being proposed that communication is a social and contextual phenomenon. Importantly, this makes the notion of the ‘voice’ of the child problematic.
Chapter 4

As a social construction, ‘communication difficulty’ does not stand on its own. Chapter 4 links it to the socially constructed aspects of ‘Childhood’ and ‘Disability’. I will explore the ambivalences in hegemonic definitions of these concepts, as well as in the recent sociological challenges to them.

Chapter 5

Chapter 5 details the research process and epistemological considerations for this project, including descriptions of the research settings. I will outline what I ‘did’ in the field and how I analysed and wrote about the data, as well as begin to reflect on the research process.

Chapter 6

In Chapter 6 I will outline and discuss research ethics, including guidelines for good research practice and how I have attempted to apply the recommendations to this research project. This chapter suggests that research ethics involve various, sometimes contradictory, dimensions and ultimately they are questions of contextual choices, morality and politics.

Chapter 7

Starting from the ‘Team Service’ data, this chapter looks at ‘communication difficulty’ as an object of rational, expert action. It describes children’s ‘communication difficulties’ as outcomes of social construction processes - professional reading and writing practices - instead of them being matters of straightforward objective facts.

Chapter 8

The specialist reading and writing practices also involved what I call the ‘sociocultural’ dimension of human interaction. The data analysis suggests that the
‘Team Service’ practice routinely featured value judgments on ‘good communication’ and ‘normal childhood’ in general. The notion of ‘sociocultural’ here is juxtaposed with that which is regarded as ‘scientific’, the former denoting personal opinions and the latter referring to a degree of impersonal, rational and value-free procedures, which the practice was expected to derive from.

Chapter 9

Chapter 9 moves onto the ‘Children’s Centre’, where, in the same way as with the ‘Team Service’, communication was a central object of action. It describes how communication was treated as a medium between minds, and the ambiguities I perceived being involved in this concept. My sociological ‘gaze’ focuses on meaning making and what was expected of the child in communication situations.

Chapter 10

Chapter 10 looks at communication as an educational and therapeutic objective in the ‘Children’s Centre’. Again, ‘communication difficulties’ were objects of the so-called ‘corrective practices’, which derived from hegemonic developmental and linguistic genres. At the same time, this chapter suggests that scientific and everyday knowledges were not separate entities, but indeed merged together in the everyday nursery practice.

Chapter 11

This chapter links the findings to sociological theory. As well as discussing features of communication in the two settings, I will propose some alternative ways for perceiving professional practice with young children, who may or may not have ‘communication difficulties’.

Chapter 12

Chapter 12 continues the discussion on my own communication difficulties as a researcher. I suggest that my reflections on my research practices can be applied to
other contexts in terms of the epistemological value of sociological knowledge accumulation and accounts. In this chapter, I emphasise the importance of being reflexive about doing research.

Chapter 13

In conclusion, I will recap the core theoretical arguments as well as propose some ideas for future research.
Chapter 2.

YOUNG CHILDREN'S ‘COMMUNICATION DIFFICULTIES’: THE NEED FOR PROFESSIONAL INTERVENTION

2.1 Introduction

As stated in Chapter 1, children's 'communication difficulties' have exclusively been the business of developmental psychology, medicine, and linguistics and of associated health, welfare and educational professions. This chapter provides a broad overview of how they are typically understood and dealt with in these dominant discourses, as it appears in the current practice oriented literature. In section 2.2, I suggest that dominant discourses construe a notion of 'good communication' as the child's skill, right and need, and promote the need for early intervention as a matter of urgency. 'Communication difficulties', thus, are perceived potentially not only as a risk in terms of the child's well being but also a wider-reaching social problem.

The literature suggests that, in general, children's 'communication difficulties' are contrasted to what is considered 'normal', typically in relation to their overall development. In section 2.3, I will look at the clinical parameters for 'normal' development, including typical milestones in child language development, as well as in non-verbal development. However, not all 'communication difficulties' are considered developmental. Section 2.4 gives examples of 'cases', which featured frequently in my field data, and which are known to be particularly difficult to diagnose for different reasons (both developmental and non-developmental).

Section 2.5 illustrates the identification process and the subsequent intervention in terms of what happens to a child who has been referred to statutory services, and section 2.6 talks about post-diagnostic intervention. I will review literature on the main purposes of speech and language therapy, as well as the promises and pitfalls of the use of augmentative and alternative communication (AAC).

Including some recent changes in the child law in England, 'listening to children' has become a recognised part of recommendations for good practice. Section 2.7 explores
this discourse in general, as well as in terms of the use of alternative and augmentative communication (AAC) in particular. I will highlight some of the current tensions between ideals for good practice and messages from practice contexts, where professionals have attempted to ‘bridge the communication gap’ with young children with little or no speech.

2.2 The rationale for and expectations of professional intervention

Commonplace understandings of human (face-to-face) communication in both expert and lay perspectives tend to construe it as a rather straightforward activity. It is typically understood as a process where thought is formed, translated into a sequence of words, and transferred into speech (e.g. Glennen, 1997). The important social function of communication is to exchange information, make requests, socialise, and interact with others: communication is understood as central to the formation of the social bonds that bind people to each other, their communities and their culture.

In recent educational discourses, communication is also seen as a key skill: the ability to create good relationships through empathy, listening and responding determines success in every area of life. For Phillips (1998), there is an overwhelming consensus from parents, teachers and politicians that the lack of communication skills amongst young people is proving to have disastrous results for them both socially and academically.

These discourses draw on a developmental emphasis on language as crucial for a child’s inner development as well as for healthy social bonding and emotional stability. It is argued that a child who is hampered by a communication disorder tends to become marginalised in society and to suffer from a natural frustration and resentment. For Bogle (1994), unlike, for instance, the deaf and the blind, these children all too frequently slip through the early-detection net. Hence there is currently a heightened emphasis on targeting these children in early intervention practices.

Initiatives for early intervention are supported by recent empirical studies of children with specific language difficulties, which have reported a high rate of linguistic,
educational and social impairment persisting many years after the language difficulty was first diagnosed. A number of retrospective studies have appeared to indicate that children with speech and language difficulties often develop academic problems, including difficulties with literacy, numeracy and attention, and lowered self-esteem (Dockrell & Messer, 1999). Early intervention is also perceived as a matter of urgency in child protection contexts. For Morris (1999), young disabled children with little or no speech are particularly at risk since their communication needs are not fully met.

Guidelines for practice involve a number of strategies for dealing with children’s communication difficulties and needs that may arise thereby. While specifically focused therapy for aspects of language handicap are fruitful and essential, Haynes (2000), among others, proposes that equal priority and time should be devoted to promoting a positive self-image as an effective communicator. Well-delivered early intervention, of which the facilitation of language skills is a major component, is believed to have long-term effects for socially disadvantaged groups in that it reduces dropout from school and teenage pregnancy rates, whilst it increases the likelihood of employment and decreases criminal behaviour (Glascoe & Sturner, 2000).

In short, child health, welfare and educational professionals’ decisions about intervention are based on whether the child is perceived as lacking ‘normal’ communication skills and to what extent this might be the case. Hence there has to be a baseline for ‘normal’ development of communication skills in childhood. This baseline draws on various developmental and clinical theories. I will now review some recent literature on ‘normal’ communication in childhood, and illustrate how language learning is seen as central to the child’s development.

2.3 Children’s communication: features of normal development

In practice accounts, it is generally agreed that the development of communication starts from the moment the child is born:

“...There is now considerable evidence that children are expressing needs from birth and indeed even *in utero*. Of course, it is impossible to describe these early
interactions as far as the child is concerned. Initially he or she is responding to the immediate physical environment, simply reacting to internal imperatives, rather than deliberately conveying a message. But parents often interpret such involuntary movements as communicative and respond accordingly" (Law, 2000, p.8).

For Law (2000), one of the child’s earliest skills is the capacity to attend and to listen. By the age of perhaps six months, the ‘involuntary’ movements and sounds have gradually developed to consistent babble. Babble primarily fulfils a motor function (drawing attention), but it starts to lose this function, once it becomes superseded by early speech.

At the end of the child’s first year there is typically a shift to intentional symbolic communication on the part of the child: language structures follow on from this. Developmental psychology assumes a symbiotic relationship between play and language in the early years. Through play and social interaction with others, the child develops a working understanding that a word can stand for an object or referent and that this relationship is communicable, as well as an understanding of social routines and physical properties of items in his/her immediate environment.

According to Law (2000), by 18 months, nearly half of all children are using more than 100 words, and by 30 months 70% of children are using 500 or more words. There are typically individual variations in terms of, for instance, learning to use the past tense of verbs correctly. By 2 years, the child may have learned social communication skills, such as turn taking and is able to hold conversation to a certain extent. By 3 years, children can typically master several speech sounds (such as m, b, p, h, w plus vowels) and become gradually more intelligible to strangers.

A model of a normal progression of the child’s language development is illustrated in Figure 1. Drawing on developmental psychology, language is constituted as a ‘vehicle for thought’. For Cooper (1978), it develops from situational understanding and conceptualising to symbolic understanding, and has a directive-integrative function. The arrows below the main figure indicate the ‘normal’ age at which these abilities and functions typically develop.
Figure 1. Processes involved in the development of verbal language (adapted from Cooper et al, 1978, p.25).

Box 1.1: The tree of language

Speech
- articulation
- phonology
- praxis
- voice
- fluency
- prosody

Expression
- vocabulary
- syntax
- morphology

Comprehension
- verbal
- non-verbal

Underpinning abilities
- cognitive skills
- short- and long-term memory
- listening/attention
- symbolic skills
- hearing

Figure 2. The tree of language (Law, 2000, p.4).

Alternatively, the ‘tree of language’ model illustrates more in detail the specific components of language learning. In Figure 2, the roots of the tree outline the
underpinning abilities that contribute to the child’s learning of language: these include cognitive skills, as well as memory, listening, symbolic, hearing and motivation related skills. The trunk of the tree represents the child’s verbal and non-verbal comprehension. For Law (2000), verbal comprehension can be context free, but non-verbal comprehension is context-dependent.

Expression can be seen as being about the formal aspects of language, as well as about the ‘semantics’: the child’s intended meaning. The ways in which people interact and share meaning with one another may be illustrated with a metaphor: water flowing through the roots, trunk and branches of the tree. This aspect of communication is called ‘pragmatics’: it refers to the skills necessary to interact effectively, to interpret what the speaker is meaning to say, or to read between the lines of the more obvious structural aspects of communication. The ‘social aspects of communication involve ‘keeping up with’ peers and learning the social functions of communication, such as telling jokes.

Law (2000) sees communication as being made up of a web of intersecting skills of which speech is but one. Fundamentally, separating out communication skills in this way helps to identify the child’s strengths and weaknesses across a range of skills and this is important for the purposes of both diagnosis and treatment. For example, vocabulary and speech is often overemphasised as a measure of communication skill: it is only one part of the overall picture and research shows considerable variation within the normal range. Furthermore, children’s communication skills should always be judged in the context of what would be expected for the child’s age. In other words, they should not be simply compared to the adult model of speech.

The tree of language model suggests that since communication is made up of a range of identifiable components, no observation is complete without consideration of all these. This has implications for child assessment practice and subsequent intervention in several ways. For example, it is not simply a matter of assessing a child on a single occasion: each one of these components has its own developmental progression and they interact differently across time. Therefore, any assessment or intervention must also include careful analysis of the child’s communication environment because each
child develops his or her communication skills in the context of the home, the school and, as they get older, their peer groups (Dockrell & Messer, 1999).

2.4 Guidelines for identification of ‘communication difficulties’

In the professional vocabulary, the term ‘assessment’ usually refers to a detailed and systematic set of investigations that attempt to specify the nature of the child’s language and other difficulties and possibly identify factors that may have caused the problems. In section 2.4.1 I will look at recent recommendations for multidisciplinary practice in terms of assessing children’s needs as a whole. Section 2.4.2 illustrates how communication difficulties are addressed, as part of general needs assessment, often prior to school entry age. The use of tests within assessments will be discussed in section 2.4.3.

2.4.1 Needs assessment and multidisciplinary practice

In the past two decades multidisciplinary and multiagency child assessment, instead of single practitioner or single agency assessment, has become recommended as good practice (McConachie et al, 1999). In the current legal literature on the care of disabled children, needs-led approaches to assessment and integrated family service provision is being promoted. This means that disabled children and their families are seen to have diverse needs, and hence flexibility by agencies providing services is needed.

‘Good practice’ in this area (Read and Clements, 2001) entails that together with the children and the adults concerned, practitioners consider the needs which have to be met in their daily lives, plan an individualised package of provision that addresses those needs, as well as monitor and review how it is working at agreed intervals and modify it as needs and circumstances change. A needs-led approach starts by assuming that disabled children have the same basic needs as all children, but because they are living with impairments some may require additional support, assistance and intervention.

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2 This recommendation was applied to practice in both research settings in this research (see Chapter 1).
The essence of the needs-led approach has now been identified: how to make service provision more responsive to the individual needs of families and children? According to the recent ‘Guidance Framework for Assessing Children in Need’ (DoH, DfEE and Home Office, 2000), and ‘Practice Guidance’ (DoH, 2000), the practitioner is required to look at any child in the context of the whole family and local community in terms of three domains. Domain A — child’s developmental needs — includes health, education, emotional and behavioural development, identity, family and social relationships, social presentation and self-care skills; domain B — parenting capacity — involves basic care, ensuring safety, stimulation, guidance and boundaries and stability; and domain C — family and environmental factors — includes family history and functioning, housing, employment, income, family’s social integration, community resources, as well as involving disabled children in the assessment process (Read & Clements, 2001). In terms of ‘normal functioning’ in school, the assessments are meant to measure physical health and function, communication skills, perceptual and motor skills, self-help skills, social skills, emotional and behavioural development and responses to learning experience (Friel, 1997).

Various ideas on improving processes have been proposed and evaluated; however, the structures and resources required to underpin those ways of working remain rather poorly defined (McConachie et al, 1999). Since there are few models for how to manage complex specialist multidisciplinary and multiagency teams and since there are no clear guidelines on operation and management for child disability services, the commissioners of children’s services are left to pick their way through the relevant parts of legislation. Moreover, there is a need to consider the nature of appropriate evidence, but there is not very much evidence available to suggest whether therapy approach A is better than therapy approach B or than no specific therapy at all. They urge service providers to address the question of effectiveness, which is the extent to which specific clinical interventions do what they are intended to do (McConachie, 1999).

Cass et al (1999) argue that assessment of children with complex disabilities is notoriously difficult, and there is frequently uncertainty about the accuracy of clinical findings, with reports of better performance in informal situations. The unfamiliar
setting may inhibit children, by having demands placed on them to respond, or by the challenge of interacting with unfamiliar people. In the assessment situation, the child’s motivational factors, or the presence of parents, may affect the outcome. These writers suggest that assessments should involve ‘non-standardised’ elements such as giving children control, interesting toys and games, humour, and spending enough time with the child.

2.4.2 ‘Communication difficulties’ as a part of needs assessment

Professional intervention into young children’s lives may take place because of a variety of needs, sometimes including communication needs. Sometimes the child’s perceived communication is seen as the child’s main problem; at other times as part of a wider range of difficulties that require intervention.

Identifying and meeting any special needs often becomes pivotal at school entry age. At the moment, in the UK, there are two different paths to identifying the child’s educational needs: firstly, an attempt to screen for specific complex developmental disorders; and secondly, a general screening of the whole year groups at school, such as a baseline assessment for school entry (Cass et al, 1999). The assessment process for communication difficulties is illustrated in Figure 3 (Parkinson & Pate, 2000).
Figure 3. Describing the communicative need (adapted from Parkinson & Pate, 2000, p. 92; SLT stands for speech and language therapist).

The figure illustrates the range of potential outcomes of a referral and the subsequent action. A speech therapist’s initial assessment may indicate that the child does not have a communication disorder, or that the child has got either a developmental or a
non-developmental disorder or impairment. When the child is perceived to have multiple needs, he/she is typically referred to a multidisciplinary child assessment team. The parents are usually involved in all the stages of the assessment, review and intervention process.

2.4.3 The place of testing within assessments

Within the developmental perspective, there appears to be a consensus that child assessments need to be based on sound judgments, which reflect the essential components of language and offer fair comparisons with peers (Dockrell & Messer, 1999; Law, 2000). In general, whether somebody’s judgments about the child’s communication competence can be accepted depends on the following factors: how long he/she has known the child; his/her professional experience; other factors that influence the child’s behaviour; what the professional means by certain descriptive words, such as ‘mild’ or ‘moderate’ difficulties; whether the child’s behaviour is typical or unusual; and the demands of the particular environment, such as the assessment room.

A wide variety of assessment devices are now available for the evaluation and diagnosis of school age children. The situation with younger children is different with fewer valid instruments available from birth to three years; at the same time, some assessment tools are more commonly used than some others (Dockrell & Messer, 1999). As indicated in Figure 3, initial assessments may involve either formal or informal tests, the latter being more typically used with younger children.

Standardised developmental screening tests have been used to overcome the potential bias of professional judgment. It is stressed that screening tests should be as accurate as possible, although acknowledging that they cannot be error-free. For a test to be valid, sensitive and specific, they have to be standardised, which means that measures must include a sufficiently clear set of directions so that they can be administered in exactly the same way by different examiners working in different settings (Glascoe & Sturner, 2000). However, messages from research have indicated that tests too are problematic in practice: they may be too long for routine use; there is little time to administer them; trying to manage the child’s behaviour during the testing can be
difficult; and the accuracy of the tests is questionable. For this reason, parental questionnaires have increasingly been used as an important supplement.

Dockrell and Messer (1999) stress that language is a multidimensional phenomenon and as such does not easily lend itself to single unitary measures. There is much variation in normal patterns of development and this makes it difficult to draw precise boundaries between typical and atypical development. For this reason, they recommend a combination of formal and less formal tests. In other words, quantitative measures of language performance can be useful when combined with some qualitative methods. Standardised measures alone may fail to address the nature of poor scores and individual problems (see Appendix 2 for Reynell Scale III). The literature also suggests that children manifest language and behaviour that can be highly context dependent and this may be particularly relevant in more formal, unfamiliar situations such as those in which a child is being tested. For example, children may be fearful, or extremely co-operative or well behaved in the assessment setting, and quite the opposite at home (Gardner, 1998).

Moreover, children with communication and other developmental problems are often aware of their difficulties. Since they are often given tasks which are too difficult for their level of skill development, they may be inherently frustrated, anxious about the effectiveness of their communication attempts or excessively dependent on those who understand them best, such as the primary carer. Many writers now believe that there is a need to consider a wide range of factors that might impinge on the child’s performance, such as the appropriateness of materials, cultural factors, attention and motivation (Dockrell & Messer, 1999).

2.5 Distinguishing between different types of ‘communication difficulties’: examples

When children are referred for needs assessment because of potential ‘communication difficulties’, the next step is, as illustrated in Figure 3, to distinguish between different categories of problems. Basically, the task of assessment is to identify whether the child has, for instance, special educational needs, what these may be and how they could best met. Sometimes the identification process is fairly straightforward.
However, sometimes distinguishing between a child whose development is ‘slow but typical’ and a child who has a specific disability, and how ‘communication difficulties’ may feature in the two instances, is tricky both philosophically and practically (McMillan, 1994).

I will now provide three different examples of ‘communication difficulties’, which have been recognised as particularly hard to diagnose and ‘treat’. I have chosen these examples because they featured frequently in my field data3 (see Figure 8, p. 77). Section 2.5.1 looks first at non-developmental speech and language impairments (SLI). According to Rice (2000), children with Specific Language Impairment (SLI) do not show other developmental delays, and their ‘immature language’ could be attributed to a simple delay in onset, which they will subsequently ‘outgrow’. Another challenge for practitioners is bilingual and multilingual children. It is not always easy to determine as to whether these children’s perceived difficulties may stem from developmental or language disabilities/delays, and/or cultural differences (e.g. Martin, 2000).

Section 2.5.2 outlines a clinical criteria and the diagnostic procedure for Asperger’s Syndrome, which is a complex developmental disorder (see Figure 4, p. 29) and may involve ‘communication difficulties’. Although there is increasing pressure to detect children with disorders of this kind as early as possible, there are a number of ambiguities involved in diagnosing it. This, as I will later illustrate in my data analysis, is problematic both practically and sociologically.

2.5.1 Non-developmental language difficulties: SLI and bilingual children

Most accounts of SLI stress the disproportionate difficulties seen with specific aspects of language structure. However, some authors suggest that some children have a rather different clinical picture. One explanation is to regard the child’s pragmatic difficulties as secondary to the structural language difficulties. An alternative view is to regard pragmatic difficulties as an indication that the child has autism or an autistic

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3 Some ‘communication difficulties’ are easier to diagnose, because they are statistically more commonplace and/or due to a particular type of impairment. For Bogle (1994), this is the case, for instance, with children who are deaf and the blind. In my observations of the ‘Team Service’, however, ‘communication difficulty’ cases were more complex. Hence this section looks at these ‘grey areas’ of the diagnostic process.
spectrum disorder, and should therefore be classified as a case of pervasive rather than specific developmental disorder – or the child’s difficulty may stem from both (Bishop, 2000).

One pervasive problem that affects the identification process is the theoretical uncertainties about children’s language acquisition. There is no universal consensus on how children, for example, learn how words represent items (Messer, 1994). However, instead of locating language acquisition merely in the period of early childhood, this process can be seen as continuous throughout the lifespan. For Tomasello (2000), it can be defined as a process by which:

“Human beings acquire the productive use of the linguistic constructions used by those around them, generalise the use of these constructions in novel ways, and combine these constructions creatively in discourse interactions with others” (Tomasello, 2000, p.13).

Assessment procedures face further obstacles when the children in question are bi- or multilingual. Many writers now stress that bilingualism is a linguistic, sociocultural and cognitive phenomenon, which is not language pathology (Martin, 2000). As against some past beliefs, there is no longer substantial evidence that becoming bilingual is disadvantageous for the children. Furthermore, the growing understanding is that being bilingual is not like being monolingual twice over: the languages are not completely separate but are inter-related and bilingual speakers and listeners draw on both. This means that being bilingual is the child’s language. Legally, it is today a recognised human right that bilinguals have the opportunity to maintain their languages.

Thus the professionals are required to clarify whether or not the language delay or difficulty solely concerns the later developing language, which will be English in most English speaking countries, or whether it concerns both (all) the child’s languages. Sometimes English might be these children’s third or fourth language, and they may have a preferred language. Quantitative assessment of language skills may not give the full picture of a bilingual child’s abilities in both languages. Indeed
comparisons ought not to be made with monolingual speakers’ language skills, but rather but more appropriately with other bilinguals’ performance.

Martin (2000) stresses that the aim for practitioners working with potentially bilingual children is not necessarily to work towards developing a ‘balanced’ bilingual, in essence someone who is equally fluent in two languages across various contexts. However, ‘semi-lingual’ as an alternative term is controversial because it may be associated with low expectations and underachievement, and suggests that poor language development may be due to within-child factors rather than being due to social factors. It also overlooks the fact that language skills may be context dependent.

The implications for the assessment of language and communication skills, therefore, are that assessment needs to be culturally embedded. Martin (2000) argues that, in many cases, practitioners aim to find assessment approaches and materials, which are acultural. On the contrary, with bilingual or multilingual children standardised tests could be done in a non-standardised manner, such as allowing the child a bit more response time. Also caution needs to be taken in the appropriateness of age-stage information. For example, language mixing is typical for these children – not a matter of disability.

2.5.2 Complex developmental disorder: Asperger’s Syndrome (AS)

Figure 4 outlines the diagnostic criteria for Asperger’s Syndrome, which belongs to the so-called ‘autistic spectrum’, and which sometimes involves ‘communication difficulties’. This criteria are frequently referred to in current literature on the topic, as well as on websites for people with AS.
Diagnostic Criteria for Asperger's Disorder

The "official" definition of Asperger's in the U.S. from the DSM-IV (Diagnostic And Statistical Manual Of Mental Disorders, 4th edition, 1994)

A. Qualitative impairment in social interaction, as manifested by at least two of the following:
1. Marked impairments in the use of multiple non-verbal behaviours such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction
2. Failure to develop peer relationships appropriate to developmental level
3. A lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g. by a lack of showing, bringing, or pointing out objects of interest to other people)
4. Lack of social or emotional reciprocity

B. Restricted repetitive and stereotyped patterns of behaviour, interests, and activities, as manifested by at least one of the following:
1. Encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus
2. Apparently inflexible adherence to specific, non-functional routines or rituals
3. Stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)
4. Persistent preoccupation with parts of objects

C. The disturbance causes clinically significant impairments in social, occupational, or other important areas of functioning

D. There is no clinically significant general delay in language (e.g., single words used by age 2 years, communicative phrases used by age 3 years)

E. There is no clinically significant delay in cognitive development or in the development of age-appropriate self-help skills, adaptive behaviour (other than social interaction), and curiosity about the environment in childhood

F. Criteria are not met for another specific Pervasive Developmental Disorder or Schizophrenia

Figure 4. Diagnostic criteria for Asperger’s Disorder (adapted from Attwood, 1998, Appendix 3, pp. 198-9).
The syndrome was originally described by Hans Asperger (and Leo Kanner) in the 1940s, but it did not achieve international recognition until the 1990s (Wing, 2002). At present, practitioners have a choice of several sets of diagnostic criteria. For this reason, the actual diagnostic process is recognised as being ‘notoriously difficult’.

For Attwood (1998), there can be two stages leading to a diagnosis of AS. The first involves parents or teachers completing a questionnaire or a rating scale. The second stage would be a clinical assessment by experienced practitioners. The diagnostic assessment takes at least an hour, and consists of an examination of specific aspects of social, language, cognitive and movement skills as well as qualitative aspects of the child’s interests. There may also be some formal testing using a range of psychological tests. Time is also spent with the parents to obtain information regarding developmental history and behaviour in specific situations. Another source of information is reports from teachers and speech and occupational therapists.

During the diagnostic assessment, the clinician engineers situations to draw out specific behaviour and makes notes on a checklist of diagnostic signs. For example, when examining social behaviour a record is made of the quality of reciprocity, how the other person is included in the conversation or play, when eye contact would be anticipated, and range of facial expression and body language. The child is asked questions on the concept of friendship and to identify and express a range of emotions. Parents are asked about the child’s understanding of the codes of social conduct, response to peer pressure, degree of competitiveness, and their abilities when playing with other children. In a clinical environment it is usually not possible to observe the child’s interactions with children of their age so a visit may be arranged to observe the child in their classroom and playground.

Furthermore, during the diagnostic assessment, a record is made of errors in the pragmatic aspect of language, in terms of how language is used in the social context. Records are made of how the child replies to adults’ questions, and possible anomalies in their vocabulary, choice or words, enunciation, as well as of incidents of the misuse of personal pronouns, literal interpretation, and whether they vocalise their thoughts on occasions where they would be expected not to talk.
The diagnosis relies on observational and verbal (spoken or textual) data. Cognitive abilities, special interests and movement skills are also assessed. Attwood (1998) stresses that none of the diagnostic characteristics of AS are unique and it is unusual to find a child who has a severe expression of every characteristic: each child is an individual in terms of the degree of expression in each of the areas. Therefore, for the practitioner, it is essential to consider alternative diagnoses and explanations.

Indeed, the literature suggests that, particularly with ‘communication difficulties’ that are hard to diagnose, such as the ones along the so-called autistic spectrum, continuous monitoring and reviews of the child’s development are necessary (Parkinson & Pate, 2000). I will now turn to what typically happens to the child in the intervention process after the diagnosis/decision has been made.

2.6 Post-diagnostic intervention

The key target in working with children with any type of ‘communication difficulty’ is how professionals and parents can most effectively enhance or improve the children’s ability to communicate. Current recommendations for good practice suggest that, to be effective, intervention strategies must be geared to the needs of the individual child and therefore must be closely integrated with thorough, ongoing assessment procedures. For Donaldson and Reid (1994), few would disagree with this statement, although there is less agreement about exactly how information from diagnostic assessments should be translated into intervention strategies; there is variation in the goals of intervention, in techniques to achieve these goals and in settings where intervention takes place.

Speech and language therapy is a central part of assessment and post-diagnosis intervention. Section 2.6.1 describes, according to guidelines for practice, what is typically involved in it in terms of young children with little or no speech. Here I will mention the speech and language therapist’s role in multidisciplinary teams and in day centre based individual intervention, since these roles are relevant to this research.

Alternative and augmentative communication (AAC) can be a significant component of post-diagnostic intervention with children with little or no speech. In section 2.6.2 I
will describe what AAC may typically comprise, particularly in terms of working with young children. The literature suggests that although the use of AAC promises to open up new communicative avenues for the clients, there are also a variety of complexities involved.

2.6.1 Speech and language therapy (SLT)

The following quotation captures the basic rationale for SLT:

"Since speech is the preferred method of communication in our society, those who cannot use it easily are handicapped. For most of us speech, in the sense of spoken language, is a convenient, flexible, and straightforward way of conveying information or exchanging thoughts and feelings. For the unfortunate exceptions, speech therapy exists to amend and develop the means by which language is conveyed" (Byers Brown, 1981, p.3).

SLT comprises a variety of forms of speech and language intervention, guidance and support. In a multidisciplinary team, the speech and language therapist’s role typically involves the provision of a specialist assessment and diagnostic service for children with difficulties in a variety of areas including communication, and the provision of a service within a multidisciplinary model of care. This includes coordinating intervention with other team members, and involving the parents in the process. SLT intervention may be carried out either individually or in groups. Speech and language therapists are expected to monitor the child’s progress on a regular basis and update goals accordingly (Van der Gaag, 1996).

In day centres, the aims and principles of SLT service delivery involve the following: to maximise the communicative potential of each client attending the centre; to facilitate an understanding of the client’s needs; to assist the centre staff to build up an appropriate communicative environment, in terms of the client’s skills, and of communicative participation and self advocacy. Sometimes this involves promoting and facilitating the use of AAC (ibid).

Speech and language therapists use models (and equipment and materials based on these models) that have been developed by doctors, psychologists and linguists: the
medical, the developmental and the language models. First, within the medical model, the procedure starts by observing the symptom and then seeks to trace it to a cause: it attempts to identify any disease of physical abnormality and then to consider the extent to which this can account for the symptom. From identification of the disease process it will move to consideration of attitude and environment. Physical examination is an essential part of this procedure (Byers Brown, 1981).

Second, the developmental model assumes that normal children move through stages of development in more or less the same way and acquire skills at more or less the same time. According to Byers Brown (1981), these stages and skills are well documented and the outside limits of normality defined. A child whose development in any area is causing concern may be placed within this framework and his progress charted. Third, the language model can be used to provide a check on procedure generated by other models. The language model looks at physical and psychological processes involved in the normal use of language, and is concerned with symbolic understanding and its functioning.

Some writers suggest that — in addition to dealing with the child’s speech and language problems — speech therapists have an important educational role to play by promoting reading and spelling skills (Stackhouse, 1992). They may also teach children non-verbal methods of communication, such as signing or picture symbols, which I will turn to next.

2.6.2 Augmentative and alternative communication (AAC)

This section now looks at what is meant by AAC and how it may or may not ‘work’ for ‘listening to children’ in either everyday or specialist contexts. Acknowledging that there are a wide variety of methods of AAC, I have mainly visual, object-like communication aids in mind, since I frequently came across such during my fieldwork in the nursery (see Chapter 1 for the ‘Children’s Centre’).

The practice literature suggests that early intervention AAC is critical for the development of communication and social interaction skills in children with physical disabilities in order to facilitate active communication exchange and to prevent
passivity (DeCoste, 1997). Figure 5 below illustrates the target areas in therapeutic intervention where AAC is being used, and which aims to enhance the child's 'communicative competence'.

![Diagram of communicative competence]

**Figure 5. Early steps towards communicative competence (adapted from MacDonald & Rendle, 1994, p.72).**

Augmentative communication means any method of communicating that supplements the ordinary methods of speech and handwriting, where these are impaired (Millar & Scott, 2001). Most AAC users use a mixture of unaided (such as signing) and aided communication (physical objects such as symbol charts or books), and a mixture of low tech and high tech aids, depending on the situation. Typically, the choice of each form of aid depends on the person's disability, skills and the practical demands of the communication situation.
For Millar and Scott (2001), the biggest advantages of aided communication are the flexibility and richness of communication that can be achieved by creating and/or customising vocabulary sets; employing sophisticated methods of storage and retrieval; and providing users with special means of accessing them, if necessary. Some types of AAC can be used by very young children, non-readers, and individuals with severe intellectual and sensory disabilities, since many are based on simple pictures and symbols (see Appendix 2). For example, low tech aids can be quick and simple to use (e.g. eye-pointing); high tech aids (e.g. computers), on the other hand, may be easier to use for people with severe physical impairments.

Millar and Scott (2001) stress that communication through the use of AAC needs to be learned by communicating in meaningful situations, particularly in the case of young children. For instance, provision of an expensive communication aid will not ensure that it is used in a versatile and truly interactive way under all circumstances. However, the use of low-tech symbol systems, which often consist of representational sets, such as picture cards, does not necessarily guarantee effortless communication. Scott (2001) suggests that for younger children it is sometimes hard to make the representational leap from understanding an object or activity itself to understanding the meaning of a two-dimensional symbol referring to that activity. Thus they may need to use real objects.

One message from the AAC developers is that it is not just the user, but also the people who deal with the input from the communication aids, and with whom the user communicates that need training, including both low tech and high tech aids (Millar & Scott, 2001). Augmentative communication does not occur in isolation: each person using AAC will have a network of people around them, consisting of both ‘experts’ and ‘laypeople’. It is suggested that the user needs to be part of the decision making process where the most appropriate communication medium is chosen – relying solely on speech and language therapy is not enough. It is also noted that people’s needs and abilities change over time.

Furthermore, learning to communicate by some augmentative means can be at least as difficult as learning to speak a foreign language – however, this is rarely acknowledged (ibid). In the case of children, because care workers and teachers
change, there is a need for continual training of the staff as well. In addition, parents and other family members need training to understand that the flow of ‘conversation’ will be different when using AAC – any technology (at the moment) cannot simply replace ‘natural’ speech, or ‘remove’ the impairment.

Sometimes the use of AAC is connected to communication as children’s legal right to have access to means of communication and thereby being able to express him/herself. The next section talks about the notion of ‘listening to children’ as it is currently addressed in literature on practice with children in general, and where disabled children are categorised as having ‘special needs’.

2.7 ‘Listening to children’

For Aitken and Millar (2002), the last two decades or so in the UK have witnessed the rise of a ‘culture of consultation’. This means that individuals are increasingly being supported to make their own decisions rather than having others make decisions for them. Notions such as ‘personal choice’ and ‘control’ now lie at the core of developments in services and opportunities. Increasingly, there have been campaigns to support disabled people as well, in order to have their views listened to and acted on.

Aitken and Millar have suggested that, given these cultural changes that have affected all citizens it was only a matter of time before the effects would begin to be seen in children. They argue that changes in UK child law have been a significant factor in this development. In child welfare literature, the ‘UN Convention on the Rights of the Child 1989’ is frequently referred to as the legal impetus in the Western world for ‘listening to children’ (Bayefsky, 2000; Middleton, 1999). In the Convention, Article 12 stated the right of the child to express an opinion and to have that opinion taken into account and Article 13 introduced the child’s right to information and to freedom of expression.

In the UK, the ‘Children Act 1989’ in England and Wales, and the ‘Code of Practice 1994 on the Identification and Assessment of Special Educational Needs’ (DFE, 1994) are also frequently referred to in practice literature as sharing the idea of ‘listening to
children’. The basic principle in the Children Act 1989, alongside duties, rights and responsibilities of parents and local authorities, was that the child’s welfare is paramount. The Act required that important decisions to be made about the children concerned, for example by courts, would need to take into account “the ascertainable wishes and feelings of the child concerned”, considered in the light of his/her age and understanding (Children Act, 1989, S17).

Discussions about the child’s ‘voice’ within the child welfare arena have typically revolved around whether adult professionals are willing to listen to children, and how listening could be done successfully. These discussions have drawn on complex debates having to do with children’s competencies, age and maturity, and the credibility of their statements (Davie et al, 1996); in effect saying whether children’s ‘voices’ could be taken seriously, and at what age this might be possible. In recent years, the ‘voice’ of the disabled child has increasingly been included in the discussions (Middleton, 1999; Morris, 1999). A core value within these discussions about ‘opening up communication channels’ between disabled children and their carers is that it is perceived to give children choices, in other words, allowing them to exert some control over their lives.

In parallel within child protection, there has been a discursive move to overcome the low value generally attached to children and their views. It has been argued that any failure to hear and validate what children say is a denial of their basic human rights (Bannister et al, 1990): the nature of communication must change from ‘advising, interpreting and controlling’ to ‘listening, hearing and validating children’s experience’ (Wells, 1989). For Wells, this would start with allowing children access to the language that would help them to disclose abuse, despite the fact that a child speaking about sex explicitly is a cultural taboo. This includes access to vocabulary or communication aids for articulating what has happened to the child. There would also be a need for empathy and respect for children’s views: adults should never assume that a child’s associations simply correspond to their own.

At the same time, it has been recognised that listening to the ‘voice’ of the child in child protection is not an easy task to fulfil. In the Department of Health 1999 publication ‘Working Together to Safeguard Children’, it was noted that listening to
children and hearing their messages requires training and special skills, including the ability to win their trust and promote a sense of safety. For example, children may feel loyalty towards their carers, not wish to share confidences or may not have the language or concepts to describe what has happened to them. It was also stressed that if a child and/or family member had specific communication needs, because of language or disability, it might be necessary to use the services of an interpreter or specialist worker, or to make use of other aids to communication (DoH, 1999).

There have been attempts to ‘bridge the communication gap’ between adults and non-verbal children, for example, by using play materials. In this context, it has been suggested that it is easier for a child to communicate information in a representational way using toys, rather than in words. For example, the disclosure of sexual abuse may be facilitated by the use of anatomically correct dolls, pens, paper and paints, activity based work, life story books, as well as by adequate talking and reading. Listening may involve learning to read between the lines, or seeing, smelling and feeling as well as hearing; also getting the setting right matters, such as the adult’s appearance, age-appropriateness of toys, the number of people in the room, and so forth (Ross, 1990).

2.7.1 Using AAC for ‘listening to children’

For Aitken and Millar (2002), the current legal context in the UK seems, on the one hand, to demand that children be involved in decisions that affect them. On the other hand, there remains a major difficulty around the concept of legal capacity. Be it in health, education, justice or social care, age and ability limit or enhance the degree to which the child can participate, be listened to and consulted about matters that affect them. If the child is ‘too young’ or ‘too disabled’, someone else will make decisions on his/her behalf.

These writers point out that, despite examples of good practice in consulting children, the reality is that they are not consulted as a matter of routine. One result may be that it then becomes more difficult for a child to know how to respond on the rare occasions when invited to express views. Furthermore, Aitken and Millar (2002) have found that the child’s views are generally not reported if the child has a severe communication impairment. Typically, the term ‘view’ conveys some formal
understanding of abstract language: words, phrases, sentences and grammar, to which these children do not have access.

The pressure to ‘give children choices’ may lead to unrealistic expectations of the use of AAC. For instance, in many care settings, ‘Yes and No’ methods are used with children and they are believed to be the first and easiest step in choice making. However, Millar and Scott (2001) have found that understanding ‘Yes and No’ is not the first but one of the later stages in the development of choice making skill. Instead, it is an abstract level of function, and depends on some linguistic understanding. Many children may not have understanding at this abstract level: even simple questions, such as ‘Do you want a banana?’ may well make the child confused. In fact, the child’s signals may actually relate to immediate and basic meanings linked to the sight, sound, touch, taste or smell of a concrete object or familiar action, not to a spoken question. In addition, the child’s signal may indicate ‘I like it’ rather than straightforward ‘Yes’; sometimes children may answer ‘Yes’ to everything, regardless of the content of the question.

The same ambiguities may apply to dealing with more sensitive issues, such as child abuse. There is now research evidence to show that many communication aids lack acceptable validity and reliability for the ways in which they are used (Wakefield & Underwager, 1998). The adult interpretations of children’s reactions and play with, for example, anatomically detailed dolls vary and are too often based on assumptions. It can be too easy to take children’s play as a reflection of actual events that have taken place in their lives, such as potential abuse. Besides, the lack of standardisation of communication aids makes every investigation situation unique.

In a study by Oosterhoom and Kendrick (2001), it was found that professionals who work with disabled children were unsure about the usefulness of AAC in child abuse investigations. The professionals indicated ambiguities in how the appropriate vocabulary could be introduced in a natural way and how links could be made between the signs and their meanings. The staff saw themselves as those most able to protect the children, but it was felt that discovery of abuse was more likely to come from them noticing physical signs, behaviour or mood changes than from the child communicating explicitly about abuse. This study also suggests that respondents
found teaching abstract concepts of sexuality to children ambiguous, if they still had difficulty in grasping more concrete examples.

2.8 Conclusion

This chapter has reviewed practice oriented literature in terms of the rationale for and expectations of professional intervention. Enabling children to access ‘good communication’ has been described mostly as a societal concern, when it is adult practitioners’ legal and ethical duty to do so. I have pointed out the increasing concern for the specific vulnerability of young disabled children with little or no speech, and some difficulties in ‘bridging the gap’, despite the professional awareness of this vulnerability.

The practice literature on ‘communication difficulties’ appears to draw on mostly developmental, medical, psychological and linguistic models of communication. By this I mean that, in general, language and the child’s cognitive development (such as symbolic understanding) is perceived as central to good communication skills. At the same time, recent debates suggest that communication is a complex phenomenon, which should not be reduced merely to the ability to speak: this has implications particularly for the understanding of very young children’s communication.

Although many writers stress the importance of incorporating the views of the parents in the process of painting a picture of the child’s problems, the professional expertise is taken as vital for making fair judgments and appropriate intervention. There are now plenty of guidelines in the English speaking world for identifying specific ‘communication difficulties’. Yet it is acknowledged that making diagnoses is not an easy task, since there are not necessarily any universal clinical criteria for certain ‘conditions’. This is particularly apparent in the case of complex developmental disorders, such as Asperger’s Syndrome. Furthermore, developmental models may not apply to all ‘cases’: in this chapter I have mentioned speech and language impaired and bilingual or multilingual children.

The purpose of professional intervention is to open up of channels for ‘good communication’, or at least for what is realistically possible (Parkinson & Pate, 2000;
Millar & Scott, 2001). Speech and language therapy as an expert specialism aims at helping children with both verbal and non-verbal methods of communication. The less children have speech, the more need there is for AAC. Many writers, however, point out that mediated communication has both advantages and disadvantages, and that persistent efforts from both adults and children are required for success.

In Chapter 3, I will make a move away from the practice view of ‘communication difficulties’. I will review sociological literature on human communication in terms of how it is understood, in general, in social sciences, and what implications this may have for the understandings of children’s communication. The focus shifts from impairment to dynamics of social interaction, and from models of ‘normal’ communication to alternative perspectives on human connections.
Chapter 3.

HOW DO WE KNOW THAT WE HAVE REALLY COMMUNICATED?
SOCIOLOGICAL CONSIDERATIONS

3.1 Introduction

What can sociology say about children’s ‘communication/difficulties’ that other theories have not already said? I attempt to answer to this question by posing some counter questions to ‘problems’ that I introduced in the previous chapter. Rather than focusing on ‘communication difficulty’ as the source of the child’s problem, I want to explore what is meant, implicitly or explicitly, by ‘good communication’. This is a move away from hegemonic, cognition and impairment focused practice models towards dynamics of human interaction and the ‘socialness’ of human communication. Over the course of this chapter, I intend to explain why and how I think this move is important.

To date, across various disciplines within the human sciences, children’s communication is typically constituted as a matter of ‘development’ and ‘language acquisition’. Traditionally, philosophers, developmental psychologists and social scientists have regarded children’s speech both/either as an inferior form of adult speech, and/or an object of adult correction through therapy and education. For example, within the so-called ‘Communication Theory’, which attempts to encompass the whole array of possibilities for human communication (Cobley, 1996), children’s communication is given marginal attention. Until quite recently, certain ‘adult’ models and theories have dominated our everyday and scientific understandings of ‘good communication’: I will give examples of these in section 3.2.1.

The previous chapter talked about ‘good communication’ and its achievement as an individual’s basic skill, need and right. In the so-called age of ‘late modernity’, we may ask whose job it is to decide who is a good communicator and what is, in the end, important to say (Cameron, 2000; Giddens, 1991). For example, there are long standing debates in English speaking countries about what might constitute ‘standard
English’ and ‘appropriate’ speech and language skills (Trudgill, 1999), and what implications this may have for different groups of people in society.

We may also question how and why language plays such a central role within hegemonic understandings of communication. This is apparent in both developmental psychology and mainstream Communication Theory, which, for a large part, draws on linguistics (Messer, 1994; Cobley, 1996). It appears that language based models of communication privilege speech and writing over non-verbal communication, the latter sometimes being regarded as, in an evolutionary sense, ‘pre-human’, or ‘non-human’ (Finnegan, 2002). Furthermore, theories of non-verbal communication typically draw on behaviouristic notions of ‘signals’, in other words, they treat gestures, for instance, as if they were words (Harris, 1996).

The previous chapter explored the notion of the child’s ‘voice’. Section 3.4 continues from it, introducing alternative, sociological perspectives to children’s and adults’ communication. Within the ‘new sociology of childhood’, for instance, it has been suggested that abstract thought, speech and literacy are a particularly western ideal, something that children are expected to strive towards (Jenks, 1996). Drawing on the Bakhtinian perspective, this chapter introduces the notions of ‘mutuality’ and ‘multivoicedness’ as alternatives to a unitary, atomistic understanding of an individual’s ‘voice’ (Wertsch, 1991).

3.2 Communication as a cognitive process of exchanging messages

Communication is typically understood as a process of exchanging messages, which takes place between ‘minds’, and is ideally mediated by words or other abstract symbols (Finnegan, 2002). This suggests that a somewhat ‘standardised’ process of exchange can take place between communicators, if there are not intervening factors, such as a physical or cognitive ‘impairment’ or external ‘noise’. Several theoretical models support this idea: in this section I will have a look at the ones that have been influential over the years across various academic disciplines.
Communication is often presented as being essentially of the mind (Finnegan 2002; Harris, 1996). The view that the ‘mind’ is the site, origin and definition of purposive human action shapes cognitivist approaches to communication, and is a long standing tradition in the western world. This idea is sometimes referred to as a ‘mentalistic’ approach, in which communication is a matter of mental representations, internal states or mental concepts. As an analogy to recent technological innovations, the ‘mind’ is also often conceived in terms of information processing, such as in computer systems, referring to the operations of the brain (Finnegan, 2002).

Odgen and Richards’ theory of communication is one example of a ‘mentalistic’ approach (Durham Peters, 1999). In *The Meaning of Meaning* (original version published in 1923) – communication was viewed as accurate sharing of consciousness and a path to more rational social relations (Odgen & Richards, 1985). For Durham Peters (1999), these writers called for an educated public, taught by experts to understand communication better, since communication for them was about matching the minds, and psychology would the best science to study it.

Another frequently cited view within Communication Theory is that communication is initiated by a sender ‘encoding’ a ‘message’ and transmitting this via a medium to a receiver. Having survived more or less accurately depending on the distortions (‘noise’) on the way, the message reaches the ‘receiver’ who ‘decodes’ it at the other end: the linear process is concluded with the successful receipt of the message. This idea is commonly illustrated by Shannon & Weaver’s model (1964; see Figure 6, p. 45), which was formulated in an engineering context in the mid twentieth century (Finnegan, 2002, pp.13-15).
In recent literature for speech and language therapists, a working definition of communication is very much in line with this model:

"Communication itself may be defined as the transmission and reception of meaning between one individual and another, or between an individual and a group – where 'meaning' is taken to include social and affective intentions and reactions, as well as prepositional content. The mode or medium of the exchange (speech, non-verbal signals, symbols, signs, writing, electronic code etc.) do not alter this definition of the central essence of communication" (Van Der Gaag, 1996, p. 88).

The ordinary image of the interpreter/translator is also very much influenced by a 'transfer' model of communication. Thinking of human interaction as a unidirectional process of transfer from one person to another is sometimes called the 'conduit' model of communication. For Wadensjö (1998), the conduit model is monological: the language use is viewed from the perspective of the speaker. The meaning of words and utterances are seen as resulting from the speaker’s intentions or strategies alone, while co-present people are seen as recipients of the units of information prepared by the speaker. The monological view of language conceptualises languages in terms of morphemes, words, sentences and other textual structures as 'carrying' certain straightforward meanings. Standardised grammars and lexical provide a strong support to this model of thought. I propose that the monological view also underlies current approaches to the development of children’s 'symbolic understanding' and I will turn to this in the next section.
3.2.2 Abstract thought and symbolic understanding

The use of symbol systems for communication, language being typically held as the most important, is sometimes thought of as the core of human nature (Finnegan, 2002). Within Communication Theory, discussions have revolved around whether language is a result of brain functions or whether language actually determines our thinking (Cobley, 1996).

Throughout western literary history, humanistic scholars and social and behavioural scientists have attempted to make links between the human mind, symbols and reality; in other words, how symbols gain their meanings in communication (Rosengren, 2000). For instance, some symbolic interactionist perspectives have stressed the importance of symbols simply because they replace physical reality: human beings label objects with symbols. In this line of thought, human society is seen as depending on ongoing symbolic communication, which constitutes the basis for human cooperation and the cohesiveness of human groups in terms of shared knowledge of their identities, history and so forth. Further, symbol usage enables the individual to categorise and thereby make sense of his environment; to adopt perspectives on the world; to think and solve problems; to transcend space, time, and one’s own person; to imagine and perceive reality beyond the concrete; and to be creative and self-determined (Charon, 2001).

The attainment of human language is sometimes portrayed as the crucial evolutionary step by which humans became differentiated from animals. The emphasis here is on our becoming intelligent beings capable of symbolic and rational thinking, leaving behind the emotional, gestural, non-rational and non-verbal forms of animal communication. Verbal language as a symbol system is seen as the necessary divide between objectivity, science, individual enlightenment, rational thought and literacy as against less ‘developed’ ways of communication (Finnegan, 2002).

Preference for symbol usage is apparent, for instance, in early symbolic interactionism. G.H. Mead labelled ‘pre-symbolic’ infants and nonhuman animals (such as chimpanzees or dogs) as ‘infra-humans’, who do not define social objects in interaction, do not use language in an ‘adult’ human way, and do not use perspectives
to define the reality they respond to. There may be communication among many infra-humans, but it is what might be called a conversation of ‘non-meaningful gestures’, where the act of one organism becomes a stimulus for a response in the other. Infra-humans have a passive relationship with their environment and their behaviour is usually ‘biologically programmed’ or learned through imitation and experience (Charon, 2001).

In a similar vein, as the previous chapter suggested, in developmental accounts, ‘symbolic understanding’ (Cooper, 1978; see Figure 1, p.18) is seen as central to children’s language acquisition. Symbolic understanding is connected to the child’s overall cognitive competencies, and delays in it are seen as resulting in difficulties with literacy. In developmental psychology, symbolic understanding and cognitive competencies are typically connected to the capacity for abstract thinking: the child’s move from ‘immediate experience’ and contextually based communication to the use of language and abstract concepts is regarded as a major developmental milestone (ibid).

This idea draws on Jean Piaget’s theory of the development of cognitive competencies, which has had a global impact on paediatric care and practice and on educational practice. For Jenks (1996), Piaget looked at a child to understand adult psychological operations better. Piaget formulated his theory of child development in terms of a cumulative transformation towards rational, intelligent adulthood. In terms of language learning, he emphasised its individual, cognitive aspect: the child learns to speak once he/she is at a relevant stage (Messer, 1994).

Piaget introduced the idea of chronologically ordered and hierarchically arranged stages in cognitive development where individuals move from low status, infantile, ‘figurative’ thought to higher status, adult, ‘operative’ intelligence. In the figurative stage, the child is instanced by particularistic activity, concentrated on the here and now, and therefore unable to transfer experience from one situation to another. Adult operative intelligence is seen as an ideal because it exemplifies logical process and freedom from domination by immediate experience (Jenks, 1996).
The idea of ‘adult rationality’ also underlies the thought of Chomsky, whose theory of language has significantly shaped professional understandings of children’s language impairments (Bishop & Leonard, 2000). Chomsky’s theory treats language as a system, and focuses on its structure, i.e. grammar. He describes the concerns of linguistic theory as follows:

“Linguistic theory is concerned primarily with an ideal speaker-listener, in a completely homogenous speech community, who knows its language perfectly and is unaffected by such grammatically irrelevant conditions as memory limitations, distractions, shifts or attention and interest, and errors (random or characteristic) in applying his knowledge of the language in actual performance” (Chomsky cited in Harris, 1996, p.146).

In conclusion, literature suggests that in various human scientific accounts there are and have been, in varying degrees, preferences for speech and abstract thought. The centrality of language and symbolic understanding is typically taken for granted. On the other hand, recent sociological literature suggests that communication in general, including children’s communication, could be approached from a different theoretical angle. Here I attempt to go beyond the definition of communication as predominantly a ‘skill’. Drawing on what are sometimes called ‘anti-cognitivist’ stances to human interaction, I will now begin to make a move towards understanding face-to-face communication as a social and contextually shaped activity.

3.3 Communication as a ‘key skill for good life’

In practice literature, communication is frequently referred to as a skill, right and need. The moral character of this framework – in terms of what constitutes a ‘good life’ – is now facing increasing challenges in social scientific writing. This challenge is not new. For example, over three decades ago, Goffman wrote:

“The moralistic language in the social sciences is built around the incredible notion that persons should be in good, clear, direct or open communication with one another is, if anything, worse – as if communication were a pill one ought to swallow because it was good for the tummy” (Goffman, 1967, p.138).
In this section I will look at how hegemonic understandings of good communication and its importance to everyday life have been deconstructed in recent social scientific accounts.

3.3.1 The technical and therapeutic discourses on communication

Despite the assertion that communication has been a subject of scholarly debates for millennia (Rosengren, 2000), Durham Peters (1999) argues that only since the late nineteenth century have we defined ourselves in terms of our ability to communicate with one another: 'communication' has become central to reflections on democracy, love, and our changing times. His question is why such a rich meaning is attached to the notion.

For Durham Peters, the two dominant discourses on 'communication' of our time are a technical one about information theory, and a therapeutic one about communication as cure and disease. Around the mid 20th century, the former was explicitly a theory of 'signals' and not 'significance', as in Shannon & Weaver's model. In this context, communication as a person-to-person activity was overshadowed by mediated communication, in other words, mass communication technologies. The latter – a person centred approach – has arisen mostly within humanistic psychology and psychotherapy.

Both the above discourses claim that the obstacles and troubles involved in human contact can be solved, whether by better technologies or better techniques of relating. The problem is that 'communication' has been 'hijacked' by experts, such as politicians and bureaucrats, technologists and therapists. At the same time, communication has become disembodied from interaction: the therapists (who want to build better relationships) and the technocrats (who want to build better systems) have done their best to suppress the truth that communication has become somewhat 'nonhuman' in itself.

In terms of the ontology of 'good communication', Durham Peters warns that the therapists run the risk of missing the eccentricity of the self to its 'owner', and the public character of signs: they imagine the self as a holder of private experiential
property and language as a courier of its messages. Therapeutic discourses perceive the alleged components of ‘good communication’ – understanding, cooperation, community or love – as genuine human goods. However, the attainment of these goods tends to overlook the circumstantial character of human communication. For example, too often the label ‘failing to communicate’ might be attached to persons when they are actually opting out of the game. He also points out that discourses on communication are essentially moral in character. Communication is envisaged as the great solution to human ills; yet most troubles in human relationships do not come from a failure to match signs and meanings. Rather, communication is more basically a political and ethical problem than a semantic and psychological one.

3.3.2 Communication as a ‘skill’ in late modernity

For Cameron (2000), ‘communication’ is another area in which expert systems are asserting themselves over more traditional, informal and diffuse ways of organizing knowledge and practice and that this has implications for the way we experience, understand and conduct spoken interaction. This resonates with what Giddens (1991) would describe as individuals’ lives becoming colonised by expert systems in late modernity.

An example of an ‘expert systems’ is education. For Fairclough (1995), during the 1980s and 1990s, competence based views of language and language education started to dominate educational thinking in the UK. There was a general shift towards seeing knowledge operationally, in terms of competence, what people can do, and towards seeing education as training in skills. Language and communicative competence as skills have become items in a list, which includes scientific, technological, practical and social competence and skills. Typically, communication skills are divided into the five aims of listening, speaking, reading, writing and interpretation, each of which is further broken down into more specific skills. For instance, ‘speaking’ involves five skills, including: talking effectively in a variety of styles and range of contexts; formulating and conveying requests and instructions clearly and concisely; initiating and sustaining conversations in a range of contexts (ibid).
Fairclough (1995) argues that competence based models in education incorporate a particular vision of a social subject and of the educability of the subject. They may be held as democratic in their view of subjects in that they imply that everyone has the capacity to learn, dependent only on training. Yet they are simultaneously normalising. They lay down common target behaviours, knowledges and understandings for all individual learners. Also they are individualising: they focus on each separate individual as housing a configuration of skills, which can be worked upon and improved, and thereby urge the contemporary ‘self’ to become more autonomous, and more ‘self-steering’. For Fairclough, these ‘ideologies’ can be traced back to, for instance, Chomsky’s grammar based notion of ‘communicative competence’.

Cameron (2000) suggests that the discourse of ‘teaching communication skills’ is a rhetorical feature of today’s enterprise culture. Although this enterprise philosophy involves goals rather than rigid rules for action, it is, at the same time, distinct from ‘bureaucracy’ in that it also has a focus on serving the needs of the customer. The managerial approach within this philosophy claims that it ‘empowers people’. This entails ‘workers’ being made responsible for motivating, disciplining and directing themselves and that their personal goals and objectives match those of the organisation. Increasingly, oral communication has become the key skill and educational objective in today’s working culture.

It appears, then, that in western societies at large, communication is still an emergent field of expertise. At the same time, the inevitable question arises: where does it emerge? Further questions may be asked: how are people being required to talk in contemporary society? What linguistic norms define good and bad communication? By whom, and for whom, are the norms constructed, and how are they enforced? What motivates the belief that communication is both the cause of all problems and the cure for all ills (ibid)?

Mainly referring to the current communication culture in the US, Cameron (2000) has observed two communication models that underlie objectives for teaching children. The ‘oracy model’ stresses intellectual functions, such as discussing and thinking. The ‘life skills’ model, for its part, emphasises self-discipline, in essence, listening,
concentrating, controlling anger and resisting antisocial behaviour. For Cameron, these elements reflect somebody's values for social competence. 'Circle time' in schools is a practice example of this: the object is to provide a safe environment where everyone has an equal opportunity to speak and to be listened. During circle times, children are encouraged to talk about their feelings and their problems: there is a strong emphasis on empathy.

In some contexts, concerning both adults and children, communication skills involve the ability to be interesting and entertaining, being 'proper', polite, eloquent and witty. In popular manuals for 'good communication', there is an emphasis on emotional articulacy (recognising emotions; classifying, understanding and dealing with people) and/or interactive skills (being assertive; asking the right kinds of questions; being an 'active listener'). Cameron (2000) connects these norms to the 'scientific' models for successful communication that were discussed earlier in this chapter. These norms draw on the idea of standardisation in the sense of uniform performance.

In some instructional material, 'good communication' is also a gender issue. Cameron sees connections between allegedly communication skills based 'disruptive disorders' and the prevalence of these in boys. The therapeutic approach holds that gender based 'communication difficulties' could be both genetically determined and learned, and, either way, controlled by therapy. This might ultimately lead to the question of what exactly constitutes a 'skill' in communication, and whether women, predominantly, have it and men do not.

3.4 Communication as a social and contextual phenomenon

"How can we know that we have really communicated? There is no ultimate answer besides a pragmatic one that our subsequent actions seem to act in some kind of concert...meaning is an incomplete project, open ended and subject to radical revision by later events" (Durham Peters, 1999, p.267).

This citation captures an important sociological puzzle in this thesis: how can we know that we have really communicated – with or without 'communication
difficulties'? As I interpret it, this question fundamentally challenges the common idea of ‘good communication’ as a relatively standardised exchange of messages, based on shared understandings of symbols. This idea steers the attention away from cognition based, decontextualised and passive models of human life towards emphasising the complex creative processes through which human beings actively interact (Finnegan, 2002). The argument proposed here is that meanings are context-bound in that they arise from situational interaction and interpretations, but are at the same time framed by influential discourses and the practices that sustain those discourses in society (Foucault, 1973).

3.4.1 Criticisms of ‘mentalistic’ and ‘conduit’ models of communication

For Finnegan (2002), Shannon & Weaver’s model (see Figure 6, p. 45) fits certain aspects of human communication, especially the transmission of messages at a distance through electrical/electronic media. The problem lies, however, in how it has been generalised and interpreted in other contexts. As a result, a narrow, mechanistic and ultimately unrealistic view of what is involved in communication prevails within the everyday, professional and academic use of the word.

The prime emphasis in Shannon & Weaver’s model is on transporting ‘the message’. This presumes that a ‘message’ retains some objective independent existence in its initial formulation, as well as in the ‘transmission process’, as if it was a distinct entity, which can be analysed separately from author and/or audience. It also appears to presume that the ‘exact transmission of message’ is always either people’s prime aim in communicating, and/or practically attainable in everyday life situations (ibid).

For Wertsch (1991), the transmission model is ambiguous above all because of the inherently monological assumptions that underlie it. The assumption that is it possible to speak of a single, unaltered meaning or message is problematic: the conduit metaphor assumes that the sender encodes a single meaning and transmits it to the receiver, who passively decodes or fails to decode it. In contrast, in human interaction, the message dissolves into a fluid, situational and multiplex process. It is a process through time, where mutual understanding and influence may eventuate during the interaction, and continue after ‘destination’; however, this should not be
reduced to ‘noise’ but held as an essential component of communication (such as in the children’s game of ‘Chinese Whispers’). In the communicative process, the audience is simultaneously a co-author. Indeed, the problem with the Sender-Receiver model is the assumption that there are always these two parties, although there can actually be more, and that ‘turn taking’ in conversation – including both verbal and non-verbal elements - does not necessarily happen in a clear cut manner (Finnegan, 2002).

In a similar vein, Aronsson et al (1995) argue that this so-called ‘conduit metaphor’ of communication is so much part and parcel of our understanding that it is often difficult to see what is problematic about it. One of the most problematic aspects of this attitude, and of rationalist, Cartesian, conception of language, thought and human action as a whole, is that the interplay of signs is not treated as a reality in its own right. Human communication is thus construed as a second order phenomenon, as merely an abstract version of the ‘objective’ world in which people have their ‘real’ interests, projects and commitments.

The Bakhtinian dialogical model⁴, as a contrast to the monological view, implies that meanings conveyed in and by talk are partly a joint product, where sense is made through common activity. In this view, communication, as well as miscommunication, presupposes certain reciprocity between the people involved, as well as multiple functions of words and utterances in layers of social contexts (Wadensjö, 1998). The dialogical model, among other things, rejects a ‘disengaged image of the self’ and the ‘atomism’ associated with it and the notion of literal meaning as the starting point for a theory of meaning (Wertsch, 1991). This idea is also apparent in Harris’ (1996) notion of the ‘fallacy of verbalism’, which, in his view, tends to dominate western notions of ideal communication.

3.4.2 ‘The fallacy of verbalism’

The above views of language argue that the cognitivist, mentalistic and grammar based views of communication treat word meanings as ‘fixed’; that is to say, they

⁴ Note: The dialogical model should not be confused with ‘dialogue’, i.e. this model can be applied to studies of situations with several communicators (Wadensjö, 1998).
assume that language is representational of reality and words act as indexes of meaning (Harris, 1996; Hodge & Kress, 1988). This approach perceives using ‘code’ and ‘sign’ in all forms of communicating as losing the distinction between the more explicit systems and the less standardised conventions, giving the misleading impression that all human communicating belongs to the former type. The problem is compounded by the primacy given to systems of signs and codes (Finnegan, 2002). Harris (1996) characterises as ‘segregationist’ the structural-linguistic view, which presupposes the autonomy of the sign in relation to its users and uses. Instead, taking on an ‘integrationist’ stance, he argues that signs are created in and by the act of communication.

Harris suggests that non-linguistic signs, such as gestures, have not been codified as rigorously as words even though their importance in face-to-face communication has been recognised. Hence problems arise when all symbol systems come to be treated as a substitute for spoken or written language, involving the assumption that signs in all forms of communication must somehow operate like words; that they must be units with a form and a meaning. This is what Harris calls a ‘fallacy of verbalism’.

In addition, many traditional communication theories see verbal discourse as a substitute for physical actions or mental discourse. In these models, signification is seen as representation, imitation, association, or just as convention. These models treat the ‘fixed code’ as an ideal towards which our imperfect systems of human communication should aspire, or in terms of which they can and should be described. An example of a ‘fixed code’ approach could be the ongoing ‘standard English’ debate in the English speaking countries. One currently held view is that standardisation consists of processes of language determination, codification and stabilisation, which, for Trudgill (1999), have been done for particular, for example: nationalistic purposes. As a consequence, by codification language acquires a publicly recognised and fixed form, usually enshrined in dictionaries and grammar books.

Cheshire (1999) argues that the notion of ‘standard English’ has been heavily influenced by written English. This is widely known and its guardians are those who

\footnote{Note: The standardisation debate is not confined to English speaking countries alone.}
are highly educated. Literacy is central to the maintenance of this standard. This involves the assumption that one written form of a word or idiom will have one meaning or at least the most accurate one. However, this assumption does not necessarily apply to spoken English, since people adapt commonly accepted forms to the circumstances of use.

Indeed when ‘meanings’ are taken to be context dependent, subject to interpretation and involving more than a person’s verbal ‘output’, we are faced with a problem in defining an individual’s ‘voice’. Are there any unequivocal linguistic signs or symptoms that may be taken as proof of understanding? Can we ever be sure of the level of mutual understanding that prevails between interlocutors? What is the relationship between understanding and agreement (Foppa, 1995)?

3.4.3 The problematic nature of ‘voices’

Bakhtin’s dialogical model focuses on ‘utterances’, which are produced by a ‘voice’, a point of view. However, for Bakhtin, ‘voices’ are processes rather than locations: they never exist in social isolation. ‘Meanings’ come into existence when two or more voices come into contact: there has to be a speaker and a listener, the ‘addressee’ and ‘addressee’ (Wertsch, 1991). The speaker always invokes social language in producing an utterance, and this social language shapes what the speaker’s individual voice can say. This process involves a specific kind of ‘multivoicedness’; the process whereby one voice speaks through another voice or voice type in a social language.

In terms of verbal communication, Wadensjö (1998) stresses that language is a historical and social phenomenon, continuously reproduced and recreated through use: ‘meaning’ cannot be described entirely in terms of an individual’s intentions, nor as properties of languages or words. Instead, the meaning(s) individuals ascribe to words and phrases can be matched to time, place, and social situations and thereby associative communicative genres.

In the Bakhtinian perspective, ‘mutuality’ is the central issue in the study of social life (Graumann, 1995) and communication. Here the notion of ‘reciprocity’ is envisaged as a moral principle, rather than a technical term. The argument follows that social
actions and interactions (including dialogue) are frequently initiated and maintained in cognitive environments or contexts in which it is taken for granted that they are common to or shared by the actors. In this respect, mutuality is a probabilistic term. Hence, interpersonal communication can never be fail-safe, and the frequent misunderstandings in human interactions are probably attributable to unfounded assumptions of mutuality.

An important feature of ‘voices’ in this perspective is that utterances take place in specific contexts (spheres), where relatively stable types of utterances - ‘speech genres’ - develop. There is an extreme heterogeneity of speech genres. Some of them feature in ordinary everyday conversations (such as parents conversing with their children at home or teachers talking to pupils at school) and some may be very specific (for example, occupational jargon). An individual may be confident in one but not in another (Bakhtin in Emerson & Holquist, 1986): it is the speech situation and the make up of the group of people within that guides the flow of utterances.

In the context of disability, communication aids could be another example of a ‘speech genre’. This can be problematic in terms of ‘voices’. In this respect, for Moser and Law (2001), the paradox of ‘giving someone a voice’ is that voices do not exist in isolation; they don't simply reflect something that is pre-existing. Giving ‘voices’ may involve the risk of limiting articulation to that which is verbal, textual or linguistic. In the context of the ‘communication difficulties’ of disabled children, voices that are non-verbal are simply not recognised or are disqualified, even though, sometimes, physical movements (actions) are obviously more important than the use of words.

3.5 Conclusion

In this chapter, I have started to develop a form of social constructionist view according to which human life is “simultaneously social, discursive and natural” (Burkitt, 1998, p.128). I have attempted to apply this in conceptualising communication, including both children and adults, in face-to-face encounters. This reflects a general trend within social sciences over the past few decades, where there
has been a shift from structure to context, from cognition to interaction, and from fixed meanings to multiple voices.

In the 1950s and 1960s, linguistics had gone through the so-called ‘cognitive revolution’, which purported to make ‘mind’ and ‘meaning’ a central concern of human sciences in general, and of linguistics in particular (Wierzbicka, 1996). This ‘revolution’ claimed to reject certain traditional psychological concepts, such as stimulus-response models, overtly observable behaviour or biological drives. However, it has lately been criticised for not actually having dealt with ‘meaning’ but rather having switched to the study of ‘information processing and computation’. What was missing, for the critics, was basically the study of how meanings come to be constructed in the human mind and/or interaction, and how meanings underlie human cognition, communication and culture.

As for Bakhtin:

“Language and words are almost everything in human life. But one must not think that this all-embracing and multifaceted reality can be the subject of only one science, linguistics, or that it can be understood by linguistic methods alone. The subject of linguistics is only the material, only the means of speech communication, and not speech communication itself, not utterances in their essence and not the relationships among them (dialogic), not the forms of speech communication, and not speech genres” (Bakhtin in Emerson & Holquist, 1986, p.118).

Mainstream approaches to communication within human sciences often overlook the fact that face-to-face human interaction takes place in specific contexts, which define the possibilities for communicative events (Goodwin & Duranti, 1992). Central to this thesis are the ways in which human actors engage in meaning making in different contexts: how they arrive (or not) at understandings of each other’s definitions of the situations.

Contextualist approaches to communication incorporate the notion of ‘social construction’. What they have in common is the interactionist perspective on language and communication where the focus is on the ‘communicative act’ (Farr & Rommetveit, 1995): the meaning of an act is in the nature of the response it elicits.
from others. Similarly, central to the Bakhtinian dialogical model is the concept of 'mutualities', which, in face-to-face vocal and gestural communications are only intelligible in the context of interaction.

Farr and Rommetveit (1995) stress that non-verbal behaviour is not the same as verbal communication, and it need not to be theorised in terms of a 'system'. In their view, when definitions of 'communication' are equated with 'encoding' and 'decoding', one has brought into play the language of a telecommunication engineer. In this respect, the Bakhtinian view of face-to-face communication is distinct from cognitive psychology, which has individualised the 'social' and places the emphasis on the 'mind'. 'Understanding', in this view, has to do with A and B who speak and listen, the utterance and the 'world'. It implies connecting the utterance with a context where it is embedded. The contexts involve the concrete setting, knowledges and attributes of people involved, their beliefs, experiences and expectations, the institutional or other framework for action, relevances and what is known of all of these factors. In this respect, understanding is related to 'responding' in that one (may) take time in thinking how to react, what stance to take, i.e. there will never be complete understanding in terms of 'absolute match' (Linell, 1995).

With its emphasis on interaction and context, this perspective challenges certain assumptions in developmental psychology. For Wertsch (1991), American psychology certainly dominates studies of children's development. Drawing on a Piagetian framework, it manifests itself in theories of children's intellectual milestones, IQ, memory strategies, and grammatical skills. For Wertsch, however, psychology has become increasingly less capable of providing insights into major social issues. He argues that it might be useful for the study of specific clinical syndrome or brain dysfunction, but not issues such as educational failure. Psychological research is often based on the assumption that it is possible and desirable to study specific areas of mental functioning in the individual in isolation. Instead, Wertsch suggests that psychology needs to come to terms with how individuals are culturally, historically and institutionally situated before it can understand mental functioning.
In this chapter, I have intended to explore what discourses of ‘good communication’ may underlie current child welfare practice in the western world when it comes to considering ‘communication difficulties’. This is not to ignore the personal experience or physical/cognitive aspects of disability. Since I believe that a lot has been written about children’s communicative impairments in practice literature, this thesis does not need to do that. Nonetheless, what this chapter aims to do is to bring out perspectives that embrace the socially constructed character of ‘communication’ and thereby ‘communication difficulty’. This is a previously more or less unexplored area in Communication Theory, developmental psychology, linguistics and Disability Studies.

For this research, Durham Peters’ (1999) question – ‘how do we know that we have really communicated?’ - opens up new avenues. First, I argue that before we can ‘give a voice’ to children, we need to understand the ambiguities that are involved in human communication. As this chapter has attempted to prove, as long as abstractions and ‘adult’ skills are held as ideals, children’s voices are in danger of remaining marginal. Second, before we teach children certain skills, we ought to understand why certain skills are preferred to others and with what implications.
DISCOURSES ON ‘CHILDHOOD’ AND ‘DISABILITY’ AND THE PROBLEM OF MULTIPLE PERSPECTIVES

4.1 Introduction

In this Chapter I intend to illustrate how discourses on children as communicators are related to various contested meanings of ‘Childhood’ and ‘Disability’. In the last fifteen years or so, alongside the changes in child law and in the legislation on disabled people’s rights, childhood sociology and disability theory have generated a range of deconstructions and reconstructions of the two notions. A typical feature of these debates, and what is particularly visible in child protection, is the positioning of young (disabled) children as both dependent, vulnerable objects and ‘agentic’ subjects with distinct ‘voices’ (Middleton, 1999; Morris, 1999).

As previous Chapters have indicated, child welfare practice literature usually emphasises rights- and needs-led approaches as necessary starting points for the provision of good quality services (e.g. Horwath, 2001; Read & Clements, 2001). At the same time, one tension between conventional and their constructionist challenges, having to do with individual rights and needs, lies in ontological considerations: What is a ‘child’? Who is a ‘disabled’ person? Another tension, that also has to do with someone’s decision making power over other peoples’ status, is epistemological: Who has the right to know about children and disabilities?

Sections 4.2 and 4.3 look separately at deconstructions of ‘Childhood’ and ‘Disability’ in recent sociological theory. I will pay particular attention to the similarities between childhood sociology and Disability Studies in their recognition of children’s and disabled people’s ‘agency’ or ‘subjecthood’ in society (Lee, 2000). In this context, many writers in Disability Studies have particularly resisted the power of Medicine to determine disabled people’s needs and rights (Oliver, 1990). In this thesis, this is an important consideration because interventions into children’s
‘communication difficulties’, as illustrated in Chapter 2, are primarily the business of medical professions.

In section 4.4 I will then introduce recent sociological arguments that have pointed out ambiguities in constructionist approaches to both ‘Childhood’ and ‘Disability’. I will draw attention to the so-called foundationalist and anti-foundationalist (Prout, 2000) understandings of the two concepts, and to attempts to overcome their dichotomisation.

4.2 Deconstructing and reconstructing ‘Childhood’

Over the last decade or two there have been some discursive changes in how children are viewed in society in the western world. For example, Chapter 2 referred to the rise in the ‘culture of consultation’ and the changes in child law as push factors for the recognition of children’s ‘voices’. In parallel to this development, childhood sociology has emerged as a distinct subdiscipline, challenging conventional understandings and representations of childhood. Within the ‘new paradigm for childhood sociology’, ‘Childhood’ is defined as a legitimate and problematic concern for research in sociology and cognate disciplines as against traditional sociological treatment of children simply as objects of socialisation processes (James & Prout, 1997). Instead, children are viewed as social actors with rights regarding their participation in society (Holland, 2001).

For James et al (1998), during the last three centuries, a particular Western vision of ‘Childhood’ has been that:

1) children are seen as different, through the calculation of age
2) they have a special nature, determined by biology
3) they are innocent
4) and therefore vulnerable and dependent.

By ‘medical professions’, I refer loosely to persons such as medical doctors, nursery nurses, clinical psychologists, speech and language therapists and/or occupational therapists. The relevance to this thesis lies in that these occupations featured in one or both research settings.
Issues such as rates of mortality and life expectancy, organisation of family life and structure, kinship patterns and different ideologies of care and philosophies of need and dependency have defined childhood, including medical, educational, parental and other adult discourses (James & Prout, 1997). Within the ‘emergent paradigm’, on the other hand, ‘Childhood’ is seen as distinct from biological immaturity, appearing as a specific structural and cultural component of many societies in terms of socially constructed meanings of age, class, gender and race (Prout & James, 1997).

Central to the ‘new paradigm’ has been the question of power relations between children and the social structural aspects of their relationships with adults. Drawing on the Foucauldian line of thought, James et al (1998) have argued that the modern conception of childhood has fundamentally to do with modern social control:

"Childhood is the most intensively governed sector of personal existence. In different ways, at different times, and by many different routes varying from one section of society to another, the health, welfare, and rearing of children have been linked in thought and practice to the destiny of the nation and the responsibilities of the state. The modern child has become the focus of innumerable projects that purport to safeguard it from physical, sexual and moral danger, to ensure its 'normal' development, to actively promote certain capacities of attributes such as intelligence, educability and emotional stability" (James et al, 1998, p.68).

In addition, sociology of childhood has recently made efforts to document not only how children are shaped by society but also how they shape it (Prout, 2000). In this view, children are positioned as a political minority, excluded from society’s decision making processes much in the same way that (western) women have been in the past (Alanen, 1994). For example, where children are the subjects of professional and judicial activity, which is concerned with their welfare needs, their rights are eroded by assumptions about their lack of cognitive, emotional and experiential competence to make decisions in their own best interests (Parton & Wattam, 1999). In short, children are often denied ‘agency’ and subjecthood because they are deemed vulnerable and incompetent.
4.2.1 Agency, competence and vulnerability

Childhood sociology's argument is that the dominant framework of knowledge about children in general makes us fail to recognise them as fully human. Dominant discourses position children as trajectories, who go through a step by step development towards becoming more 'cultural' and 'rational' actors, away from 'natural' and 'irrational' states of being. Different human scientific accounts have emphasised different 'deficiencies' that children may have; nevertheless, children's competencies are seen as inferior to those of adults. For instance, conventional sociology has highlighted children's lack of mental contents, and psychology the lack of mental processes (Lee, 2001).

The 'new paradigm' has sought to challenge pervasive developmental preoccupations with children's biological age and associated abilities. The notion of the 'social competence' of children has been introduced as an alternative to conventional views of children's 'skills' or 'achievements' (Hutchby & Moran-Ellis, 1998). 'Social competence' is seen as an active practical accomplishment. It has to do with children's ability to manage their social surroundings and to engage in meaningful social action within given interactional contexts; and how children manipulate material and cultural resources in order to engage in contextually appropriate behaviour.

The notion of 'social competence' constitutes children as having a potential to act agentically (ibid). By contrast, in practice contexts, such as in child protection, disability or childhood illness, this assertion appears controversial. In contexts like this, children are typically perceived as being in need of adult help. For Christensen (2000), most discussions in the western cultural perspective, particularly those using a psychological approach, focus on understanding of the child as dependent on others. This is a negative attribute in relation to the dominant cultural ideal of the individual as autonomous, responsible and mature. For instance, discourses on 'special needs' aim to detect factors in children's physical environments that may cause pathological conditions or developmental problems in children's lives (see Chapter 2). In this sense, 'Childhood', is associated with weakness, innocence and that which requires nurturing and protection.
Agency, competence and dependency have also been central concerns in Disability Studies. The next section will look at them in terms of both adults and children. 'Disabled childhoods' will be specifically addressed in section 4.3.1. Since this research project took place in clinical/therapeutic settings, there is a particular focus on the 'Medicalisation' argument within disability theory.

4.3 The 'Medicalisation' of 'Disability'

"In popular imagery disability continues to be perceived as being about specific impairments (such as blindness and paralysis) or forms of assistance and technologies (such as guide-dogs and wheelchairs). Such a 'model' of disability assumes that disability is a tragic aberration which afflicts a minority of people. This common-sense assumption is pervasive. It shapes much of the medical, social and educational treatment of disabled people (Marks, 1999, p. ix).

From a disability theory point of view, the above quotation represents a so-called essentialist perspective of 'disability'. It supports the belief that 'disability' or 'impairment' is inherent within an individual and is likely to have biological causes. From a practice point of view, it assumes that once the individual's problems are identified, appropriate medical and educational provision can be made (Riddell, 1996).

In contrast, since the 1980s, a number of disability scholars and activists in the UK have developed a 'social model of disability', which sees disability as the effect of an environment which discriminates against and disables certain 'impaired' individuals. These writers have typically highlighted the 'medicalisation' of disability as a significant contributor to disabled people's invisibility in society (e.g. Barnes et al, 1999; Oliver, 1996). This is because the medical 'gaze' has been used to regulate disabled people, treat them as patients and label them, often with stigmatising and physically and emotionally damaging consequences (Oliver, 1990; Priestley, 1998).

Some writers understand Medicalisation as a particular feature of modern times. Oliver (1996), for instance, has associated 'Medicine' with the modern concept of 'progress'. In late industrial societies, medical intervention has shifted from cure to rehabilitation, and rehabilitation philosophy emphasises physical normality ('living as
close to normality as possible’), in other words, close to able-bodied behaviour. The problem emerges when medical facts determine not only the form of treatment, but also the form of life for the disabled person. For Oliver, it is not immediately obvious that medical training and qualifications make doctors, for example, the most appropriate persons to be so involved, nor some other related professions such as speech or occupational therapy, which draw upon the same framework of knowledge. For Oliver, the latter are ‘pseudo-professions’ that Medicine has created in its own image.

Other writers point out that since some disabled people are more likely to be subjected to unwanted medical interventions than others, they are not a homogenous group. According to Gillman et al (1997), case histories of people with learning difficulties, for instance, tend to privilege such information that is useful to professionals, for instance, IQ and medical diagnosis. Such information allows professionals to categorise people for the purposes of ‘treatment’ and prognosis. Case records, as they are currently constructed, may further silence an already oppressed group of people, especially when they do not contain information about their lived experiences. Gillman et al (1997) consider this a dehumanising practice, which allows professionals to psychologically distance themselves from their patients, and to treat people as objects that can be controlled through ‘respectable’ professional theories and their discursive practices.

4.3.1 Medicine as a ‘regime of truth’ in relation to disabled childhoods

For Prout (2000), the development of paediatrics as a distinct medical discipline, at first as a speciality concerned with the diseases of children, and later attempting to claim a concern with the health and development of children as a whole, has produced an array of categorisations and classifications of children. In paediatric practice, children are identified, counted, surveyed and contrasted to the ‘normal’. Various standardised administrative procedures, such as the medical discourse of examination, questioning, diagnosis and prescription are involved in the classification process (Foucault, 1973). In this view, Medicine has become an institutionalised discourse, where ‘experts’ are produced as subjects with particular authority, knowledge and skills that are superior to those of lay people. For instance, since the impaired body is
not always fully visible (Corker & French, 1999), special training and experience are needed for ‘seeing the problem’.

On the other hand, for Middleton (1999), disabled children in particular are marginalised, because the medicalisation of disability creates ‘special needs’. Because of the medical hegemony, parents and members of multidisciplinary teams that work with disabled children often rely on medical expertise, or comply with it. Yet medical experts are known to not always have ‘known’. For instance, in child welfare contexts, uprisings against the power of medical professionals have tended to emerge in situations where their decision making has been perceived as inaccurate. A vivid example of these was the 1987 Cleveland Crisis in England, where 125 children were diagnosed by local paediatricians as sexually abused. As the number of diagnoses increased, questions were raised about their accuracy by other agencies, such as Social Work and Police (Lee, 2000).

The fact that children were not consulted during the diagnostic process in the Cleveland cases became thereafter an important consideration for child protection work. Recently, the same concern, as indicated in the previous Chapters of this thesis, has been increasingly extended to disabled children. For Morris (1999), there are widespread assumptions that disabled children lack the skills, not just to act in their own best interests, but also to make their views known in a comprehensible way. One thing is that the child and his/her physical disability are seen as the source of the communication difficulty, rather than the adults who are not familiar with, for example, methods of augmentative and alternative communication. Another problem is that needs assessments tend to be presented as if they were value free and based purely on objective evaluation of the clients (Marks, 1999).

In disability theory, the power of professionals over individuals’ lives is often referred to as the ‘colonisation of the life-world’, which ignores the disabled person’s own constructions of what is important in life (Gillman et al, 1997). Yet we may ask: How can people and organisations in positions of power and privilege care without colonising? For Code (1994), this question is epistemological in that it often means: ‘Who knows?’
Code argues:

"To my mind, the very possibility that caring can be practiced universally and 'objectively', by invoking a set of value-free ideals that, at best, pay lip service to principles of liberal tolerance, is a product of the empiricist-positivist epistemologies that underwrite the conviction that knowing people is no different, in its methods and formal structures, from knowing physical objects. Those epistemologies inform the utilitarian instrumental moralities and political theories that govern social welfare policy-making in most liberal democratic societies" (Code, 1994, p.183).

For Code, the epistemological power of carers as 'knowers' is a moral and political matter. Lee (2000) has also raised this question of medical epistemologies, for example, in the case of the Cleveland Crisis. His point is that it would be easy to blame the paediatricians simply for being wrong in their diagnoses because they believed that child sexual abuse was widespread. However, perhaps a more central consideration could be the paediatricians' epistemological stance, which treated bodily traces as causal agents. For Lee:

"Physical traces never speak directly for themselves, they can only be made to appear to do so [...] The paediatricians' only problem was their faith in the possibility of reaching pure unmediatedness, their failure to recognise that mediation cannot be avoided, and is essential to the production of credible evidence" (Lee, 2000, p.166).

In addition, diagnosing children with, as in this research, communication difficulties pose a further challenge, because not only is 'seeing' (Fox, 1994) but also the clinical criteria for certain 'conditions' characterised by uncertainties. Consequently, an ethical problem arises from the societal pressures on child welfare professionals - such as paediatricians, social workers and the police - to fulfil their duties towards individuals 'in need'. Therefore, since values play a central role in sustaining disabling social relations, it is necessary to ask where these values come from, why certain values are dominant over others and whose interests would be threatened if they were challenged (Priestley, 1998).
4.4 Disabled childhoods dichotomised: some ambiguities

The key difficulty in challenging Medical hegemony over disabled people's lives — whether they are adults or children — is the problem of multiple perspectives. How can one distinguish between the 'bodily reality' of impairment and its effect on an individual's life, and socially constructed aspects of 'Disability'? Is this, indeed, a necessary distinction for understanding lived experiences of disabled people, where efforts are made to promote their rights and meet their needs? The same argument can be considered in terms of 'Childhood'. Although 'Childhood' can be defined as a structural concept in relation to 'Adulthood', how useful is it to categorise children as an equivalent to a 'political minority' and/or a class of their own? Furthermore, how can we understand and distinguish between common and individual experiences of childhood/disability at the same time?

According to Corker and French (1999), the 'social model of disability' distinguishes between 'disability', which is socially created, and 'impairment', which is referred to as a physical attribute of the body. The distinctions can be seen as equivalent to those of sex/gender and race/ethnicity. Nonetheless, despite the political significance of the 'social model' theory for disabled people, Corker & French find the dichotomisation of disability and impairment — one part of which (disability) tends to be valorised and the other part (impairment) marginalised or silenced — as a potentially discriminating approach.

These writers stress the importance of 'reclaiming discourse' in the study of disabled people's lives and social change. Approaches to 'Disability' that avoid being reductionist by resorting to neither 'social model' nor impairment-centred explanations are promoted for understanding the interplay between discourse and lived experience. In a similar vein, Priestley (1998) has suggested that disability theory requires more than a distinction between individual and social model approaches, or materialist and idealist explanations. For Priestley, these models are best understood as ideal types. As for Corker and French (1999), much more varied

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7 In my understanding, 'disability theory' is an umbrella term, incorporating, for example, the UK and the US theories of disability. In the UK there is an academic discipline called Disability Studies, of which the 'social model of disability' is one part (Corker & French, 1999).
and multifaceted descriptions can be found in disabled people’s accounts of their own lives.

The same can be argued about ‘Childhood’. For Prout (2000), social constructionist accounts of ‘Childhood’ and the body tend to underplay the possibility that social life has a material as well as discursive (or representational) components. The so-called ‘anti-foundationalists’ are unwilling to distinguish between the body and its representations. In contrast, ‘foundationalists’ view the body as a real, material entity, which functions independently of its social contexts, although it bears upon itself many different frameworks of meaning. The emphasis of this phenomenological perspective is on the lived experience of ‘being inside one’s body’.

Within childhood sociology, anti-foundationalist approaches to ‘Childhood’ have also been critiqued on a more general level. For Qvortrup (1994), for instance, relativist constructionism tends to underline what is unique over what is common. The problem is that in practice contexts, professionals are expected to bring together the general and the particular. Decisions have to be made about what the law should allow for different children, such as verbal and non-verbal children, and how these allowances could be realised in practice.

In the case of disabled children, inclusion has been an increasing trend in recommendations for good practice (Read & Clements, 2001). As indicated in the previous Chapters, practice and research literatures pinpoint listening to children’s ‘voices’, because they have been ignored for a very long time and even though there may be significant barriers to communication due to a profound impairment, one should not assume that disabled children ‘have nothing to say’ (Beresford, 1997).

On the other hand, it has been argued that (disabled) children’s needs and rights are also social constructs and that these constructs are interrelated and often contradictory (e.g. Doyal & Gough, 1991). For Woodhead (1997), conceptualising ‘Childhood’ in terms of ‘needs’ reflects the distinctive status accorded to young humanity in contemporary western societies. It is commonplace to regard the needs-led approach as a progressive and enlightened framework for working with children, by contrast with former times and other societies. Nevertheless, the concept of ‘need’ conceals in
practice a complex of latent cultural and personal assumptions and judgments about children, which are not attributable to children's 'innate' nature as such. In this respect, the ambiguity of 'Disabled Childhoods' is an essentialist one.

Lee (2000) has proposed that the rights and needs discourses have, particularly in child protection, disability and childhood sociology contexts, constructed an autonomous 'subjecthood', incorporating a particular understanding of the child's 'voice'. Hence 'agency', both in relation to 'Childhood' and 'Disability', becomes a problematic issue. The question arises whether it is an empowering or a rhetorical device. Is it simply one that attempts to furnish (disabled) children with a western value of competence, while at the same time, paradoxically, purporting to undermine hegemonic notions of a 'skill'?

For Prout (2000), however, the observation that children can exercise agency should be a point of analytical embarkation and not a terminus. In other words, merely replacing one essentialist argument (that children are incompetent) with another (that they are competent) appears unsatisfactory. It is possible that disabled children can be, at the same time, vulnerable and competent; however, their positioning in this respect tends to be in the hands of adults. As for Wyness:

"The more we talk about children, the less likely children themselves seem to be part of these dialogues" (Wyness, 2000, p. 29).

4.5 Conclusion

This Chapter started from the assertion that definitions of 'Childhood' and 'Disability' are numerous and that there is a tension between the so-called essentialist and social constructionist approaches to the two notions. Indeed, the two constructs are a contested terrain (Wyness, 2000) both in child welfare practice and sociological arenas. The nature of this contest, as I interpret it, is inherently of moral-pragmatic and political character, where the meeting of individual rights and needs plays a central role.
The above arguments gain further depth when located in their historical contexts. For example, many western accounts suggest that in the 'bad old days' - whether it was by the Ancient Greeks, the Roman Catholic Church or Victorian eugenicists - disabled people (including children) were treated with remarkable cruelty (Marks, 1999). In these accounts, the contemporary, 'civilised world' is associated with progress: thanks to medicine, welfare and enlightenment, disabled people are nowadays treated with greater humanity and respect.

However, drawing on Foucauldian thought (Lindgren, 2000), both childhood sociology and disability theory have critiqued the particularly modern, pathologising nature of conceptualising Disabled Childhoods in the contemporary western world. As section 4.3 indicated, many disabled people today do not feel that, for example, medical interventions into their lives are particularly humanising (e.g. Gillman et al, 1997). Furthermore, in the UK, events such as the Cleveland Crisis stirred opposition to medical professionals’ decision making power. Obviously, this poses a problem for professionals whose duty is to provide services. The literature that I have reviewed in this Chapter and in Chapter 2 indicates that there is indeed a lack of clarity in the way adults are supposed to relate to children or to each other in practice contexts (Wyness, 2000). It seems obvious that in addressing children’s ‘communication difficulties’, we cannot escape these practical and theoretical ambiguities.

However, some writers have pointed out that many accounts of Disabled Childhoods often appear rather pessimistic (Barnes et al, 2000). For instance, protectionist arguments continue to construe disabled children as vulnerable victims (Morris, 1999), and typically de-emphasise the ‘other side of the story’. An example of an optimistic account could be the following:

“Disabled children, even those with the most severe impairments, are able to communicate their feelings about their lives and the treatment which they receive. Disabled children are not passive victims -- many are happy and feel successful”

“Disabled children are not powerless: oppressive individuals, cultures and structures do not damage disabled children beyond repair. To suggest this would be to subscribe to the notion of disabled children as being ‘tragic but brave’ victims' (Barnes et al, 2000, pp.1-4).
Consequently, in the study of disabled childhoods, the researcher is also faced with this plethora of perspectives of 'Disabled Childhoods' and (disabled) children’s positioning as communicators. This makes social research on this topic, on different levels, a challenging task. The next two Chapters will now turn to the methodological and ethical choices that I made in the field. They will be further discussed and reflected upon in Chapter 12.
PART 2: METHODS AND ETHICS

This thesis does not only adopt a social constructionist perspective vis-à-vis 'communication/difficulties', but also in relation to my own qualitative research practices. My chosen methods will be described and discussed in Chapter 5. Chapter 6 talks about research ethics, and questions of morality and politics in this research. This includes, for example, a critical appraisal of the social researcher's right to 'know'. Furthermore, the attention is drawn to ambiguities within qualitative sociology and its 'use value' in other than sociological arenas.
Chapter 5.

METHODS: CRAFTING A SOCIOLOGICAL ‘TEXT’ OUT OF THE TWO RESEARCH SETTINGS

5.1 Introduction

Bearing in mind what has been said so far in this thesis, I am now asking: what and how can I as a social researcher know and talk about children’s ‘communication/difficulties’ in clinical/therapeutic settings? I intend to answer this question by detailing the methodological choices and their theoretical sources. This chapter describes what I did in the field and how I turned those ‘realities’ into a sociological text.

Sections 5.2, 5.3 and 5.4 are descriptive. I will first talk about the ‘Team Service’ and the ‘Children’s Centre’ as research settings. This involves details of what they were like as physical spaces, as well as of the actors as research subjects. I will also define the scope of the study, which came to be different from the original design for this research project (see Appendix 1 and Chapter 1). I will then outline the chosen methods and the qualitative data analysis process, and highlight the theoretical premises for the ways in which this research project is ethnographic.

Section 5.5 makes a move towards a destabilisation of the ‘solidity’ of my research approach. Drawing on the phenomenology of Alfred Schutz (1982), I will discuss the philosophical roots of my epistemological stance. This makes a case for a reflexive account of my own research practices, which I will formulate in section 5.6. My intention is to explain why and how I, as a social researcher, have experienced an ‘epistemological crisis’ during this research project, and how I have subsequently sought to come out of it and re-stabilise my approach.

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8 I have intended to describe the research settings without compromising the children’s, their parents and the staff’s anonymity.
5.2 Descriptions of the research settings, actors in the field and the scope of the study

In Chapter 1, I introduced the two research settings, as they were described in promotional publications for parents. This section continues from that. I will first describe the use of space in the two arenas for action. For confidentiality reasons, I cannot provide photographs of either of the settings. I will then describe the actors in the field and the nature of my encounters with them. This includes the children, the staff and the parents of the children. Finally, I will explain the scope of the study in terms of the number of my observations and the time spent in the field. More detailed descriptions of the (inter)actions in the two settings will be provided in the data analysis Chapters (7-10). I will further discuss my own research conduct in Chapter 12.

5.2.1 The 'Team Service'

Figure 7 illustrates how the observation room, which had one way screens on both sides, was located in between two assessment rooms. The assessments usually took place in the large assessment room; the smaller one was used when the practitioner wanted to do one-to-one assessment with the child. In the large assessment room there were a lot of assessment related toys and equipment, as well as a seating area for the
parents. There was room for the child to run around and, for example, ride a toy car. In the small assessment room there were only a table and a couple of chairs, that is to say, as few stimuli as possible any other than what the practitioner would bring in for a particular test.

In Chapter 1 I explained the reasons for selecting and obtaining access to the ‘Team Service’ setting: ‘communication difficulties’ were a frequent reason for referring children there. Children would visit the setting on an individual basis, typically twice. Figure 8 describes profiles of children who were referred for the service.

<table>
<thead>
<tr>
<th>Number of observations</th>
<th>25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of children observed and/or planned</td>
<td>28</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>- Boys</td>
<td>25</td>
</tr>
<tr>
<td>- Girls</td>
<td>3</td>
</tr>
<tr>
<td>Ages in years</td>
<td></td>
</tr>
<tr>
<td>- 2</td>
<td>5</td>
</tr>
<tr>
<td>- 3</td>
<td>4</td>
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<td>- 4</td>
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<td>- 6</td>
<td>1</td>
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<tr>
<td>- 7</td>
<td>1</td>
</tr>
<tr>
<td>- 8</td>
<td>1</td>
</tr>
<tr>
<td>- not known (under 5)</td>
<td>10</td>
</tr>
<tr>
<td>Reasons for referral (sometimes in combination)</td>
<td></td>
</tr>
<tr>
<td>- Speech, language and social interaction (possibly autistic) difficulties</td>
<td>16</td>
</tr>
<tr>
<td>- Other communication/language difficulties</td>
<td>11</td>
</tr>
<tr>
<td>- Behaviour (e.g. aggression; attention problems)</td>
<td>6</td>
</tr>
<tr>
<td>- Motor</td>
<td>4</td>
</tr>
<tr>
<td>- Severe developmental disability</td>
<td>3</td>
</tr>
<tr>
<td>- Developmental delay</td>
<td>5</td>
</tr>
<tr>
<td>- Psychological difficulty</td>
<td>2</td>
</tr>
<tr>
<td>- Child protection needs</td>
<td>2</td>
</tr>
<tr>
<td>Ethnicity/language</td>
<td></td>
</tr>
<tr>
<td>- British English speakers</td>
<td>20</td>
</tr>
<tr>
<td>- Non-British English speakers</td>
<td>4</td>
</tr>
<tr>
<td>- Multicultural, including English language</td>
<td>3</td>
</tr>
<tr>
<td>- Non-British with no English language</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 8. Profiles of children in the ‘Team Service’ assessments.
In my observations, the ‘core’ Team typically consisted of at least six members, including the co-ordinator, a paediatrician, a nursery nurse, a speech therapist, an occupational therapist and a physiotherapist. Sometimes a social worker or a clinical psychologist would take part in decision making as well. Occasionally, observers such as health visitors, medical students or primary school teachers would attend the assessments, usually one or two at the time.

In the ‘Team Service’ setting, I conducted 25 observations over nine months. I would usually stay in the setting for half a day per visit; in other words, for the length of the assessment and Team meetings. Because I conducted observations on varying days, I would meet different members of staff. I also encountered different practitioners, because there were some changes in staffing during my fieldwork period.

The Team members would either assess the child in one of the rooms and observe in the observation room, or spend some time in the staff office. I always remained behind a one way screen, which somewhat limited the scope of observation and participation. Otherwise I was free to come and go, as long as it was not inconvenient for anyone else in the setting, for privacy, confidentiality or other reasons. There were some conversations with the staff members; however, interview-like conversations would have disturbed the assessments too much.

I occasionally encountered parents of the children, particularly if they were seated in the observation room. Sometimes they asked questions about my research project on the basis of the information leaflet that I had given to them. I then explained that my research was confidential and that I was a student and would not take part in the decision making. Therefore, I avoided making any comments about the children in the presence of their parents.
5.2.2 The ‘Children’s Centre’

Figure 9. The physical layout of the ‘Children’s Centre’

Figure 9 illustrates a larger space – ‘general area’ - where most joint activities took place, such as meal times, circle times and some other activity times. In this thesis, I call this area ‘nursery’. The ‘floor corner’ in the nursery was a designated place for children who could lie on the floor instead of sitting in a wheelchair. Sometimes all the children watched television there. Free play would often stretch over all the areas. Play and education related materials were scattered all over the room, including the walls. Therapy rooms for one-to-one sessions were located outside the main nursery area: they were not, however, as stimulus-controlled as the small assessment room in Figure 7.

I had regular contact with the same children in the ‘Children’s Centre’. There were up to 15 children together per day in the Centre. All the children were under 6 years old. They were all British and predominantly of white ethnic background. They had been
diagnosed with a disability, which involved a range of physical and cognitive impairments. Due to their impairments, most children in the nursery had little or no speech, and were receiving speech and language therapy.

In my observations, there were typically one adult per child working in the nursery, particularly in the case of children with gross motor impairments. The therapists would work in the ‘therapy rooms’ with individual children, but would sometime take part in, for instance, helping out at mealtimes in the nursery, or lead group activity sessions. Other actors in the setting involved qualified nursery nurses, child care workers, volunteers and sometimes student nurses.

I spent about nine months observing the ‘Children’s Centre’, visiting twice a week on average, for half a day each time. I would go in on varying days and at different times of the day. I did not only observe the main nursery area, but also individual therapy sessions with children. I conducted some video recordings⁹, which allowed for detailed data analysis. Furthermore, a couple of times during my first year, I went out with health professionals to the community to observe what was involved in their work outside the ‘Children’s Centre’. This enabled me to learn about the interventionist process beyond child assessments and the nursery work with ‘special needs’ children.

Unlike with the ‘Team Service’, in the ‘Children’s Centre’, it was possible to move about and interact with children, and to find different locations for conducting observations. When an opportunity arose in the ‘Children’s Centre’, I had informal discussions with members of staff about children’s communication. As previously mentioned, these discussions were helpful in that I thereby gained a comprehensive understanding of the aims and objectives of practice, with particular focus on children’s communication. I did not encounter any parents of the children. For example, obtaining consent forms from the parents was dealt with by a member of staff.

⁹ Prior to video-recordings, I had obtained informed consent from the parents of the children. I agreed with the staff that after I have finished the analysis, I will return the videotapes to them, and will not keep any other copies of it myself.
5.3 Methods

In this section, I will detail the ways in which I drew on sociological research ‘manuals’ for conducting qualitative research. I will first talk about observation, since it was the main method of enquiry in the two settings. Section 5.3.2 describes the data generation phase, and section 5.3.3 the qualitative data analysis process.

5.3.1 The starting points

Strauss and Corbin (1998) have suggested that before beginning a project, a researcher may review the literature to formulate questions that act as a stepping off point during initial observations. The researcher will then turn to questions and concepts that emerge from the analysis of the data. As intended in the original research design for this project (see Appendix 1), asking the research question started from a broad, in some ways novel ‘problem’ which then became more specific in the course of the research process. In both settings, my descriptions were meant to provide detailed accounts of ‘what was going on’ in general that affected the children’s experiences in the setting. During my pilot observations, my fieldwork relied on the Geertzian (1999) concept of ‘thick description’ and on the sociological ‘manual’ guidelines for doing ethnography and participant observation in particular (Berg, 1995; Mason, 1996; Morse, 1994).

Later on I discovered that my research strategy could also be described as ‘constructivist Grounded Theory’ (Charmaz, 2002). This approach involved a phenomenological understanding of ‘reality’ (Berger & Luckmann, 1991) as well as the following principles of Glaser’s (1992, p.16) version of Grounded Theory:

1) The need to get out in the field to understand ‘what is going on’
2) The importance of theory, grounded in reality
3) An understanding of the nature of experience in the field for the subjects and researcher as continually evolving
4) The active role of persons in shaping the worlds they live in through the processes of interaction
5) An emphasis on change and processes, and the variability of and complexity of life; and

6) The interrelationship between meaning in the perception of the subjects and their action.

As for Gubrium and Holstein (2000, p.487): "qualitative enquiry’s analytic pendulum is constantly in motion". As the fieldwork progressed, I became interested in what was being accomplished, under what conditions, and out of what resources. I then combined Geertzian and Grounded Theory approaches with ethnomethodological and Foucauldian concerns (Silverman, 1987; Potter, 1996), focusing on how members put discourses to work as they constitute their social realities: the ‘analytic bracketing’ started from ‘whats’ and moved on to ‘hows’ (Gubrium & Holstein, 2000).

5.3.2 ‘Being’ and ‘doing’ in the field

In order to learn ‘what was going on’ in the field, observation was an obvious starting point. Observation allowed me to look at the members’ interactions, their verbalised interpretations of what was going on, in the ‘here and now’ of the daily contexts for communication (Mason, 1996). Sometimes I enhanced my observations by making video recordings, sometimes I simply asked questions when opportunities for that arose. Ideally, observation as a method allows the researcher access to the ‘natural setting’. For Mays and Pope (1996), observational methods are particularly well suited to the study of the workings of organisations and how people within them perform their functions – indeed it is becoming more and more common to use observational methods in health care settings.

The way in which I conducted observations is best described as a process. First there was descriptive observation where I wrote down ‘everything’. Then I made a move to a more focused observation that involved asking questions (informal interviews) and concentrating on particular types of group activities. After a while I was ready to conduct systematic selective observation, focusing on the attributes of different types of activities (see Angrosino & Mays de Pérez, 2000). The moves from one stage to another were not clear cut. Instead it was a matter of feeling that I had ‘seen enough’
to be able to do so (Gubrium & Holstein, 2000), or that I simply wanted to ask questions to complement or clarify what I had seen earlier.

In both settings, my sociological gaze tracked down the following components: ‘space’ (what it allowed the actors to do), ‘actors’ (adults and children in differing ‘roles’), ‘activities’ (recurrent interactive activities in the setting, such as meetings), ‘objects’ (e.g. communication aids), ‘acts’ (specific individual actions, such as feeding a child), ‘events’ (particular occasions, such as Christmas party), ‘time’ (the sequence and duration of acts, activities or events), ‘goals’ (explicit purposes of the actors) and ‘feelings’ (apparent emotions in particular contexts, including my own) (Burgess, 1984). These starting points allowed me to create initial codes and categories for the subsequent analysis of the data.

For Geertz, culture is a context that has to be ‘thickly described’ (Schwandt, 1994). The ethnographer describes language and symbols, as well as the actions of the members of the culture (including the researcher’s own), since these both construct and signify meaning. He/she generates a reading of the meaning making processes of the people he/she studies. In this reading, the resulting text, one creates accounts of ‘passing moments’ rather than claiming to describe the ‘souls of the members’ (ibid). The data extracts, as I intend them to be, in this thesis are descriptive examples of these ‘passing moments’.

5.3.3 Analysis: conceptualisation and writing processes

During this research process it has come clear to me that data analysis is a far more complex and long lasting activity than what typically comes across in qualitative research manuals. My analysis first started to evolve simultaneously with observation and note taking. I started to sketch some preliminary codes at the early stages of the fieldwork: with Atlas.ti, the computer software, I arranged them in ‘code families’ and displayed them as ‘conceptual maps’. These were then subject to change as new concepts came along. Using Glaser’s (1992) notion of the ‘constant comparative method’, I searched for concepts in the literature, then in the data, and then again in the literature. The fieldnotes of the two settings were coded with different sets of codes, although there was some conceptual overlap in the end (Morse, 1994).
I agree with Strauss and Corbin (1998) in that analysis draws on both critical and creative thinking: it is the interplay between researchers and data. I began with a ‘working hypothesis’, expecting that ‘communication difficulties’ could be understood as a sociological problem. Since neither of the settings was familiar to me, however, I was open to whatever might come: it was obvious that the theory would, for the most part, emerge from the data.

Coding (both manual and computerised) enabled me to identify patterns in the data and to start producing stories from it. This synthesizing process decontextualised the description: it moved from an individual level to a more abstract, generalised level. Strauss and Corbin (1998) have distinguished ‘open’, ‘axial’ or ‘selective’ coding; coding for process (as well as for structure); and developing a conditional/consequential matrix for concepts. They have also suggested the use of the following analytic tools: 1) asking questions about the data 2) focusing on a word, phrase or sentence 3) making comparisons 4) and ‘waving the red flag’. These are meant to steer the researcher’s thinking away from the confines of both the technical literature and personal experience or standard ways of thinking about phenomena; stimulate the inductive process and focus on what is in the data; listen to what people are saying and doing, and spot ‘diamonds in the rough’ (ibid); as well as to discover categories, labels and concepts. The software package that I used — Atlas ti. — was based on this version of Grounded Theory by Strauss and Corbin.

In short, the theorising phase involves ‘cutting down the ‘noise’ in the data so that the common and relevant issues (to the research question) remain. As for Morse (1994, p.33), the process of data collection and analysis “should not be forced and cannot be rushed”. This ongoing character of theorising can be seen as typical of ethnographic research. Thus, I will now turn to what I consider as particularly ethnographic in my chosen methodology. This is important for the justification of observation as a useful method, as well as of the ways in which I have collected, analysed and written about the data.
5.4 Doing ethnographic research

Since ethnography can be conducted in different ways, I want to specify the theoretical underpinnings for the approach that I have adopted in this research. My methodological approach can be characterised as what Smith (2002) calls 'institutional ethnography', with a particular focus on what was 'social' in the two settings.

5.4.1 Institutional ethnography and the focus on the 'social'

For Smith (2002), the object of institutional ethnography's attention is the 'social', which is conceived of as arising in peoples' activities (what they do, say, write and so on) in particular local settings at particular times. As a study of the 'social' and interaction, institutional ethnography relies on the language in which people speak of what they know how to do, of their experience, and how they get things done.

Institutional ethnography takes it for granted that people experience and perceive things differently. Institutions, as generalising and objectifying forms of concerting peoples' activities, are distinctive in that they construct forms of consciousness – knowledge, information, facts, administrative and legal rules, and so on – that override individual's perspectives. In this respect, institutional ethnography incorporates the Foucauldian understanding of the interplay between discourse and practice.

How can an ethnographer talk about the institutional world? What should he/she focus on and why? Smith proposes that institutional ethnography begins with some issues, concerns or problems that are real for the people in the setting. These problems will give direction and focus to the research. The specialized theories, used by the researcher, recognise and analyse different levels or aspects of the social:

"Disciplinary concepts and theories function to regulate sociological discourse [...] out of the primary dialogue with people who constitute both the resources for the accounts to be written and their ultimate users, we fashion a secondary dialogue within the sociological discourse, constrained by its conventions, methodologies,
rules of evidence, discursive objects and other aspects of the ‘order of discourse’ (Smith, 2002, p.20).

The aim of institutional ethnography is to produce accounts of the social relations that will enlarge individuals’ perspectives beyond what they can learn directly from their participation in everyday life. Since it will involve discoveries and learning, it will never be completed. On the other hand, it recognises that institutional forms and relations are always being produced by individuals at work, and yet that they are generalised and standardised. In this way, institutional ethnography opens up into larger social relations, exploring the institutional order.

Smith (2002) highlights the role of ‘texts’ in the study of social interaction. By ‘texts’ she means printed, computerized or otherwise replicated material, which are written and read in the everyday practice of peoples’ work, and which coordinate what people do in one local setting with work done by others elsewhere or at different times. The significance of texts lies in that they concert activities. They produce stability and replicability of organisation or institution: the materiality of them is important in terms of how they join everyday activities and social relations in settings. For Smith, ‘ruling relations’ are based in texts and manifest themselves within institutions.

Institutional ethnography recognises both the local sites of action and the wider network of institutional order. Power is the key to sociological analysis; however, as for Foucault (McHoul & Grace, 1983) it is not a monolithic notion: it is rather seen as dispersed and discursive, yet stabilised by texts, talk and interaction in specific contexts. The researcher can try to make sense of those contexts with the help of specialised theories, translating the language of ‘everyday/evverynight world’ of the setting to a sociological one. The starting and finishing points of enquiry will, nonetheless, always be what the research subjects treat as ‘real’ (Smith, 2002).

There are, obviously, other ways of researching clinical/therapeutic settings. For example, ethnographic methodology is sometimes set against the conversation analysis approach. Studies within the conversation analysis tradition have focused on how participants organise their communicative conduct so as to display and realise their subjective experience of the current social activity, and how they perceive their
own and others’ roles in it. The proponents of this approach stress that their analysis is based on only what is explicit in the data rather than on categories imposed by the researcher (Wadensjö, 1998).

Ethnographically orientated studies, on the other hand, have a different kind of interest in patterns of social organisation. In a study of institutional spoken discourse, for instance, this means that the researcher has reasons to obtain a thorough insight into peoples’ long-term or short-term relations and social networks; and into the rules and customs of the institutions where data is collected. Many ethnographers also emphasise the necessity of describing the circumstances in which research takes place, and the researcher’s role in creating these circumstances (ibid).

Both conversation analysis and ethnography share the idea that meaning is the topic rather than resource of analysis. Then again, coming from the so-called ‘linguistic turn’ in sociological writing, conversation analysis is interested in the linguistic (or non-verbal but language-like) meaning (Williams & May, 1996). As explained in Chapter 3 (see Harris, 1996), my understanding of ‘communication’ in this thesis is not limited to the purely linguistic in the two settings. Like Schutz (1982) has suggested, I have focused on ‘action’, and I have openly imposed my interpretations on what I have seen. For this reason, in section 5.5 I will outline in more detail how I have adopted aspects of Schutz’ phenomenology in this research. Moreover, my interest in ‘action’ in the two settings has included the minutiae of social construction processes in the generation and consumption of ‘scientific’ knowledge. This will be addressed in the next subsection.

5.4.2 Doing ethnography in ‘scientific’ settings

Woolgar (1988) has suggested that in situ observation of scientific activity gives the benefit of the experiences of an observer undergoing prolonged immersion in the culture being studied. This makes it possible to ‘retrieve’ some of the craft character of science. Typically, the focus of interest in the field, as in ethnographic studies on laboratory work, has been the process of transcription.

Ethnographies of laboratories have aimed to deconstruct. As for Knorr-Cetina:
"Within laboratory studies, the insistence on direct observation and detailed description has consistently served as a device that calls forth and sustains the constructionist attitude"; “Detailed description deconstructs - not out of an interest in critique but because it cannot but observe the intricate labour that goes into the creation of a solid entity, the countless non-solid ingredients from which it derives, the confusion and negotiation that often lie at its origin, and the continued necessity of stabilizing and congealing (Knorr-Cetina, 1995, pp.147-8).

The deconstruction performed by constructionist studies is a method of observing the real time mechanisms at work in knowledge production. For Knorr-Cetina (1995), they question the idea that laws and propositions of science provide literal descriptions of material reality, and therefore can be accounted for in terms of this reality rather than in terms of the mechanisms and processes of construction.

In light of this, I am now facing fundamental epistemological questions of the nature of sociological knowledge production and its relation to ‘reality’. If I regard actions in the two clinical/therapeutic settings as social construction processes, what can be made of my own research practices? Drawing on the phenomenology of Alfred Schutz and some subsequent use of his thought in sociological writing, I now intend to clarify my epistemological position.

5.5 The sociological epistemology in this research: considerations of reality and knowledge

Definitions of ‘reality’ and ‘knowledge’ have behind them a long history of philosophical enquiry. The problem for a sociologist is that, in the same way as was described in the previous Chapter, there is a range of definitions. Yet the choice of any particular research question, subjects, settings and methods will fundamentally rely on assumptions of aspects of social reality and what can be known about it.

My sociological epistemology and methodology in this research stem from what are broadly called ‘interpretivist’ and ‘constructivist’ perspectives within the social sciences. I have adopted a stance, which combines what these two ‘traditions’ share:
"The constructivist or interpretivist believes that to understand this world of meaning one must interpret it. The inquirer must elucidate the process of meaning construction and clarify what and how meanings are embodied in the language and actions of social actors. To prepare an interpretation is itself to construct a reading of these meanings; it is to offer the inquirer's construction of the constructions of the actors one studies" (Schwandt, 1994, p.118).

I will now turn to the philosophical background to these perspectives.

5.5.1 Phenomenological epistemology

The ontological starting point for my research can be formulated more or less along the lines of Berger and Luckmann:

"It is our contention, then, that the sociology of knowledge must concern itself with whatever passes for 'knowledge' in a society, regardless of the ultimate validity or invalidity (by whatever criteria) of such 'knowledge'. And insofar as all human 'knowledge' is developed, transmitted and maintained in social situations, the sociology of knowledge must seek to understand the processes by which this is done in such a way that a taken-for-granted 'reality' congeals for the man in the street (Berger & Luckmann, 1991, p.13).

Berger and Luckmann's treatise on sociological knowledge draws on the thought of phenomenologist Alfred Schutz. For Schutz (Natanson, 1982), the 'common sense' world is characterised by taken-for-grantedness. We tend to take our everyday lives and their components for granted, without particularly questioning all the time why or how we are doing what we do. The attitude of 'taken-for-grantedness' consists of a person's a) biographical situation; b) stock of knowledge at hand (typifications, i.e. classification of things 'as something'); and c) the co-ordinates of the social matrix (intersubjectivity). The goal for a social scientist is to see beyond this taken-for-grantedness and generate sociological constructions of the social world.

What ought a social scientist to focus on in the study of the social world? For Natanson, traditionally, 'perception' has been taken as the decisive issue for philosophical orientation and appraisal. The full impact of Schutz' work, however,
leads to the denial of the validity of this starting point for any philosophy concerned with social reality. Instead, ‘action’ becomes a dominant theme.

For Schutz (1982), human actions are purposive, projective and conscious. The goal of sociological enquiry is, then, the understanding of social action as the meanings, which the actors bestow upon their own actions. Schutz called the actors’ meanings ‘first order constructs’ and the philosophical/sociological meanings of them ‘second order constructs’. Importantly, taken that the Lebenswelt (inner world) of each actor is different, varying interpretations of the same situations can be made: there are no ‘objective’ situations. Furthermore, actions are never isolated, unrelated to other actions, or divorced from the world.

Central to Schutzian phenomenology is the idea of ‘multiple realities’ (Natanson, 1982). He was interested in the meanings of our experiences (sub-universes), not in the ontological structure of objects. As ‘everyday’ actors, or as social researchers, we typify and describe these objects from our own vantage points. Therefore, a fundamental question arises: can a social researcher make an epistemological ‘leap’ from his/her world to that of the others?

Schutz (1982) suggested that since a social scientist is a ‘disinterested observer’, he/she can go beyond the ‘biographical situation’ and analyse situations with logical and consistent ways and adequately enough so that the actors can understand his interpretation of it. Yet the scientist’s versions cannot be regarded as more correct than anyone else’s since there are no such things as ‘facts’. For Schutz, all facts are from the outset facts selected from a universal context by the activities of the mind. They are always interpreted facts, either abstracted or situated. This does not mean that, in daily life or in science, we are unable to grasp the reality of the world: it means, instead, that we grasp merely certain aspects of it, namely those which are relevant to us either in everyday life or scientific thinking with its own rules of procedure.

We now need to consider what implications the phenomenologically based epistemology may have on the usefulness of my accounts of the two research settings. In the next section, I will reflect on the research process in terms of both practical and
theoretical problems that I have encountered, and how I have sought to overcome those problems.

5.6 Reflections

In any research project, unexpected problems may occasionally arise. Chapter 1 detailed how the first major shift in this research stemmed from the fact that child protection issues were not as frequent a concern in the field as was expected in the research design phase. In Chapter 1, I also described how other significant societal and practice concerns around ‘communication’ and ‘communication difficulties’ (which I regarded as consequential to child protection contexts as well), and sociological questions about them, started to emerge from the fieldwork experience. With this shift of focus, instead of being merely an ‘analytical tool’, social constructionism and the process of oscillating between ‘realism’ and ‘anti-realism’ became a central consideration in my research approach. This section gives an account of the oscillation process. The key element of my discussion is power and the ways in which it is a matter of concern in terms of every encounter in the field.

To begin with, the researcher’s role in studying children’s lives is today a much debated topic (Alderson, 1995). I will refer to some of the ambiguities of this debate in section 5.6.1 in the context of my fieldwork experience. Furthermore, my role, particularly in the ‘Team Service’ setting, was greatly affected by the different discipline based ways of ‘seeing’: section 5.6.2. talks about the theoretical and practical dimensions of this epistemological clash. In section 5.6.3, I will then reflect on how I have constructed a sociological text (this thesis) from the data. The reflections in the following subsections are important in terms of the data analysis later on in this thesis.

5.6.1 The researcher’s role: some ambiguities

Discussions on the researcher’s role in sociological research manuals often revolve around the degree of participation of the researcher in the activities in the field (Bryman & Burgess, 1999; Mason, 1996; Robson, 1993). These accounts typically address the impact of the researcher’s participation on the setting, what roles are
available for any particular researcher in the settings and ethical issues having to do with the chosen role.

My participation in activities in the field varied depending on the setting and the situation. With the ‘Team Service’, it was made clear to me from the beginning that it was not appropriate for me to take part in the action. Thus I always remained behind the one way screen, and did not initiate conversations with the parents when they were in the observation room. In the ‘Children’s Centre’, on the other hand, I was encouraged to ‘socialise’ with children, and even help out, if feasible. At the same time, I had to make contextual judgments about whether my participation in activities, where I did not have a ‘specialist’ part to play, was in any way beneficial for the children or the staff. Therefore, my role in the two settings required adaptability.

The personal attributes of the researcher are another factor that affects the development of his/her role in the field. One constant feature of my role in both settings was that I clearly felt like a cultural ‘outsider’. Denzin and Lincoln have written:

“The bricoleur understands that research is an interactive process shaped by his or her personal history, biography, gender, social class, race, and ethnicity, and those of the people in the setting. The bricoleur knows that science is power, for all research findings have political implications: there is no value-free science” (Denzin & Lincoln, 1998, p.4).

In addition, because I was a foreigner, I tended to pay attention to issues that I thought of as being particular to British culture, or at least different from the common sense ‘norms’ of my own culture.

Furthermore, my background in sociology turned out to be an obstacle to developing a rapport with the staff. First of all, my role in the field seemed vague for all concerned, particularly in the ‘Team Service’ setting. This may stem partly from the fact that often researchers in health settings aim to evaluate the quality the service. I soon realised that I was suspected of doing evaluation as well. Hence, my attempts to explain what my research was about, and what I was doing in the field, were sometimes strongly questioned. This problem was exacerbated by the fact that since I
had no background in the health professions, I sometimes struggled to find the appropriate vocabulary to explain my objectives.

Another problem had to do with the manner in which I collected the data. The staff members once called me to reintroduce the research, because they were worried about what exactly I was writing down. I then attended a staff meeting and talked about my research: about its purpose, qualitative aspects, confidentiality issues, and so forth. It appeared that my academic world – particularly qualitative research methods and social constructionist theories – was poles apart from the medical ‘realities’, and that a shared understanding could not be achieved.

In other words, the ‘communication difficulties’ between my role and theirs seemed to create a barrier to the study of the children’s communication. Because I still had to solve this problem in order to continue with my fieldwork, I ended up emphasising that my research will describe, not criticise, the practitioners’ work, and that the data will not be compared to other settings or published in a way that the staff, children and their families involved could be identified. I will now further explore this matter in terms of its implications for the perceived validity of sociological research in clinical/therapeutic settings.

5.6.2 Differing ‘gazes’ and the validity question

Belgrave et al have noted:

“...The growth of qualitative research holds the potential for vastly enriching our understanding of phenomena in the health sciences. However, the potential of this trend is hampered by a widespread inability of quantitative and qualitative researchers to talk to each other” (Belgrave et al, 2002, p.1427).

One of the grave problems of this research has been the definition of what exactly has been the nature of my sociological gaze, and explaining it to audiences, who are more familiar with quantitative than qualitative research methodologies. The most severe clash between sociological and medical epistemologies happened at the Medical Research Ethics Committee (MREC) meeting, where the usefulness of qualitative
research methods was attacked. The Committee members – all being medical professionals – compared my research to natural scientific norms, which are based on quantification or predetermined variables and the use of strict measurement scales for analysis (Silverman, 2001). Practitioners in the ‘Team Service’ setting were worried about my data collection methods, because they could not establish a link between ‘writing down’ fieldnotes and rigorous data analysis. This became clear in some (albeit rare) conversations with the Team members, who expressed concerns about my presence in the field.

However, I have found explaining my ‘gaze’ as a difficult task in more ways than one. Obviously it has been hard to explain to medical professionals or any other non-sociologists, whose disciplinary view of the world is different. More distressing at the time, though, was the fact that I was unsure about the sociological gaze myself. This was because I had been reading some philosophical discussions on the so-called ‘triple crisis’ of representation, legitimation and praxis that, for some people, face qualitative researchers in the human disciplines (Denzin, 1997).

The representational crisis deems all ethnographic writing to be narrative production. Critical post-structuralism challenges the assumption that an author of a text can be a mirror to the world under analysis: there can never be a final, accurate representation of what is meant and said, only different textual representations of different experiences. Geertz’s (1999) idea of ethnographic writing is an example of this kind of approach; Smith’s (2002) institutional ethnography talks about ‘texts’ in a similar fashion. In terms of ‘legitimation crisis’, the notion of ‘epistemological certainty’ is being challenged by various discourses, such as post-structuralism, feminism, or constructivism. In these discourses, a text’s authority cannot rely on the assumption the ‘world out there’ is truthfully captured by the researcher’s methods. Validity claims become the researcher’s ‘mask of authority’ that allows a particular regime of truth within a particular text to influence the reader (who are typically other scholars). The first two crises shape the third (praxis), which questions: “Is it possible to effect change in the world, if society is only and always a text?” (Denzin, 1997, p.4)

While I was observing observations and describing descriptions, I found myself asking the question: is this merely a relativist/rhetorical chain of interpretative
practices? Throughout the most part of this research project I was puzzled by ‘post-sociology’s’ requirements for being reflexive about one’s own work (Sanchez-Jankowski, 2002; Coffey, 2002), while the same rules did not seem to apply to the medical-scientific discourses and practices that I came across with in the two settings.

I searched for solutions to this dilemma and in the end found some reassurance. For example, according to Silverman (2001), the validity of a research project is identified with confidence in our knowledge but not the certainty of its truth, whereas reality is assumed to be independent of the claims that researchers make about it: it is always viewed through the particular. Hence our accounts are best described as representations – they do not reproduce reality.

What we actually do with our sociological representations is an important question (Potter, 1996). For Mason (1996), research data can be read literally, interpretatively and/or reflexively. The explanatory logic may stem from, for example, theory based descriptions, comparisons between different variables, or extracts from the data that are used to illustrate key points. The last example has sometimes been criticised as ‘anecdotalism’ (Silverman, 2001) because the extracts may not be representative of the whole dataset as such (Mason, 1996). This attitude was something that I encountered both in the MREC meeting and in the field. How could I overcome this obstacle?

I suggest that issues that increase ‘validity’ and ‘credibility’ in my research involve the following factors: prolonged engagement; persistent observation; negotiation with both academics and field setting staff; thick description; and reflexivity, as far as it is possible (see Lincoln & Guba, 1999). As it seems to me, this position is ultimately a matter of drawing a line between what is possible and what is not. This raises some fundamental research ethics related questions, which I will discuss in Chapter 6.

5.6.3 Analysis as translation: from fieldnotes to a ‘text’

What happens to accounts after the fieldwork is problematic to the same extent as data collection. Typically, sociological research guidelines for rigorous social research offer strategies by which data can be sorted, categorised and indexed and then
communicated’ to one or more audiences (Mason, 1996). As a result, as a postgraduate student, I have had the impression that analysis is a somewhat separate process from data collection and writing about the research. I have believed that, for example, by using qualitative software it is possible to make relatively smooth moves from fieldnotes to codes to themes.

What qualitative research manuals do not stress all that often, however, is the analytical significance of the process of writing up – in this case, a PhD thesis. In my experience, which, of course, may be different to other PhD students, my findings really only took their final shape towards the end of the writing up period. Some might argue that this is inevitably a weakness in my capacity as a researcher. On the other hand, Geertz has observed:

“This backward order of things – first you write and then you figure out what you are writing about – may seem odd, or even perverse, but it is, I think, at least most of the time, standard procedure in cultural anthropology” (Geertz quoted in Wolcott, 2001, p.77).

I now understand that comprehending my own data has required a lot more than an ability to apply apparently logical categories to sections of data. Indeed, the agony of translating ‘thick description’ into readable text – whether for academics or health professionals – is a challenge in itself: no computer software can do that job for the qualitative researcher.

Therefore, I regard ‘bricolage’ as a useful analogy for describing the end product of the research, in that it refers to how a ‘whole’ consists of parts, and that these parts have to be assembled together for a meaningful end result. These parts may consist of multiple methods and theories, which are all meant to lead to a complete, convincing ‘story’ (Denzin & Lincoln, 1998). The key argument here is that labelling a PhD thesis as a ‘story’ needs not be associated with insincerity or fabrication.

Reiterating Mason (1996): research data can be written in different ways but also read in different ways. I also agree with Geertz (1988), for whom good ethnographic texts are plain and unpretentious, which neither invite nor reward a close, literary-critical
reading. Although I have assumed an authorial role in this thesis, and I have been the bricoleur going along a learning curve, I have believed that the outcome will be coherent in the end. Indeed, I associate the patience and endurance that is required for this construction work with the ‘rigour’ and ‘quality’ of qualitative enquiry.

Smith’s (2002) recommendation for keeping in mind what the research subjects treat as ‘real’ has been my guiding light: it has kept my feet on the ground, so to speak. The writing process has helped my sociological learning process; it has been a research tool as much as observation. Moreover, writing separate reports for practitioners has forced me to think what their point of view might be, and how this research could generate something that they regard as helpful for practice. I will return to this aspect of research process in Chapter 6.

5.7 Conclusion

This chapter has discussed the epistemological dimensions of social constructionist research: what it makes of ‘reality’ and the generating of sociologically sound accounts of it. The discussion has stressed the difficulty of doing this kind of research in settings, where the premises for ‘knowing’ are different and how unexpected ‘communication difficulties’ arose in my attempts to translate between the sociological and practitioner worlds. In addition, I have destabilised sociological justifications for ‘knowing’ and struggled to find solutions to the emerging epistemological dilemmas.

I have come up with a number of solutions. First, Janesick (1998) uses the term ‘methodolatry’, a combination of method and idolatry, to describe a preoccupation with selecting and defending methods to the exclusion of the actual substance of the story being told. In this view, qualitative research does not have to comply with ‘quantitative’ demands for validity, reliability and generalisability: the aims of qualitative research projects maybe different but equally or more valuable.

Second, for Denzin (1997), ethnographic research has gone through – or is still in the midst of - a ‘representational crisis’. In this research, one of the main headaches has been the criticism of qualitative methods by non-sociological audiences. At the same
time, some writers have questioned the ‘crisis’ scenario (Snow, 2002) in terms of its
cpolitical connotations. Others have talked about similar kind of situation within
constructionism and its place within sociology. According to Maines:

“There is no definitive body of knowledge that I know of called the ‘social
cconstruction of meaning’. Yet no practicing sociologist can avoid this topic, and all
level-headed ones realise that their subject matter is composed exactly of various
degrees, kinds and situations and structures of meaning and absurdity” [...] “The
implication here is that there does not exist some deep and enduring fault line
between constructionists and non-constructionists, which is a fiction that sociologists
tend to perpetuate among themselves” (Maines, 2000, p.581).

Where to go from here? In terms of the so-called realism/anti-realism dichotomy in
sociological theory (Williams & May, 1996), I consider that this research is connected
to everyday lived experience, which is shaped by various discourses. Ontologically, I
assume that some ‘realities’ in research settings, such as what is perceived as ‘normal’
communication, are socially constructed rather than based on indisputable facts
(Burkitt, 1998), and this has had a significant impact on the ways in which I have
thought about my own research practices.

Third, Wolcott has usefully pointed out that qualitative researchers are often tempted
to rely too heavily on the sanctity of the method, and especially on fieldwork
techniques, to validate their research (Wolcott, 2001). I have tried to avoid this,
placing the emphasis on the ‘construction’ of a text (the assembling of a bricolage). I
regard the concepts of ‘interpretation’ and ‘construction’ as denoting the same
activity. The inquirer makes cognitive, subjective and discipline specific
interpretations out of it, and then constructs ‘texts’ out of those interpretations. At the
same time, I maintain that writing about constructed meanings, whether they are mine
or somebody else’s, can make a difference, since once meanings become incorporated
into the ongoing cultural and social structural arrangements of a society, they can be
highly consequential (Maines, 2000).

Epistemologically, I assume that the study of ‘texts’ and interactional events using
qualitative methods can combine discursive and material aspects of human
experience. Therefore purposeful descriptions of this experience can be generated:
instead of claiming to simply produce ‘alternative truths’ about the research settings, this research focuses on describing observable action that has significant consequences for the lives of (disabled) children.

As I have pointed out several times in this chapter, this research project involves a number of important ethical considerations, which will be addressed next. In Chapter 6, I will discuss the ways in which studying (disabled) children’s lives and ‘communication/difficulties’ is a moral and political enterprise.
Chapter 6.

RESEARCH ETHICS: QUESTIONS OF MORALITY AND POLITICS

6.1 Introduction

Questions about research ethics have significantly affected every stage of this research process. This chapter talks about the practical steps I had to take to carry out the research, as well as the theoretical issues, which arose both from the literature and the research experience. I suggest that although there are plenty of guidelines available for a social researcher, the decisions of what ultimately constitutes good research practice ought to remain contextual. This may appear to be a controversial statement, especially when it is applied to research practice in clinical/therapeutic settings. Hence this chapter is built on my efforts to justify it.

The key ethical issues in this research have revolved around the ‘validity’ of non-clinical research on disabled children, the protection of research subjects (children, their families and the staff in the two settings) from harm or undue intrusion by research, and informed consent. My route to unravelling the ambiguities regarding these issues starts from introducing official academic guidelines for ethical social research. Section 6.2 draws on guidelines by Social Research Association (SRA). I have chosen this example since the document in question is recent and well recognised within British sociology.

Section 6.3, focusing on research on/with children, challenges some aspects of ‘official standards’, such as SRA guidelines. This is since recent trends in literature concerned with children’s welfare and/or rights have called for more child centred research. An important consideration in this context is with the notion of the child’s ‘voice’. In section 6.4 I will then demonstrate how I have applied the above guidelines in my research and what problems I have faced in doing so. There is a special focus on studying children’s lives in clinical settings. Requirements for reflexivity and ambiguities in achieving a morally and politically coherent attitude to research will be specifically addressed in section 6.4.3.
6.2 Guidelines for ethical social research

The ethics of social research can be articulated in terms of the researcher's 'obligations' to all those parties that will be, directly or indirectly, affected by the research. According to a recent sociological publication by SRA in Britain, the researcher has obligations to society, funders/employers, colleagues and research subjects (SRA, 2002).

In terms of the researcher's obligations to society, the SRA guidelines (2002, Ch. 1) consider responsible professional practice for social researchers to balance a concern for individual rights with the greater benefits to society of their research activity. It is recommended that social researchers should use the possibilities open to them to extend the scope of social enquiry and communicate their findings, for the benefit of the widest possible community (Section 1.1). This also involves considering conflicting interests:

"Social researchers must be sensitive to the possible consequences of their work and should as far as possible, guard against predictably harmful effects" (SRA, 2002, Section 1.2).

'Pursuing objectivity' may be kept in mind as a goal; on the other hand, it may be argued that research can never be entirely objective, and social research is no exception (Section 1.3).

Obligations to funders and employers include clarifying each party's obligations and roles in advance (Section 2.1); assessing alternatives (in terms of theory and method) impartially and explaining these to all parties (Section 2.2); and guarding privileged and confidential information. The 'confidentiality rule' excludes methods and procedures that have been utilised to produce published data (Section 2.3).

Obligations to colleagues involve a number of factors. For example, maintaining confidence in research, although without exaggerating the accuracy or explanatory power of their findings (Section 3.1); peer reviews within the limits of confidentiality (Section 3.2); and communicating ethical principles to all parties. This will also
contribute to the reputation of social research, which, at the end of the day, depends on the actual conduct of individual researchers.

The researchers should leave a research field in a state which permits further access by researchers in the future and ensure that social enquiries are conducted within an agreed ethical framework, perhaps incorporating principles or conventions from other disciplines (Section 3.3). Furthermore, (while understanding that ‘risk’ is a part of everyday life), it should be acknowledged that some research activities may place the researcher in the field in some degree of extra risk of physical/mental harm (Section 3.4).

The notion of obligations to subjects, first and the foremost, means avoiding undue intrusion:

“Social researchers [...] have no special entitlement to study all phenomena. The advancement of knowledge and the pursuit of information are not themselves sufficient justifications for overriding other social and cultural values” (SRA, 2002, Section 4.1).

On the one hand, undue intrusion may cause distress to the subjects. On the other, people can feel wronged without being harmed by research: they may feel they have been treated as objects of measurement without respect for their individual values and sense of privacy.

Secondly, ‘obligations to subjects’ involve typically obtaining informed consent. For SRA, gaining informed consent is a procedure for ensuring that research subjects understand what is being done to them, the limits to their participation and awareness of any potential risks they incur (SRA, 2002, Section 4.2). At the same time, it is being acknowledged that the principle of informed consent from subjects is necessarily vague, since it depends for its interpretations on assumptions about the amount of information and the nature of consent required for constituting acceptable practice: no universal rules can be framed.
Sometimes it is inappropriate to overwhelm potential subjects with unwanted and incomprehensible details about the origin and content of a social enquiry. Yet it is ethical to inform subjects of their right to information and detail their degree of control:

"A subject's participation in a study may be based on reluctant acquiescence rather than on enthusiastic co-operation" (SRA, 2002, Section 4.2).

Sometimes the researcher-researched relationship is mediated by a gatekeeper, which involves a further set of ethical considerations. This is particularly urgent in the case of 'vulnerable' populations (typically disabled children are classified as such). In recent years, consent forms have become more or less standard. The SRA recommends that, at minimum, there should be information about opt in- or opt out arrangements, the length and degree of commitment required of respondents, the precise goals of the research, plus debriefing of subjects (Section 4.2). Respecting rights in observation studies should involve post hoc consent at the very least (Section 4.3).

SRA guidelines assert that social researchers should help subjects to protect their own interests by giving them prior information about the consequences of participating, in terms of psychological, material or other harm caused by the research, predictable or not, and about being member of a group (Section 4.4). Social researchers also have a responsibility to ensure the participation in research of those people who might like to take part, by dealing with potential barriers of communication, understanding, access or financial expense (Section 4.5). Moreover, social researchers should maintain the confidentiality of records, even though the research data were unconcerned with individual identities. The best means for this are safe storage of data and restricted access to it (Section 4.6). One may prevent disclosure of identities by using pseudonyms (Section 4.7).

In the context of this research project, the ethics of research on/with children is an additional consideration. Although SRA does not omit children from its recommendations for ethical research, the guidelines do not particularly address this aspect either. Thus I will now provide a brief overview of literature that does.
6.3. The move to ‘listening to children’ in social research

The UN Convention on the Rights of the Child 1989, the Children Act 1989 and their concept of ‘listening to the ascertainable wishes and feelings of the child’ (see Chapter 1) have affected recent social research ethics discussions. For Morrow & Richards (1996), while there are plenty of sociologically ‘relevant’ discussions of children’s problems and ‘problem children’, there are few sociological studies based on children’s accounts of their everyday lives and experiences. Sociologists and anthropologists are increasingly asserting that sociological research (as opposed to psychological, behavioural, medical research) with children is underdeveloped.

As indicated in Chapter 4, childhood sociology has shifted the focus of socialisation and child development to a sociology which attempts to take children seriously as they experience their lives as children in the here and now. Morrow and Richards argue that the absence of any discussion, within sociology, of the practicalities and ethics of carrying out research with children is hardly surprising, because sociology as a discipline has tended to ignore children, and left them to psychologists to study. For example, a lot of research has been done on children in educational settings or as part of their families but not about their experiences per se.

Can general ethical guidelines for research, such as those mentioned above plus those of BSA, MRC or NCB\(^\text{10}\) be useful for researching children? According to Alderson (1995), agreed ethical standards for research have mainly been developed in medical, rather than social research. She argues that the three frameworks in professional ethics - duty, rights and harm, and benefit - are based on centuries of patriarchal law and philosophy. Doing ‘good’ and feeling ‘good’ might provide the motivation for studying children but the question remains of who is ultimately going to benefit from the research. For many people, to be a professional/expert means to be the best judge of what is good – however, there is no clear consensus about what is good in the end.

Alderson has suggested ten ethics topics that should be taken into account in research with children: the purpose of the research; risks or costs; privacy and confidentiality; selection criteria; funding; research review; information for participants; consent; dissemination of results; and impact on children. These address more or less the same ethics issues as the SRA guidelines, but from a child centred point of view.

Morrow and Richards (1996) claim that general research ethics guidelines are centred around two key preoccupations: informed consent and protection of research respondents, both of which are problematic in research with children in several ways. Usually research on children involves adult gatekeepers and parental consent. There is also a tendency to focus on the age of the child, and little attention is paid to ethnicity and gender, the child’s competence or the researcher-researched relationship. Thus ethical choices should ultimately depend on the researcher and therefore be context-specific and situational. Furthermore, it is hard to bring about changes in practices when there is no ‘culture of listening to children’. When ‘childhood’ is seen as a period of powerlessness and irresponsibility, and children are seen as weak, passive and open to abuse, their dependence on adults is explained by their physical weakness and lack of experience. This is used to justify their lack of political, economic power and civil rights.

For Christensen & James (2000), only through listening and hearing what children say and paying attention to the ways in which they communicate with researchers will progress be made towards the conduction of research with, rather than simply about children. The main epistemological questions, then, address how a researcher may gain access to the children’s perspective, or participate in children’s worlds. It is suggested that this can be done, for example, by paying attention to children’s use of language, their conceptual meanings and their actions to understand social interactions. James (cited in Morrow & Richards, 1996, p.100) suggests that children have different abilities, and are encouraged to be skilled in different communication media (drawings, stories, written work and so on); but are nonetheless competent and confident in them, and so as researchers, we need to draw on these. This would take into account the fact that neither children nor researchers are homogenous groups.
6.3.1 Ethics of research on/with young disabled children in clinical settings

In clinical settings, a different set of ethical guidelines apply from those of the SRA. Disabled people's lives, including children, are often studied in environments that are categorised as clinical: once a setting is deemed as such, social researchers do not have powers over the medical ethics criteria. Typically, in clinical settings, social research proposals are formally reviewed by ethics committees, whose rationale for this practice lies in standardisation.

Within social research, challenges to the hegemony of medical ethics have been attempted. Ethics committees, for example, have been criticised for promoting institutional protection rather than operating in the interests of subjects of researchers. It has been recognised that biomedical models can be inappropriate in social settings. Furthermore, if the social research ethics are not really understood by medical specialists, the competence and knowledge of the committees becomes questionable (SRA, 2002, Section 5). Another area of resistance has been developed within the Disability Studies paradigm, where it has been argued that the purpose of research – clinical or not - must be of direct benefit to the participants:

"What will the research achieve in terms of improving the lives of those whose selves become 'sources' and whose meaning becomes 'material'? Will it achieve any more than furthering academic careers and publication lists?" (Stone & Priestley, 1996, p. 703).

The emancipatory research paradigm objects to the 'use' of 'passive research subjects', urges researchers to recognise both commonality and difference in the experience of disablement, and reminds us that a plurality of methods may be needed to capture different aspects of disablement (Stone & Priestley, 1996). When it comes to disabled children: researchers must avoid pathologising them and understand the socially constructed nature of the notions of 'childhood' and 'disability' (Moore et al, 1998).
Drawing on recent medical ethics literature, it appears that disabled children's rights are by no means ignored in medical academic writing (Koch, 2001). On the other hand, despite the changes in the 'esoteric circle', it is not necessarily guaranteed that the 'social model of disability' is taken into account in the everyday practices of medical professionals. The same, of course, may apply to social researchers. Studying aspects of children's lives is now increasingly being seen as posing additional challenges to social researchers.

Recent trends within the social sciences have involved a movement away from traditional experimental and interview methods of hypothesis testing in research on children's linguistic, communicative and socio-cognitive development towards participation in the children's culture. In the early literature of this kind (Corsaro & Streeck, 1986), entering directly into children's worlds was recommended to establish how the development of children's 'social competence' is embedded in social contexts. In many subsequent studies of 'children's cultures' there has been an emphasis on how children acquire, use, and refine social knowledge and discourse skills in their everyday interactions with peers and adults and on the communicative procedures by which they structure the interpersonal world around them. This may be achieved either by direct observation or by micro-ethnographies in institutions (Hutchby & Moran-Ellis, 1998).

In addition, some writers have promoted a phenomenological research approach that may help in getting into 'children's worlds', including young disabled children: this involves very detailed in-depth observations and prolonged interaction where the child 'allows' the adult to take part, or the child leads (Goode, 1991). The ethical aim here is to promote equality in research relationships, and to give children a 'voice'.

On the other hand, it has been noted that participant observation with preschool children is not the same as with those who are older (Fine & Sandstrom, 1988). One of the points made is that the meanings of children of this age are not always apparent to adult researchers, the interpretations become problematic and there may be a temptation to assign one's own meanings to the child's talk and activity. Although the goal of participant observational research is to establish equal status contact with
one's informants, this may not be entirely possible with preschool children. The so-called 'least-adult' role (Mandell, 1991) where the adult attempts to be part of the children's peer group, for instance, may not work for establishing trust with children (Fine & Sandstrom, 1988). Furthermore, researchers ought to bear in mind their 'adult responsibilities' towards children as well.

As already described in Chapters 1 and 2, the message put forward in children's rights legislation is that children's 'voices' should be listened to by adults who make decisions concerning children's lives – this involves research on/with children. Yet, a question arises: what are children's voices and how should we listen to them? Davis (1998) suggests that there are a variety of children's voices and that it may be possible to attribute equal value to these voices by employing techniques, which enable researchers to reflexively question their presence in children’s worlds.

6.4 Applying the guidelines to this research project

In my case, research ethics considerations in terms of Alderson's ten ethical points (in section 6.4.1) satisfied the funders and the Medical Research Ethics Committee (MREC) and granted me access to the 'Team Service' setting. However, in the course of doing the research, I encountered some other ethical considerations that are not often discussed in sociological or other ethics manuals. The first concern deals with the epistemology of observational research in a medical setting, as discussed in section 6.4.2. I mainly have the 'Team Service' data in mind, the analysis of which will be the topic of Chapters 7 and 8. In section 6.4.3, my second concern has to do with the notion of the sociologist's 'reflexivity' and its moral and political dimensions.
6.4.1 Alderson’s ‘ten commandments’

I will now begin to describe the ethics related choices that I made in relation to both settings, in part paraphrasing Alderson’s ten points for ethical research with children (Alderson, 1995). Although Alderson’s points steer the attention to children, I will include adults as well because my research involved data on health specialists as anonymous adult experts, who interacted with children.

1) **The purpose of the research** has been to understand the phenomenon of ‘communication/difficulties’. It has been expected that new insights in this area, which have not yet been researched sociologically would contribute to the sociology of childhood, communication and disability, as well as provide discussion points for professional practice.

This research has been meant to serve the interests of disabled children: for example, in terms of child protection, in-depth understandings of social processes of communication are vital in order to safeguard children’s human rights and well being. Letters, information leaflets and interim reports for professionals in the two settings have involved statements of hoped for benefits: i.e. what can be gained through a greater understanding of children’s communication and ‘communication difficulties’.

The thesis and any intended academic publications extracted from the thesis are meant to point out some theoretical and methodological ambiguities that prevail in the existing literature. It seems that existing theories and texts on face-to-face communication have been more or less exclusively been formulated in medical and developmental literature. Furthermore, the literature that deals with listening to children usually focuses on able-bodied children, or on children who are over seven years old. This thesis also aims to
unravel how professionals interpret children’s communication competencies and how these interpretation procedures may be sociologically – and in practice - problematic.

2) Are there any risks or costs? There were no direct obvious mental, physical or emotional hazards to the children involved. I observed the assessments from behind a one way screen so that there was no physical or other contact with the children. I had more opportunity to interact with children in the ‘Children’s Centre’, although always under the supervision of the qualified staff – I was mainly a marginal observer, with certain adult responsibilities, for example, to try to prevent children from having accidents. At the time, it appeared that this role suited best for me and the children, since I did not have a professional background in care work.

3) The protection of privacy and confidentiality were sought for, first, by using pseudonyms for all names and locations involved in the research, and by referring to these so that they cannot be identified or individualised. The fieldnotes will be kept in a secure locked filing cabinet for five years after the last publication has been released on them. The videotapes were given to the ‘Children’s Centre’ after the data analysis was finalised. Documentation of clinical assessments or case histories was not included in the research.

In both settings, parents and practitioners were given an opportunity to opt into or out of research, particularly the video recordings and assessments. In order to observe assessments, parental and practitioners’ consent was sought – the purpose and implications of the research was explained to them. There was no pressure on any of the participants: the privacy of the children and their families, as well as of practitioners, was respected at all times. The children in
the 'Children's Centre', in particular, were said to be used to having adults observe them. Finally, my police records and employment history with children were checked before the fieldwork started.

4) There were no particular selection criteria for the research subjects; for example, the representativeness of the findings was not central to this research. The only 'factor' that the two settings shared, in terms of my research question, was that 'communication difficulty' was a concern in them both.

5) The funding for the research came from the ESRC, Finnish Government and a registered voluntary organisation, which did not have any commercial interest in the research.

6) Research review: The research was under continuous supervision by academic and professional supervisors. Interim reports for the supervisors and the staff members were provided in the course of the research.

7) Information for participants: When parents and practitioners received information leaflets about the research, I did my best to ensure that this information was understood. The contact details of the researcher and the supervisors were provided in case there were any questions or complaints.

8) Consent: Because the children concerned were very young, written or spoken consent or assent was not asked from them directly. However, the parents were given a full explanation as to what was involved. This took into account that some of the parents were not necessarily literate. It was made clear that participation or non-participation did not affect the services the child received, or the decisions that were made by the professionals about the abilities of
the children. Furthermore, parents were assured that they could withdraw their child from the research at anytime during or after observation. The practitioners were asked to give group based consent. I did my best to explain that I was not evaluating their work, or talking about them as ‘individuals’ in my data in a manner that would allow them to be identified. They were also given an opportunity to dissent.

9) **Dissemination**: Different kind of reports will be extracted from the thesis for different audiences: journal articles will include theoretical and methodological considerations. Reports for the staff in both settings have involved examples of the data, and left any recommendations or decisions for the staff members to make.

10) **Impact on children**: The hoped-for benefit of this research to (disabled) children is a heightened awareness of ambiguities in human communication within child welfare practice. It has been acknowledged that any benefits may not be immediate, but may instead contribute to practice on a long term basis.

The above points outline the practical steps that I have taken in order to pursue ethically sound research. However, certain events prior to and during the fieldwork led me to consider whether there is more to research ethics than is stated in the guidelines. One of my ethical concerns revolved around the epistemology of observation and the different ways of ‘seeing’ between disciplines (see also Chapter 11).

**6.4.2 Ethics of observation in clinical settings**

As mentioned in Chapter 4, the meeting with MREC was an eye opening experience of the power of Medicine as a discipline. No obvious attempts were made to understand the point of view of a qualitative researcher: instead, a great deal of attention was drawn to the protection of the practitioners in the setting. I believe that
since my approach to children was ‘non-interventionist’ and therefore perceived as a low risk one, I did not have great difficulties in getting my application accepted in the end. On the other hand, if anyone believes that my research is not just ‘harmless’ but also ‘useless’ for practical purposes, as the MREC members suggested, it is necessary to further discuss the ethics of my theoretical and methodological choices.

The Committee expressed concerns about my research methods, being in doubt about their validity and use value, thereby mocking the integrity of sociological knowledge as well as my ‘inability’ to nail down some ‘hard facts’. I agree with some of their concerns: it can sometimes be very unethical to do research that will not benefit the research subjects’ lives, particularly in the case of disabled children, who are not perceived as a powerful group in society.

The health specialists also expressed concerns about my ability to ‘observe’, in particular, asking: “What do you see that we don’t?” On several occasions, I attempted to explain this to the staff members, especially within the ‘Team Service’. I often felt that this was a matter of me being accused of not being able to ‘translate’ the sociological jargon to everyday language. The implication was that ‘communication difficulties’ between different disciplines that seemed to constitute a barrier to the study of the children’s communication, were perceived as my personal problem: I was supposed to be able to effortlessly oscillate/mediate between the two worlds. However, there was more to the story: I eventually realised that the epistemological clash between medicine and sociology had to do with the philosophy of observation. I will come back to this idea in Chapter 11.

Hence I will ask: what exactly does social constructionism challenge in the ‘clinical’ and/or the ‘scientific’ work? Epistemologically, the practitioners’ interpretive practices (Holstein & Gubrium, 1998) in both settings relied on what was empirically taken to be objective, observable, essential and real. In medicine and developmental psychology, it appears that a ‘communication difficulty’ is taken to be a quantifiable, measurable and pathological phenomenon. At the same time, I stress, again, that I have wanted to explore the social aspects of clinical work (Smith, 2002). I have never claimed that I would particularly search for some factual ‘errors’ in the ways in which the health specialists view children: instead I would point out the discursive,
interactional, context-bound elements of clinical work, which is done by human beings in social situations. I believe that my sociological ‘gaze’ can do that and therefore I regard my sociological observations as ethical. At the same time, I have recognised the ambiguities of translating the gaze into an academic text: I will now look at the ethical dimensions of this translation process.

6.4.3 Reflexivity and ethical dimensions of representation

In Chapter 5 I talked about the ambiguities in ethnographic writing in terms of its process-like and textual nature, and how it thus undermines ‘scientific’ notions of descriptions being factual. In this section I return to speaking positions, drawing on my personal experience as an ‘evolving’ speaker, who talks on behalf of other people. I intend not only to reflect upon my research experience, but also try to understand what reflexivity means and how it can be put to ethical use.

‘Reflexivity’ in terms of research methods and ethics refers to the relationship between the knower and the known: hierarchies, ‘good’ and ‘bad’ research, and the normatively constituted speaking positions (Adkins, 2002). For Coffey (2002), ethnographic writing has a biographical dimension in that ethnographers are concerned with observing, reconstructing and writing the lives and experiences of the Others. This has also been highlighted in Disability Studies, where the able-bodied researcher’s right and authority for doing research on behalf of disabled people has been strongly challenged (Barnes & Mercer, 1997).

In my two research settings, the health specialists were undoubtedly regarded as the ‘knowers’. I was, at least in the beginning, positioned as a ‘non-knower’: a student, a non-practitioner, and an able-bodied person. I had no problem with that, however. I did not enter the field to ‘colonise’ the actors; I had, myself, accepted that I had to learn in order to ‘know’; but, being a sociology student, my learning outcomes would be different from those I would have reached, for instance, in a medical school.

Reflexivity in my research also has to do with the realism/anti-realism dichotomy. By this I refer to the dilemma of using realist methods and then giving reflexive accounts of the data (Coffey, 2002). This is because, although this research uses ‘social
constructionism' for the analysis of the Other, my initial observations were based on 'realist' principles. Eventually, I had to make it clear to myself and others that I could not contradict myself like this, i.e. regard certain things (such as communicating about child abuse) as 'real' and others as constructed (such as 'Childhood' and 'Disability').

My solution to this dilemma drew on Smith (2002): what the actors in the setting treated as 'real' was the object of my study and my knowledge claims of their realities would be presented as constructions, which can be read in differing ways by different audiences. Indeed, after a long period of confusion and agonising about how to go about this research, I have understood that I am experiencing what Denzin calls the 'messy moment' in ethnographic writing: the texts consist of a "cacophony of voices speaking with various agendas" (Coffey, 2002, pp.314-316). This has been a liberating realisation for me. I can now reassure myself that 'polyvocality' – which I think my research attempts to incorporate - does not necessarily mean simply the same as being 'immoral' or 'unethical'. Yet I am not expecting that other people, who have been involved in this research, ought to experience this moment in the same way.

For Skeggs (2002), 'telling has always been moral'. I agree that even though I delegate some interpretive power to the reader, I do have to take the chief responsibility for the content of this thesis and for its potential implications for practice. The next section continues from this, suggesting that 'telling' is not only moral but also political.

6.5 Questions of morality and politics

In this section I intend to recap on what I have argued so far in this chapter. I will emphasise not only the complex and contested definitions of what is ethical, but also how moral choices have been, and are, linked to the politics of research. I am talking about knowledge claims and their significance to the researcher and the researched, as well as for academic debates within and between disciplines.
6.5.1 The moral character of medical and sociological knowledge accumulation

In recent years, the relationship between real life moral decision making and the forms, styles and content of reasoning used in bioethics have been the subject of academic debates. In some accounts, moral theorists and, in particular, bioethicists have presented the view that their theories of moral reasoning provide a more rational and ordered account of the moral theorising we all do on a daily basis. In contrast, the critics of mainstream bioethics, particularly from the social sciences, argue that the forms, styles and language of bioethics bear little relationship to the ways in which ordinary people describe and explain their moral problems (Braunack-Mayer, 2001).

Braunack-Mayer argues that, in bioethics, ethical dilemmas are defined narrowly, as situations in which, on moral grounds, persons ought both to do and not to do something. Such a definition implies that issues of conflict and choice are central to moral dilemmas. Furthermore, most bioethics texts suggest that moral dilemmas or ethical problems invariably involve conflict, choosing between equally desirable or undesirable alternatives, or balancing options. For instance, obtaining a signed consent form may be imperative to scientists, while other ethical considerations in the research subjects' lives may remain unnoticed.

This thesis is a continuation of a long string of academic texts across disciplines that seek to question some legitimate aspects of scientific (here medical/clinical/specialist/therapeutic) knowledge. My intellectual problem is that, in recent years, sociologists have been increasingly sensitive to their own knowledge production. For example, Seidman has argued:

“Disciplinary insularity seems less detrimental to the natural sciences but, it promotes intellectual obscurity and sterility in sociology” (Seidman, 1992, p.47).

It has been recognised that sociologists who specialise in theory acquire sufficient fluency in its language and discursive strategies to be able to theorize in a way that confers credibility, social status and material reward. As a result, few people except theorists read sociological theory texts (ibid).
In the same manner as natural scientists, many sociological theorists have believed that science is an epistemologically privileged type of knowledge. The ethical problem here is, again, that when rooted in the positivist world view, explanations of social life are considered incompatible with the representations offered by the participants themselves. In terms of research problems, style, and content, research production presumes greater mastery and clearer illumination than the non-experts who are the targeted beneficiaries (Christians, 2000).

Protecting and promoting individual autonomy may have been the philosophical rationale for value neutrality since its origins in the Enlightenment writings. However, the incoherence in that view of social science is now transparent. By limiting the active involvement of rational beings or judging their self-understanding to be false, empiricist models contradict the ideal of rational beings that ‘choose between competing conceptions of the ‘good’ and make choices ‘deserving of respect’. The verification standards of this instrumentalist system “take away what neutrality aims to protect: a community of free and equal rational beings legislating their own principles of conduct” (p.149). This, I think, is a particularly obvious dilemma in research on disabled children.

I agree with MacIntyre (1982, p.178) in that the social sciences are quintessentially moral sciences: “The only question is: which morality is it to be?” The concept of social benefit is, in the context of our particular intellectual and political culture, essentially debatable and contestable. Moreover, often a multiplicity of individual rational decisions may produce a process, which is itself not susceptible to rationality as a whole; someone might always be wronged in some way. Nevertheless, being ‘wronged’ is not necessarily the same as being ‘harmed’.

6.5.2 Politics of ethical choices

With regard to the previous section, the basic ethical problem here is based on the notion of ‘pluralist’ society (Barnes, 1979). In this view, social enquiry may be seen as a process of interaction and negotiation between the social researcher, sponsor, gatekeepers and citizens. The wider community is involved in the process in several ways in that social research depends on the acceptance of a plurality of interests and
views within the community. For Barnes, each of the parties to the process of enquiry has its own interests and values, its own expectations or lack of them, about what may or should emerge from the enquiry, and its own ideas about what is morally right or wrong in making enquiries into social phenomena.

I want this thesis to be not just fundamentally guided by but also reflexive about moral values and choices. I agree with Bulmer (2002) in that being ethical limits the choices we can make in the pursuit of truth:

"Ethics say that while truth is good, respect for human dignity is better, even if, in the extreme case, the respect for human dignity leaves one ignorant of human nature" (Bulmer, 2002, p.45).

I do not think the pursuit of knowledge is necessarily the same as ‘the truth’. Nonetheless, from a human rights perspective, I should not ruthlessly pursue anything at the expense of other people. Indeed, a political problem arises where I suspect that other people might harm them: if I do not take action, I then might, indirectly, let exploitation happen. Therefore, studying disabled children’s lives in the contemporary world is inevitably political.

It can be argued, though, that care has to be taken to distinguish rhetoric from practice. For Roberts (2000), listening to children is not necessarily ‘good’ but may be, in fact, intrusive and the cause of further distress: more listening may not inevitably mean more hearing. In other words, researchers should think about when and how to conduct research with children so that it is as ethical as they claim it to be:

"It is clear that listening to children, hearing children and acting on what children say are three very different activities, although they are frequently elided as if they are not" (Roberts, 2000, p.238).

As already described in Chapter 2, the message within children’s rights discourse is that children should be listened to by adults who make decisions concerning their lives – this involves research on/with children. Yet, I repeat: What are children’s ‘voices’ and how should we listen to them (Davis, 1998)? Now that I have experience of the day-to-day lives of young (disabled children), I find the rhetoric of ‘listening to
and hearing children’ rather problematic. This claim will be elaborated in Chapters 9 and 10, where I will present my data analysis from the ‘Children’s Centre’.

### 6.6 Conclusion

The typical concerns in social research ethics debates revolve around informed consent and the short- and long-term implications of one’s research for all parties involved. Recently also the nature of the researcher-researched relationship has been under increasing scrutiny. In this chapter I have identified further concerns: epistemological considerations in observational qualitative research, the ethics of the researcher’s reflexivity, and the notion of morality as a discourse. I have only briefly sketched some issues around these areas, appreciating that each of them deserves a lot more in-depth treatment: I have merely intended to point out the importance of these debates to this thesis. I now want to conclude with some defences that I have come up with in the face of the primary audiences of this research.

In terms of research ethics, my definition of ‘reality’ is based on Smith’s (2002) suggestion: what is real to the subjects is what matters. My access to the realities of (disabled) children has been limited in both settings. What I know about it has been, for the most part, mediated by adults; children’s participation has not been fundamental to this research. However, that mediated knowledge has been sufficient enough to convince me that the purpose of this research – to develop new understandings of (disabled) children’s communication issues – is ethically sound.

Before I entered the two settings, I was prepared to encountering questions about my research to some extent. I was also aware of the complexity of the sociological jargon. For that reason, I tried not to overwhelm people with too much theory – in the beginning, the staff members actually expressed that they preferred that. Nevertheless, at that point I was increasingly being accused of not clarifying enough of what my research was ‘really’ about. I had to explain ‘social constructionism’ over and over again without being understood. I took the blame: perhaps I did not find the right words to express it to non-sociologists. I argue that this was clearly a case of a no-win situation. The researcher cannot create rapport, empathy and trust alone: it is a matter
of a two way, reciprocal relationship. Perhaps the 'empathy' model better suits settings where the researcher is clearly more powerful than the actors in the field.

In both settings, I did not feel that I was unduly invading anyone's privacy since I was not individualising the subjects. For example, I use pseudonyms for the children; the staff members are called 'workers' or 'practitioners'. For me, they were actors who were playing their parts in a 'social drama' (Turner, 1974), or members of a group concerting activities in an institutionalised context (Smith, 2002). I did, of course, perceive all the concerned parties as individuals and respected them as such; yet my sociological analysis is not about them as medical 'cases'.

My approach turned out to be vague and strange to many health specialists, whose own research practices stem from 'positivism' and bioethics. This can be seen as a situation where people are not harmed but where they may feel wronged. My defence here is that, as a student and without any professional background in medical settings, I was not able to foresee this conflict or to prepare for dealing with it.

Bearing in mind the power of MRECs, I stress that the central issue in any risk/benefit equation such as this is: who is to draw up the balance sheet and determine whether particular methods are justified or not? Whose causes and ethics are the right ones in social research (Bulmer, 2002)? Resulting from this question, I have decided that this research will incorporate 'multiple voices' rather than insist on reaching a one-dimensional conclusion (Gergen & Gergen, 2000).

My experience of doing this research suggests that moral encounters are not about following rules but matters of contextual decision making. In this view, morality is not voluntary and it comes prior to any calculating action, purposefulness, reciprocity or contractuality. Morality is not an optional responsibility: it is both external and internal to the agent. I agree with Morrow & Richards (1996), who suggest that ethical choices should ultimately depend on the researcher and be therefore context specific and situational; at the same time, openness about these choices is a necessity.

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11 See British Psychological Association (BPA): 'Appendix B: Ethical Principles for Conducting Research with Human Participants (British Psychological Society)' in Robson (1993).
PART 3: FINDINGS

Part III presents the data analysis and findings of the two research settings. Chapters 7 and 8 focus on the ‘Team Service’, and Chapters 9 and 10 on the ‘Children’s Centre’. The two settings are addressed separately for the sake of clarity, although - analytically and thematically - both draw on a particular kind of clinical/therapeutic genre. The data extracts are intended to serve an illustrative purpose; they offer snapshots of social interaction under investigation, where communication played a central role. The presentation of the data takes into account the research subjects’ right to confidentiality and anonymity: hence pseudonyms are used throughout the analysis.
Chapter 7.
IDENTIFYING ‘COMMUNICATION DIFFICULTIES’: THE ‘TEAM SERVICE’ AND SPECIALIST TRANSLATION PRACTICES

7.1 Introduction

In Chapter 2, I described the statutory process of professional intervention that children go through, when there are concerns about ‘communication difficulties’ and/or other needs. In this chapter, I analyse data from an early stage of that process, where children’s needs were being assessed by a multidisciplinary team. Along the lines of the argument that I started to develop in Chapter 3, the analysis intends to illustrate sociologically problematic elements in understanding and dealing with children’s communication and ‘communication difficulties’. The analysis takes up a social constructionist perspective, as discussed in Chapter 5.

The ethnographic focus of my analysis is on child assessment as an interactional ‘event’. Indeed I conceptualise the child assessment event as context-bound, framed by implicit and explicit norms and rules for good practice. It is a situation where descriptions of the child’s past, present and potential future become crystallised, modified and articulated in a legitimised, specialist genre. This chapter talks about the techniques of ‘knowing’ and turning this knowledge into strategies of further action.

The findings suggest that techniques of ‘knowing’ within the ‘Team Service’ produced a particular reading – a decision about or a diagnosis of the child’s difficulty - through a clinically trained gaze (McHoul & Grace, 1993). Sociologically, I intend to destabilise the assumption that a translation between the child’s interactions with others and descriptions of his/her communication skills is straightforward. By this I mean that within what appeared, on the surface, systematic within the context of clinical work, one could also perceive fluidity and situatedness of interaction, talk, and interpretive practices around them. In this process, aspects of the child were overtly, actively and selectively translated from on-going action into verbal statements according to clinical relevances and for institutional purposes.
My analysis, thus, is supported by the idea that clinical work consists of certain reading and writing practices. By the term ‘reading’ I denote both the activity of reading texts, as well as, metaphorically, the observational ‘gaze’ and interpretative work. Reading also means the act of meaning making: what is first seen and then verbalised into interpretive statements. ‘Writing’ is the process of inscription: turning spoken words into ‘hard copies’ that represent reality (Potter, 1996).

The main argument in this chapter is that the assessment work treated communication as a skill that can be accurately ‘measured’ according to developmental milestones. ‘Communication difficulty’ was perceived as a deviation from the norm and pathology as against, as Goffman (1967) might put it, a situational impropriety. The ‘scientific’ presumably systematic, standardised, generalisable means of establishing a ‘communication difficulty’ were supplemented by moral-pragmatic ends, and vice versa. By this I mean that the ‘Team Service’ working patterns assumed that observational data and standardised tests, combined with specialist knowledge, were sufficient for ‘knowing’ and decision making.

I will now illustrate the findings with some data extracts. Section 7.1.1 provides a broad overview how the Team set the scene for the assessment of each child. Here ‘selectivity’ becomes a dominant theme. Following on from this, section 7.2 turns to ‘communication difficulty’ as an object of rational, ‘expert’ action, which I describe as ‘scientific’. In section 7.2.1, this is illustrated by one particular case, who I shall call ‘Sam’ for the purposes of this text. I have chosen this case to represent a typical assessment of ‘communication difficulties’, which have been recognised as hard to diagnose.

In section 7.3 I question the assumption that ‘scientific’ (clinical/therapeutic) work is systematic, standardised or generalisable. My data extracts will explain why this is a central finding in my observations. Indeed my analysis conceptualises the practitioners’ act of ‘reading’ as a particular mode of interpretation, which is inherently a social activity.
7.1.1 An assessment day at a glance

Typically, the ‘Team Service’ went through several assessments a week and they were organised in the following manner. Once a week an assessment day started with a ‘planning meeting’, where a Team member (who had observed the child in another setting, such as the home, school or nursery), introduced the case to the Team. The Team members often called this stage ‘setting the scene’. In planning meetings, the Team would usually plan the assessment procedures for one or more children, who were to be assessed either on that day or in that week.

When there was a child who had already been to one assessment and was now visiting for the second time, the Team would also hold a ‘preliminary meeting’, where they would recap the results of the first visit. These meetings were shorter than planning meetings and would normally take place right before the second assessment session. Once the scene had been set, the Team members who were directly involved in the day’s assessment stayed in the setting. They took turns to introduce themselves to the parents, assessing the child and observing the child from behind a one way screen in the observation room. The assessments varied according to what the child’s assumed problems were, based on what was known from the referral, previous records and home or school visits by Team members. Frequently, in my observations, ‘communication difficulty’ was the main reason for referral.

All Team members would make comments about the child’s communication and speech during and after the observation, but the actual tests to establish the ‘degree’ of ‘communication difficulty’ were carried out by speech and language therapists. The test materials typically involved ‘age-appropriate’ toys and pictures: according to the practitioners, the younger and/or presumably more ‘disabled’ the child, the more ‘play-like’, or simplified the tests. School children were typically assessed with language based tests, including, for example, word recognition and sentence completion. The assessments were usually one-to-one. Sometimes, however, another Team member or a parent would either observe nearby in the same room or take part (‘help out’) in the test. Most parents also spent some time in the observation room while the child was being assessed.
Once the practitioners had finished their expertise-specific tests, they would talk about them with the parents and then begin writing up their results and accounts. After all the assessments and medical examinations had been completed, the practitioners then gathered together in the large assessment room for a feedback session. At this point, the parents and the child would have gone home or been taken to a ‘family room’ or outside for a walk. The end of the child’s first visit, the ‘feedback session’ was more ‘informal’ than the ‘final meeting’ at the end of the second visit, where the Team would often (but not always) generate a diagnosis. Frequently, one or two visitors would attend the final meeting, where decisions about further actions were made and reports were written down.

7.1.2 Notes on the extracts

The methods and ethics chapters discussed how the data extracts in this thesis are my ‘accounts’ of what happened in the field. I have also explained how I used this notion as a methodological tool as I was taking fieldnotes. This choice was based on my pilot observations and findings, which indicated that the Team work, for the most part, culminated in verbal statements about children’s needs. Therefore I treated professional statements as ‘accounts’, and the processes of reading and writing as constituting account making.

Since the talk in the setting was not tape recorded, a detailed word-by-word analysis is not possible. However, I do not regard this as strictly necessary since the extracts are meant to paint a broader picture, where individual sentences may be detailed in terms of their significance to the whole interactional situation. It may also be worth mentioning that I did not have access to all possible accounts in the setting, because sometimes practitioners’ ‘gatherings’ were held in a small office, where there was no room (physically and metaphorically) for me.

For confidentiality reasons and practical purposes, in the data extracts, all the practitioners are referred to as ‘P’ or ‘she’; the children are given pseudonyms and referred to as ‘he’. Section 7.2 details the progress of the ‘communication difficulty case’ called ‘Sam’: the others examples are a selection of different instances. Furthermore, some details, such as the child’s accurate age or family relations or
exact diagnostic signs have been altered to protect confidentiality and maintain anonymity.

Speech and language therapists, whose role was very important in the assessment of the child’s communication skills, are occasionally referred to as ‘SLT’ – one may bear in mind that there were several speech and language therapists in the Team. Teachers, health visitors, students, outside social workers or nurses (other than the core Team members) are referred to as ‘visitors’. Where there is a conversation between two or more Team members, they are numbered P1, P2 and so on in their speaking order.

7.2 ‘Communication difficulty’ as an object of ‘scientific’ action

As a whole, my data analysis describes situations in (disabled) children’s lives in expert encounters, where ‘communication/difficulty’ (possibly among other suspected needs) was an explicit object of concern and/or action’. In this section, the focus is on the ‘scientific’ character of that action.

I argue that the ‘Team Service’ work strongly drew on certain empiricist epistemologies with the emphasis on standardised and systematic fact finding procedures. When put into practice, these epistemologies produced a particular reading of a child through pre-selection of a clinical problem (communication difficulty), its translation from something fluid to something solid by means of observation and tests, and its joint inscription in the form of a case report. Standardised and systematic work involved the use of clinical criteria, protocols and test materials, all of which allowed for a verbally or numerically quantifiable output.

I will now map out the typical features of an assessment day from planning/preliminary meetings to observations of assessments to concluding/final meetings. This is to illustrate the explicit logic of the Team’s construction work and emphasise its process-like nature: how the definitions of ‘communication difficulties’ arose and transformed within a specified time span.
7.2.1 ‘Setting the scene’

At the point of introducing the child in the preliminary meeting, a ‘slice’ of the child’s characteristics was given to the Team. Previous records were outlined in terms of what was relevant for the problem at hand. This meant that, although the protocols recommended looking at the child’s needs as a whole, the problems defined by the referral tended to be the core concerns. ‘Communication difficulty’ featured frequently in these concerns.

The existing records and their reading during the preliminary meeting linked the child’s past to the present and formed a baseline for the assessment; in other words, they ‘set the scene’. They affected the initial decisions that the practitioners had to make: what tests to carry out and how, or what diagnostic signs or needs to look for. Thus, prior to the assessments, various selective and descriptive processes had been gone through. The ‘reliability’ of existing records appeared to vary depending on who had offered them and when. This was evident when the Team members, for example, were cautious about the comments that had been made by absent Team members, parents and so on.

I will now describe a preliminary meeting, where the Team talked about ‘Sam’, who was visiting the setting for the second time. This is a typical example of a ‘communication difficulty’ case, where features of the so-called autistic spectrum were a concern.

Sam is referred because, apparently, he has social communication and interaction problems. A practitioner (P) presents the background: He’s got English speaking (non-British) parents; his speech is good and polite, even though ‘there was a slight stutter on a particular day’; he can speak a lot, ‘almost like verbal diarrhoea’. The P sees the mother as protective. One P says that there were no signs of that last week (this is the family’s second visit) apart from the fact that there is a ‘shoes off’ rule at home. Apparently the mother suspects Asperger’s syndrome.

Another P is looking for medical records and is amazed because there are a lot of them. One P has a sample of his drawings. Reports are being circulated and comments made. She refers to the previous week and mentions ‘repetitive play’; Sam
had asked her name which she thought of as being unusual; he had needed a lot of refocusing; he had asked a lot of Why questions; he had wanted to show his achievements to his parents. I asked later on what the problem with ‘repetitive play’ is, and she said that it has implications for other areas of life in that the child does not want to extend his knowledge.

On the basis of the family’s first visit, the Ps thought that Sam was rushing to do things – ‘he had no concept of doing things slowly’. A P was wondering whether there were problems with his balance: apparently the mother had tried to make him slow down. He had not crawled a lot as a baby – he had started walking on tiptoes. P1: ‘Autistic type behaviour?’ P2: ‘I saw him flapping hands once’. P3: ‘I wouldn’t make decisions on that basis’.

The ‘background’ to Sam’s current referral difficulty was presented in a form of a spoken ‘one person narrative’ that was supplemented with ‘relevant’ written documents. The speaker had observed and interacted with the child at home and paid selective attention to the clinically relevant points in the child’s behaviour, family and the home. Descriptions of the child’s ‘problem’ were made with caution, such as that ‘there was a stutter on a particular day’. The description involved the speaker’s personal slant, such as that the child’s speech was ‘almost like verbal diarrhoea’. I interpreted that the statement - ‘there’s a ‘shoes off’ rule at home’ - referred to the comment about the mother being (over) protective. In addition, the mother’s opinions of the child’s ‘problem’ were stated.

The verbal accounts in planning and preliminary meetings were typically informal ‘feelings’ rather than formal, conclusive statements, as the conversations between the three practitioners indicate. Criterion related descriptive words were used, such as ‘repetitive play’, ‘hand flapping’ or ‘walking on tiptoes’: the practitioners were looking for symptoms of Asperger’s Syndrome-type behaviour (see Figure 4 in Chapter 2, p. 29).

7.2.2 Translating procedures

Once the scene had been set, the practitioners would begin observation and tests to either prove or disprove the referral concerns and the outcomes of
planning/preliminary meetings. The assessment sessions followed a routine pattern: they always started with an adult facilitated play session, during which the child was expected to settle in the large assessment room. Meanwhile, the practitioners, who were observing in the observation room, made comments about the child.

Translating the ongoing elements of the child’s communicative skills into a coherent narrative, which was expected of each practitioner in the end of the assessment, necessitated structure: the tests meant that the every child had to do certain tasks in a required manner under adult instruction. The parents sometimes expressed that they did not always ‘see the point’ of the tests and consequently the practitioners had to explain what they were trying to do.

In the large assessment room, a P makes a point (to the parents) that her tests are ‘standardised’; she keeps mentioning that word. Sam is still in the large assessment room, asking: ‘Where is ‘Mary’?’ Another P is having a chat with the father in the assessment room. Father: ‘I don’t know what you are looking for with these assessments; I think he’s very clever’. The P explains something general about doing standardised skills assessments tests. I can sense the father’s concern.

Now there are three Ps in the large assessment room. One of them tries to get the child to a smaller room to be tested. Sam: ‘Have you got toys next door?’ P then confuses him by saying that later on he wants him to do a different test for her in the big room. For a little while he does not seem to know where to go, but then follows another P to the small room.

Both of the parents are in the observation room, clearly conscious of my presence as well. They keep making comments to me about how they think Sam is doing; I try to only nod rather than speak. The mother says that she thinks Sam is really bright. Then Sam does not follow the instructions in the test and the parents think that it is funny but the P seems to take it really seriously. For example, Sam was told to put one brick at the time into a box but he grabbed five at the same time.

While one P is doing an assessment with Sam, another explains to parents that since the tests are standardised, the Ps cannot, for example, ask the same question twice. I asked about this later and they agreed that the Ps expectations vary depending on activity setting. They also said that over time the Ps would see the child’s capacities better – one-off assessments tend to be too short.

When P writes results in her notepad, Sam asks: ‘Why did you do that?’ P: ‘I’m writing down how clever you are’. Sam looks at the mirror, sometimes smiles at it.
He pulls a card off the P’s hands: ‘Excuse me, it’s my turn now’. He does not want to do the test: ‘I don’t want to write onto paper’. He is asking people’s names and the names of colours, but the P does not answer – she carries on with the test.

Both practitioners emphasised the standardised nature of their tests as a positive and necessary thing. However, the parents and I made various interpretations of the situation. The parents kept saying that in their opinion Sam was a bright boy who just was not following the adults’ instructions. Later on I asked the practitioners about how they knew when to standardise and when to adapt to a unique situation. I asked the same question many times of different practitioners, and they tended to resort to their expert knowledge and the ‘eye’ that they had from work experience with ‘this kind of children’. For example, in the case of Sam, standardisation meant that only the adults asked questions and children’s questions were not necessarily answered.

7.2.3 Constructing readings

The reading of the child’s skills was framed by pre-established scales for a ‘normal range’ of communicative abilities. During the tests, the practitioners who sat in the observation room would make comments about their readings of the child. Towards the end of the assessment day, they would write down their individual reports either in the observation room or in the office. This is what I call ‘translating descriptions of the child’s assumed skills into clinical genre’.

By the final meeting, the reading and writing procedures had started to merge in the form of each practitioner’s reports. The next step was to make individual accounts public and turn several reports into one: the final report.

One of the Ps starts, again mentioning the word ‘obsession’. She outlines the ‘developmental milestones’ (apparently they are vague in the case of Sam). The family’s medical and educational history as well as some recent major changes in their lives are described. Their accommodation is described.

One P says: ‘He sometimes plays with the same toy for 4 weeks’. Earlier in the observation room, the mother said that Sam did this once. The P points out that he ‘looks normal’, but his muscle tones are low, although: ‘I’ll leave that to the expert to say’. Another P thinks his speech is programmed rather than intuitive.
P1 says that his communication is within ‘normal limits’, even though he’s got a habit of asking questions, and that he also ‘has a bit odd intonation’ (P2 adds: ‘robotic’) and poor eye contact. P3: ‘He looked at me well’. They were trying to fit him in the autistic spectrum but he did not meet the criteria. Also his politeness was seen as a problem because it was too ‘learned’.

One P says: ‘He was unable to cope with the instructions’. Another P asserts that she had never seen anyone swapping hands like Sam whilst drawing. The Ps seem to be very precise – one of them says that his ability in one of the tasks was at the level of a 3year 7 month old. She says: ‘There was some rigidity in his performance’. P1: ‘Obsession?’ P2: ‘No, rigidity’.

One P suggests that some of Sam’s skills are 12 months behind. It is mentioned that Sam was surprisingly interested in a medical bag (unlike many other children) and focused on it a lot. P1: ‘Obsession?’ P2: ‘I wouldn’t call it obsession but rather inquisitiveness’.

This section reveals how one practitioner may offer the notion of ‘obsession’ while the others systematically refute it with alternative words, such as ‘inquisitive’ or ‘rigidity’. Indeed the final meeting was for a great part concerned with finding appropriate descriptive words to write down in the report, negotiating or even arguing about them. The arguments were not always verbal: sometimes merely glances (that I interpreted as meaningful to the participants) were exchanged. Most negotiation concerned whether the child was ‘too much’ or ‘too little’ of a particular criterion: the ‘normal’ limits were not necessarily clear cut in those accounts. The differences in the child’s behaviour between the first and the second visit were noted.

The Team members called the child’s speech ‘programmed’, ‘learned’ or ‘robotic’. In addition, one P mentioned that he had ‘strange intonation’: none of the Team members, however, mentioned that his parents had non-British accents. She thought his eye contact was poor, whereas another P defended that it was not too bad. It was also pointed out that he had ‘a habit of asking questions’: this seemed to be part of the ‘problem’ that ‘he was unable to cope with instructions’.

The child’s level of development was expressed in numbers: three years and seven months. This was based on the information gathered from standardised tests, which involved ticking boxes on score sheets and a more elaborate verbal account from the
therapist in question. Different issues about the child, such as the ability to communicate, or levels of muscle tones, were compared to 'normal' scores.

The practitioners paid attention to anomalies in Sam's behaviour. However, in this case it appeared to me that, as they were giving second hand accounts from the parents, they usually reduced those accounts into fewer words. It was also typical to mention whether the parents were educated, in good health and had a 'normal' home.

7.3 Oscillating between rigid and fluid readings of the child

The previous section has given a taste of how the assessments typically unfolded. I will now turn to analysing 'interpretive practices' in more depth. In this section I define 'communication' as a contextual activity that entails processes of meaning making. By using the notion of 'context' I denote a juxtaposition of two entities: first, a focal event; and second, a field of action within which that event is embedded (Goodwin & Duranti, 1992). 'Context', such as the clinical setting being researched, is seen as being shaped by the specific activities being performed at that moment. It is also the physical environment, and shaped by social dimensions and historical processes. Moreover, actors in the setting are seen as being situated in multiple contexts, some of which are more stable and others more dynamic and constantly changing (ibid). I propose that various readings of each child were possible, depending on the context, although a limited number of those versions became authorised. The authorisation process was not straightforward, which I now intend to illustrate.

7.3.1 The tree of language: sturdy oak or weeping willow?

When the children had speech but were referred for communication difficulties, the assessment always involved speech and language tests. I have earlier talked about the 'tree of language' (see Figure 2 in Chapter 2, p. 18; Law et al, 2000) and the compartmentalisation of different elements of language and speech into 'branches'. Law et al stress that the 'organic tree analogy' serves to illustrate the active rather than static nature of communication (p. 8). Metaphorically, I suggest that Law's model of communication could be described as a 'weeping willow' that is blown
about by the wind\textsuperscript{12}. Yet, within the ‘Team Service’ setting, I suggest, the normative, written down version of communication appeared to be something quite solid, like a ‘sturdy oak’.

The next extract describes a preliminary meeting, where language difficulties were the major reason for referral. The child had already been assessed once by another team: I was not told why a reassessment by the ‘Team Service’ was needed.

This is seemingly a communication difficulty case. The child’s medical history problems are outlined by two Ps who read out another team’s earlier reports: ‘They did not understand what he was talking about’, he has minor language difficulties but more with the ‘use of language’.

A visitor starts her description next: she tells what ‘Tony’ likes to do in his peer group: he may sometimes spend time on his own ‘watching the world go by’ but ‘does get upset if someone is hit’. She says that he makes up stories and is very easily distracted. She also gives an example of him getting very upset if there is a break in a routine. Furthermore: ‘He generally comes across as a bit clumsy’. She has not mentioned any obvious problems, but one P mentions that he has got some ‘phonetic’ problems. Furthermore, he cannot apparently construct proper written stories and ‘when he starts saying something, he has to finish it’.

One P points out that the mother had said that ‘a lump is missing from his brain’, meaning that he apparently cannot make connections. She had seen him privately and said that his eye contact had been brief but ‘I was not even looking at his social communication’. Therefore another P will do a school visit.

It was mentioned that the previous team had not understood ‘what he was talking about’. Some other autism related features were noted, such as clumsiness, routines and slightly unusual behaviour with peers and adults. One practitioner, who had seen the child privately, mentioned that while she was busy looking at other, expertise-specific features about Tony, she had not been able to observe his communication skills. Social communication with peers was treated as something that could be observed at school and this task was delegated to a relevant specialist, who would do a single visit.

\textsuperscript{12} Although the ‘tree of communication’ in Figure 2 looks more like a sturdy oak than a weeping willow, I suggest that Law’s model could be better illustrated by the latter example.
The rigidity - ‘sturdy oak’ like character - of inscribed versions of the child’s communication difficulties became particularly apparent in final reports, where the extent of the ‘problems’ was measured. The quantification process, which was central to report writing, would make the child’s skills comparable across time and space, in terms of the child’s development, and what was regarded as ‘normal’.

P1 describes ‘Harry’s’ communication difficulty as ‘mild’ or ‘moderate’ – ‘He uses more complex language than what he understands’. P2 now wants to conclude that he has a global developmental delay, but P1 challenges her in this: she wouldn’t use the word ‘global’ but rather conclude that ‘Harry’ has got difficulties in some areas. P1 comes up with descriptive words, such as ‘discrepancy’, ‘inconsistencies’ or ‘disorder’. P2: ‘Can you quantify that?’ She says that she needs to come up with something that will help the school, which referred Harry to the Team. P1 says that ‘global delay’ has a slant that she can’t agree with. P3 suggests ‘dyspraxia’ and some other Ps laugh at this. However, it seems that P2 is happy with that.

In terms of social communication, one P thinks that Harry’s eye contact was prolonged and inappropriate: ‘He couldn’t just casually look at something’; ‘he said ‘hello’ to me in an overfriendly manner, even though we have never met before’. She also says that his vocal tone and loudness were socially inappropriate. The Ps calculate his ‘developmental age’ (4.9) and agree with the label: ‘universal delay’.

There was a lot of discussion and negotiation about what exact words should be written in the final report. However, as P2 put it: it was important to come up with a clear and pragmatic result that would help the school, which referred the child to the Team, in other words, a label. I perceived that the ambiguities in decision making were not apparent in the final reports, which reduced the practitioners’ accounts to fewer words. The child’s social communication skills were measured by both words (such as ‘prolonged’ eye contact, ‘overfriendly’ manner or ‘universal’ delay) and by numbers. The child’s ‘developmental age’, as against biological age, was a sum total of each practitioner’s calculations.
7.3.2 Meaning making activities: alternative readings

'Team Service' work involved objects, such as toys, texts or pictures, the use of which had specific meanings and purposes for the practitioners. My analysis suggests that these test 'tools' were structured and that they constituted particular kinds of frames for interaction. The logic of testing overlooked the complexities and ambiguities of meaning making where the child was not merely a passive object of testing, but an active agent. These points are illustrated in the following two extracts, which describe speech and language assessments.

The SLT starts her tests and the mother, P and I in the observation room. 'Colin' seems to be doing outstandingly well, repeating sentences such as 'the computers and printers were donated by school governors'. He also asks a couple of times what the sentences mean (either as a whole or individual words), e.g. 'Why did they donate them?' Colin also notes things that are not part of the test, such as a note on the wall saying 'Please close the window'. He asks the SLT why it needs to be closed and she does answer his question, not ignoring it or rushing back to the test.

Colin really loves the 'absurdity pictures' (he was shown some picture cards where there was 'something wrong'); for example: 'The bird is flying upside down!! He laughs. The umbrella picture is a bit more puzzling – he goes: 'Wait a minute, the rain should be everywhere' (not just underneath the umbrella). He adds: 'But could the rain not be behind the umbrella?'

SLT wants him to list some food items, and she starts: 'Pizza, apple...'. 'No, you are spoiling it', shouts Colin. Listing jobs (occupations) seems to require more probing. He starts listing domestic chores, such as washing up, cooking. About more public jobs, SLT says: 'If you are ill...the correct answer would have been '...you go to see a doctor'. Colin had said: 'You go to hospital'. The mother makes a different interpretation of the situation.

Another practitioner in the observation room explained to Colin's mother and me that Colin was doing cognitively better than most children in the test. He understood the instructions and the purpose of the tests, but we noticed that he would go 'beyond' them as well: for example, instead of just repeating sentences, he would inquire about their semantic content, or ask why the window needed to be closed.
Once Colin had to start ‘explaining’ the contents of pictures, several interpretations emerged. For the speech therapist, there was a narrow range of correct meanings of each picture; for example, the rain was ‘underneath’ the umbrella, not ‘behind’. In addition, Colin’s ideas of ‘occupations’ involved domestic tasks rather than paid work outside the home. The mother then pointed out to me that various interpretations could be made of the same situation: for example, when Colin would ‘go to hospital’ instead of ‘a doctor’.

As the above extract and the next indicate, children may interpret the practitioners’ questions in various, imaginative and sometimes surprising ways. The next extract describes a speech and language test, which assessed ‘Daniel’s’ verbal comprehension:

The SLT starts a sentence completion test. P: ‘What is a dress?’ ‘Daniel’: ‘Skirt and a t-shirt’. SLT: ‘What is a bed?’ D: ‘It is for sleeping with a pillow’. SLT: ‘What do you need to do when you cross the road?’ D: ‘Stop, look and listen’. The SLT probes to get a desired answer, by repeating the question if Daniel says something else. SLT: ‘It was a lovely day’...D: ‘And then a ginormous sunflower came’ (excitedly). SLT: ‘What is a hat?’ D: ‘A hat...is a sort of planet shape’, doing a rim with his hands above his head. Ps in the observation room comment that he is probably thinking of Saturn. SLT: ‘The bird flies, the fish...’ D: ‘Does not fly’. After that question he seems to give up or gets fed up and replies: ‘I don’t know’.

The SLT seems to be rushing, looking at the clock and moving forward fast. She then asks Daniel to explain pictures on cards – he does not recognise all of them and the SLT shows the same cards a few times. Daniel starts imitating her: ‘We’ll go back to that one’. The SLT carries on: ‘How are a man and a dog different?’ D: ‘Because human and a pet are the right answers’.

The practitioner’s task was to sort out the ‘correct’ answers from incorrect ones, based on her interpretation of whether the child had comprehended the question. Interestingly, this time the practitioner was allowed to ask the same question more than once; on some other occasions, the requirement for standardisation had prevented this.
Thus, meaning making was a complex activity, both verbally and non-verbally. Sometimes the practitioners expressed their awareness of this to me, as in the following extract.

‘Jeremy’ is spotting ‘mistakes’ in P’s pictures – he laughs when a person in the picture puts food in the washing machine and not in the oven. Meanwhile, another P in the observation room talks about his enunciation, which seems to be the problem, not comprehension (he starts words with the letter D). This P is convinced that the Ps are ‘tuned in to understand’ what the child says (when I was wondering whether the parents would understand him). Still they all keep saying, every once in a while, that they don’t understand a word that Jeremy is saying during the test. One P says that when she did a test, she just nodded to pretend that she was following him.

It seemed obvious that Jeremy did not have any problems with understanding the intended jokes in the pictures. However, I was having trouble with understanding his speech and expressed this. I then asked whether anyone else in the observation room could make any sense of it. Whereas one practitioner said that as experts they are ‘tuned in’ to understand the child, another said that she pretended to understand in order to carry on with the assessment.

I stress that, in the assessments, interpreting children’s meanings was always locally contextual, on the ‘here-and-now’ level. Sometimes it was also the wider contemporary context – in this case, television news at the time – that gave the practitioners clues for interpretation.

(Shortly after September 11th) ‘Kevin’ seems to focus a lot more now on building blocks than during his first visit. He is building a tower and playing with a fireman: ‘He’s gonna get killed’, Kevin says to a P. The Ps in the observation room say: ‘That’s a sign of the times, isn’t it?’ He plays with the blocks – we can see an aeroplane hitting the tower.

In my observations, visitors and parents would frequently interpret the children’s behaviour and meanings in different ways. Sometimes these alternative readings contradicted the versions that were either written down in earlier reports or what the practitioners were stating at the time of assessment:
'Oliver' does not have speech: he makes a distressed noise, when, for example, he can't reach a toy that he wants. The visitor, who had spent a lot of time with Oliver before, points out that he is not actually 'clingy to mum' even though this was stated in the previous assessment report by another team. Earlier in the observation room she had said to me that she thinks the situation matters to the way in which children behave.

The visitor asks exactly how standardised the tests are – one P says that sometimes they use the test forms just as a guideline. Another P suspects that the child has some autistic features, such as hand flapping. He seems to move slowly. However, some games help him interact more than others – such as bubbles. He says something like 'yeah'. The visitor says that Oliver’s hand flapping meant 'go'.

When an opportunity arose in the observation room, the visitor and I talked about the child. She knew the child and the family and did not agree with the previous assessment report that had, for example, described the child as being 'clingy to mum'. For this reason, she was also suspicious of the Team: would they come up with the same or a different label and how? She kept asking the practitioners about their methods and reasons for doing assessments in certain ways. She also made her own interpretations: for example, for her, the child’s hand flapping meant ‘go’ whereas it was a possibly autistic feature for the practitioners.

It appeared that competing interpretations emerged and practitioners used explanations – sometimes persuasion – to authorise the clinical readings. Usually, when the parents asked about the ‘validity’ of the assessments, the practitioners justified their work by its standardised nature. This time, however, the practitioner mentioned that she sometimes had to use the tests just as a guideline, based on her personal judgment that the child was not up to the test.

7.3.3 The practitioner knows better

Although information about the child, such as referral forms or previous case reports, formed a baseline for the assessment, the practitioners retained their authority to judge whether the referral concerns were worth taking into consideration.
‘Mark’ is playing in the large assessment room. I can see that he is a young child. One P asks the parents about what he likes to watch on TV. The mother then goes and takes part in the play as well. He seems to be too young to speak but he ‘communicates’ non-verbally, e.g. ‘slurp’ (‘drinking tea’), or ‘bleep’ (‘picking up the phone’). They give him Teletubbies. Meanwhile, one P in the observation room says: ‘The mother thinks he’s autistic’. I ask a P about the referral and she reads out the text in it; he had been referred by a health visitor. Apparently he has poor eye contact. P: ‘The mother has been concerned for a while but that does not mean there’s anything wrong – he’s just 2’.

It appeared that both the mother and a health visitor had concerns, and that the mother suspected autism. According to the referral form, this assumption was based on the observation at home that ‘Mark’s’ eye contact was poor. When I enquired about this in the observation room, the practitioner explained that since the child was very young, an assessment and expert opinion was needed.

The following extract indicates how Team members’ also trusted in each others’ expertise, as well as various interpretations of the child’s comprehension. This extract is also an example of an assessment where the practitioners attempted to establish whether a ‘communication (language) difficulty’ was a cause or an effect of some other ‘condition’.

P wants ‘Paul’ to find ‘cheese’ and he picks ‘keys’ – the cheese was not an obvious one though, said the Ps in the observation room, because it was Edam-style. The father in the assessment room says that Paul did not know it because he ‘does not have dairy’.

Now, all of a sudden, Paul displays very aggressive behaviour (because he did not recognise the cheese?). He will not sit on his chair, but sits on the table even though one P tells him not to. They now try to get him outside. I cannot see him but I hear Paul screaming ‘idiot, idiot’, kicking and struggling. It is such mayhem: he throws things on the floor and people run after him. He says ‘boring’ when they try to get him back to the small assessment room.

One P asked about how he had behaved before she came into the observation room. I said that he had been ok, but she did not really listen to me. As soon as another P came in, she asked her instead. The Ps mention a ‘short fuse’ and that the child will become a dangerous adult if he keeps behaving this way. One P thinks he is testing boundaries. They suggest doing some chromosomal tests to see whether he has too much testosterone.
After the tantrum, addressing ‘bad behaviour’ became a primary target of intervention. This had been on the agenda anyway since the referral. Nevertheless, it appeared that although the practitioners asked questions of the parents and me, they did not really listen to what we said. Both medical and social explanations of the child’s behaviour emerged, and the practitioners then negotiated between these various possibilities. There were no reflections on the effect of the context, however, on the child: the child’s problem was perceived as ‘innate’.

7.4 Conclusion

In the ‘Team Service’ practice, ‘communication’ had a particular, object-like meaning. Like other needs, it was referred to and treated as something that could be quantified and measured using scales. ‘Normal’ communication was defined using developmental parameters, which sometimes involved the use of tests and sometimes not. ‘Communication difficulty’, on the other hand, was perceived as a deviation from a norm. It was treated primarily as a cognitive, psychological or physical pathology that could be identified by clinically trained experts. The experts used specific tools – observation and tests – to explain aspects of reality. Various structures, protocols and background material were incorporated in the activity of generating a ‘scientific’ reading of the child.

The ‘Team Service’ practice aimed at generating a diagnosis of the child’s ‘communication difficulty’, and/or decisions about the child’s needs. This typically involved a great deal of negotiating and selecting the most accurate descriptions of the child, particularly in the process of writing down the final report. In the case of disputes about the various interpretations that would arise during the assessments, the practitioners retained their authority over lay perspectives. To put it in sociological words: decisions were connected to action via texts such as case reports, which were an outcome of social construction work, including ‘setting the scene’, ‘translation’ and ‘inscription’ procedures.

The child, his/her communication and possible ‘communication difficulty’ were objects of structured adult instruction, interpretation and action. In this respect, I argue, the assessment setting was a different context from the child’s other everyday
experiences. For example, there were specific ‘time-slots’ to allow different kinds of communication to emerge. During the tests, the child was expected to demonstrate that he could follow the rules of the game. The assessments typically involved continuous testing, so there was not much time left for more spontaneous interaction. At the same time, the ‘settling in’ session at the beginning of each assessment day was the only time when the child was ‘allowed’ to do his/her own thing; in fact, was expected to do so. During the tests, in contrast, the child was not supposed to ‘explore the nursery’ but focus on the task at hand. Typically, the children did not separate time and tasks in this kind of clear cut manner.

Indeed the ambiguity of meaning making appeared to be a frequent feature of assessments. Standardised tests - such as tests that measured verbal comprehension - had a limited range of ‘correct’ answers (Gardner, 1998). In this respect, a reading of the child’s performance was down to the practitioner’s situational judgment. This was questioned many times by parents and visitors, who observed the assessments from behind the one way screen.

This chapter has concentrated on the practical accomplishment of constructing a diagnosis/decision of a child’s ‘communication difficulty’. It has detailed ‘science in action’ (Woolgar, 1988); how guidelines for good practice and expert knowledge were put in practice within a specified time span in a particular context. I have attempted to paint a picture of ‘what was going on’ in the day-to-day, localised practice of the ‘Team Service’. In the next chapter, I will continue with analysing what I call the ‘socialness’ of clinical interaction. I will take on a broad discursive perspective to what I perceived as ‘sociocultural’ within the clinical/therapeutic practice.
8.1 Introduction

In the previous chapter I described how the child’s communication skills were treated as something that could be systematically observed and measured by ‘scientific’ means. My focus was primarily on the epistemology of clinical process of identification: in other words, the ‘gaze’. I argued that the epistemology of clinical work was often justified by the assumptions that it used standardised tools and techniques. I then started to develop an argument that the ‘scientific’ in the clinical work was typically ‘messy’ (Gilbert & Mulkay, 1984) rather than straightforward. I propose that this messiness of clinical work revealed something about the human face of expert work, in that it was through and through social.

What I label as the ‘social’ components of the ‘clinical’ challenge a conventional view of clinical/therapeutic work being based on unbiased knowledge of ‘hard facts’ in the natural world. As Woolgar (1988) has suggested, scientific activity is indeed social in three main senses:

1) social rather than individual in that it involves teamwork, networks, culture, and so forth
2) all scientific actions are imbued with pre-selection of certain problems
3) scientists direct their activities at other social beings.

I will now turn to this ‘socialness’ aspect of Team work and the assumed ontology of ‘communication difficulty’. I will explore how certain value based features of ‘normal/good communication’ were defined by the Team members. My focus here is centred on some normative statements that would occasionally emerge in the midst of meetings and informal conversations in the observation room. These statements were
not necessarily agreed upon, and they could be called ‘hints’ rather than explicit arguments.

Nevertheless, I stress that child assessment practice routinely involved statements of someone’s personal preferences or stereotypical thinking in terms of gender, or the children’s and their families’ social class and ethnicity. This is important in terms of what happened to the child after the assessment; in essence, what was being done with the statements - whether they were treated as factual or not.

8.2 Making sociocultural distinctions

The extracts in this section are examples of ‘communication difficulty’ cases. At the same time, I intend to address aspects of conceptualising ‘normality’ in a broader perspective than simply communication, involving further issues that were held to be as significant to the child’s overall needs and development. I will first use the distinction between ‘nature’ and ‘nurture’ in child development as an analytical tool, in terms of how the Team members distinguished between these two causes for the child’s perceived problems. Second, I give some examples of how the child’s family was sometimes positioned along the nature/nurture spectrum in terms of ‘good communication’ and ‘communication difficulties’.

8.2.1 ‘Nature and/or nurture’: looking for causes

Decision making in the assessments typically involved identification of the ‘problem’ in its current state as well as causal explanations for it. These would often entail factors other than only references to physical or cognitive impairment.

One P says that ‘Nick’ is capable of ‘situational understanding’ and ‘echoing’, and using jargon instead of spontaneous language. Social interaction happened ‘sometimes’. Another P says that he has expressive hands. It is suggested that ADD (attention deficiency disorder) might be the condition behind all his difficulties. One P seems to be unsure: ‘It’s hard to say whether it is ADD or an inability to do things’. The Ps mention the problem of ‘self-directness’. The Ps agree that Nick’s biscuit eating looked funny and one P adds: ‘They might be the sort of family who don’t eat at a normal table’.
The conversation in the extract revolved around specifying what particular communication skills the child had or did not have, including non-verbal behaviour. It might be noted that the practitioners did not do a standard speech and language assessment with this child, because they believed that he was not up to it, developmentally or otherwise. For instance, they mentioned the word ‘self-directness’: the child would do his own thing rather than follow adult instruction.

The practices of detecting anomalies in the child’s general behaviour included observing the way he was eating the biscuit. One practitioner connected this to the child’s home environment: ‘They might be the sort of family who don’t eat at a normal table’. Here I perceived not just a social class based preference but also a somewhat fluid move ‘from nature to nurture’.

A similar situation took place with another ‘communication difficulty’ referral, ‘Philip’, although, this time there were no perceived problems with ‘nurture’:

One P had done a home visit and she said that everything there seemed to be ‘very nice’ (the equipment, toys, furniture, parental care; the mother was ‘gentle and calm’). She said that the children interacted well with her; she had played peek-a-boo with them. She had talked about ‘Philip’ with the mother, i.e. what words he says and what noises he makes, such as animal noises.

The Ps say that he is too young to be assessed with standardised methods: ‘Everybody will just have to put it together’. This was ‘because of his personality’, not just about his age. P1 asks: ‘Is he fisty’? P2: ‘I was looking for all the usual markers...’. P1 also asks: ‘So his speech is ok then?’ P2: ‘He’s very shy’.

The Team agreed that Philip was too young for standardised tests, but that they had to achieve some kind of decision about the nature of his difficulty. At this point, the problems in his communication were connected to his behaviour – being ‘shy’ – rather than to any specific disability.

13 In the above situation, I understood the word ‘fisty’ as referring to a child who tends to close his hands tightly and may be aggressive. I interpreted this meaning from the speaker’s illustrative hand movements.
Sometimes 'nature' was explicitly intertwined with 'nurture'. The next extract describes an occasion where a practitioner was questioning the mother in the observation room, while the child was being tested in the small assessment room. There was another practitioner present as well and we had been told that this child was a potential Asperger's case.

One P starts chatting with the mother (the father is outside). The mother says he gets stressed with other children in school: the teachers say that he has behavioural problems and is not conforming. The P also asks whether there is anything 'Andy' is good at. The mother mentions, for example, technical things such as switches with which his play can be quite repetitive. P: 'Is this an obsession'? The mother does not think so.

The mother then says: 'I have to confirm with the father, his perspective is different'. The mother is in tears. The P says: 'I think you have done a marvellous job (as a parent). Mothers always tend to think they have done something wrong. That's why I'm asking you, I do not think men see these things as easily as mothers. Men are the weaker sex. This is the way they cope'. Another P in the observation room says nothing.

It seemed that the parents did not agree with each other about the 'problem' and the practitioner attempted to console the distressed mother by referring to the mother's alleged ability to perceive 'these things' better than the father. I saw a gender stereotype in use on this particular occasion. Later on the practitioner, who heard the above conversation between the mother and another practitioner, approached me in private:

I had a long chat with a P in the observation room — it was almost as if she was dying to get certain issues off her chest. Her point was that the Team members do not always voice their opinion even though they disagree with some of the others. She mentioned the following issues: 'well known' hierarchies among occupational statuses and among professions, sweeping statements/generalisations, for example, about the families' social statuses, dated opinions of motherhood. I sensed that this P did not agree with another one in the observation room who was making stereotyped comments to the mother about parenting [as described in the previous extract].

This P said that she sometimes felt that some Team members do not necessarily recognise that teamwork should be equal and everyone is an expert in their field.
Sometimes, in her opinion, differences in attitudes could stem from generational issues as well. Another P came to the room and the conversation ceased.

This was the first time for me in this setting that I realised the importance of hierarchies in the setting. It was not something that would have been openly discussed in my presence. Nevertheless, some underlying discrepancies within the Team work were momentarily unveiled.

I regard the occupational hierarchies and the incorporation of stereotypes into assessments as a particularly social element of professional practice: people in groups may approach the same goals in different ways, and this may stem from their personalities, as well as from their social-structural position in their institutions and society. However — as the practitioner stressed — sometimes, within teamwork situations, it is difficult to voice one’s opinion, for one reason or another.

Thus, teamwork is much more complicated than simply putting different areas of expertise together into a coherent whole. It involves human interaction, which is contextual, and depends on who is present and what the object of action is. In this sense, for example, the causes for and interventions into any particular ‘communication difficulty’ are socially defined as well. The next section follows on from this finding.

8.2.2 ‘Communication difficulties’ between adults

The children who were referred for the Team were assessed in the context of their family background. In this section, I intend to illustrate situations where the parents were seen as lacking communication skills, with some implications for the understandings of the children. The following extracts show, however, that somewhat casual remarks about the parents were not necessarily agreed upon. In my observations, these statements were typically related to the client’s social status.

One P thinks that this week’s session with ‘James’ was a lot better than last week’s one, and that she also felt more relaxed this time with him. One P mentions that

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14 My use of the word ‘teamwork’ refers to work performed by a team in general, whereas ‘Team work’ refers to the clinical/therapeutic work particular to this research and the ‘Team Service’ setting.
James had ‘verbally abused’ his parents during the last visit: ‘whether you can call it that from a 5-year-old’. Another P mentions that he says ‘sorry’ but he does not really mean it; they suspect that he has emotional problems but not Asperger’s.

A visitor says: ‘He’s not trying to communicate meanings to you’. She also thinks that it is difficult to communicate with the parents – ‘the father talks too much’. One P mentions that he may not have anyone else to talk to about this matter. The visitor thinks that the parents may be ‘thick, lacking comprehension’. They conclude that the child has ‘situational behaviour problems’.

This occasion was the family’s second visit to the ‘Team Service’. The visitors started to interpret James’ meanings: at this point, differences between the visitors’ and the Team members’ opinions started to show quite clearly. For example, ‘talking too much’ is one of the features of Asperger’s Syndrome (see Figure 4 in Chapter 2, p. 29). It appeared that one of the visitors attempted to link the father’s talk with the syndrome. However, the Team members interpreted the situation in a different way. On this occasion, the visitor located the problem with the speaker, whereas a Team member hinted that the problem could in fact have been with the listener.

The next extract illustrates a situation where the parents, again, are seen as having special communication problems. However, during the meeting, the Team members themselves appeared to have difficulties in ‘sending messages across’.

P1 outlines some points about the child’s past – it is noted that both parents are illiterate. The parents’ occupations and residence are mentioned, as well as the family’s medical history. Then P2 starts to talk about changes in the assessment meetings to P1, so that after the family’s first visit there is just discussion rather than ‘writing down’. This is because sometimes ideas are not clear after the first visit.

P1 says that she had been thinking of an underlying syndrome, but did not find symptoms for it. P1 and P3 speak louder and louder over each other but not clearly arguing. Then they think that it may be the child’s impulsive nature rather than his ability to do things, which is the problem. P1 repeats that the mother had previously said: “I did go to school but did not learn anything”.

This time a slight conflict arose mostly between one practitioner and the rest of the Team, which mainly revolved around how to go about the meeting and ‘writing down’. It seemed that P1 was eager to come up with a diagnosis, including the
parents’ illiteracy and educational attainment ‘problems’, whereas the others wanted to leave the decision making until later.

The dynamics of the Team work is one example of the ‘socialness’ of action in a clinical/therapeutic setting. I will now turn to another persistent feature of the assessments: how the sociocultural nature of Team work particularly manifested itself in definitions of ‘good’ and/or ‘normal’ speech.

8.3 Definitions of appropriate communication

Although non-verbal communication, especially eye contact, was taken into account in the assessments, speech and language were at the heart of the assessment of communication needs. This section illustrates how understandings of ‘good communication’ were culturally embedded in the ‘Team Service’ practice.

8.3.1 ‘Locally appropriate’ communication

Team work as sociocultural practice involved understandings of ‘good communication’ as something locally appropriate. What I mean by ‘local’ is not referring to the actual field location as such, but more generally to a certain regional accent or manner of speech that was implicitly or explicitly preferred in the setting. These preferences would frequently surface in the Team members’ accounts, sometimes in clinical, sometimes more in lay terms. Hence, the clinical notion of ‘social communication’, I argue, is a social construction of what is deemed locally appropriate. Within assessments, it included judgments of what was perceived as ‘good manners’, as in the following extract.

The Ps discuss ‘Charlie’s’ play. P1 wants to quantify his developmental age, and P2 replies that it is ‘nowhere near 3’, which is his biological age. P1 points out that some of his social communication was nice, such as saying ‘please’. P2 thought that this was unusual in her job. P3 adds that Charlie had been telling her about how he hurt his head, even though she did not understand him until the mother translated this.
Frequently in my observations, the children were praised for using polite phrases, such as ‘please’ and ‘thank you’ in social interaction. In terms of what one of the practitioners said – that this was unusual in her job – I interpreted that most children were not perceived as polite in that way. In Charlie’s case, it seemed that there was a speech problem rather than a developmental disorder. It appeared that the mother understood the child whereas the Team members did not. For this reason, calculating his developmental age was difficult: Charlie was seen to have ‘mixed skills’.

A similar situation emerged in the case of ‘William’:

It appears that the child is not a native English speaker. I asked to look at the referral that said: speech concerns. A ‘visitor’ says that ‘William’ is so sociable and wants to communicate with the world, whereas in the referral it says that he has no meaningful interaction with the world. She had taken part in writing up the referral.

Then William plays a kitchen game with one P. The Ps in the observation room notice that he is talking to a doll, looking at it in the eye, and interacting with it. One P says that he is very self-directed and hard to engage. The visitor and one P discuss William’s eye contact. Visitor: ‘Is he engaging or just ‘staring towards you?’

Here I sensed a few contrasting interpretations of whether the child’s communication was ‘appropriate’ or not. The visitor herself seemed to be oscillating between whether the child was ‘sociable’ or did not have normal interactive skills. The practitioners then pointed out that William interacted ‘normally’ with a doll. Nevertheless, since the child did not have much speech, this was a problem on the basis of the developmental tests for 2-year-olds.

The visitor did not consider how the fact that the child was not a monolingual English speaker and possibly learning two or more languages simultaneously may have affected his spoken English, or how his cultural background may have shaped his non-verbal interaction with adults. I observed situations similar to this whenever there were other than monolingual English children in the setting. The next subsection continues with the assessments with one or more languages, where English was not the child’s mother tongue.
8.3.2 The child ‘gabbles in an unusual language’

As indicated in Figure 8 (p. 77), children who were referred for the Team came from various backgrounds. When ‘communication difficulty’ was a referral problem, the Team members would mention whether, for example, the parents had non-English (e.g. ‘French’) or regional accents (e.g. ‘South London’)$^{15}$ or whether another language was spoken at home. I was told that sometimes a professional interpreter was needed for assessment; however, this did not happen during my observations.

The following extract describes an instance where the child’s family spoke several languages and this was seen as a problem, because, according to English based developmental tests for 2-year-olds, the child was delayed.

A ‘visitor’ comes in and talks about her home visit where ‘Robert’ had ‘gabbled in an unusual language’ so she had referred him to the Team. She says: ‘I could see there was a problem’ and she bases her judgment on developmental tests for 2-year-olds. ‘Having said that’ she continued that ‘he had a good eye contact’. In her opinion, multilingualism was a problem, as well as the parents’ cultural isolation.

She had encouraged the parents to speak only one language at home. She said that Robert did not look at books ‘in a meaningful way’. The visitor had done one home visit. P1 then talks about what he can and cannot do for his age, such as that ‘he deconstructs rather than constructs’; ‘his action is purposeless’. She concludes that she cannot actually put a developmental ‘age’ on him, joking: ‘He’s still doing peek-a-boo’.

P2 describes Robert as: ‘impulsive’, ‘self-directed’, and ‘single-channelled’. The others do not necessarily agree with her. For example, she says that she did not see symbolic play or pretending, whereas two other Ps saw him playing phone conversation. She also did not see him saying ‘brick’ – P3 said that Robert said ‘brick’. But P2 thought he did not copy properly. The Ps say that he is developmentally delayed, not ‘disordered’, negotiating this nuance. The delay was estimated to be about 6-10 months. The SLT says at that stage they cannot yet quantify receptive/expressive language.

This is a typical example of how monolingualism was regarded as the norm to which children were compared. The visitor made comments on the meaningfulness of the

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$^{15}$ These are pseudonyms.
child’s non-verbal communication based on one home visit. It appeared that the child was not ‘up to’ quantification, so any particular ‘disorder’ could not be established: the negotiation revolved around whether this was a matter of ‘disorder’ or ‘delay’.

Nonetheless, cultural differences were typically discussed at Team meetings, whenever a non-British child was to be assessed. A lot of the time, assessments were concerned about whether the child was ready for school, or whether the child needed a special needs school instead of mainstream school. This proved problematic with non-British families who were used to a different kind of education system, for instance, where children started school at a later age than British children.

In the next extract, which refers to this kind of situation, I have, for confidentiality reasons, replaced the actual languages in question with ‘French’ and ‘German’.

Visitor 1 sets the scene. Apparently the father denies that there is anything wrong with his son. They then check what ‘surveillance checks’ had been done in his past. Visitor 2 describes his eye contact: ‘He looks through/past you’. Now there is some disagreement whether he speaks ‘French’ or ‘German’: one P says French and the others say German. Apparently he also has some English words.

P talks about a lot of things, mentioning, for example, that in ‘France’ children don’t have to go to school until they are 6 or 7 and that the mother prefers that. P says that the mother claims that she is the only one who really understands ‘George’ and she doesn’t want any interpreter in the assessment. The Ps suggest strategies for getting her to change her mind; one of them says that an interpreter is needed so that they can assess how intelligible he is to people other than parents.

In one P’s opinion, the mother’s parenting style is ‘rude’: she would say ‘build, build’ to the child, rather than gently ask him to build with legos. Apparently the mother has accepted the speech delay problem but is still reluctant to get him assessed. Visitor 2 was surprised, because the mother is a ‘powerful woman with a deep voice’ so it was odd that she did not demand that he be assessed.

One P is concerned about the non-existing quantification of the child’s difficulties: ‘We need to have a baseline’. She had met the child once but ‘it was too short a period of time’.
Frequently, when the parents did not accept the referral, the practitioners would talk about ‘parental denial’. In the above extract, the denial was partly explained by the father’s outright disbelief, partly by the family’s different cultural experiences. Nonetheless, the main reason for the assessment was to see whether the child could communicate with people other than the mother, particularly at school. The mother, however, did not think that an interpreter would help, or that her child needed to go to school at such an early age. Furthermore, there are reasons to believe that the legal duties for early intervention do not necessarily exist in other countries in the same way as in the UK today. This could be one of the reasons why there were not always previous medical records about the child by the time they came to be assessed by the Team.

8.4 Conclusion

I argue that the notion of ‘good communication’ in the Team practice – as distinct from the clinical/developmental notion of ‘normal’ communication – was in part a matter of sociocultural preferences. From what I gathered from the practitioners’ accounts, ‘good communication’ seemed to be regarded as something quite self evident. It involved norms for how families ought to organise their home life, a preference for monolingualism (English language in England) and for certain accents, and certain general rules for face-to-face conduct. However, some practitioners and visitors emphasised this side of communication more than some others: I can only talk about those assessments that I witnessed. Moreover, not all the comments that I have illustrated in the extracts came to be written down in the final reports.

In addition to the previous chapter, this chapter has illustrated how clinical work fundamentally entailed ‘socialness’. The sociocultural elements of practice were something that would surface only sometimes, although in a consistent manner. Communication as a skill was now a matter of something more than the child’s innate abilities: it was a reflection of an approved ‘nurturing’ environment as well.

At the same time, in terms of ‘sending messages across’, I sometimes perceived ‘communication difficulties’ occurring between adults as well as between adults and children. Thus it becomes clearer that communication and understanding are not
straightforward phenomena. People do not always agree on things, or share the same cultural constructions of ideas, objects or actions. In the Team Service setting, I got the impression that the Team members would modify their 'verbal output' to suit the requirements of the assessment situation, instead of always 'reveal' all of their thoughts. This surfaced on the occasion, when one of the practitioners told me about the hierarchical dynamics of the Team work. She approached me in private since this would have been a difficult topic to bring out in front of other members of the Team.

My analysis of the 'socialness' of 'communication/difficulties' continues in the next two Chapters, where I will talk about the 'Children's Centre'. My analysis in both settings questions achieving understanding as a basic feature of 'good communication'. I argue that, more so than in the 'Team Service' setting, this was salient in the everyday practice of the nursery.
Chapter 9.

THE AMBIGUITY OF RATIONAL ACTION: OBSERVING EFFORTS TO ‘BRIDGE THE COMMUNICATION GAP’ IN THE ‘CHILDREN’S CENTRE’

9.1 Introduction

This chapter talks about the ‘Children’s Centre’. Thematically, (inter)actions in the nursery represented a point in the interventionist process where children had already been diagnosed and were receiving additional support and therapy.

There were differences between the two settings in terms of the children’s perceived needs and disabilities. In the ‘Team Service’ setting there were children with a variety of ‘needs’. In the ‘Children’s Centre’, on the other hand, all the children had been diagnosed with a particular type of disability, the clinical definition of which involved a range of cognitive and physical impairments. Among other things, these impairments were seen to create barriers to the child’s communication and efforts were made on a continuous basis to alleviate or eliminate those barriers.

What the two settings shared was the concern for ‘communication difficulties’, which were understood to be impairment based and therefore perceived as requiring specialist intervention. The Team’s role was to ‘identify’ and make decisions about ‘communication difficulties’, and in the nursery these decisions (although not literally the same ones\(^{16}\)) became implemented. Both settings explicitly drew on the same legislation, rules for professional conduct and recommendations for good practice.

As with the ‘Team Service’, in the ‘Children’s Centre’ my sociological gaze focused on how various understandings of ‘good communication’ and ‘communication difficulties’ arose from practice. First, I argue that, in the nursery, verbal (unmediated) communication involved ambiguities: having ‘words’ did not guarantee a direct link between the adults’ and the child’s ‘minds’.

\(^{16}\) Here I am referring to the intervention process that children may go through (see Figure 3, p. 23).
However, since many of the children in the nursery had little or no speech, observations of entirely non-verbal communication made up a great deal of my fieldnotes. After some time spent in the field, I started to observe the use of picture communication symbols in detail, since they featured in daily practice more frequently than, for example, the use of sign language. The use of communication aids was part of what I call 'communication as a medium'. They were material objects that were intended to replace words or enable the child to express a need or choice, and thereby establish shared understandings between the carer and the child.

Second, I argue that the use of visual aids fundamentally involved ambiguous processes of meaning making: the hoped-for 'shared understandings' between children and adults in the setting had an accomplished and situational character. This meaning making was based on a certain logic: it imputed rationality to both adults and children. My analysis questions the feasibility of such logic, first and foremost because it was meant to serve moral-pragmatic purposes. Third, I observed some ambiguities in how routine practice in the nursery constituted the child as an agent. I argue that, for example, choice making situations assumed rational thought and action on the part of the child, whereas on some other occasions it was commonplace to treat the child as an 'irrational' being.

This chapter concentrates on the 'rationality' of communication in the nursery; the 'socialness' of it will be the topic of Chapter 10. The previous chapters have described how the focus of my observations developed during the beginning of the fieldwork period in the nursery. In a similar way to Chapter 7, section 9.1.1 describes a typical day in the field. This 'first encounter' is intended to provide an overview of what was going on in general. It creates a categorical baseline for my further analysis of the data in this chapter and the next. The rest of the chapter develops the above arguments.
9.1.1 A ‘thick description’ of a typical afternoon in the nursery

The following lengthy extract is meant to set the scene, in the same way as in Chapter 7. As with all the extracts in this thesis, the children are given pseudonyms and some details have been altered for confidentiality reasons. The nursery staff are either generically referred to as ‘workers’, regardless of their occupational status; or given pseudonyms.

We are in the middle of a Teletubbies watching session – there are 6 children, 5 workers, the lunchtime is just over. I am introduced to the staff on duty that day and told what I am not allowed to do (e.g. lifting up a child, walking, or carrying them); and what I can do (e.g. talking, playing and asking all the time). The children say hello to me. They seem to be in a good mood, there is no crying. The child (‘Martin’) who cried all the time last time is on the floor again, I get eye contact with him. In the timetable, this is called ‘floor activity’.

‘What's going on (in the video)?’ A worker is trying to interpret what ‘Jemma’s’ noise means: ‘Is that what you are trying to say?’ The children are all glued to the TV screen. The worker calls Jemma a ‘noisy girl’? Meanwhile, ‘Steve’ has been carried in. Another worker is talking about Steve to ‘Anna’, who is watching carefully: ‘Let me take his jumper off, it's really hot’. Another worker says ‘good boy’ to Steve. He wiggles on a mat. Then Anna is taken to the corner separately, where they play with kitchen toys. Another girl is strapped in a special chair and she has fallen asleep. Steve sneezes, and the worker says: ‘Bless you son’. It's very quiet and peaceful in the nursery.

I focus on Jemma now. She has made noise for a while and every time someone says ‘Why are you making noise?’ Two people are talking to her about Teletubbies: ‘Is it funny, Jemma?’ She can turn her head towards movements or sounds, and makes noise, frowns or smiles when people talk to her. ‘That's ‘Simon’ next to you. Do you like this bit? You like the rabbits, don’t you? The same worker keeps talking. She is left alone for a while, and then she starts making even more noise. The workers react: ‘What would you like? Have you had enough of Teletubbies?’ A worker says about Jemma: ‘I love that grin’, and a minute later: ‘Don't give me that sad face’. I think Jemma understands the worker – at least there is clear eye contact. She is the noisiest one. For example, ‘John’ repeats the same hand movements over and over, claps his hands. Steve does not 'say' anything. There is only one child who speaks.
Circle time is about to begin and they start walking the children to chairs. The nursery is all of a sudden quite noisy with singing, talking and noise making. Some children are resisting this but Jemma smiles on the floor.

The talking child (‘Mike’) still wants to watch Teletubbies: no singing, ‘no cars’, but John is clapping already. They look at Martin’s eye movements about what song he wants to choose. Mike keeps blowing raspberries rather than singing. He is told off and then he chooses a song and talks (after the worker says she wants to hear him talk). I am sure Steve can recognise this song as well – it looks as if he is enjoying it. The workers talk to him as if ‘he’ was ringing the bell, even though it was the workers. Why are they doing this? One worker has to hold Martin’s head upright all the time. A worker asks John to choose a song. He holds on to a page in the songbook but the book is then taken away. He starts crying.

Some children follow the song and play if they can actually touch nose, head etc., many cannot. Then they start listening to a story (one protest here... by Mike). When one worker has to leave the room, another says: ‘I’ll keep them occupied. Change the story’. She almost read the same story again, making comments like: ‘Jack thinks it’s a Mummy mouse’. There is signing going on at the same time as puppets come out – the workers are making up a story themselves, improvising. But when they read aloud, it is a particular way of reading to children.

They are now asking everyone, in turn: ‘What did you do this weekend?’ Steve is pointing out pictures for ‘Mum’, ‘Granny’ and so on in his picture book. ‘Yes’ and ‘no’ answers are possible in this activity.

Many of the children in the nursery were verbal, although they might have been diagnosed with speech delays of various degrees. As the extract illustrates, they were actively encouraged to talk: for example, Mike often tended to, say, burst into tears or make ‘meaningless’ noise (blow raspberries), even though he was capable of uttering some intelligible words and signing. In the extract, he was encouraged to choose a song (which he did reluctantly) and say his choice out loud.

In the extract, the workers asked the children: “What did you do at the weekend?” One of the explicit educational elements in circle time was to practice social and disciplined behaviour, such as turn taking. Two observations can be made here: firstly, there was a ‘question-answer’ model built into circle time, and this facilitated, according to the staff, practising of communication via picture communication

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symbols, testing the child’s memory or teaching them to follow adult instruction, and so forth. Secondly, circle time was an opportunity for all the children in the nursery, verbal or non-verbal, to do joint activities, which was believed to be as beneficial for child development as, say, individually tailored therapy programmes.

There was, of course, opportunistic and spontaneous talk between adults and children as well. This casual talk could be about anything: joking, helping out, chatting, playing, having fun, and so forth: sometimes structured and more casual elements of talk merged together. The interactions between adults and children followed the pattern displayed between Jemma and the worker in the extract, apart from the fact that children would occasionally talk back or initiate conversations.

The extract illustrates a situation where a worker was ‘conversing’ with Jemma. Whenever Jemma made noise or rolled her eyes, the worker would comment on it, or ask her a question, such as: “What are you trying to say?” She was interpreting Jemma’s noise making during a situation, which was referred to as ‘chatting’, and thereby engaging her in the social situation in the floor corner. I later learned from another worker that this kind of ‘engagement’ was one of the routine aims in the nursery, particularly in more structured activities, such as circle time.

The extract also suggests that not everyone was a ‘noisy girl’ like Jemma: interpreting non-verbal behaviour included interpreting hand or eye movements as well. Some non-verbal children, who had more control over their movements, would, for example, sign when the workers prompted them. They would make other gestures as well, some of which were interpreted as meaningful, such as waving ‘bye bye’. On the other hand, some gestures, such as John’s repetitive clapping, may have been seen as symptoms of certain types of disabilities.

The use of visual communication aids, such as picture communication symbols, was typically related to the act of ‘choice making’ with non-verbal children. For example, in the extract, Martin was asked to choose a song, and expected to indicate his choice by eye movements and John was expected to do the same by hand movements. Apart from this occasion, in my observations, picture communication symbols were frequently used during meal times (see Appendix 3).
There were practical reasons for the choice of communication aids that were available: for example, I was told that head pointers were not used in this nursery, because they can cause physical strain to the children. Picture cards were convenient to use: they would often be arranged in books to suit each child’s projected needs, and it was possible to take the books home. With therapeutic assistance, some children were also practising the use of computers for their communication, as well as for other special needs. The communication aids that were available were adapted to the children’s ‘developmental age’. Changes in these arrangements happened if the staff members were convinced that the child was ready to use more complex material.

Communication aids were one means for attempts to establish a ‘meeting of minds’ in the nursery. The next section will address the ambiguities that were involved in daily practice, where ‘bridging the communication gap’, either verbal or non-verbal, was, directly or indirectly, the object of action.

9.2 Communication as a ‘medium’ between minds

This section looks at communication as ‘medium’: how it was perceived as a tool for transmitting messages and enabling the meeting of the child’s needs. For the sake of clarity, I will talk about verbal and non-verbal communication separately.

Adult-child communication in the nursery fundamentally entailed adult interpretations of the children’s meanings. The workers expected the children to learn certain ‘fixed’ meanings that they had applied to words, signs or pictures. I argue that this assumed face-to-face communication to be something rather linear and straightforward. My observations suggest that this view was consistently applied to nursery practice with both verbal and non-verbal children.

My data extracts have a specific focus on acts of choice making, which was part of the ‘good practice’ ethos in the setting. This is because situations where children were encouraged and expected to make choices crystallised certain understandings of communication and of the child in the research data. Both verbal and non-verbal interaction in choice making situations drew on the idea that children are not only entitled to choices but also willing to make them.
The possibility of ambiguities in verbal choice making suggests that there were ambiguities in non-verbal choice making as well. The ambiguities did not, however, necessarily stem merely from the child's lack of cognitive abilities, or that the child had not learnt the meanings of, for instance, picture cards. Instead, the ambiguities would arise from situational and contextual interaction, where unpredictable turns of events and behaviour were commonplace. This observation challenges some taken-for-granted preferences for 'rational action' and 'intentionality' that a great deal of specialist work in the nursery was based on.

I also suggest that children were typically encouraged to make choices when it was appropriate in terms of adult frameworks, such as daily timetables. My data illustrates how meal times may have been one of the few opportunities for the children to initiate their preferences. In this respect, 'communication' in the nursery was tied to adult judgments of what was the primary task at hand, as well as, for instance, to the management of a number of children at the same time.

9.2.1 Verbal communication in the nursery: 'transmitting messages'

The following extracts describe verbal choice making during meal times, where children were served a 'three course' meal, and before each round they were given options to choose from, such as apple juice or orange juice, or different kinds of pudding.

Eating goes on as usual. At first, 'Sarah' is the only adult who keeps talking to the children, e.g. 'If you don't eat it you will always be as tall as that'. Then two other workers join in -- especially 'Tracey (loudly) and newcomer (quietly): 'Would you like some more? Good boy'. Two workers talk about 'Martin' -- they think that he might have chickenpox. Robert is crying -- Tracey: 'Enough noise now -- you are going to have pudding'. Tracey seems to be in charge of the situation that way. 'Brian' says: 'I would like some custard'. Sarah: 'Well you are allowed to change your mind' (I did not see whether he wanted something else earlier).

Verbal children would sometimes initiate choice making, like Brian who wanted 'some custard'. However, verbal choice making was sometimes quite ambiguous too.
A worker says to ‘Mike’: 'You are looking at this one and pointing at other one Mike. Which one do you want?' Mike says: 'Something', and the worker smiles at me. Tracey did a very quick round with the food items; still, quite a lot of speculation is involved in the choice making. Children are given ‘something’, anyhow. Martin still cries quite desperately. A worker asks Mike whether he wants to have apple juice; He replies: 'No no no - yes!' and the workers laugh at this. Then Mike says something but no one hears it. Eventually the worker brings out the actual food items and he points approximately at the apple juice.

Although the children may have understood the intended meanings of the cards and the purpose of using them, they were not necessarily bothered about making choices. Yet they were typically quickly given ‘something’ anyway unless they expressed a very clear ‘no’. In this extract, the worker first tried to get Mike to point at picture cards of orange or apple juice: when this method did not work in the way she intended, she brought in the actual cartons, and Mike then rather casually pointed at one of them. In my interpretation, the worker assumed that Mike did not comprehend the link between the picture cards and the food items.

In contrast to the previous examples, I will next describe a situation where the child actively ‘sent a message’ – several times - and faced some mixed responses to it:

This appears to be an educational session. The children are sitting at a table and a worker is teaching them numbers through play. 'Jonathan' is complaining about stomach ache. Worker1: 'It's nearly lunchtime, you must be hungry'. 'Jerry' knows what to do next. The children are banging the table with sticks really loudly. 'Paula' is not with this at all. She keeps banging the table. She repeats 'tick tock'. Jonathan: "I need to wee". Worker1 says no because he has just been to the toilet. Worker2 then enters the room, hears this and asks Worker3 to take him to the toilet.

The children sing a pat-a-cake song with playdoh. The worker explains to me how the children anticipate the events, because they remember them from the previous session. Paula is falling asleep. The others are clapping and messing around – they seem to have fun. Some of them shout rather than sing. Jonathan protests: “I'm tired”.

This is an example of a situation where different interpretations of the child’s verbal intentions emerged. Worker1 interpreted that Jonathan was complaining because he was hungry, but since lunchtime was approaching it was not a problem for the worker.
Worker1 also dismissed his request to go to the toilet, whereas the other two workers took notice of this. It was typical of the nursery practice that situational judgments of the child’s intentions and needs were made like this.

9.2.2 Non-verbal communication and meaning making

I have suggested that verbal communication in the nursery involved ambiguities, but also that non-verbal communication was often even more obscure. This, I stress again, is not simply a matter of a lack of speech on the part of the child. Instead, the ambiguities arose where non-verbal communication – or attempts to establish such – was treated according to ‘ideal’ models for verbal communication (see Chapter 3).

In the next description, non-verbal children, who sat in their wheelchairs, were arranged in a circle so that they could face each other.

The children are given toys while they are also taken to the toilets one by one. I can see that ‘Alan’ does not like the doll he is given. ‘Steve’ is trying hard - I think he's quite patient. The toy falls on the floor every once in a while - does he want it to drop? He takes breaks and starts again. Alan notices that Steve’s toy keeps dropping - smiles when I go ‘oops’. Alan is now a very smiley boy - makes noise (almost shouts) but ‘Jemma’ goes quiet again. Then she makes noise and her toy falls down.

On occasions like this I certainly became aware of my own lack of understanding the children’s worlds. I was looking for some signs of interaction between the children, but did not see it, at least in any conventional sense. On the other hand, the children may have been perfectly aware of what was going on – for example, Alan seemed to be amused by the fact that Steve’s toy kept falling on the floor. This time it was impossible for me to tell why the children made noise; whether it was social and meaningful or not. It seemed that I would have needed to spend a lot more time (than a three-year long CASE studentship, for example, allows for) with these children to better understand what they were like as individuals.

Aware of my own shortcomings in the attempt to ‘bridge the communication gap’ I felt that non-verbal communication in the nursery was a challenge to all participants in the setting. It seemed obvious that verbal expressions made the daily tasks easier,
and therefore children were encouraged to use either straightforward words or expressions that resembled words. The function of picture communication symbols was to replace speech.

With non-verbal children, the same model of communication was used as with verbal children. An adult asked what a child wanted, and the child's answer was 'retrieved' from eye or hand movements, which were interpreted as pointing at one or the other card with oppositional meanings.

A worker is using 'yes' and 'no' cards with 'Simon' - a more experienced worker tells the newcomer what hand movement means 'yes' – it is not quite obvious to me. He actually refuses the food by not swallowing it even though his hand movement is interpreted as having meant 'yes'. The newcomer tells this to the older one. The workers then take turns in using the cards and offering the food. He refuses again and the meal is taken away. The newcomer is still practising with yes/no cards.

What Simon wanted was never clear to either of the workers, but the more senior worker encouraged the newcomer to offer food items to him. There seemed to be a power play – or an educational situation - between two workers of different statuses. The senior worker did not allow the newcomer to 'give up' too easily, in other words, to immediately interpret that the child said 'no'.

The use of picture cards involved a question-answer model that did not allow children to ask questions or to dismiss the question. They only provided dichotomies, such as 'yes' or 'no', rather than, for example, 'I don't know'. Obviously, there were practical reasons for the simplicity of the cards. On the other hand, the cards, for this particular reason, only facilitated adult-led 'conversation'. They also expected the child to be in the mood for, and capable of, making rational choices.

At its extreme, it appeared that choice making had become an end in itself so that the adults insisted the child give an answer. I frequently observed the workers making decisions on behalf of the child when an ambiguous situation arose:

It seems to take quite a long time to feed 'Jemma' (or to teach her to eat by herself) – others have gone through their pudding already. Now she is shown both food items
The worker seems to be fed up because Jemma did not look at the 'no' picture card but refused a banana. Another worker says 'I think Jemma likes custard so let's have that'.

The problem is in that one could never be sure exactly what the children wanted until they either swallowed the food or not; by then, they might have just changed their minds anyway. As such, there were no exact means to measure whether the task of giving children a choice was successful on each occasion.

Sometimes it seemed that the child really did not want to make choices or choose anything that the adults suggested; yet the adults had their objectives to deal with the child’s ‘needs’. The next extract is a detailed (video-recorded) example of such a situation. This lengthy illustration shows in detail what meal times typically looked like to me; here the focus is on one child, ‘Adrian’. The worker’s talk is in bold.

Adrian eats and the worker sits beside him, holding a picture book on her lap. She wants him to sit on a box. The picture book is not much in use. The worker corrects his sitting, wipes his hands. She does not talk much. All the children are eating; it is quite quiet in the nursery. Adrian makes noise, pointing at two other boys with a spoon. Now the worker helps him to finish the plate. The phone rings, Adrian stands up.

Worker: ‘Adrian, sit down on your box because this is lunchtime. Good boy.’
Adrian keeps moving and the worker correcting. Worker repeats: ‘It's lunchtime; you have to sit on your box. Good boy’.
She asks Adrian to put the plate on the table. Worker: ‘Do you want some more?’
(at the table, no communication aids were used). Adrian makes no noise, sits down on the floor. He stands up again; she holds his hand, pointing at food.
‘Show me if you want some more’ – the worker decides to put some pie on his plate, while he is walking around the table

Worker: Sit down. He sits down and starts eating again. The worker signs: ‘Do you want some more? Are you finished?’
Adrian stands up, makes noise and looks distressed. They go together to take the plate away. Another worker signs at him too behind the table and points at his box.
Worker: ‘Stay there, stay there’. She repeats this many times. She has to continuously struggle to keep him on the box. Adrian is restless.
Now a picture book is taken out. **Worker:** 'Adrian, do you want some pudding?'
Adrian walks away. He falls on the floor again and the worker goes to lift him up.
Adrian goes to sit down. **Worker:** 'That's it; you are going to the chair now'. She takes his chair and makes it ready.
She brings the pudding and orders him to sit down on the box. Adrian looks at the two options; real food items are shown to him. He nearly catches the banana, which is taken away. The worker puts the custard away and comes back with the banana and peels it: '1, 2, 3 - here's a banana'.

The worker takes the picture book again (she had said earlier that today they would practice with it). Adrian falls off the box, still eating the banana. **Worker:** 'Do you want a drink?' Adrian points at the table. The worker takes his hand and shows a picture card (it was upside down). She interprets yes.
The worker has enough of messing and secures him in the chair17. Adrian goes: 'Noo!' He pretends to drink from the mug. Then real juice cartons are shown to him: 'Which one?'
He points at the orange. **Worker:** 'Orange? OK'.

The worker is glancing at the picture book pages. She shows him the 'more' card: 'Adrian do you want some more?' She puts her finger on the picture. Adrian puts his finger on the picture as well and she goes to get some more. **Worker:** 'Good boy'.
He is given a mug but it is taken away.
The worker is trying to find 'pudding' in the picture book. Adrian is looking the other way. The pudding bowl is brought for him to see, he points at it but then turns his head away. **Worker:** 'Do you want some of this? I heard you make some noise'.
Adrian looks tired [or full]. **Worker:** 'I don't know what you are pointing at'.
**Worker:** 'Are you finished? Wipe your hands'. Adrian does what she says.

The use of picture cards entailed an insistence that a child make choices. However, it seemed that the child did not share this objective with the worker. The only time it appeared very clearly that Adrian made a choice was when he resisted being secured into his chair. At the same time, he may have made some other more subtle choices, such as wanting to hold the banana or the mug, which were taken away from him18.

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17 Children like Adrian had their own, specially designed chairs, which sometimes had straps on them to prevent them from falling.
18 These suggestions were later discussed with the nursery workers, when we watched the videotape together.
Outside meal times, the above example is very typical of what was going on in the nursery with non-verbal children. It describes how a model of a straightforward exchange of messages via communication aids is unthinkable in an everyday childcare context. I argue that interaction and communication in the nursery were inherently ‘messy’. The objectives of adults and of children (whatever they may have been) did not inevitably coincide despite the workers’ efforts to follow the recommendations for good practice.

9.2.3 The ‘irrational’ child

So far I have talked about how the nursery staff typically interpreted what the children meant. I have suggested that in choice making situations the child was expected to be ‘rational’, that is to say, clearly indicate a choice between two or more options. In this section I describe how the staff, at the same time, treated the child as an ‘irrational’ being. This, I argue, further illustrates the complexities that are involved in face-to-face communication between adults and children, as in the next caption.

‘Joshua’ has tried to peel a toy banana – a worker explains and signs to him that it is ‘make-believe’ one: ‘You cannot peel it but you can ‘cook’ it’ [in the toy oven]. Joshua is going back and forth between the floor corner, where all the others are sitting, and the kitchen corner. He is carrying items of food and a huge teddy around, demanding that others ‘cuddle it’. I interpret that ‘Mike’ is crying ‘attention-cry’ – he stops and smiles when one of the workers says: ‘Excuse me’. ‘John’ is making repetitive sounds.

It appeared to me and to the worker that Joshua had tried to peel a toy banana and the staff member made sure that Joshua understood what he could do with the toy. Neither Mike’s nor John’s noises were interpreted as ‘appropriate’ social communication by the workers or me: the former was treated as attention seeking and the latter, as the workers had previously explained to me, a feature of John’s disability.

While in the previous extract the worker tried to lead the child away from play towards ‘reality’ (so that he would not eat the toy banana), in the next the opposite
took place. This is an example of a free play session, where ‘Harry’ made a lot of noise and the worker tried to keep him quiet.

Harry was scared of the ‘dinosaur’ – a worker tricked him to be quiet so that the dinosaur does not wake up... Harry was funny - he walked on tiptoes, trying to be quiet. I thought he was easily led into this fantasy world. Harry said to me: ‘Bye bye, I want to get my car’. Soon he came back and parked his car near the kitchen corner. I asked whether there was ‘petrol’ in the tank. He said: ‘Bedroom?’ And he went to sleep on the kitchen corner floor because he was ‘tired’ and he decided that this was his bedroom.

In my observations in the nursery, adults routinely ‘managed’ the children by mixing reality and play, or simply had a laugh with the children this way. As it appeared to me, sometimes this was acceptable but sometimes not. This depended on the judgment of the adult involved. My impression here was that Harry was easily led into believing that there was a ‘real’ dinosaur, because he was quieter after the worker tricked him. It seemed that the distinction between play and reality became blurred to him, and it appeared that he did not see the adult agenda. When I took part in play with Harry, I accepted that he did not necessarily understand the word ‘petrol’, and that he easily moved from one ‘scene’ to another: from the car to the ‘bedroom’.

My point is that during free play sessions a different kind of child was constituted than on more structured occasions: in the former case, it was accepted that children were ‘irrational’, in the latter they were expected to be more ‘rational’. Nevertheless, I argue that whatever the situation, what was deemed to be ‘rational’ or not was judged by the adults and based on interpretations. This applied to children’s communication in different ways, for instance, in terms of whether their talk ‘made sense’ to adults:

A hand-puppet teddy (the user can move its mouth) is now used by ‘Tracey’ (kisses and cuddles). ‘Mike’ likes it. Another worker comes in, and he says as a first thing: “I don’t need my dummy”. This refers to the situation before, when a worker asked whether he has a dummy at home. Mike still keeps repeating that he does not need his dummy. Then he says: ‘Come back here’ and a worker asks ‘Whom are you talking to?’ He starts repeating ‘This way’, looking at ‘Steve’ who is wiggling on the mat. Mike calls the teddy Fred – he wants to cuddle Fred, dragging it towards himself.
Since I had been observing the situation for a while, I knew that a worker and the parents had wanted to wean Mike off the dummy. When another worker came in, she did not know why Mike was talking about the dummy and asked: ‘Whom are you talking to?’ It appeared that Mike was a bit distressed about the dummy episode – I was only able to interpret this from the context – but the workers did not appear to realise this, and ignored his talk. In short, what could have been logical for the child in any particular situation did not necessarily appear as such to the workers, if they did not know what had previously happened to the child. Hence the constructions of the child as either ‘rational’ or ‘irrational’ were contextual.

9.3. Conclusion

In this chapter I have described communication in the ‘Children’s Centre’ in terms of ‘rational action’. I have referred to situations where communication was perceived as something relatively straightforward, cognitive and preferably symbolic. In the nursery, it was treated as transferring messages between actors via words or symbols in particular situations, where it was appropriate. Choice making during meal times was an example of such situations.

My main argument here is that what was regarded as ‘rational action’ on the part of the child, particularly in the context of using visual communication aids, appeared rather ambiguous and context-bound to me. However, this was not due to the child’s impairment alone but to the multiplicity of meanings that were possible during interactions. Different meanings could be attached to what children ‘said’, verbally or via picture cards. Thus I challenge the desire that an unproblematic, direct connection could be established between the child’s intentions (or a lack of them) and the adults’ minds with the aid of AAC.

I argue that the use of picture communication symbols, in particular, constituted the child as a rational actor, requiring them to want and need. Nursery practice fundamentally involved preferences for not only rational action but also for rational thought. In contrast, during free play sessions, for instance, children’s ‘irrationality’ was openly addressed and often used as a means of managing them in a group.
Another dimension of ‘rational action’ in my findings involves the adult frameworks for when to communicate one’s intentions. I observed that meal times were constructed as opportunities for the child to express his/her wishes and needs, whereas at other times this was not apparent. Sometimes, for example, during circle times, children could choose a song, and so forth. On occasions like this, choice making was on the adult-led therapeutic and educational agenda.

This chapter has looked at how ‘communication’ was understood in the ‘Children’s Centre’ and how this manifested itself in the daily practice. I have explained that this had to do with assumptions of what children were like, what they ought to do, and what was good for them. The next chapter will move to a more specific concern – ‘communication difficulties’ – and analyse how children were objects of specialist intervention. Again, the key underlying theme in Chapter 10 is the notion of ‘socialness’.
Chapter 10.

'COMMUNICATION DIFFICULTIES' AND CORRECTIVE PRACTICES IN THE 'CHILDREN'S CENTRE'

10.1 Introduction

This chapter continues with the 'Children's Centre'. My data analysis features routine events and activities where notions of 'good' and 'normal' communication played a central role. I will describe how hegemonic discourses manifested themselves in the daily practice, and construed children as objects/receivers of care, education and 'correction'.

The findings suggest that in the 'Children's Centre', 'good' and 'normal' communication was a central institutional objective: daily activities involved the conceptualisation and treatment of communication as a particular 'skill'. In section 10.2 I will look at some ways in which specialist knowledges and practices framed the nursery day, and how conventionalised forms of communication appeared to be a taken-for-granted element of interaction. Section 10.2.1 describes how children's communication was sometimes compartmentalised in different branches, in a 'sturdy oak' fashion (see Figure 2 in Chapter 2, p.18). Some elements of everyday versus specialist norms for 'social communication' skills will be described in section 10.2.2.

Educational and therapeutic activities in the nursery – with both verbal and non-verbal children – involved targeting literacy and oral skills. Symbolic understanding and clear speech were at the heart of these activities. In section 10.2.3, I will illustrate how the nursery work involved an explicit preference for abstractions and words as ideals for 'good' and 'normal' communication. At the end of the chapter, I will summarise all the findings from the two settings.

10.2 Communication as an educational and therapeutic objective

In the same way as in the 'Team Service' setting, the routine patterns of nursery work involved rules for how to communicate. I have previously mentioned how children in
the ‘Team Service’ setting were expected to behave in a certain way at ‘appropriate’ times – this section takes up this notion again. My analysis explores the various ‘corrective practices’ in the nursery, which aimed at making children’s communication as ‘normal’ as possible.

10.2.1 The ‘sturdy oak’ revisited

The first data extract describes ‘Joshua’ and ‘Tom’ receiving speech and language therapy. This is an example of a situation where developing ‘as-close-to-normal-as-possible’ speech was the purpose of interaction and how children’s speech was routinely compartmentalised into separate skills, where they may have had a variety of ‘deficiencies’ see (Figure 2 in Chapter 2, p.18). On occasions like this, I argue, I observed the developmental ‘science’ of therapy merging with the ‘socialness’ of real-time interaction.

Joshua and Tom had been diagnosed with different kinds of communication difficulties, one having to do with phonology, and the other with comprehension. From the therapist’s point of view, both of these difficulties affected the children’s verbal and literary performance. During the therapy session, the speech and language therapist (SLT) emphasised those aspects of the game that were the most appropriate for each child. For example, the SLT asked Tom to repeat certain letters over and over again, or to sign, whereas Joshua practiced with connecting words with symbols on the screen.

The extract is a transcription of a typical speech and language therapy session, where the boys were looking at a computer screen. The SLT had chosen a few interactive games that would suit both children. In the games, the computer voice asked a question about a word or sound, and the child was supposed to repeat it, as well as match words and sounds with correct symbols on the screen. It appeared that the boys had played these games before. The SLT’s questions are in bold.

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19 This was a video-recorded session. I had obtained permission for doing it from both the SLT and the parents of the children.
The boys are sitting at the computer next to each other. The SLT starts the programme.

SLT: “I want us to play ’I spy with my little eye’ - who wants to go first?”
Tom: (raising hand) “Me!!”
SLT: “Off you go.”
Tom clicks the button.
Tom: “It's not coming...”

SLT: ”Joshua, are you watching? ”
Joshua turns to him and nods.

Then the SLT repeats the computer’s question:
SLT: “I spy with my little eye something that begins with ’d’ - what was that noise? ”
Joshua is still distracted by me. Tom takes hands off the mouse and points at the screen when the SLT asks what there is.
Tom: “There!!”
SLT: ”What is it? Do you know? ”
Tom: ”d...”
Joshua is smiling. He knows how to say dinosaur, smiles at me. The computer rewards: ’All right’, when the correct button pressed. Tom pushes the mouse to Joshua saying nothing.
SLT: ”Tell him that it is his turn. ”
Joshua takes the mouse and plays with it. He does not appear to find the required symbol.
SLT: ”Not there. ”
Joshua: “Why?”
SLT: ”You have to put it there. ”
Joshua: “Why?”
SLT: ”Because it turns the page! ”

The game was about articulating sounds – in this case ‘d’. It displayed things starting with ‘d’, such as ‘dinosaur’, on the screen. The boys were expected to recognise the ‘thing’ on the screen, enounce the sound correctly and take turns in doing this. In other words, they needed to understand the rules of the game.

Tom: “Next page...”
Tom repeats the new sounds after the computer while looking at the SLT - I think he is definitely listening, Joshua says nothing.

SLT: "Don’t play with the roller ball. It’s your turn. Have a look at what you want."

Joshua picks 'I' instead of 'N'.

SLT: "Jiii-nsect.

Joshua still keeps pointing at it.

SLT: "Does that begin with 'N'?"

Joshua: "OK."

SLT: "OK, if you think so."

There are just 3 symbols on the screen. Joshua got it right eventually.

SLT: "Nnnn-ails."

Joshua repeats: "Nnnn-ails", looking bored.

SLT: "Can you do it Tom?"

Tom: "Nnnn..."

SLT: "Well done, that's very nice talking Tom."

Tom: "My turn."

SLT: "Tom can you just try that sound for me - nnnn?"

Tom: "nea..."

Joshua pushes the roller ball back to Tom.

SLT: "Well done Joshua, thank you."

The computer says to Tom: "Well done, you are doing really well."

3 new symbols appear on the screen, including the letter Z.

SLT: "Difficult sound, isn't it?"

Joshua knows 'Zip' as well. The SLT asks him to show where he's got a zip and he shows his jumper. Joshua is not talking but smiles when asked whether he's got a zip as well in his clothes.

SLT: "Not today."

Joshua goes excitedly 'ooh' when Z comes up on the screen.

SLT: "Can you say ZZZZ Tom?"

Tom: "I don't know."

Tom pushes the roller ball to Joshua, trying to say 'Z' as he does so.

SLT: "Nice try".

As I interpreted it, Tom was eager to follow the instructions and repeat the sounds; he demonstrated that he understood what he was supposed to do. Because Tom was seen as having difficulties in uttering certain sounds, the SLT tended to specifically ask him to repeat the sounds. Joshua did not appear to connect the words with the correct items on the screen, and the SLT had to prompt him until he got it right.
Tom: "Next page..."
K comes up.
Joshua: "Kal!"
He repeats it correctly and stands up. Tom says 'Kangaroo' almost right.
SLT: "Very good Tom. Now your turn Joshua."
Joshua is looking the other way, he does not say 'Kangaroo'.
Tom takes the roller ball: "My turn."
Now Joshua looks really bored, leaning his head in his hands.
'H' comes up. The SLT suggests making sentences with 'House'.
Tom: "I live in..." [The SLT had said earlier that he tries to teach Tom to make more
than one-word sentences]. Joshua is looking at me now.
The SLT is signing 'mummy' and 'daddy' with Tom, who is repeating and signing as
well.
The whole exercise is based on repetition.

The SLT asks his own questions now.
SLT: "What about your house Joshua? Who lives there at the moment?"
Joshua: "David and Mommy."
He doesn't sign, even though the SLT signs to him.
Tom: "Daddy has gone to work, Daddy has gone to work."
Meanwhile Tom steals the roller ball.
SLT: "Tom are you taking Joshua's turn?"
'Haha', Tom smiles as well, mischievously.
'T' comes up.
SLT: "Would you like me to help with it?"
Joshua: "NO!"
Now Joshua has got 'I' right and says 'Insect'. But he refuses to say it again after
Tom has tried to say it several times. Joshua hides his face in his hands.
SLT: "Just say no if you don't want to say it."
Joshua nods, he's had enough of this game. The programme ends.

At this point I realised that Joshua was probably bored with the game, but also
distracted by my presence. While Tom was trying hard to get things right, including
signing back to the SLT, Joshua was looking the other way and fidgeting in his chair.
Tom kept taking the roller ball; as it appeared to me, the boys did not really want to
take turns.

SLT: "Do you know what 'quit' means?"
The boys nod.
Joshua is happy when the rocket game starts: ‘Yeah, I like it’, he smiles. But Tom chooses the balloon game instead and stops the rocket game. The computer says: ‘Let’s play the balloon game. Look at the pictures in the balloons’.

The symbols are ‘thumb’, ‘thimble’, ‘oblong’, ‘thermometer’ and ‘sheep’. The sounds are supposed to be connected to the right pictures, and the ones that start with the same sound should be selected. Then a letter representing the sound comes up. The SLT explains the game, repeats all the words and points at them. The SLT thinks it’s a difficult game, because it deals with ‘TH’ and ‘SH’ sounds.

It seemed that Joshua would have preferred the rocket game; however, Tom managed to choose the balloon game first. It was another one that emphasised enunciation.

**SLT: “Do you know what you are trying to do?”**
Both boys seem to be really concentrating. Tom tries hard now that he’s got the roller ball. Joshua looks totally lost, smiles at the SLT when he says: ‘TH, TH.’ Joshua refuses to say thimble, says thumb when the SLT asks: ‘What is that?’ The SLT asks him to stick his tongue out like Tom when he says TH, but he refuses to do it. The kids look at each other every once in a while. Joshua is leaning on the table - he has been more restless than Tom so far, but Tom also is getting tired now.

New pictures come along. Joshua can play this game really well – he got them right instantly! Joshua laughs at the SLT’s ‘egg-degg’ joke [egg does not begin with d...] - it sounds funny. Now Tom looks bored and tired.

**The SLT asks which one starts with D.**
Joshua points at the symbol in the corner of the screen that turns the page.
**SLT: “No, that’s the chap who helps us with the programme”.
Now Joshua starts getting things wrong and Tom says the right answer. The SLT helps Joshua to point at the right symbol.

The boys seemed to get tired or bored at different times. This either affected, or was affected by, their performance.

**SLT: “Would you like to play the rocket game now?”**
Joshua nods: ‘mmmm’.
Tom: “I want a rocket game”.
Computer: “Let’s play the rocket game. Click on the letter that makes the beginning sound of ‘yak’.”
Letters are written on rockets, and the rocket launches when the correct letter is chosen.
The computer says: “This letter makes the sound…”
Now Tom yawns. The rocket is launched.
Joshua: “Where did it go?”
Joshua takes Tom by the hand when Tom tries to move the roller ball. Now Joshua is, reluctantly, holding his hand over the roller ball and whispering 'stupid'. The children smile at the rockets. Joshua waits the SLT’s permission to take his turn again.
Joshua keeps playing with a wrong letter (o instead of y; yoghurt). He clicks on the wrong one many times and the computer repeats what he did wrong: ‘This letter makes the sound…o’, every time. He smiles at this repetition.
SLT: “I think we had better stop now.”
Joshua: “Are we going to turn it off now?”
SLT: “No, we are going to take one quick turn each.”
The boys look at each other. Joshua asks Tom: ‘What?’
SLT: “I think he is waiting for you to do it.”

The goals of the games in the extract were clear: they all addressed a particular ‘skill’, whether it was phonetic, or having to do with symbolic understanding. The training in these skills is geared towards the development of the child’s oral output and literacy. Having two children in the session at the same time also created an opportunity to practice social skills, such as turn taking.

The two boys were regarded as having different kinds of ‘communication difficulties’, and therefore being in need of different types of exercises. However, I perceived that there were also other situational differences that affected their performances. These would include what they were interested in, whether they were tired, what was amusing to them, who were present and so forth. It appeared that ‘success’ in the games was contextual and depended on whether the adult and the children shared the same understandings of the situation.

10.2.2 ‘Social communication’ skills

‘Social communication’ skills were an explicit objective of action in the nursery. Attempts were being made to encourage child-child communication and co-operation.
So far I have mentioned, for example, turn taking. Social communication would also include everyday polite behaviour, such as simply saying ‘thank you’.

There are now lots of children in the nursery, but not that many workers. ‘Leslie’ and ‘Mike’ are crying. ‘John’ makes noise. ‘Joshua’ is playing with toy cars on his own. The workers take children to the toilets one at a time. There is a lot of noise in the room. Then the workers start planning the next group activity. ‘Tracey’ says to Joshua: “Thanks for tidying up (toy cars)”. Mike says about Joshua, who is sitting in a car: “He’s in the car”. The workers repeat and grammatically correct what he says. They are continuously asking questions, such as: "Where are you going?"

Then Mike goes to sit in the car. He starts to cry all of a sudden. Did ‘Adrian’ do something to him? I did not see. Tracey: “Stop crying. Do you want to get out?” Other children watch him crying. Tracey: “Mike, that’s enough, hush”. Adrian brings in an apron for ‘Steve’. A worker says ‘thank you’ on his behalf (Steve does not have speech).

The workers typically rewarded children for having ‘good’ manners and ‘helping out’; this was mostly quite spontaneous. The children were particularly praised when they were polite towards each other, such as when Adrian, of his own accord, helped Steven, who was in a wheelchair.

However, it often seemed that child-child communication in the nursery was not obvious. The verbal children would very rarely talk to each other without adult encouragement. Many children preferred playing on their own, or together if there was an adult co-ordinating the play; often there was one adult per child present, which allowed for one-to-one contact between the two. This was particularly apparent when the adults attempted to engage the whole group in a joint activity.

‘Gareth’ and ‘Jenny’ are fighting – they slap each other and squeeze arms. The workers notice this immediately: ‘Stop. You have to say sorry’. The children start looking the other way. ‘Leslie’ is looking at (not speaking) the children and adults beside him. The nativity play starts – ‘Tracey’ explains how it works. Some children are crawling on the floor. Each child has a different role in the play - Leslie remembers other children’s roles but not his own.

The workers sign the story and give hats and other accessories to children. They are singing ‘little donkey’ when ‘Jemma’ (the donkey) is pushed forward. Also ‘Mary’ (‘Jenny’) comes forward. The workers do not appear to remember the words but are
planning how to do it. They explain to the children what is going on, trying to get
them to learn the lines. The children are so funny, we just laugh. They bounce
around and do the opposite to what they are told. ‘Denise’ knows it’s time to ring her
bell. (Jingle bells). Some children are more engaged in this than some others.

Even though the rehearsal focused on verbal communication and signing, there was
non-verbal communication going on between the children. The latter was not
necessarily perceived as social though: for instance, the workers had to intervene in
Gareth’s and Jenny’s fight and remind the children that ‘they had to say sorry’.

It was difficult to get the children together for the rehearsal: the children had to be
actively engaged, particularly the ones who were physically mobile. The situation was
rather chaotic, and this seemed to amuse the staff. Leslie, however, appeared to be
interested in the rehearsal and showed that he had listened to other children’s lines the
last time. Some other children were enjoying their roles as well, and did what they
were told.

At the time of the observation, in my eyes, the active engagement of many reluctant
children in the play looked like an attempt to simulate ‘normality’, that is to say,
trying to make the rehearsal a ‘normal’ social situation. I had observed the same
‘simulacra’ during other circle times where children were seated in a circle, facing
each other, but where the adults did all the talking. I could not help regarding most
children in the nursery as passive recipients of instruction, who were not interested in
communicating with other children. However, this assumption was challenged
sometimes.

Lunchtime is starting and the children are prepared for it. The children are now ‘told’
what to do such as ‘sit up’. A worker comes in and starts helping a trainee. The room
is all of a sudden really noisy when all the kids are brought in.

Some children are sitting around the table - the others, who are in wheelchairs, are
quietly watching. What does a worker at the table say to a boy? ‘Eat properly’;
‘Leave it on your own plate if you don’t like it’; ‘Denise, what are you doing?’;
‘Don’t bang your plate’. ‘Martin’ is being fed and given medication – the worker puts
his hand in the potato mash. The worker is telling him what the food is like. I asked
why and she replies: ‘Because he has missed the messing with food that normal
children do’.
Other children have already finished. I think there is quite a lot interaction between children at the table. They are looking at each other; smiling, laughing when other kids are told off. The children are expected to sit down until everyone has finished eating. They cannot wait though. All the children are being talked to individually by the workers.

What the extract suggests is that children would interact with each other when the adults did not necessarily expect them to, or when they treated it as 'noise'. I observed a lot of non-verbal behaviour going on, some of which indicated to me that the children were engaged in the situation, even though they did not talk to each other.

At the same time, I noticed that there was a practical division between verbal and non-verbal children. The former sat at their own table, whereas the latter were seated in their wheelchairs behind the verbal ones in a semi-circle. It was typical to divide children into different groups depending on their self-help skills, also at other than mealtimes. There were plenty of practical and understandable practical reasons for this: yet the constant presence of adults, particularly on a one-to-one basis, seemed to impose limitations on the child’s hoped-for attainment of social skills with other children.

Verbal exchanges between children and adults were much more common than those between children. For example, sometimes children would initiate play:

‘Harry’ took the initiative from the start. I went to sit at a table and he guided the game: “Would you like a cup of tea? Would you like some more?” He kept putting things on plates in front of me, answering my questions such as: “Do you like oranges? What’s that?” (e.g. spaghetti). I didn’t correct him when he called toy spaghetti a ‘plate’. ‘Anna’ tried to come to the kitchen corner too but he did not let her. ‘Don’t come here’ he said and shouted to the other workers: “We are playing”. Anna looked at us and I said to Harry: “Maybe she’s hungry”. He asked “Why?” as if he wanted to ‘own’ me, and Anna went away. Harry asked: “Why is she taking the fruit?”

Our verbal exchange on this occasion followed the culture-specific conventions that I had seen adults teaching to children before in the ‘kitchen corner’: Harry would ask polite questions and offer me a cup of tea. We seemed to naturally slip into a ‘question-answer’ model, although unlike what the staff members would have done, I did not ‘correct’ Harry’s item labelling. I also felt that both Harry and Anna preferred
playing with an adult to playing with other children. I draw this conclusion from the fact that Harry chased Anna away and asked me, instead of her, why she took the fruit.

10.2.3 The primacy of speech and symbolic understanding

Labelling items was a typical feature of adult talk to children, during ‘free play’ or more structured educational or therapeutic sessions. With verbal children the adults labelled items with words.

Three children and Worker1 are playing in the kitchen corner. ‘Diana’ says hello to Worker2 – ‘Robert’ cuts toast. The worker looks at me: "Safe cutting...". She talks all the time naming the items and actions: marmalade, peanut butter, plates; i.e. to have a meal and what the items are like. Worker1 tells Robert to pick up a jar that he had thrown on the floor - he starts sidling in that direction but sits up on a chair instead. Then he goes to sit in a car. Worker2 comes in with a keyboard and the children are now interested in that and leave the kitchen corner.

With non-verbal children the same idea was used, although words were replaced with signing or picture communication symbols. The following extract is an assemblage of data gained from some informal interviews with staff members over the course of the observations, when I opportunistically asked about their views on picture books and their use; my questions are in bold. It offers a rationale for the ways in which the picture books were employed in the nursery.

Why do you use picture books in the nursery?
Picture books are simple to start with: at first there are only 2 symbols per page. The books have 2 uses: to tell the child what is happening so that they can start to learn meanings. The way in which the book is organised facilitates choices that they can start to make. The books used will change as the children grow older: they will be more categorised, including e.g. mealtimes, places...subject categories; they will facilitate using a wider system of vocabulary once the child is ready to use it; they will have 4 colour coded pictures per page – colours also represent meanings (see Appendix 3).

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20 This assemblage is a reconstruction of my data (rather than ‘raw data’) for two reasons: 1) to bring together fragmented pieces of information that were gathered over a period of time, and 2) to protect the identities of the staff members.
Do the parents use the books at home?
Some parents like this idea but most of them would prefer their children to speak - sometimes parents are either lazy or don't believe that picture books help.

Where do these symbols come from?
There are various symbol systems – staff members have to choose suitable ones and sometimes create new ones or borrow from other systems. Signing should be just one system (there is still diversity - similar to languages in general). Not all parents want/like to sign and workers do not always either - like the children themselves, they prefer speech. Different systems work differently depending on the child (e.g. whether to trust hand or eye movements). One should know the child to make it easier to understand symbol usage; staff members may know the child better than the parents.

Who decides what symbols to put in these books or to use? Experts and parents combine their ideas about the child's needs; the child's needs come from the everyday life societal pool of knowledge.

What are the written words for in the picture books? For adults and some children who learn to read (IQ is mentioned); this is purely a developmental view based approach. However, children are not always interested in learning the symbolic meanings - they may not be mature in that way or maybe simply disinterested, but one has to probe though.

The symbols in the books were categorised logically (see Appendix 3): in the simplest books these could be categories such as mealtimes ('yes' or 'no', food items, and so on) or places (home, nursery, playground), as mentioned in the extract. In the more complex books, they could also be categorised by colour, for example: green representing 'health care', blue representing 'hobbies', brown representing 'family members' and so forth.

The books were creatively designed by the nursery staff, who had consulted the parents, and the changes in the books took place when they felt that the child was ready to learn more symbols. It was noted that it helped when the adults knew the child well. Including symbols for body parts in the books was, to an extent, a sensitive issue, because of the various connotations they may entail; however, this was not a routine concern in the nursery.

In the nursery practice, it was stressed that children had to be taught symbolic meanings, in the form of abstractions. In the extract, it is acknowledged that the
teaching and learning processes were tedious, not just for the child but also for the parents and workers, who sometimes just stopped trying altogether. For example, the child might be frustrated if the earliest picture book is too simple to express those ideas he/she wishes to communicate; on the other hand, a new book with a more complex structure may also be frustrating to teach and learn for different reasons.

Even though staff members explicitly stated that the rationale for using picture books was based on the somewhat ‘scientifically proven’ developmental view of children’s symbolic understanding, the actual construction of the books drew on a general ‘societal pool of knowledge’. This is an example of how expert knowledges merged into more everyday knowledges.

In the ‘Children’s Centre’ picture books were mostly used to replace ‘missing’ speech. They were socially constructed ‘texts’ that were meant to establish links between reality, the child’s mind and the adult’s mind; the success rate in this was judged in terms of the child’s overall development. Since the children were very young, it was obvious that other people constructed the books for them. The extract indicates that this construction process was seen as being easier for people who knew the child – his/her needs’ - best. As I interpret this comment, ‘knowing’ the child was, thus, a joint project, where specialist input alone did not suffice.

10.3 Conclusion

This chapter has suggested that communication was an important institutional objective in the ‘Children’s Centre’. Children’s communication was first and foremost treated as a skill. If children were perceived as lacking certain skills – phonetic, vocabulary, understanding and so on – the staff had duties to work on the impairment. Sometimes the ‘corrective practices’ were quite structured, such as in speech and language therapy; at other times they would be incorporated into free play and other everyday activities.

Children in the setting were expected to speak, or communicate via AAC, in a certain way. By this I mean that culture-specific social conventions for ‘good’ communication were a routine element of education and therapy: it was the staff
members’ duty to pass the 'societal pool of knowledge' on to children. Moreover, a particular view of social communication was a salient element of nursery objectives: joint activities, interaction between children and talk/signing whenever possible were encouraged.

In the nursery, targeting communication was a central part of all activities. Speech and literacy skills were emphasised in education and therapy: children were straightforwardly taught words, or symbols to replace words. The importance of certain words over other possibilities was visibly manifested, especially in the individual picture books. In these books, which I understood as socially constructed 'texts', preferences for abstractions and understandings of what each individual child was like were brought together.
PART 4: DISCUSSION AND CONCLUSIONS

In Part IV, I will discuss the findings, and draw the thesis to its conclusion. Chapter 11 reviews the findings in the light of the sociological theories that were outlined in Parts I and II. Following my own advice on 'doing' reflexive research, Chapter 12 continues the discussion that started in Part II. Chapter 13 concludes the thesis, with some ideas for future research on 'communication/difficulties'. 
Chapter 11.

DISCUSSION: THE SOCIAL CONSTRUCTION OF YOUNG (DISABLED) CHILDREN’S ‘COMMUNICATION/DIFFICULTIES’

11.1 Introduction

I will now discuss the findings in light of sociological theory. The title of this Chapter is meant to stand for what my discussion aims to bring together under the term ‘social construction’. First, I regard ‘good communication’ and ‘communication difficulties’ as social constructions. Second, I connect these constructions to the discursive features of ‘Childhood’ and ‘Disability’, bearing in mind that the children in my study were young, but not necessarily ‘disabled’; nevertheless they were all participants in clinical/therapeutic encounters.

In section 11.1.1 I will summarise my findings from the two settings. This Chapter then talks about social construction of ‘communication/difficulties’ on both discursive and everyday interaction levels. Section 11.2 relocates my data on young children’s ‘communication/difficulties’ in the context of current moral-pragmatic discourses in the UK (England). I argue that certain dominant discourses, when translated into social interaction in the two settings, drew on notions of ‘good communication’ as a skill, right and need and ‘communication difficulty’ as an object of specialist action.

In section 11.3, I intend to deconstruct the above notion of ‘good communication’ with regards to my data. I will discuss how understanding and treating ‘good communication’ as a medium and objective in the two settings was connected to rationalist assumptions about the human mind. Yet communication - in other words, meaning making - between adults and children (and between children) was contextual. This finding challenges the primacy of verbalism and abstractions within hegemonic ‘adult’ models for communication.

The knowledge/power of the expert in this research manifested itself in the social construction of ‘Childhood’, ‘Disability’ and ‘communication/difficulties’. Section
11.4 considers this in terms of ‘techniques for knowing’. With reference to specialist ‘reading’ and ‘writing’ processes, I will discuss the significance of decision making being in the hands of the clinical/therapeutic expert. The juxtaposition of the ‘scientific’ with the ‘socialness’ of human interaction aims to deconstruct specialist epistemologies, in terms of how they operated in the ‘Team Service’ practice in particular.

In section 11.5, I will return to powerful societal discourses on the necessity of communication for a ‘good’ life. I argue that the pathologisation of ‘communication difficulty’ may contribute to disablement of young children in that it normalises and gives priority to some skills over others. My findings have indicated that, typically, discourses for good practice involve preferences for ‘rationality’, which permeated relationships between experts (subjects) and children (objects). I suggest that my findings in the two research settings, can, in this respect, be generalised to other arenas of ‘child centred’ action in western societies.

Sections 11.6 and 11.7 follow on from this, by addressing the practical difficulties that the ideal of ‘meeting children’s needs’ poses to health professionals. This is to acknowledge that changes in child law and other societal discourses do not easily translate to practice. However, it would be too short-sighted to simply blame the professionals. Instead, I suggest that the notions of children as ‘agentic beings’ are beset with ambiguities, which childhood sociology has not yet resolved (Lee, 1999). This, in my view, has profound implications for child protection work, as well as everyday ‘child centred’ practice.

11.1.1 Summary of findings

The ‘Team Service’

In the ‘Team Service’ practice, communication was perceived as a measurable skill. ‘Normal’ communication was defined using developmental parameters, where language played a key role. ‘Communication difficulty’ was treated primarily as a mental and/or physical pathology that could be identified by clinically trained experts.
The ‘Team Service’ practice was decision orientated. Decision making typically involved negotiation and selective descriptions of the child. The practitioners retained their authority over lay perspectives. Their expertise involved the use of specific tools to explain aspects of reality and to generate a ‘scientifically proven’ reading of the child. Decisions were connected to action via texts such as case reports, which were an outcome of social construction work.

The assessment setting was a different context from the child’s other everyday experiences. It was structured by adult-led activities, and the child was expected to follow the adult logic. The assessments typically involved so-called standardised tests; yet the child’s performance was subject to situational adult interpretation. They frequently featured individual Team members’ sociocultural preferences for ‘good communication’ and ‘normality’.

The ‘Children’s Centre’

In the ‘Children’s Centre’, communication was perceived as the process of transferring messages between actors via words or symbols in particular situations, where it was appropriate. Communication was seen as vital to, for example, choice making, and as a choice maker, the child was expected to be a rational actor. Yet the choice making situations revealed the ambiguous character of meaning making via abstractions. Furthermore, at other times, it was ‘all right’ for the child to be ‘irrational’. As a communication event, choice making was on the adult-led therapeutic and educational agenda.

Children’s communication was treated as a ‘skill’ that could be improved. Any ‘difficulties’ in communication skills were addressed with various ‘corrective practices’. Children were actively encouraged to speak and develop literacy skills whenever possible. Furthermore, children in the nursery were expected to speak, or communicate via AAC in a certain way. Culture-specific social conventions for ‘good communication’ were a routine element of daily practice.
11.2 The place of children’s ‘communication/difficulties’ in the landscape of moral-pragmatic discourses

In view of the practice literature that I reviewed in Chapter 2, work with children in the two research settings followed contemporary recommendations for good practice. The explicit understandings of children’s ‘communication/difficulties’ drew on moral-pragmatic discourses, the purpose of which was to identify and meet children’s perceived needs. In both settings, communication was treated as a skill, which some children lacked to some extent because of developmental or other ‘difficulties’. Thus these children were in need of professional intervention, in the form of assessment, therapy and/or education.

11.2.1 The ontology of ‘good communication’ as a skill, right and need

Chapter 2 described how dominant practice discourses on communication presented it as the essence of human life (Glennen, 1997; Phillips, 1998). These discourses suggested that, legally and ethically, a professional’s duty is to enhance the child’s communication skills and promote a positive self-image as an effective communicator. This was seen as beneficial for the individual - in both the short and long term - in terms of what society can offer to them.

By and large, these discourses draw on developmental psychology, within which I distinguish two different ways of understanding ‘good communication’. First, there is a hegemonic discourse, which positions language as playing a central role in child development. Figure 1 (in Chapter 2, p. 18) illustrated Cooper’s (1978) model of children’s language development, which conceptualises language as a vehicle for thought. Models like this construe the ‘normal development’ of the child’s communicative skills evolving from pre-language and situational understanding to symbolic understanding. The Piagetian theory of child development has been influential in this respect with its emphasis on developmental stages that children go through (Jenks, 1996).

Second, there is a more recent, although, as it appears, less influential trend within developmental psychology, which understands children’s communication as a
multiplex phenomenon (Bishop & Leonard, 2000). This view stresses that vocabulary and speech is often overemphasised as a measure of communication skill: language is seen as only one part of the overall picture of child development, and that recent research shows considerable variation within the ‘normal’ range (Law, 2000). This poses a challenge to, for example, Chomsky’s grammar-based theory of children’s language development.

I argue that in the two research settings, ‘good communication’ was fundamentally treated as a cognition-based skill along the lines of the above hegemonic discourse. In the ‘Team Service’ setting, children’s speech was explicitly compared to developmental standards. The practitioners would come up with a numerical score for the child’s developmental age, of which speech and language were regarded as a central part. When the child was perceived as being ‘up to’ a standardised test, his/her skills were tested on the basis of measures of ideal-typical average ability at a certain age. Children at pre-language stage were often assessed with less verbal tests than ‘more cognitively able’ children, who would, for instance, complete sentences, or repeat complex sentences. Sometimes standardised tests were not used at all, if the child was seen as being either too young or too ‘disabled’.

In the ‘Children’s Centre’, teaching communication skills to children was an explicit objective. Speech, signing and the use of picture communication symbols were the dominant forms of communication that were practiced with children both within everyday social interaction and therapeutic intervention. Since literacy training (AAC) was central to the work of the nursery, I argue that in terms of ‘good communication’, there was a preference for symbolic exchange.

In terms of children’s perceived rights, the notion of ‘good communication’ also features within the discourse of consultation. This discourse promotes personal choice and control, the child’s right to information and to freedom of expression, and, when appropriate, having his/her wishes and feelings listened to (Morris, 1999). In a similar vein, in both settings, communication skills were understood as a need. In the ‘Children’s Centre’, signing and the use of picture communication symbols were examples of efforts to ‘bridge the communication gap’ between adults and children.
with little or no speech. Enabling children to make choices was an important objective in the nursery in this respect.

11.2.2 ‘Communication difficulty’ as an object of action

Practice literature has suggested that developmental discourses constitute ‘communication difficulties’ both as societal and personal problems, and well-delivered early intervention is seen to have long-term positive influences on children’s lives (Glascoe & Sturner, 2000). This research has specifically studied ‘communication difficulty’ related expert intervention in child assessments and speech and language therapy. The former focus has explored the identification process for ‘communication difficulties’, and the latter has looked at ‘corrective practices’ in post-diagnostic intervention.

My findings indicated some discursive ambiguities in these practices. I argue that the pressure for early intervention and the practical difficulties in diagnosing children under three appeared to be a significant contradiction within the ‘Team Service’ practice. Frequently, in my observations, the child was seen as too young to be reliably assessed using formal tests. At the same time, recent literature suggests that many ‘difficulties’ may resolve of their own accord (Dockrell & Messer, 1999) and early intervention, therefore, might not be necessary after all. Because of the variation involved in clinical criteria for different ‘difficulties’ and the recognition that children do not manifest the ‘symptoms’ in a straightforward way, a lot of ‘cases’ constitute a grey area for the practitioners.

The main ambiguities in the assessments that I witnessed21 revolved around diagnosing complex developmental disorders, distinguishing between different ‘conditions’ and the feasibility of using standardised screening tests. Several times in my observations, the referral had suggested Asperger’s Syndrome (or another ‘disorder’ along the so-called autistic spectrum) as the source of the child’s ‘difficulty’. This suggestion was sometimes initiated by parents, sometimes other

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21 As indicated in Figure 8 (p. 77), ‘communication difficulties’ were a frequent reason for referring the child to the Team for assessment. In my interpretation, the Team carefully considered all possibilities for the child’s difficulties: a complex developmental disorder was one of the possibilities.
agencies, such as primary school teachers or health visitors. In the literature on complex developmental disorders it is recognised that they can be notoriously difficult to diagnose (Attwood, 1998). I observed that, typically, in the assessments the Team members looked for autistic-type symptoms. 'Communication difficulties' sometimes being part of a syndrome, poor social communication skills were pointed out, including, for example, unusual eye contact.

The Team’s role here was to first question the parents about the child’s behaviour at home and then either confirm or reconsider referral concerns. When the parents or other visitors were in doubt about the outcomes of assessments, the practitioners emphasised that their tests were standardised and each child would thus receive equal treatment. The complexities of actually pinning down the label or category for the child’s difficulties were not openly discussed in the presence of parents or me. For example, it was not always certain whether the child had a developmental or language disorder, or a combination of both.

Another challenge in assessing the child’s language ‘difficulties’ were bilingual and/or multilingual children. Recent practice orientated literature on communication difficulties in childhood suggests that bi/multilingualism should not be treated as a disadvantage, and that the child’s skills should not be simply compared to monolingual norms (Martin, 2000). In the ‘Team Service’ practice, it was acknowledged that the Team members could only assess the child’s skills in the English language. However, I observed some sociocultural preferences emerging from the assessments of these children.

In both settings, the speech and language therapist’s duty was to maximise the child’s communication potential. In the assessments, his/her role involved identifying each child’s communicative needs, which required further intervention. In the ‘Children’s Centre’, this role entailed enhancing children’s speech and literacy skills, as well as the use of AAC. Nonetheless, it appeared that speech and language therapy in both settings tended to compartmentalise the child’s skills into different areas, i.e. different branches of the tree (see Figure 2 in Chapter 2, p.18). The whole tree would come into the picture in terms of calculating the test scores and comparing these with
developmental milestones. In speech and language therapy sessions the focus was on a particular ‘weakness’, for example, in symbolic understanding or phonology.

My data analysis suggests that, in both settings, speech and language therapists explicitly drew on medical, developmental and language models (Byers Brown, 1981). I argue that these models essentially located ‘communication difficulties’ in the speaker. Communication was construed as a matter of speech and symbolic understanding, which had to be taught to children. ‘Communication difficulty’ was perceived as a pathology that prevented the child from functioning ‘normally’ and the effects of which could potentially be alleviated by therapeutic corrective practices; i.e. the child needed to be corrected.

I will now discuss what, in my view, constituted ‘good communication’ in the two settings. Drawing on interpretivist, interactionist and integrationist perspectives, I suggest that there are various methods of communication, but that only some of these forms tend to be preferred over others. This is sociologically problematic, and, according to my observations in both settings, fundamentally affects adult-child interactions in daily practice.

11.3 Communication as a contextual and interpretive accomplishment

This thesis proposes that meanings in human communication are ultimately context-bound. In the two settings, they arose from situational interaction and interpretations, although they were at the same time framed by influential discourses and practices that sustained those discourses. This finding not only challenges the ideal of ‘good’ or ‘normal’ communication in childhood, but the feasibility of this normalising ideal anywhere, including various modes of communication.

Bakhtin’s dialogical model of speech communication provides an alternative to the hegemonic monological view. It suggests that meanings are a joint product, and mutual understanding of them requires a certain reciprocity between actors (Graumann, 1995). This rejects certain traditions in the study of semantics, where word meanings, for example, are reduced to their dictionary-like form. It also rejects an atomistic view of the ‘self’ as either sender or receiver of messages, and places
emphasis on the interaction between human actors, including the communication medium (Wadensjö, 1998), which can sometimes be another person, text or a method of AAC.

I discuss these ideas, firstly, in section 11.3.1, which turns to the notion of the ‘fallacy of verbalism’ and preferences for abstractions in how they emerged from my findings. Secondly, section 11.3.2 looks at what implications the understanding of communication as contextual and rational, and ‘communication difficulties’ as socially constructed may have for conceptualising children’s ‘voices’. Finally, in section 11.3.3, I question the feasibility of a child wanting to express his/her innermost thoughts, wishes and feelings in institutionalised contexts regardless of the medium of communication.

11.3.1 The fallacy of verbalism and the ambiguity of abstractions

It is probably safe to generalise that talk and literacy, for many of us, are taken-for-granted skills. The two settings were not exceptional in this respect: children were actively encouraged to talk and develop literacy skills. For instance, nursery workers would label items for children in order to extend vocabulary and teach social communication skills through play. In the nursery, signing and other methods of AAC were practiced with children who had little or no speech. An important purpose of teaching children abstract symbols and conventional literacy was to enable them to develop context-free modes of communication.

Nevertheless, my observations of the two research settings suggest that communication in them was thoroughly contextual. This was because the typical daily events, although patterned and conventionalised in many ways, always involved an element of unpredictability. Although the staff’s roles were to act as ‘puppeteers’, children would employ their own perceptions of the situations in their actions, or there were other situational factors (such as the parental presence) that ‘interfered’ with rationalised plans of action. This was not only the case between children and adults but also between adults. Because of the contextuality, I argue, communication in both settings was often, if not all the time, ambiguous.
The basic problem was that, in verbal or non-verbal communication, there was an underlying although obvious ideal model for transmitting messages, coupled with the expectation that, when the adults so wished, the child would be a rational, intentional being on those occasions. Choice making by using picture cards epitomised the idealisation of ‘fixed’ meanings. Symbols were used as a language: they were treated as part of a system as words are in sentences. Often, in practice, they also came to be used as if they were directly representative of reality (Potter, 1996). I see a connection between this finding and Harris’ (1996) term, the ‘fallacy of verbalism’, in that non-verbal signs were treated as words.

In addition, noise making in the nursery was often attended to in this manner, so as to include non-verbal children in social situations. For example, the workers would ask: “What are you trying to say?” Sometimes they did not pay attention to it, or they deliberately treated it as distracting ‘noise’ rather than ‘good communication’. The adult responses to children depended on the situation: they were by no means consistent. At any rate, I ask: how could they have been? The workers’ situational interpretative work was based on how they felt at the time in terms of what they ‘knew’ about the child.

Thus I argue that meanings, in general, were generated through interactions, which were, in turn, subject to interpretation again. This became particularly apparent in the use of picture communication symbols, as well as during free play sessions, when children would initiate and create their own meanings. Typically, children would creatively mix and match adult-type conventions (such as polite requests) with their own fantasy worlds. Children also expressed their imagination in the ‘Team Service’ assessments, for example, when they interpreted the meanings of pictures in their own words.

11.3.2 Children’s ‘voices’ and the problem of meaning making

I agree with Law et al (2000), who have stated:

“[The] organic ‘tree’ analogy is helpful because it relates the various subcomponents with another in an active sense. Nothing about communication is static either in
I have previously used the metaphor 'sturdy oak versus weeping willow' to describe how something fluid becomes abstract and solid by interpretive action. In this respect, the notion of 'the voice of the child' appears problematic, regardless of whether the child has been diagnosed with 'communication difficulties'. On the basis of my findings, I question the construction of children's 'voices' as coherent entities that can be systematically and in generalisable ways retrieved either through verbal or non-verbal interaction. Unlike in developmental and mentalistic approaches, however, I am not justifying my argument by young and/or disabled children's less developed cognitive functioning or lack of experience alone. Instead, I want to steer the attention to complexities of adult-child interaction in situations where the child's 'voice' was sometimes explicitly on the agenda. I encountered this kind of situations in both research settings.

In my attempt to theorise children's 'voices' in the two settings, I draw on the Bakhtinian point of view, where they are conceptualised as processes rather than locations (Foppa, 1995). This perspective suggests that they never exist in social isolation: meanings come into existence when two or more 'voices' meet. Bakhtin's concept of 'multivoicedness' means that 'voices' do not simply come from an individual's head but are shaped by others in society. For this reason, interpersonal communication is never fail-safe. In this section, I connect my version of this view to both verbal and non-verbal communication in my findings.

I argue that the child's 'voice' in the 'Team Service' setting was fundamentally framed by the fact that the child there was primarily a test subject and in the nursery by the fact that the child was a receiver of care, therapy and education. Furthermore, in the nursery, efforts were regularly made to 'bridge the communication gap', whereas with the 'Team Service', listening was not built into the assessments as such. In both settings, I argue, the child's 'voice' was attended to if and when an opportunity arose and when it was allowed for by the professional adult agenda.²²

²² Sometimes this involved child protection concerns; however, for confidentiality reasons, I have not detailed these situations in my data.
Teaching ‘social communication’ skills as an institutional objective in the nursery is an example of how children’s ‘voices’ were addressed in daily practice. During circle times, children were encouraged to learn skills, such as turn taking and polite manners. They were also encouraged to express their opinion, either verbally or via picture communication symbols or toys. The staff told me that disabled children were often passive: active participation in social life had to be taught to them. Here I perceived children’s ‘voices’ and communication being understood as social and assertiveness skills.

Recommendations for this kind of practice can indeed be found in recent literature commenting on the place of communication skills in the current National Curriculum in Britain. Circle times, for example, are seen as opportunities for children to ‘talk’ in a safe, fun and supportive environment (Phillips, 1998). I observed elements of this ethos being applied to both verbal and non-verbal children during circle times. All the children were addressed in the same way, to choose a song for example. Picture books were sometimes used so that non-verbal children could ‘talk’ about what they did at the weekend, for instance. Obviously, the ambiguities that I have already described in the use of picture communication symbols were present here as well. Hence I often equated ‘stimulation’ with ‘simulation’: non-verbal children were stimulated to express their ‘voices’, although the interaction typically simulated talk-like conversation. Nevertheless, this practice entailed the philosophy of inclusion, and therefore followed recommendations for good practice.

Another typical feature of adult-child interaction in both settings involved what I call a question-answer model, where the adult asked the questions and children were expected, for instance, to make a choice or give a correct answer to the test question. This practice might at first appear as something perfectly commonplace in that, as I think is safe to say, adults typically talk to children like this in everyday life. However, I argue particularly that non-verbal children and children in assessments had little chance to reverse these roles. For instance, in assessments, children’s interpretations and questions about pictures were not obviously taken into account (see e.g. Gardner, 1998).
In the nursery, children’s individual picture books were crafted according to their perceived needs. This framed the ways in which they could express themselves, provided that they had first learned the meanings of the symbols. Nevertheless I argue that because of the ambiguous nature of the use of picture communication symbols, they were not necessarily the best medium for communicating about abstract and sensitive topics such as abuse. As Oosterhoom & Kendrick (2001) have found, there can be some completely different subtle ways of finding out about abuse, but this can only be realistically possible over a longer period of time.

Even though difficulties in using AAC have been acknowledged in recent practice oriented literature (Millar & Scott, 2001), some problems still seem to remain unresolved. For example, it has been suggested that methods of AAC may to be learned by communicating in meaningful situations. This, in my opinion, makes it difficult to talk about sensitive topics, things that have happened in the past or things that simply are out of context in some way. As Scott (2001) has argued, for younger children it is sometimes hard to make a representational leap between a symbol and what it represents in the ‘real’ world. In this literature it is also acknowledged that any technology cannot simply replace speech or remove impairment: yet, in my observations, picture communication symbols were used as if they could do just that.

11.3.3 Children’s ‘voices’ and the problem of ‘subjecthood’

I thus propose that even though the ethical purpose of listening to children was a recognised part of the nursery’s work, children’s ‘voices’ and meanings were ultimately interpreted by adults. This idea surfaced particularly when two or more adults interpreted the child’s behaviour at the same time and came up with different retrievals. In situations like this, notions of communication as a medium and an objective became blurred. The staff attempted both to give the child choices and teach the meanings of picture cards; however, it was not always clear whether the child had made a ‘genuine’ choice or learned the ‘fixed’ meaning of the card. It was often hard to get the child to focus on choice making – for one situational reason or another. In fact sometimes, during meal times, the workers would bring in the actual food items, when picture cards ‘didn’t work’. Nonetheless choice making remained ambiguous, despite the workers’ patient efforts to listen to the child.
The same ambiguities prevailed within verbal exchanges between children and adults. For example, if a child expressed a ‘need to wee’, it was not necessarily taken as a credible statement. Indeed it appeared that the workers had to make situational judgments of children’s meanings and needs, based on what they knew about the child in terms of past or present experience. They also typically distinguished between what they perceived as ‘reality’ and children’s make-believe world, and whether it was appropriate to resort to one or the other.

I would like to note that there was often a practical reason for addressing children like this, including, for instance, attempts to manage a number of children in a group or prevent accidents. After all, it was the adults who had responsibilities over what happened in the setting. I stress that I am not jumping to the simplistic conclusion that choice making by adults was inevitably detrimental to the child. This was clear in terms of the child’s daily needs, such as being fed. At any rate, the expectation of the child to be an active and purposeful choice maker has implications for perceptions of the child as a communicator.

It therefore seems that the notion of the ‘voice’ connotes the idea of clear thought/opinion in an individual’s mind that he/she wants to express to others. In a similar vein, Lee (2000) has talked about child witnesses in court, who, since the 1991 Criminal Justice Act, have been provided with the possibility of giving their evidence to the court through the medium of pre-recorded video-recorded interviews with them. For Lee, however, rather than simply turning the child into a ‘speaking subject’ (p.149) like adults, the video medium enables children to perform a particular kind of subjecthood’. This ‘subjecthood’ is equated with the notion of a one-dimensional, rational and intentional actor.

Other studies have described the use of AAC, with both adults and children, in a similar fashion. For Moser & Law (2001) communication aids play a role in what it is to be a competent person in contemporary Western societies. Methods of AAC are intended to give disabled people a ‘voice’ that others can hear and reflect the desires, concerns, needs and abilities of each person. Then again, the ways in which they are usually designed assume that the user is a modern rational technologically ‘adapted’ subject who is able to distinguish instantaneously between discrete and hierarchical
options. In addition, the options provided within the capacity of any type of communication aid are limited - giving one 'voice' takes away another and centres the subjectivity on 'preferred' needs. Passivity, for instance, is not an option: one has to be an active and competent, decision making, rational subject.

In my observations, this kind of 'subjecthood' also surfaced in speech and language therapy sessions, where the main objective of action was to teach skills: communication as a medium did not feature there as much as in other situations. This is an example of how the adult framework set the parameters for how the child could 'communicate'. The idea was to match the child's mind to that of the adult, who was in charge of the situation. Children were expected to understand and follow the rules of the game.

As literature suggests so far, there are no reliable methods available for exchanging messages of this nature with very young children. On the other hand, this is not necessarily a matter of neglecting the child's right to express him/herself: it is about a practical difficulty of interpretation. I am also asking who claims the right to interpret the child's intentions in settings outside the family, such as clinical/therapeutic settings, and why parental interpretations of them may be downgraded. At the moment, the expertise in this area, particularly in the case of disabled children, lies in the hands of the Medical profession. In the next section I will address the knowledge/power of the clinical/therapeutic expert and how it operated in the two settings.

11.4 The 'scientific' and 'social' elements in specialist knowledge and practice

The epistemology of medical reasoning is an important topic of investigation, since it can have a significant impact on a person's life – and, sometimes death. In common sense thinking, we expect health professionals to 'know' and solve practical problems. Yet certain theories underlie their knowledge, and theories change over time. A distinction can be drawn between medical scientists who generate knowledge and practitioners, who are the consumers of knowledge (Rochel De Camargo, 2002).
This section looks at how knowledge about children's 'communication difficulties' was generated and consumed in clinical/therapeutic practice. I have drawn on both philosophical/theoretical considerations and empirical studies for this purpose. First, certain sociological 'schools of thought' — Foucault, the sociology of scientific knowledge (SSK), ethnomethodology — have provided me with lenses through which I view the problems of knowing about and representing reality. This is because they all share an understanding of aspects of 'reality' as being socially accomplished, represented, (re)constructed and reflected upon in talk and (inter)action.

My findings have suggested, as for Holland (2001), that in spite of a tendency for social work rhetoric to claim that children are at the centre of their work, the children in these assessments in fact tend to be represented as objects rather than as subjects. Especially young children's behaviour is observed and understood through the professionals' knowledge of developmental charts. In other words, children are known and portrayed through a developmental 'gaze' (p. 334). For Walkerdine (1993), this calculating and classificatory gaze produces the very object it claims to describe.

Holland's (2001) studies of child protection assessment have indicated that developmental charts imply a rational, scientific measurement of behaviour. However, much of the terminology can be seen as value laden and culturally specific, in that they delineate what is 'normal', 'appropriate' or 'realistic' behaviour. In sociology, this is not new. At the same time, White (1998) has noted that despite the critiques of developmentalism in academic literature, there is little evidence of scepticism among practitioners about the 'validity' and purposes of their practices.

I argue that, particularly in the 'Team Service' setting, discourses about child-objects manifested themselves in 'case histories' (Gillman et al, 1997). These 'texts' consisted of a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events (Smith, 2002). Indeed:

"Everything exists in a fuzzy and fluid state until crystallized in particular texts or particular interactions" (Potter, 1996, p.103).
This refers to the idea that experts’ decisions are not merely simple outcomes of tests or observations. On a textual level, the notion of ‘social construction’ in this thesis emphasises that descriptions are human practices, and that they could have been otherwise (Potter, 1996). This is an important consideration because, regularly, it is in the interest of relatively powerful groups that some discourses and not others receive the stamp of ‘truth’ (Burr, 1995).

In my data analysis, I have posed the following questions about clinical/therapeutic work: What is it about expert, scientific knowledge that sets it apart from ‘non-scientific’ knowledge? What does scientific knowledge production consist of? Who are the actors and what competence do they have? How do the actors achieve agreement (Callon, 1995)? In this section, I will discuss established clinical/therapeutic understandings of what can be known about children through ‘scientific’ methods, and the ‘socialness’ of this practice.

My findings have highlighted what may be called the ‘messiness’ of everyday scientific work (Gilbert & Mulkay, 1984), with the conclusion that clinical facts result from social construction processes. The ‘science’ of clinical/therapeutic knowledge tended to be emphasised, particularly in the ‘Team Service’ setting. Central to the assessment practice was the clinical/therapeutic ‘gaze’, which was justified by its scientific merits. I make a connection between this ‘gaze’ and the so-called essentialist perspective within science, which assumes that scientific knowledge is determined by the physical world, and that aspects of this world can be known through observation, carried out by actors with appropriate skills (Woolgar, 1988).

The ‘Team Service’ practitioners drew upon empiricist epistemologies, which typically involve standardised and systematic fact finding procedures (Potter, 1996). Similar findings have emerged from other recent sociological studies on medical settings, which have described how scientific epistemology of the physical world has been applied to practice. These studies have described medical work in terms of the use of clinical criteria, protocols and test materials; all of which allow for verbally or numerically quantifiable output (Berg, 1997).
In this section and the next, I will discuss the process-like character of the Team’s construction work, which aims at a diagnosis or a decision within a specified time span. I argue that ‘knowing’ the child’s communication skills took place through what I call the practices of translation (Berg, 1997), in other words, specialist reading and writing practices, where the clinical gaze and verbal accounts (written and spoken) turned aspects of ‘reality’ into manageable objects of action.

11.4.1 Carving out the ‘difficulties’

In the same way as illustrated in Figure 3 (p. 23), the ‘Team Service’ work followed certain established procedures for intervention. In Chapter 7 I described the assessment process in how it typically unfolded. In the planning and preliminary meetings, this process started off with ‘setting the scene’, where the plan of action focused on core concerns, such as ‘communication difficulty’.

I have argued that the initial accounts entailed a great deal of selectivity, stemming from referrals, and considerations of whether the ‘problem’ was something that belonged to the expertise area of the Team. Accounts were also subject to selections in terms of who provided them. In general, the Team members trusted in each other’s accounts, and if they did not, they would negotiate or argue. A definite line, however, was drawn between those who were experts and those who were not. Observations and tests were then employed either to prove or disprove the initial ‘hypotheses’ that the Team members constructed during the planning and preliminary meetings.

Holland (2001) has found similar procedures taking place in specifically child protection focused assessments. She argues that ‘information’ about the child was mediated through the representations provided by the social worker, for instance, in the narratives from home visits. In most of the assessment reports in this study, children were in fact minor characters in the narrative, whereas parents were often portrayed in a detailed manner. In other words, the social worker selected aspects of family life and reassembled them into a bricolage, where children were positioned as objects of adult actions.
In this respect, the phenomenon of ‘summarising’ (Berg, 1997) was central to the Team work. With each new child, information from diverse sources was transformed into short statements of ‘what is the case’. In the case reports, the information gathered from tests, Team members’ talks with the parents and previous case records was condensed, to create a concise statement of the ‘current problem’ and its relevant history. When the child’s situation was re-evaluated, the entries made earlier are taken as the ‘grounds’ upon which the next evaluation proceeded. These statements were stripped of their situational uncertainties and the specific context in which they emerged.

In this way, for Berg (1997), decisions about patients are spatially, materially and temporally distributed. The temporal distribution of decisions, however, may not always be apparent. Yet, within ‘Team Service’ practice, lines could be traced back to previous negotiations about the child: ‘feelings’ became conclusions, and previous steps were undone, changed, or simply discarded. In other words, an image of orderly and systematic work leading to decisions is portrayed by the production of ‘rational’ and ‘typical’ narratives. This is where the fluid nature of the ongoing heterogeneous medical work disappeared. However, this was necessary for the process of making the child’s problem manageable.

Berg (1996) has found Medical Record to be a fundamental constitutive element of medical work. He has defined it as an artefact, which mediates the social relations in specific contexts through practices of reading and writing. Another important organising principle in clinical/therapeutic practice is the ‘Protocol’ (Timmermans & Berg, 1997). The Protocol, as a link between knowledge and practice, functions as a crystallisation instance. Problems may arise when protocols make something appear universal and standardized, thus steering the attention away from the local and situational. Hence, instead of seeing ‘Protocols’ as straightforward guides for action, they can be defined as outcomes of negotiations between actors and agencies.

Since all Team members could not always be present in the assessments, or record everything that happened in great detail, they often had to rely on each other’s accounts, and trust these accounts. For this reason, I argue, texts, such as case reports, were of primary importance as mediators between the child and the decision makers.
in the social construction process of ‘communication difficulty’. I agree with Knorr-Cetina in that ‘scientific’ procedures were constructive and descriptive, rather than simply ‘reporting’ features of the world out there:

To the constructivist, in contrast, “rather than considering scientific products as somehow capturing what is, we will consider them as selectively carved out, transformed and constructed from whatever is. And rather than examine the external relations between science and the ‘nature’ we are told it describes, we will look at those internal affairs of scientific enterprise which we take to be constructive” (Knorr-Cetina, 1981, p.3).

I define clinical/therapeutic epistemology and practice as a matter of ‘literacy’ instead of ‘knowledge’ since the latter implies some kind of privileged access to reality. By the former term I mean that Team work consisted of reading and writing practices: the act of ‘reading’ included both the literal activity of reading ‘texts’ (Smith, 2002), as well as observational gaze and the interpretations of the child. In another sense of the word, ‘reading’ also meant the act of meaning making through observation.

The process of report writing in assessments started from initial jotted notes and gradually developed to a coherent narrative. At the same time, this was a transformation from personal thoughts to public knowledge: from a vast amount of details to a concise output. The established criteria for professional reports involved ‘readability’ and ‘relevance’ in relation to the proposed audiences of the report. Relevant points were actively selected out of the multitude of possibilities according to clinical criteria for ‘communication difficulties’. In short, the selections were fundamentally interactional accomplishments.

11.4.2 The ‘gaze’

Although a widely used method in clinical work, observation can be rendered a problematic way of ‘knowing’. For a constructivist, the core of the epistemology of scientific observation is that it sees things as something: the categories are not some neutral and abstract set of descriptive pigeonholes but are derived from theories and belief systems. However, for Chalmers (1999), what observers see, the subjective
experiences that they undergo, when viewing an object or scene, depends on the experience, knowledge and expectations of the observer.

In the essentialist view of science, the scientist’s competencies are typically assumed to be sensory and cognitive:

“The scientist must be capable of articulating statements that integrate her observations. S/he is thus dependent on her five senses, and particularly on sight (observation is always mentioned). The scientist must also be capable of imagining statements that are not directly linked to observation and of introducing translations between them” (Callon, 1995, p. 32).

Indeed empiricism and positivism share the common view that scientific knowledge should in some way be derived from the facts arrived at by observation (Chalmers, 1999). It is assumed that facts are directly given to careful, unprejudiced observers via the senses and that they occur prior to, and are independent of theory. This assumption is based on the belief that a human observer has more or less direct access to knowledge of some facts about the world insofar as they are recorded by the brain in the act of seeing, in other words, two ‘normal’ observers viewing the same object or scene from the same place will ‘see’ the same thing.

The notion of rational activity, as part of the scientist’s role as a ‘knower’, also rests on the capacity to make credible decisions. The scientist has to have the ability to justify why one statement – selected out of a variety of sometimes contradictory theories – is to be preferred to another in a particular context. For Callon (1995), scientists base their judgments on the belief that there are explicit and shared standards, whether these standards are hypothetical, categorical or based on conventions.

In a similar vein, Aronsson et al (1995) have talked about ‘the voice of medicine’ as a form of scientific discourse, a scientific, biomedical frame of reference, within which problems are understood and interpreted. Significant discursive features of this voice are ‘affectively neutral, functionally specific, context-stripping questions and responses by physicians’. Furthermore, there is a focus on ‘objective parameters’ of
the situation that isolate symptoms from patients’ more general problems and life-world experiences.

In the Team assessments, the ‘gaze’ was used in the above, essentialist sense. A practitioner’s question to me - "What do you see that we don’t?" - implied how the Team members drew the line between their knowledge and those of other people. The practitioners seemed to assume that there was not much else to see than what the clinical/therapeutic gaze allowed for, and that the nature of that ‘gaze’ was more accurate than a lay person’s gaze. The Team members were adamant in this assertion, whenever it became an issue, even though, at the same time, they did not always agree with each other.

11.4.3 Standardisation

Another ‘scientifically proven’ justification for Team work was its standardised nature. I argue that an ultimate manifestation of standardisation in assessments was testing. Tests involved certain tasks that the child was expected to accomplish in a required manner under adult instruction. When the child did not achieve these requirements, the Team members tended to look for reasons for his/her ‘difficulty’ within the child or the family, and, again, selected clinically relevant pieces of information that was available from the child’s past. The assessments worked on the basis of a ‘normal range’ of communication skills. As a result of planning and preliminary meetings, the Team members then selected which tests to use. The ‘scientific’ action in assessments was constructed around what were perceived as observable and ‘testable’ characteristics of the child. These involved, for instance, eye contact, as well as quality and quantity of language use.

For Andersen (1994), tests are a construction of Western psychology, where they have been used for practical purposes, validated by ‘the aura of hard science’. Typically, testing is based on the notion of a self-contained individual, who ‘does abstract problems in his head’. The test subject is expected to be in an ‘optimal’ state and the tester assumes that all variables but one - the individual capacity - must be controlled:
"The test ‘subject’ has the passive and reactive role, more of an object than a subject, an object that must produce isolated responses on demand, rather than a subject that interacts with his or her world in ways which reflect the choices and self-reflection of an agent in charge of his or her reality. The test subject is to sit still, pay attention, listen carefully to a stranger, follow all directions given, keep one’s mind focused on the task at all times […] The tester, on the other hand, is clothed in great institutional power and authority […], commanding the situation, giving instructions, coding the responses as good or bad, right or wrong. The tester, of course, controls all the information obtained in the session, writes up the test results, with the authority to transform the responses obtained into […] a test score” (Andersen, 1994, p.128).

Some may argue that not all variables could be controlled: the entire context must be considered, including the roles, the thoughts, and the setting as well as the expectations of the participants (ibid). For Andersen (1994), a good training ground for taking IQ tests would be to live one’s childhood in the typical environment of an affluent, middle-class family where there are many books and toys, but especially one where the family sits down together each evening for dinner. It became evident in my data that middle-class values like this occasionally surfaced during the ‘Team Service’ assessments.

Standardisation in the assessments also involved regulated use of time and quantification processes, both in terms of the child’s biological and developmental age. Children were assessed for their success in accomplishing tasks at a certain rate within a specific timeframe. They were expected to follow adult instructions at certain times, but take initiative in play and express themselves at other times. This contextually managed time was then compared to what the child ought to be capable of at his biological age. Overall, interactions during the assessments followed a certain timetable, which framed the ways in which the adults could co-ordinate their interactions. They then attempted to incorporate the child’s actions into this ‘system’ by the Team, one way or another.

Furthermore, I observed that standardised as well as non-standardised test materials typically allowed for interpretations: only Team members would have specific meanings for certain toys, pictures, and ways of addressing the child. The parents
would regularly notice this, as my findings indicate. The child’s interpretations were not typically taken into account in my observations.

Quantification was another standardising feature of assessment and report writing in that it made the child’s skills comparable across space and time. My findings indicated that quantification of communicative skills drew on ‘the sturdy oak’ model, measuring the ‘degree’ of the child’s problems, according to established parameters for normality. Eye contact is an example of a communicative feature to be measured in assessments. Individual remarks on its ‘normal length’ were made and its meaningfulness was then retrospectively evaluated and negotiated about in the meetings. The Team members tended to be careful in which particular words were used; for instance, describing the child’s eye contact as ‘atrocious’ was something that ought not to be written down in the final reports.

I argue that understandings and uses of time and quantification had implications for the notion of the ‘accuracy’ of the gaze. For example, during the assessments, the Team members would often chat or go in and out of the room. In other words, they were not observing all the time. When they left the room, they would say to me that they had ‘seen enough’, in terms of what they thought they needed to know about the child. Since the Team members had by no means observed everything, it seems plausible to argue that their attention was inevitably selective. This assertion, however, is not meant as a criticism. My point is that whilst a practitioner was focusing on one thing, she could not register everything else as well, such as the child’s ‘muscle tones’ or ‘social communication skills’ at the same time. On a surface level, teamwork was expected to bring different pieces of the mosaic together in this way. From my sociological point of view, however, this is an example of how ‘communication difficulties’ were outcomes of social construction processes, which fundamentally involved selections, albeit regarded as standardised procedures.

11.4.4 ‘Communicative repertoire’

In child assessments, I frequently recorded statements of stereotypical thinking or personal preferences, although all the Team members did not necessarily agree on these. Normative value statements revolved around the nature/nurture distinction, and
involved judgments of 'normality'. These statements often emerged in the context of distinguishing the child’s personality traits from symptoms of ‘disorders’. I observed this happening in relation to the child’s socio-economic and cultural background, in terms of what I have called ‘locally appropriate’ speech.

For Keating (2001), each speech community (such as native English language speakers in Britain) is recognised to have a repertoire of language codes and ways of speaking. This includes all varieties, dialects, or styles used in a particular socially defined population, and the constraints, which govern the choice among them. The notion of ‘communicative repertoire’ refers to patterned ways of speaking. It also includes non-verbal communication, although it is recognised that this varies from one individual to another.

In both settings, I observed a particular ‘communicative repertoire’ being rewarded. I argue that this became very apparent in the assessment of bi- or multilingual children. As expressed in Chapter 2, these children often mix languages; in other words, their languages are not separate entities. Obviously this might make their speech incomprehensible to other people than their carers; hence, I assume, children like this were referred to the Team for other reasons than difficulties in learning a foreign language. Yet their performance in the English language was judged by monolingual standards.

Moreover, my data indicated that sometimes the pressures of early school entry age in Britain and for early intervention to detect complex developmental disorders caused problems between the Team and these children’s families. The contexts of the use of different languages were not considered in assessment room based testing. The visitors, in particular, tended to stress these children’s ‘maladjustment’ to the school environment, and expected the Team to find solutions to this problem. However, I argue that this was a prime example of what I call the ‘disablement’ of young children. I will now turn to the wider societal discourses on this matter.
11.5 The pathologisation of ‘communication difficulty’ and the disablement of young children

I have noted that, in addition to academic disciplines and child welfare practice, behavioural and other childhood syndromes appear to be a topical matter of controversy in the British media as well. There are frequently debates on the fact that the number of children registered with ‘special needs’ has almost doubled over the last decade (see e.g. Owen, 28.7.03, p.3). Some argue that this is because psychologists are keen to ‘make a quick buck’ by diagnosing the child with a behavioural syndrome, whereas in fact neglectful parents may be to blame (Alderson in ibid).

For Talbot, on the other hand:

“Childhood these days is often a land of diagnoses. Detours from the developmental path can easily get a kid tagged with one new syndrome or another. And as far as many parents [and clinicians] are concerned, this is an unmitigated good. These parents [...] are grateful to have an explanation [...] and are relieved to know that they are not alone. We don’t hear quite as much from parents [or clinicians] who react to such labels with tortured ambivalence, who wonder whether their child’s individuality has been reduced to pathology and what might be lost if it has” (Talbot quoted in Paul, 2000, p. 205).

This statement captures my attitude to this research project: ‘communication difficulties’ are real for children and their families. Hence this thesis does not simply dismiss or overlook the relief that a diagnosis or decision, or the subsequent intervention, can bring to all parties concerned. Nonetheless, what I am trying to do here, though, is to understand why ‘communication difficulties’ these days are regarded as social and individual ills to such an extent, and why Medicine and associated professions have assumed a monopoly over these matters. In section 11.5.1 I discuss pathologisation in the context of the knowledge/power of childhood disability experts; and in section 11.5.2 in the context of socialisation of children towards ‘adult rationality’.
I agree with Durham Peters (1999), for whom the discourses on 'communication' of our time are a technical one about information theory and therapeutic one about communication as cure and disease. Across the human sciences, children's communication is typically constituted as a matter of 'development' and 'language acquisition' and regarded as inferior to adult speech. In the case of 'communication difficulties', children are made into objects of therapy and correction.

For Cameron (2000), communication is another area where expert systems colonise individuals' lives. This is now explicit in educational and therapeutic practices, where normalising ideologies rule (Fairclough, 1995). In today's enterprise culture and its alleged requirements, somebody's decisions over what it means to be a good person - a 'good communicator' - may have a significant influence on individuals' lives (Cameron, 2000). Another dimension of 'communication difficulties' is that they can be seen as pathologising boys. Since most children referred to the 'Team Service' were boys, an inevitable question arises as to whether 'communication difficulty' is indeed essentially a gender issue. This stems from the discursive preferences for emotional articulacy, interactive skills, and listening skills, which are typically seen as missing in autistic type syndromes, which were also a frequent concern in this setting.

However, along the lines of the above criticisms of hegemonic discourses on 'communication/difficulties', in this thesis, I attempt to conceptualise children's communication as something other than merely a 'skill'. As previously stated, this thesis understands 'reality' as socially accomplished, represented, (re)constructed, reflected upon in talk and interaction (Potter, 1996). I am deconstructing 'communication/difficulties' in the context of 'Childhood' and 'Disability', because those children's lives, who have or are thought to have disabilities/difficulties, are to a significant degree colonised by what I have called clinical/therapeutic practice.

My findings indicate that in the two research settings, 'communication difficulty' was first and foremost located in the speaker or the non-speaker, or his/her family. In the assessments, as in Medicine and Developmental Psychology in general, the child was isolated as an individual 'case'. In both assessments and therapeutic interventions, the
child’s abilities were compartmentalised into different sets of skills, some of which could be ‘corrected’ through individual therapy, social interaction training, ‘better’ parenting or an appropriate school environment. In the ‘Team Service’ setting, practitioners would often explain to me what they were doing and how they knew what was going on, something that a non-specialist would not see. Yet there were times when they admitted they could not understand the child’s speech or non-verbal behaviour. In this respect, the practitioners placed the problem with the speaker rather than with the ‘listener’.

This finding resonates with the Foucauldian (1973) conceptualisation of Medicine as a mechanism of knowledge/power, whose purpose is to correct and normalise under the guidance of rational reason. In this view, the medical gaze is a technology of that power in terms of how the object can be ‘known’ to the observer, since medical competencies are typically given more credibility than to those of lay people. As implied in Chapter 4, many Disability Studies writers have objected to this ‘medicalisation’ of disabled people’s lives. Oliver, for instance, has asked what is so good about walking:

“If Jenny Morris is right when she says ‘disabled people are increasingly challenging the attitude that says that if you cannot walk, then your life isn’t worth living, and I believe that she is, then that challenge faces us all. As Ken Davis put it, we have to put our struggle to create a decent society above our vain attempts to force non-walkers and nearly-walkers to walk. I hope, in addressing the question ‘What’s so wonderful about walking?’ I have made a contribution to this struggle” (Oliver, 1996, p. 109).

In parallel to this, I ask: what is so good about talking? My contribution to sociological writing on ‘communication/difficulties’ questions the taken-for-granted notion of ‘locally appropriate’ speech, as well as preferences for speech and writing over other means of communication. We may ask whose definitions of ‘good communication’ are being imposed on others. At the same time, I am questioning the sociocultural values that are attached to seemingly objective and neutral practice in the two settings, such as rationality and autonomy. This steers the attention away from evaluation of the quality of practice. Instead, it analyses the interplay between the
everyday constraints and allowances for professional work and powerful, discursive rhetoric in the form of recommendations for good practice.

11.6 The ambiguity of conceptualising the child as a particular kind of agent

As explained in Chapter 4, the 'new paradigm of childhood sociology' involves attempts to understand children as agents - as shaping as well as shaped by their circumstances. The aim of this proposition has been to make a move away from treating children as targets of socialisation processes and thereby merely as incomplete versions of adults (James et al, 1998), as has traditionally been the case within sociology and other human sciences.

This paradigm has posed a strong challenge to Piagetian epistemology, which has influentially shaped our contemporary understandings of the child. The Piagetian approach is here seen as deriving from positivism and rigid empiricism, with its procedures of measuring, grading, ranking and assessment of children. As for James et al:

"Under the hegemony of developmental stage monitoring it is not just iniquitous comparison with their peers which children suffer through testing and league tables, but also a constant evaluation against a 'gold standard', whether in education, bodily development or welfare, the repercussions and sanctions are strong" (James et al, 1998, p.19).

Western childhoods, in general, are seen as social constructions that have developed through time. For centuries, children have been subject to philosophical enquiries, where 'Reason' has played a central role. Prominent Enlightenment thinkers, such as Locke and Rousseau, for instance, viewed children as either becoming rational through education, or indeed needing the external stimuli and appropriate environment to develop their natural reasoning skills. James et al (1998) have suggested that both of these views of children are still present in the education system.

My data indicates that both of these views also manifested themselves in the two research settings. In the 'Team Service' practice, the child was constituted as a test
subject, with or without the rational skills that were required to succeed in tests. In the test situation, the object of action was the child’s ‘individual capacity’ (Andersen, 1994). In the nursery, choice making demanded a particular kind of rational agency of the child. Speech and language therapy, the use of AAC and literacy training (explicitly and implicitly) all shared the same goal of rationalisation. The objectives of adult action were to teach children ‘rational’ thinking and communication, which they could use in different arenas of their lives with different people. ‘Irrationality’ was something that the child was expected to express through free play, rather than during more structured activities, such as circle times.

I argue that in both settings, the point of action was to enable children to be socialised in the ‘correct’ way. Rationality, locally appropriate speech genres, and preferences for symbolic exchanges were apparent elements of this socialisation process, which was referred to as meeting the child’s ‘special needs’. From the practice point of view, the staff in both settings successfully fulfilled these goals. In addition, in the nursery, the child’s ‘voice’ (of a particular kind) was seen as an important object of action.

In the child protection context, Lee (2000) has observed a shift from the body to the ‘voice’. This shift is similar to the shift promoted within Disability Studies, where the goal is to achieve societal change and enhance disabled people’s rights (e.g. Marks, 1999). Yet, in my findings, the material equation of the mind with the body as ‘handicapped’ and ‘delayed’ and ‘undeveloped’ remained. I argue that this derived from the clinical/therapeutic regime of truth. Therefore, I witnessed a contradiction between the ethos of care and the simultaneous aim of enabling children to (sometimes) perform ‘subjecthood’. In other words, although methods such as AAC can be seen as a significant development unlike previous strategies of dealing with children, they did not solve childhood’s ambiguity (Lee, 2001); in other words, young disabled children’s simultaneous positioning as subjects and objects.

I thus attempt to come up with some ways around this ambiguity. For instance, in terms of the child’s ‘subjecthood’, I do not see why the notion of multiple dimensions of the ‘self’ (Moser & Law, 2001) could not apply to young (disabled) children in the same way as to anyone else. Different aspects of these ‘multiple selves’ may manifest themselves in interaction, verbally or non-verbally. The point is that there may not be
an ‘ultimate truth’ to social interaction and meaning making: what is revealed to others in interaction might be what matters to the individual at the time. Obviously, this causes practical problems for people whose duties are to provide services to young children with ‘communication difficulties’ and their families. It is not useful to waver between different theories, possibilities and propositions: ‘good practice’ today denotes firm decision making. For a practitioner, this may create a no-win situation, which I want to address in the next section.

11.7 The ambiguity of meeting the child’s ‘needs’

For Marks (1999), whilst the medicalisation critique in Disability Studies represents a convincing and powerful challenge to the hegemony of medicine, it is important not to exaggerate its influence over peoples’ lives. Marks renders the medicalisation critique as negative in that it suggests that the recipient of a label is a ‘victim’ and always harmed by medical authority. For example, a refusal to label people may actually deny them access to important services and treatment. Considering this, constructionist views, which are based on an extreme interpretation of Foucauldian theory, tend to portray Medicine and its ‘pseudo-professions’ (Oliver, 1996) as a tyranny rather than as helpful and necessary practice.

However, I argue that young (disabled) children may fit the ‘victim’ category better than disabled adults, since the former do not obviously possess the highly-valued ‘rational mind’. Even if adults believed that they did, disabled children are nevertheless under constant and necessary supervision by adults. In addition, the contemporary urgency for early intervention constitutes children as a target group, because of the expectation that once ‘communication problems’ are addressed and dealt with in childhood, the individual in question will have better chances of achieving success in adulthood. Hence, the power of Medicine and Developmental Psychology is unquestionable in current professional practice that deals with children’s communication.
11.7.1 The ambivalence between theory and practice

As Woolgar (1988) has noted, everyday scientific work (such as Medicine) can be seen as different from public beliefs or accounts of it. For Woolgar, in scientific practice, decisions and activities are rarely undertaken in the manner of a dispassionate search for truth. Scientists have little time for a reflective evaluation of the epistemological status of their actions and interpretations: most of the time, the main and immediate aim is to make things work.

Furthermore, within the Medical scientific community, there may be a knowledge, communication or language gap between the ‘esoteric circle’ (the medical scientists) and the ‘exoteric circle’ (the practitioners). When new developments in knowledge arise in medical scientific work, they may not necessarily translate easily into everyday practice, often simply because practitioners do not have time to read the latest literature. In addition, sometimes economic dynamics influence what kind of medical knowledge is being produced and most widely diffused (Rochel de Camargo, 2000).

Hagstrom (2001) has argued that practitioners are not routinely given the tools to construct and communicate theoretical practices in their work. Basically, clinical hypotheses that lead to decisions of ‘problem/no problem’ are linked to worldviews organized by general theory. For example, one may suggest, drawing on Piagetian theory that children cannot talk because they lack the cognitive underpinnings needed to support language. On the other hand, drawing on the Vygotskian perspective, one might suggest that they may not have much language but may still be developing cognitive functions. In everyday practice, the practitioner has to determine what to privilege in the assessment of the child’s ‘communication difficulties’.

Hagstrom has also argued that integrating theory with clinical concerns and outcomes has been pivotal to the development of communication disorders as a professional culture, and contributed to the field’s delineation of itself as a science. Science, by definition, uses theoretical perspectives to make predictions and formulate coherent explanations and understandings. The field of communication disorders has evolved as philosophical views and theoretical perspectives advanced by the scholarly
literature have defined appropriate areas of study, and in so doing defined what is practical.

The general theories of both Piaget and Vygotsky have been used as the bases for innumerable research studies and clinical applications. Researchers have investigated aspects of these theories to prove, disprove or elaborate them, and practitioners have translated them into procedures and practices. Dealing with empirical data has become a habitual aspect of reporting both research and clinical results. Consequently, over time, this practice can lead to a fossilisation of theory defined by data if the relationship between specific and general theory is lost (Hagstrom, 2001).

An example of the implications of ‘lost theory’ comes from a recent study that has looked at the vagueness of the actual labels that are attached to individuals. A study by Peters et al (2001) has compared and contrasted different professionals’ familiarity with three terms - clumsiness, dyspraxia and developmental coordination disorder - and the extent to which they found them acceptable, and then characterised any systematic similarities and differences in the perception of each term. The results have indicated that the respondents tended to be unfamiliar particularly with the latter two terms, but there was a variation between occupational groups. The definitions of the terms reflected occupational knowledges. Teachers, for instance, would note difficulties in carrying out certain classroom specific tasks whereas doctors would give a clinical definition. Many professionals found discussions about terminology tedious.

Furthermore, Peters et al (2001) have argued that vagueness of terms has prevailed since their dawn at the turn of the century, when the idea that there might be a discrete childhood syndrome, which had ‘clumsiness’ of movement as its defining symptom, began to emerge. The problem is that despite recent attempts to standardise the terminology used, variation continues to compromise interprofessional communication and interpretation of research. For some professionals, different diagnostic labels are used interchangeably. For others, the different labels are used to refer to slightly different conditions and may be coloured by the particular background of the user.
As a result, I argue that clinical/therapeutic work is constrained by factors, which the practitioners do not necessarily have power over, even though they might recognise the ambiguities involved in their decisions and actions. The practitioner’s goal is to meet the child’s needs, and in an attempt to treat all children fairly, base his/her judgments on standards that are available to them. Changes in child law and often varied interpretations of them further complicate the practitioner’s task. Therefore, work with children’s ‘communication difficulties’ entails an ever-present tension between ideals, rhetoric and everyday practice.

11.8 Conclusion

In this chapter I have made links between contemporary discourses on ‘communication/difficulties’ and my findings. I have concluded that in the two clinical/therapeutic settings, ‘communication/difficulties’ were perceived as individually based pathologies and objects of expert action. Interventions in children’s lives were carried out for moral-pragmatic purposes; yet, as I have argued, the objectives of specialist practices involved many discursive and contextual ambiguities.

My findings indicated that ‘good communication’ in the two settings was presented primarily as the child’s skill, right and need. I have argued that clinical/therapeutic practices, particularly in the staff members’ accounts, were justified by their ‘scientific’ merits. My sociological perspective, however, has destabilised this view. I have highlighted ‘social’ and ‘sociocultural’ elements in expert knowledge and practices, as well as in the discourses that underlie them.

This chapter suggests that communication in the two research settings was a matter of contextual and interpretive accomplishment. I have criticised the idealisation of the so-called ‘mentalistic’ model, which included the ‘fallacy of verbalism’ and the ambiguity of abstractions; as well as preferences for rational thought and action as primary goals of socialisation. I have seen this as misleading in that it may, in some contexts, simplify what is involved in listening to children’s ‘voices’. I have then discussed the notion of the ‘voice’ in terms of not only its ‘semantic’ nature, but also of what it makes of the child. I have concluded that recent accounts in both child
welfare practice and some accounts in childhood sociology promote a particular kind of agency (e.g. Beresford, 1997; Middleton, 1999), and I found this problematic in light of my data.

I have also questioned why there is such a heightened need for ‘talk’ in today’s society and increasing numbers of children diagnosed with various syndromes. I have suggested that pressures on professionals to ‘detect’ communication difficulties as early as possible is a result of discourses, where certain ‘competencies’ are valued above others. Indeed, in this sense, I have delved into the question of the morality of ‘good communication’ and intervention into ‘communication difficulties’. In the next chapter I will continue with issues or morality and ethics in terms of my own research practices, returning to matters that I raised in Chapter 6.
Chapter 12.

THE PROBLEM OF CONSTRUCTING SOCIOLOGICAL KNOWLEDGE
AND TALKING ABOUT IT: REFLECTIONS

12.1 Introduction

Previously in this thesis, Chapters 5 and 6 have described how I went about doing institutional ethnography (Smith, 2002), and the practical, theoretical and ethical issues that were involved in the process. I have also talked about the ambiguities involved in taking on a social constructionist stance and, at the same time, having to decide ‘which side I was on’ in order to conduct ethically sound research.

This chapter continues the discussion on my own ‘communication difficulties’ as a researcher. I suggest that what I have gone through in the field can be generalised to other similar research contexts, because it brings to the fore important questions about the epistemological value of sociological knowledge accumulation and accounts. The focal point of this chapter is on my researcher’s ‘voice’, and how it was lost and found. Section 12.2 discusses how communication became a ‘difficulty’ to me as a qualitative researcher.

12.2 The dilemma of ‘communication’ in doing research

Ironically, my study of ‘communication difficulties’ included those of my own. Section 12.2.1 looks at how requirements for reflexivity contributed to my sociological ‘communication difficulties’. In section 12.2.2, I argue that, in the two research settings, ‘communication difficulties’ were perceived as the problem of the speaker, including my position as a researcher.

12.2.1 The problem of reflexivity

The importance of being reflexive has been acknowledged in social science literature for some time – however, it has only recently been pointed out that reflexivity has not been translated into ‘doing’ research (Mauthner & Doucet, 2003). As explained in
Part 2, this has been a major source of my 'sociological angst' in this research project. My research interest has been in 'whatever passes as knowledge in society' (Berger & Luckmann, 1991); the difficulty has arisen from the expectation of looking at my own research practices with the same analytical eye.

Whilst observing the 'Team Service' setting in particular, the ambiguity of interpreting interpretations finally hit me. I realised that I was trying to use 'realist' methods to capture 'social constructions' and that this was not a balanced approach. For Mauthner and Doucet (2003), this kind of ambiguity stems from the inevitable inseparability of epistemology, ontology and research practice. In the beginning, I assumed I would be representing other people, and would thereby be able to distinguish my own 'voice' as a researcher from them. Gradually, I had to come to terms with the fact that I was not representing the voices of either children or adult actors in the settings; instead I ended up deconstructing the notion of 'voice' altogether. Having taken on postmodern and poststructuralist writers' rejection of the authorial 'voice', and the deconstruction of 'truths' (Barthes, 1974; Geertz, 1988; Lyotard, 1994), I struggled with the crisis of representation and legitimation in ethnographic writing. At the time, this crisis was a reality for me.

At that point I also realised that, in the same way as report writing within the Team Service practice, the development of my thesis was a matter of another construction process. As a (social) scientist, I too was selective, employed a particular kind of sociological gaze and engaged in reading and writing practices that followed academic conventions. The reason why the 'grounded theory' type approach was a problem for me is because doing research in clinical/therapeutic settings did not allow for hesitation. For instance, for the MREC members, the idea of letting concepts arise from the data appeared to be completely alien in terms of proper research practice.

Interestingly, social sciences seem not to be able to escape the traditional parameters for accumulating scientific knowledge either. Typically, sociological textbooks (Mason, 1996) try to justify qualitative research methods by their 'rigour', 'detail', 'constant comparative method' (Glaser, 1992) and so on. Qualitative research manuals often involve defences of the validity of an interpretive, phenomenologically based view of the world, as set against natural scientific norms. The idea here is that
unless research is somehow ‘standardised’, it is inevitably anecdotal (e.g. Silverman, 2001) or otherwise not ‘scientific’.

Since I did not come up with straightforward, ‘factual’ findings in the field, the staff members did not understand what my research was trying to accomplish. I felt very strongly that, as a researcher, I was perceived as having ‘communication difficulties’, and that these difficulties were seen as exacerbated by the fact that English was not my first language. I perceive this as mirroring what was going on between adults and children in both settings; hence it is an analytically significant point in this thesis.

12.2.2 ‘Communication difficulties’ of/between adults in the two research settings

It has always been clear to me that doing sociological research in a foreign country in a foreign language means that as an ethnographer, at least to some extent I would be a cultural outsider. Yet I have not thought of this as a major problem; instead, I have regarded it as something to take into account as an inevitable part of my researcher ‘self’. For sure, my ethnographic gaze has been very much influenced by this attitude, for example, in having a heightened interest in communication as a matter of meaning making and translation. My interest in how bilingual or multilingual children were assessed within the ‘Team Service’ setting is another example of the same viewpoint.

I do not deny the fact that speaking and writing in English requires additional effort on my part. I have experienced this particularly in my difficulty with translating sociological writing into plain, spoken English. It is, of course, possible that oscillating between expert and lay terminology might be difficult in my native language as well, and that this also might be tricky for native English speakers. Nonetheless, I do not want to be wrongly accused of being arrogant and not willing to ‘translate’, as happened in one of the research settings. I also think the listeners ought to be receptive to what the speaker needs to say: otherwise different disciplinary speech genres have fewer chances to meet.

Eventually, my ‘communication difficulty’ as a researcher manifested itself as a ‘lost voice’. I still am not sure in what speech genre a researcher should speak. Should I be proud of having learned some abstracted sociological jargon? Should I abandon it and
try to talk about sociology to various audiences? After all, throughout this thesis I have been criticising the ‘fallacy of verbalism’ and the ‘ambiguity of abstractions’ – I should know better.

Yet I argue that my ‘communication difficulties’ during this research project have derived from my inferior status as a researcher in relation to the actors in the field. This contradicts certain literature on reflexivity in social sciences, often found in feminist writings, which typically locate power within the researcher. Within this discourse, the researcher is expected to create a rapport with the research subjects, be sympathetic and understanding (May, 2002). Given the problems that I had to address, I do not think that this positioning applies comfortably to my research experience.

I did not regard the adults in the two settings as vulnerable subjects. For instance, the ‘Team Service’ practitioners did not fill in the self-completed questionnaires that I had prepared for them. I had offered them a chance to express their point of view, but could not compel them do it. In addition, in the MREC meeting, I was totally at the mercy of powerful Others.

My point is that I wanted to listen and be listened to, but this did not always happen. There were too many uncertainties, ambiguities and misunderstandings in the way. I argue, however, that it was not all attributable to my inability to articulate my thoughts. Whilst my status and lack of experience as a student was not helpful, it was perhaps partially up to the adult actors in the two settings to be more receptive. On the other hand, as indicated in the previous Chapter, health professionals already have their hands full of work and typically struggle with frequently changing recommendations for good practice. Why should they listen to another ‘theory’, particularly one that does not draw on genres that were familiar to them? Why should they listen to a postgraduate sociology student?

12.2.3 When I saw the light

I have now understood that doing a PhD studentship is basically a matter of learning. Part of the problem for me has been that I did not understand that I was learning while
I was doing it. Only now that I have been there, I am more open to the fact that I will continue to do so. Learning is not a matter of linear progress: sometimes it involves two steps forwards and one step back. At this point it is obvious that someone else would have done this research in a different way, simply because people go to the field with different ‘baggages’. Therefore different accounts would arise in the end.

I suggest that the more you cross borders, the more you will experience ‘communication difficulties’. I have, during this research, crossed a few borders: cultural, disciplinary and experiential. My research practice has been characterised by Bakhtinian ‘multivoicedness’ (Foppa, 1995). At the same time, I can only talk about what I thought I saw in the field, because my ‘gaze’ was framed by a number of discourses and different aspects of my researcher and everyday ‘self’. In this respect, other sociologists’ texts have provided reassurance. While I am writing this, I am convinced that my research does not merely stand on its own; it is instead anchored in a well-established sociological genre, in other words, in texts that recognise the complexity of human communication, social life and doing sociological enquiries about it.

I believe that my experiences in the field were by no means unusual; however, in typical sociological accounts the craft character of qualitative research has tended to be swept under the carpet. I suggest, on the other hand, that instead of seeing construction as a weakness it can be perceived as a strength. Since human social life is ultimately complex, multidimensional, contextual and therefore often unpredictable, attempts to describe it cannot be anything but multifaceted as well. I argue that the preoccupation of ‘scientific’ accounts with orderliness, rationality and logic, whether in natural or social sciences, is inevitably reductionist. In qualitative research – in ethnography in particular – there are other possibilities for description.

12.3 Conclusion

In this chapter I have reflected on my ‘sociological angst’ about ontological, epistemological, ethical and practical uncertainties involved in this research project. The purpose of this exercise has been to highlight issues that can be relevant to future research on children’s (and adults’) lives. After all, communication as a phenomenon
will be central to any research project, whether or not it is the object of enquiry in itself.

As I have attempted to illustrate, in the field, ‘communication difficulty’ was perceived as the problem/pathology of the speaker, whether of a child or the researcher. During this research project, I genuinely felt that I could not oscillate effortlessly between sociological and non-sociological speech genres. I was very aware of the fact that, in the two settings, my research approach was not seen as particularly ‘scientific’ for this reason. This feeling led me to explore why this might be the case, and thereby I learned more about social constructionism. Looking back now, my ‘communication difficulty’, then, was a phase where I had yet to read and observe more.

One of the issues I had to learn was that there was something ambiguous about the idea of ‘listening to children’ in the first place, and that I could not build this research on that basis. Indeed the so-called ‘child centred’ approaches continue to be questionable (Middleton, 1999; Morris, 1999). They frequently lack a critical appraisal of communication as a phenomenon (Goffman, 1967). It is often implied that children (and adults) have message-like thoughts that can be exchanged, and intentions that match the situations defined by adults; therefore they can be researched in an ethical fashion (Alderson, 1995). My findings, as it should be clear by now, have indicated otherwise.

In general, ethnographic research is always a process of discovery. What I have discovered in this research included the deconstruction of ‘voices’, both those of children, adult actors in the two settings, and my own. As a result, I understand them as multidimensional social constructions, which are subject to change rather than as stable entities. At the same time, they are manifestations of discourses, practices and contexts in which they occur. What is ‘true’ and ‘real’ about voices remains an unresolved puzzle; on the other hand, as for Bakhtin (Emerson & Holquist, 1986), they are always social. Therefore they can be studied and reflected upon by means of sociological enquiry.
Chapter 13.

CONCLUSIONS

13.1 Introduction

The core arguments of this thesis are, first, that ‘communication’ – whether by adults or children, disabled or able-bodied, mono- or multilingual - is a complex social phenomenon. Face-to-face, adult-child and child-child communication is situational and gains its momentary directions from the contexts in which its different forms occur. This view poses a challenge to hegemonic, monological models for ‘good’ or ‘normal’ communication, which construe it as a rational, cognitive process of exchanging messages, preferably via words and/or abstract symbols. Second, this thesis proposes that certain aspects of ‘communication difficulties’ are social constructions. These constructions draw on various hegemonic discourses - child Health, Education, Welfare - underpinned by Developmental Psychology, and are both (re)constructed and consumed in local interactional practice.

This thesis has not been aimed at denying the existence of physical and cognitive impairments that the child may have. Instead, it has been intended to describe how intervention into the child’s life is a process, which is shaped by not only what the child ‘is’, but also by what expert discourses and practice make of what he/she is, and what he/she should become. By deconstructing essentialist views of children and the knowledge base of clinical/therapeutic work as scientific practice in this particular area of expertise, through this thesis I have attempted to illustrate how the interventionist process has a ‘human face’.

I suggest that the key implications of this thesis for sociology are threefold. Firstly, this thesis includes young (disabled) children in the sociological theorising of human communication in face-to-face contexts. This makes a move away from conventional Communication Theory, where children’s communication has so far been given marginal attention (see Chapter 3). Secondly, this thesis intends to contribute to both childhood sociology and Disability Studies by highlighting some interconnections between socially constructed notions of ‘Childhood’, ‘Disability’ and
Finally, in this thesis I apply various sociological perspectives (Bakhtinian, interactionist, integrationist, interpretivist and constructionist) not only to the analysis of 'communication/difficulties' of the research subjects, but also of the social researcher in institutional, specialist settings. This makes a case for reflexivity, which I regard as necessary for sound ethnographic research practice.

In the following two sections I will return to the research questions that were introduced in Chapter 1 (pp. 5-6). The questions are in italics. In section 13.2, I will recap the distinction between 'good communication' and 'communication difficulties' in this research. Section 13.3 reiterates how the (disabled) child, both in discourse and practice, has become a moral project of our time. In section 13.4, I will return to the so-called 'sociological communication difficulties' and how these might be dealt with in future research.

13.2 'Good communication' v 'communication difficulties'

Does non-verbal communication follow the same logic as verbal communication? What kinds of theoretical models may underlie the use of augmentative communication? How may this be manifested in practical contexts?

In the two research settings, 'good communication' was, implicitly and explicitly, treated as an innate, measurable, naturally arising skill that could be taught to and nurtured in a child. The so-called mentalistic, conduit and monological models manifested themselves in daily practice as norms to which children were compared. These models, in combination with a developmental and clinical/therapeutic understanding of the (disabled) child, were applied to both verbal and non-verbal communication.

As a result of my experience in the field, I learnt that as a researcher I could not make distinctions between the 'logics' of verbal and non-verbal communication. What I could do, though, was to observe patterns of social interaction between adults, adults and children, or between children. It appeared that communication situations, as they were organised by the staff for institutional purposes, manifested a clinical/therapeutic
‘regime of truth’, based on expectations of rational thought and action. The overall impression in both settings was that since the activities were mostly structured and adult-led, few opportunities would arise for spontaneous communication. Furthermore, spontaneous communication on the part of the children was not necessarily regarded as ‘good’ or ‘normal’.

Choice making during mealtimes and circle times in the nursery, and tests in assessments, were prime examples of situations where children were expected to be rational actors. The use of AAC and test materials were typically based on the assumption that pictures and symbols were representative of reality and allowed for a predetermined range of ‘correct’ interpretations. Daily practice in the two settings tended to prioritise speech and symbolic exchange, the purpose of which was to enable the child to engage in context-free communication and learn literacy skills.

How did health professionals construct ‘communication difficulties’ in multidisciplinary interaction? Was there anything particularly ‘social’ about the assessment work?

The findings in both research settings suggested that children’s ‘communication difficulties’ were understood as pathologies. They were primarily addressed in terms of clinically definable disorders or disabilities, the child’s verbal output, developmental immaturity/delay or deficiencies in (English) language. The causes for the child’s ‘symptoms’ were sometimes located in ‘nature’, sometimes ‘nurture’; nevertheless Medicine and its ‘pseudo-professions’ were regarded as the most suitable ones to deal with the ‘problems’. This principle was justified by the specialist’s expert knowledge as against lay knowledge of children’s communication.

The ‘Team Service’ setting was taken as appropriate for ‘context-free’ assessment: its form was justified in the name of standardisation. When standardisation ‘did not work’, it was explained with the notion that the child was not up to the test. In my data, for many parents and visitors this was reductionist: the ‘outsiders’ in the setting did not share the same gaze on the child, as the Team members - the experts. In addition, the former sometimes remarked that the child’s behaviour in the assessment was not the same as at home or at school; i.e. it varied depending on the situation.
Despite the surface appearance of the 'scientific' character of clinical/therapeutic work, my findings have described the ambivalence between the 'social' and the 'scientific'. The child in both settings was facing expectations of rational/irrational action, the expressions of which were regarded as 'normal' when they fit an adult framework. The adults also oscillated along the rational/irrational continuum of knowledge and action, sometimes resorting to their expertise, and other times explicitly to their 'common sense'.

The assessment procedures in themselves followed a set protocol, including attempts to systematically track down the child's 'symptoms'. The rationale of testing was based on controlling other factors apart from the 'individual capacity'; the underlying logic was to isolate the child as a case and his/her 'mind' and/or body as objects of expert scrutiny. At the same time, the tester's impact on the situation was not reflected upon in the same systematic manner.

Nonetheless, although the 'scientific' basis of assessments manifested itself in processes of quantification, its 'socialness' surfaced in each step of the procedure. The assessments were selective, involved interpretive work, account making and negotiation, and were in their decision orientation fundamentally moral-pragmatic, as well as occasionally coloured by sociocultural preferences for 'normal' family and home.

13.3 The (disabled) child as a moral project of our time

What kind of institutional discourses framed the principles according to which the adults communicate with children? What kind of communication did these principles allow?

In the two settings, an essentialist view of science and children's communication as its object crystallized in the clinical/therapeutic 'regime of truth'. In this discourse, 'Childhood' was a status characterised by 'becoming' in relation to notions of time, culture, body/mind and biological growth, and adulthood. In terms of communication, children were at an 'infrahuman' stage. Disability, disorder, delay, difficulty, and
other diagnostic labels were markers of deviation from the gold standard of 'normal' childhood.

I associate the contemporary urgency of professional intervention into 'communication difficulties' with the general societal trend, where children – disabled and able-bodied – have become a moral project. As for James et al:

Children have become supremely an issue of our time. Nations are investing in educational and moral futures and public concerns abound with issues of protection, rights, and citizenship in relation to the young. It is all too easy to become embroiled in the urgent hyperbole of paedophilia, child abuse, child pornography, childhood criminality or even the perpetual party political battle ground of educational standards: they are all 'the' issues of today and appear to require an immediate answer, or at least an opinion" (James et al, 1998, 197).

I see this thesis and the two research settings as being at the heart of this contemporary discourse, which manifests itself in moral-pragmatic justifications and political rhetoric and action. What is important here, as I agree with James et al (1998), is that in sociology, we need to consider this urgent focus on childhood analytically. In this respect, I am not drawing distinctions between studying the lives of disabled or able-bodied children, although I acknowledge that the former are more subject to the clinical/therapeutic gaze.

Indeed what most children have in common in Western societies is the regime of schooling. Education, as in the Children’s Centre, was characterised by Foucauldian (1997) type control: discipline, shaping children’s activities, and learning moral and conceptual values; as well as the importance of timetables and divisions in classes according to age and ability (James et al, 1998). Adult structures, such as Education are concerned with skills – communication these days is at the forefront of these structures. Within this discourse, a distinction is being drawn between children who have the capacity to learn those skills, or already have them, and children who need additional support.

The concept of ‘special needs’ in itself refers to a separation between a mainstream educational route and a more appropriate environment to ‘maximise the child’s
potential’. The purpose of the ‘Team Service’ was to do the weeding out: the ‘Children’s Centre’ was a ‘special needs’ setting in that ‘corrective practices’ aimed to bring the child closer to the ideal of ‘normality’.

‘Good communication’ – as a medium and an objective – was a crucial element in these operations. Hegemonic, ‘adult’ models for ‘good communication’ manifested themselves in daily practice, where ‘locally appropriate’ speech and the use of symbols were prioritised over other modes of human connections (Finnegan, 2002).

What underlying assumptions did the idea of an individual’s ‘voice’ entail in the two settings, if and when it was an object or feature of interaction?

I propose that models for good communication that prefer rational, abstract thinking and action discriminate between different groups of people. In this research this has been observed taking place between adults and children, although in the guise of meeting the needs and individual rights of the latter. In this respect, the findings of this thesis have particularly urgent implications for the notion of ‘listening to children’ as a moral-pragmatic ideal. The so-called ‘culture of consultation’ involves many controversies, when ‘extended’ to children by virtue of legal-ethical obligations.

At the same time, according to my findings, the ‘culture of consultation’ was less apparent in the initial process of identifying the child’s needs in assessments, where emphasis was on decision making and quantification of aspects of the child and his/her life. As I have previously argued, discovering a ‘communication difficulty’ – rather than consulting the child – was the objective of action in the ‘Team Service’ practice.

Nonetheless, this thesis has not only considered the existence or non-existence of a child’s ‘voice’ in the research settings: it has begun to deconstruct the notion of ‘voice’ in itself. I have questioned a particular version of the child’s agency. I link the idea of a rational, autonomous ‘agent’ as an intentional subject to a wider individualisation process in the Western world: recognising and accounting for children’s ‘voices’ presumes rational action on the part of the speaker. This
perspective has the moral goal of giving rights to children; yet, when not clarified, it may dismiss the complexity of communication as a local interactional activity.

13.4 Sociology and 'communication/difficulties'

In more ways than one, this thesis has involved processes of translation from a multiplicity of probabilities to texts. I have observed adults' translations of children's meanings and actions, as well as the inscription of these translations into case records. Likewise, I have described my own—often unsuccessful—attempts to translate from sociological genre to lay terms, from my private thoughts to public texts. In short, I have pointed out the prevalence of a disciplinary gap (in terms of epistemology and vocabulary) between sociology and clinical/therapeutic fields, which has constituted a 'communication difficulty' in itself.

One cynical aspect of the notion of 'translation' is that it seems unlikely that constructionist sociology can contribute to practice because of these 'communication difficulties'. Nevertheless, it is also possible to view this situation in a more positive light: difficulties, in whatever form they arise, may raise important questions about the 'taken-for-grantedness' of the sociological 'right to know'. Since sociology comprises of such a range of perspectives, I have suggested that the social researcher ought to be reflexive about his/her research conduct.

13.4.1 Some suggestions for future research

In Chapter 3 I introduced some recent discourses on how certain dominant understandings of human communication are a salient feature in the so-called 'late modernity', and are generated as well as sustained by 'expert systems' (Giddens, 1991; Durham Peters, 1999; Cameron, 2000). However, it appears that, so far, little empirical sociological research has been carried out on why and how communication should be such a major concern in our societies, and what is made of this assertion in everyday lived experiences.

In this respect, I believe that it is possible to carry out 'user-friendly' research, bearing in mind that what is 'real' to the research subjects and participants is what matters. A
sociologist’s and/or ethnographer’s task is to describe what these realities are like and make connections with levels of discourse beyond the individual experience of those realities. Therefore, institutional ethnography provides ethically and politically sound ways of studying aspects of children’s (and adults’) ‘communication difficulties’ in institutional settings (Smith, 2002). It allows scope for exploration, reflexivity and change of directions, when necessary.

At the same time, studies on children’s ‘communication difficulties’ need not be confined to institutional settings. For example, in-depth qualitative interviews with parents of children with ‘communication difficulties’ appear to be an under-utilised resource in current practice recommendations (e.g. Law et al, 2000). Furthermore, longitudinal, qualitative follow-up studies could be conducted on what happens to children who go through an intervention process, and what they might think about it once they grow older.

However, future research needs to pay special attention to the epistemology, ontology and practice of qualitative research. This is particularly important in research, which encourages the participation of children in the data generation. I have found that within the so-called ‘child centred’ discourse in childhood sociology, children are often granted an individualistic status as subjects/agents and as intentional beings, whose ‘voices’ may remain unheard because of the developmental ‘tyranny’ over their lives. Previously, also Lee (2000) has referred to the ambiguity of childhood sociology and the construction of the child’s ‘subjecthood’ in this fashion:

“As sociologists of childhood have attempted to bring children into sociological focus in their own right, the disciplinary concern with the ‘complete’ has required that children be attributed the properties assumed more normally to belong to adults. The sociology of childhood has thus preserved the privilege of the complete and the mature over the incomplete and immature” (Lee, 1999, p.458).

As my findings on face-to-face communication with both verbal and non-verbal children and/or children with or without disabilities indicate, communication is a complex, context-bound phenomenon. Whatever part children’s communication competencies play in encounters with researchers, they are ultimately constructed and interpreted by adults. For this reason, I suggest that researchers ought not to impose a
'voice' on a child, but should instead think critically about what the notion of 'voice' may entail.

The main epistemological and ontological issues here emerge from the same ambivalence between the observer and 'reality' as I described happening between practitioners and children in the two settings. To reiterate, I assert that the researcher has to decide between 'realist' and 'constructivist' approaches. It does not make sense to see one's own actions and research design as the former, and apply the latter to the actions of the actors in the field (Williams & May, 1996). Once more, reflexivity about one's methods is vital.

'Bridging the gap' between adult researchers' and children's worlds has been subject to debate also in terms of the researcher's role. Mandell (1991), for instance, has suggested that adults who research children's lives should avoid authoritarian or patronising attitudes towards children. Some others have emphasised the engagement of children in research as equal participants (e.g. Beresford, 1997).

I only learned what role was comfortable for me in the field once I had spent some time in the two settings, where I gained experience of being both a detached and a participant observer. In the end, I preferred being a detached observer, since I did not see how my participation would have benefited the children or advanced this research. At the same time, I acknowledge that some other researchers might find it more comfortable and fulfilling to take part in children's worlds and open up innovative avenues for doing it. This obviously depends on the research design and context. At any rate, I suggest that one way around this problem is to conduct some pilot work in order to learn what is and what is not possible to accomplish in the setting.

Research ethics is another important consideration. When it comes to Alderson's (1995) ten points for ethical research conduct with children, I argue that since listening to children is not a straightforward thing to do, judgments of need and harm remain contextual to a certain extent. Decisions need to be made about whether children want to talk if they can - is it really always 'good to talk?' As far as I am concerned, the contemporary, presumably 'child centred' discourse on listening tends
to advocate the Freudian type ‘talking cure’ (Cameron, 2000), and does not take into account the possibly harmful effects of ‘having to talk’.

Medical research ethics committees, in my view, can be important in weeding out projects that may obviously harm children, who are based in specialist settings. Then again, the problem arises where children no longer are the main concern, but the protection of the Medical profession, as seemed to be the case in the MREC meeting. Instead, there should be established social research ethics committees, or medical research ethics committees should have members with experience of qualitative research methods. In this way the ‘communication gap’ between medical and, as in my research, social constructionist views could be avoided or, at least, made smoother.

13.5 Conclusion

This thesis has described and analysed notions of ‘good communication’ and ‘communication difficulties’ in two specialist settings, where they were objects of action. It has linked local practice to wider societal discourses, where the (disabled) child is constructed as a moral project of our time, within which notions of ‘good’ and ‘normal’ communication play a significant role. I have also discussed the problem of sociology and ‘communication difficulties’ between academic disciplines, as well as between people who do not share the same ‘communicative repertoire’. In conclusion, in this Chapter, I have suggested some ideas for further research on children’s ‘communication/difficulties’.

As mentioned earlier on: although I retain the authorship and take responsibility for this thesis as an ethnographic text, I will also leave some freedom of interpretation with the reader. In this regard, I have intended this thesis to be an ethically sound project and for it to be beneficial to the children whose lives were the subject of this research, and for the working practices of their adult carers.
At this point, I would like to revisit the original research proposal for this CASE studentship. This is to spell out some of the reasons for my ‘sociological angst’ that I have not previously referred to in this thesis, since they are not central to my main arguments. I would like to momentarily return to the ways in which I initially interpreted the purpose of the original research design, and what urged me to apply for the studentship. The following extracts are drawn from the CASE proposal for the ESRC (see Appendix 1). The points that I want to address are underlined.

Project Title:

The social construction of ‘communication difficulties’ in child protection assessment for disabled children

Background to the research:

The difficulty in actually perceiving what a child is communicating about their life is compounded where there are difficulties in adult-child communication due to a disability. This difficulty in communication is especially problematic since disabled children have an increased vulnerability to all forms of abuse compared to non-disabled children (Kennedy 1996; Westcott and Cross, 1996). Thus not only are disabled children at higher risk of abuse in their everyday lives both within families and in institutional care settings, but the mechanisms available to them to communicate about any abuse they are experiencing are restricted. These restrictions lie partly in the skills of adults to understand what the child is communicating, and partly in what can be communicated through modes such as signing, Makaton boards or other iconographic aids.

In the beginning, I became interested in this CASE studentship because I wanted sociological research to contribute to child protection work. On the basis of the proposal, I understood that disabled children are more vulnerable to abuse than able-bodied children and this is sometimes due to the fact that they have little or no speech, and/or that adults do not take children’s accounts of abuse seriously (Morris, 1999).

However, my pilot observations in the ‘Children’s Centre’ started to fundamentally destabilise the theoretical premises for ‘listening to children’ and the child’s ‘voice’. My investigations into the methods of AAC, in particular, steered the attention away
from whether or not they allowed for ‘communicating about abuse’ towards the
dynamics of adult-child interaction. The complexities and ambiguities of
interpretation, which became apparent in my observations, challenged understandings
of communication as a straightforward exchange of messages, and the positioning of
the child as a particular kind of communicator. These findings led me to analyse the
practice conceptualisations of communication as the child’s skill, right and need, and
to question the notions of ‘subjecthood’ and ‘social competence’, which have been
promoted in recent childhood sociology (Lee, 2000).

Consequently, this research evolved to be deconstructionist in more ways than one.
This resulted in conceptual and practical changes to the proposed research
methodology:

1. Ethnographic-type observation of (put not direct participation in) the assessment of a
minimum of 40 disabled children at the Team Service with a balance between those
assessments that are specifically child protection focused and those that are more generic.
2. Interviews with assessment staff following from the observations, with a focus on
constructions of competence/incompetence in communication, and constructions of abuse in
context of disability.

My observations of the ‘Team Service’ established that there were fewer child
protection cases than expected, and that these were not necessarily ‘communication
difficulty’ cases, or vice versa. Furthermore, not all children who were referred to the
service were subsequently diagnosed as ‘disabled’. Consequently, Morris’ (1999)
assertion that ‘good practice involves understanding the communicative needs of
disabled children’ became problematic, because it implies a somewhat homogenous
image of disabled children as a group. As the practice literature and my findings have
suggested, ‘communication difficulties’ are not always a matter of ‘disability’, and a
‘disability’ does not necessarily involve ‘communication difficulties’.

As a result, I had to reconsider the original objectives of the research:

1. Explore the place of the child’s ‘voice’ in the multi-agency assessment of needs
(including protection needs).
2. Analyse constructions of disabled children's competence to communicate within this setting, and within other groups of practitioners who work with or have contact with disabled children.

3. Examine the affordances that assisted communication techniques (e.g. signing, iconographic aids, computer-assisted speech) make available for children wishing to communicate about their lives and experiences.

4. Develop recommendations for policy and practice in this area.

5. Make a significant contribution to the sociology of childhood with regard to the positioning of competence and communication.

When it comes to the fourth objective, my 'sociological communication difficulties' made me wonder about how exactly this research could contribute to policy and practice. In addition, its contribution to sociology is yet to be seen.

Indeed the above may sound like a critique of the original research proposal. Yet this is not my intention. In fact, I would like to express my respect not only for the original proposal, but also for those, who work in the field of child protection, and who care for disabled children. For someone who does not have a professional role in these environments, either institutional or home-based, it can all be incredibly overwhelming. Hence, throughout the making of this thesis, I have wrestled with the moral and political questions about child protection, and doing research with children. These have been serious questions about what is right and what is wrong.

I have also dwelled on my anxieties about moving back and forth between different disciplinary 'speech genres'. I have called this whole experience a 'sociological angst', which I have now encountered for the first time. The problem is that this angst has an intellectually and emotionally paralyzing effect. Apparently, many postgraduate students experience it, although not necessarily in the same way; I am not unique in this respect.

Nevertheless, I have gained immensely from this research. Although I have faced arrogance and suspicion, I have also witnessed unconditional caring. I could leave the two settings knowing that the children there were well looked after. Moreover, at the final stages of writing up this thesis, I have started to recover from my angst. I have
learned a lot about the 'grey areas' of human social life and that sociology is an appropriate subject for studying those areas.

In here I rest my CASE. I am grateful for all the advice and help that I have received over the course of this studentship. This is something one cannot quantify.
REFERENCES:


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CHILDREN ACT 1989, London: HMSO, Ch. 41.


EMERSON, C. & HOLQUIST, M. Eds. (1986) 'Speech Genres and Other Late Essays; M.M. Bakhtin' Austin: University of Texas Press.


OWEN, G. 'Hyperactive? Just Go to a Park and Climb a Tree' in 'The Times', 28.7.03, p.3.


SOCIAL RESEARCH ASSOCIATION (SRA): ‘Ethical Guidelines 2002’


A CASE studentship proposal for the ESRC; Section 2

Project Title:

The social construction of ‘communication difficulties’ in child protection assessment for disabled children

Outline of Proposed Project:

Introduction

A key element in protecting children from abuse lies in a) identifying situations where children face high risk of such abuse occurring, and b) being alert to situations where abuse or harm may already have occurred. For the latter, adult sensitivity to hearing children when they are trying to tell an adult that they have been maltreated in some way or are describing incidents that would be seen professionally as constituting abuse is vital. It is clear from research, however, that adults in both professional and lay capacities may not ‘hear’ children indicating a need for protection (Speight, 1989; Blagg et al, 1989).

The difficulty in actually perceiving what a child is communicating about their life is compounded where there are difficulties in adult-child communication due to a disability. This difficulty in communication is especially problematic since disabled children have an increased vulnerability to all forms of abuse compared to non-disabled children (Kennedy 1996; Westcott and Cross, 1996). Thus not only are disabled children at higher risk of abuse in their everyday lives both within families and in institutional care settings, but the mechanisms available to them to communicate about any abuse they are experiencing are restricted. These restrictions lie partly in the skills of adults to understand what the child is communicating, and partly in what can be communicated through modes such as signing, Makaton boards or other iconographic aids.

Morris (1995; 1999) found that the experience of abuse by disabled children was not recognised as such by professionals, and that different standards appeared to operate as to what is acceptable in the lives of disabled and non-disabled children. Furthermore, there was a lack of recognition and provision of the support and assistance for children with communication difficulties needed in order to communicate an experience of abuse or a fear of abuse, and the needs of disabled children for protection from abuse were not generally met.

In the light of this, the project seeks to explore, with a sociological focus on children and communication, the means by which child protection needs for disabled children are assessed and how disabled children are positioned as communicators about their lives or as people with ‘communication difficulties’. This will draw on paradigms from the new social studies of childhood (see James and Prout, 1998; Hutchby and Moran-Ellis, 1998), which questions assumptions about children’s lack of agency and competence. In this context the research will explore both the positioning of the child’s communication in the assessment process, and the more general positioning of disabled children’s communication in institutional and family settings. This is a complex area relatively unexamined sociologically, and the research design will reflect both the openness of the field and the need to focus in order to undertake effective research.

The disabled children attending ‘Team Service’ (a pseudonym) will form the research population for the study. Some 60-70 children a year are assessed by the Team Service. Approximately 50 % of these assessments are specifically related to child protection concerns, and the other half are general assessments of need.

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1 This is an extract from the full original document. It has been shortened for confidentiality reasons, and for the sake of relevance to the points that I make in Chapter 1. The author of the original proposal: Jo Moran-Ellis, Senior Lecturer; The University of Surrey, Guildford, the UK.
Aims and objectives

1. Explore the place of the child’s ‘voice’ in the multi-agency assessment of needs (including protection needs).
2. Analyse constructions of disabled children’s competence to communicate within this setting, and within other groups of practitioners who work with or have contact with disabled children.
3. Examine the affordances that assisted communication techniques (e.g. signing, iconographic aids, computer-assisted speech) make available for children wishing to communicate about their lives and experiences.
4. Develop recommendations for policy and practice in this area.
5. Make a significant contribution to the sociology of childhood with regard to the positioning of competence and communication.

Proposed methods

The research will have a flexible, qualitative approach to facilitate the development of the project as more data and findings emerge from the fieldwork and literature reviews. However, in general the following methods will be employed:

1. Ethnographic observations (in a nursery) with a focus on the positioning of communication in the everyday work of professionals and the everyday lives of the children.
2. Ethnographic-type observation of (put not direct participation in) the assessment of a minimum of 40 disabled children at the Team Service with a balance between those assessments that are specifically child protection focused and those that are more generic.
3. Interviews with assessment staff following from the observations, with a focus on constructions of competence/incompetence in communication, and constructions of abuse in context of disability.
4. Tracking 10-15 cases of child protection concerns as they progress through the child protection system with interviews with relevant groups of professionals.
5. Interviews with a number of families and children about communication strategies employed.
7. Textual analyses of communication aids, i.e. exploring what can and cannot be said via the aids/assistance mechanisms. This may also involve interviews with communication professionals, such as speech therapists.

Anticipated outcomes

It is anticipated that this research will make a significant contribution to the fields of social studies of childhood, and disability studies. In addition, it is seen as having key significance for policy and practice in the care of disabled children.

References


APPENDIX 2
<table>
<thead>
<tr>
<th>Name:</th>
<th>(M/F):</th>
</tr>
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<tr>
<td>Date of birth:</td>
<td>Date of testing: 1st session:</td>
</tr>
<tr>
<td></td>
<td>2nd session:</td>
</tr>
<tr>
<td>School/Nursery:</td>
<td></td>
</tr>
<tr>
<td>Tester:</td>
<td>Percentile score</td>
</tr>
<tr>
<td></td>
<td>1st</td>
</tr>
<tr>
<td>Comprehension</td>
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<td>Expressive</td>
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</tr>
<tr>
<td>Comments</td>
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</table>

*Chronological age
### COMPREHENSION SCALE

#### Section A: Single Words

<table>
<thead>
<tr>
<th>Single Words *</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>teddy</td>
<td></td>
</tr>
<tr>
<td>brush</td>
<td></td>
</tr>
<tr>
<td>cup</td>
<td></td>
</tr>
<tr>
<td>sock</td>
<td></td>
</tr>
<tr>
<td>doll</td>
<td></td>
</tr>
<tr>
<td>purse</td>
<td></td>
</tr>
</tbody>
</table>

#### Section B: Relating Two Named Objects

<table>
<thead>
<tr>
<th>Action</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Put teddy on the bed.</td>
<td></td>
</tr>
<tr>
<td>Put the keys in the box.</td>
<td></td>
</tr>
<tr>
<td>Give me the apple and the teddy.</td>
<td></td>
</tr>
<tr>
<td>Put the apple on the bed.</td>
<td></td>
</tr>
<tr>
<td>Give me the bed and the chair.</td>
<td></td>
</tr>
<tr>
<td>Put the keys on the bed.</td>
<td></td>
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</tbody>
</table>

#### Section C: Agents and Actions

<table>
<thead>
<tr>
<th>Action</th>
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</thead>
<tbody>
<tr>
<td>Make teddy sit.</td>
<td></td>
</tr>
<tr>
<td>Make rabbit jump.</td>
<td></td>
</tr>
<tr>
<td>Make teddy walk.</td>
<td></td>
</tr>
</tbody>
</table>

*Toys required for each section are shown in brackets.

2 Illegal photocopying is theft and may result in prosecution.
### Expressive Scale

#### Stimulus (Target) | Response | Score
--- | --- | ---
Ci | **INFLECTIONS - PLURALS** (*picture book*) |  
17 | (bananas) |  
18 | (balloons) |  
19 | (hats) |  
20 | (books) |  
21 | (cows) |  
22 | (buses) |  

#### Ciii | **INFLECTIONS - THIRD PERSON** (*picture book*) |  
23 | Every day I eat dinner, every day you eat dinner. Every day he... (eats) |  
24 | Look at this girl. Every day she... (runs) |  
25 | Here's another girl. Every day she... (reads) |  
26 | Every week I wash my car. Look at the lady. Every week she... (washes) |  

#### Ciii | **INFLECTIONS - PAST TENSE** (*picture book*) |  
27 | This baby cries a lot. Yesterday he... (cried) |  
28 | This lady likes walking. Yesterday she... (walked) |  

---

**Expressive Scale: Section C Score (max. 12)**

#### Stimulus (S) | Target (T) | Response (R) | Score
--- | --- | --- | ---
**D** | **3 AND 4 CLAUSAL** (*teddy, rabbit, flag, apple, table, bed, blue car, red car, bricks, truck, knife*) |  
29 | (S) Teddy's waving the flag. Now you tell me what's happening. (T) Teddy's waving the flag. (R) |  
30 | (S) Tell me what's happening now. (T) Teddy's eating the apple. (R) |  

---

6 Illegal photocopying is theft and may result in prosecution.
APPENDIX 3
<table>
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<tr>
<th>yes</th>
<th>no</th>
<th>swing</th>
<th>painting</th>
<th>mustard</th>
<th>banana</th>
</tr>
</thead>
<tbody>
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<td>chair</td>
<td>swimming</td>
<td>standing frame</td>
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<td>enough</td>
</tr>
<tr>
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<td>daddy</td>
<td>walking frame</td>
<td>Bertha</td>
<td>apple juice</td>
<td>forest fruits</td>
</tr>
<tr>
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<td>grandad</td>
<td>lunch</td>
<td>pudding</td>
<td>orange juice</td>
<td>sieveslairspace</td>
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<tr>
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<td>home</td>
<td>eat</td>
<td>drink</td>
<td>milk</td>
<td>water</td>
</tr>
<tr>
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<td>red</td>
<td>blue</td>
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<td>telephone</td>
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</tbody>
</table>
no

yes
Dear Parent/s,

I am a post-graduate research student at the University of Surrey. My PhD research is looking at the methods of communication that disabled children use. My research is under the supervision of Jo Moran-Ellis (The University of Surrey, Guildford) and ‘Collaborative Supervisor’. I am writing to you to ask whether you would be willing for your child to be in my study of communication difficulties.

As part of my study, I would like observe a number of children while they are being assessed by ‘Team Service’ practitioners. I would make my observations from behind a one-way mirror so as to not disturb the assessment.

I have enclosed an information leaflet about the research. If you would like further information, do not hesitate to contact me.

If you are happy for me to observe your child, please return the enclosed consent form. It can be returned in the free-post envelope, preferably at least a week before your child's appointment with the ‘Team’. Please be assured that if you do not want me to observe your child, this will not affect any of the services you will receive in any way.

Yours sincerely,

Ms Sirkka Komulainen
BaSocSc(sociology); MA(Econ)

e-mail: S.Komulainen@surrey.ac.uk

Home phone number
INFORMATION FOR PARENTS

Title of the PhD project:

A study of 'communication difficulties' in multi-agency needs assessment for disabled children

I am asking your consent to involve your child in my PhD-study. Before you decide I would like to explain why the research is being done and what it will involve. Please do not hesitate to ask me if there is anything that is not clear or if you would like more information.

Thank you for reading this!

1. What is this study about?

This study looks at how children's 'communication difficulties' are dealt with by different practitioners who assess children's needs. The purpose of doing this is to understand children's communication difficulties better. This is still an unexplored area in the sociology of childhood.

2. How will the children be involved in the study?

I will be observing the children, who are being assessed by 'Team Service' practitioners from behind a one-way mirror. In other words, the child will not see me or the other practitioners who are behind the mirror. The study that takes about 9 months starting from October 2001. I will carry out up to 40 observations.

Because the children are young, I am asking parents for their consent to carry out the observations. Non-participation in the research will not affect the assessment of your child. You are also free to withdraw your child from the research at any time during the assessment or afterwards
3. **How does this study aim to benefit the children and their families?**

I will inform the practitioners of the research results. Discussions with practitioners will then be used to develop their practices. Parents will receive a research report explaining how communication difficulties are dealt with and how children might be understood better. This aims to provide some help to solve some communication difficulties that the parents and children may have experienced at home.

4. **What will be done to protect the privacy of children and their families?**

The notes that I will take during the assessments will be kept in a secure locked place, and they will only be seen by me as the researcher. The final results of the study would be part of my PhD thesis and possibly referred to in other publications, such as in sociological journals. However, the identity of all the children and their families will be protected so that, for example, their real names will not be used, and the location of the research will not be revealed. Any records (medical or other) of the children or their families will not be part of the study.

5. **Who else is involved with the study?**

The study is supervised by Jo Moran- Ellis who is a lecturer at the University of Surrey (Department of Sociology) and ‘Collaborative Supervisor’. The research is reviewed by Local Medical Research Ethics Committee. The researcher receives a student grant for doing PhD research.

6. **Contact details**

If you would like further information, please do not hesitate to contact us! (details withheld for confidentiality reasons)
CONSENT FORM

Title of Project: A study of 'communication difficulties' in multi-agency needs assessment for disabled children

Name of Researcher: Sirkka Komulainen

1. I confirm that I have read and understood the information sheet dated............for the above study and have had the opportunity to ask questions.

2. I understand that the participation of my child is voluntary and that I am free to withdraw my child at any time, without giving any reason, without the services that my child receives affected.

3. I understand that my child's medical or other notes will not be used in this study.

4. I understand that my child's name, or the name of the place where my child is assessed, will not be used in the study.

5. I understand that the research is fully confidential.

6. I agree my child to take part in the above study.

Name of Parent Date

Signature

Name of Child

Researcher Date

Signature
1. **The nature and purposes of the study**

This study looks at how disabled children's 'communication difficulties' are dealt with in the multidisciplinary assessment of needs. Findings that will be based on observational and questionnaire data, aim to suggest recommendations for policy and practice, as well as contribute to the sociology of childhood.

The hoped-for benefits of this research for disabled children are development in practices that deal with their everyday life events and actions, define their status as individuals, and decide about options and choices open to them. The benefits for the practitioners would be the addition of sociological insights to their work practices.

This study does not seek to evaluate the work of the 'Team Service' or provide immediate solutions to possible practical problems. Instead, it aims to inform academic audiences about the nature of child assessment work: this is an area that has not yet been addressed in sociological literature on childhood and disabilities. The participation of 'Team' members is highly appreciated, keeping in mind that their participation is voluntary.
1.1 Research questions

With regard to children's rights, ability to hear children's accounts of their lives is a skill that adult practitioners and lay people need to possess. However, hearing the child's voice is problematic, especially in the case of disabled children who have little or no speech. Thus this research project poses the following questions:

1. What kind of interactions take place among adults and between adults and children in the assessment situations?
2. What is seen as 'normal communication'?
3. How may children's rights be taken into account in the assessment process?

1.2 Methods

a) Non-participant observation of assessments from behind a one-way screen.
   b) Self-completed questionnaires

The resulting data will be strictly anonymous and confidential, and stored in a secure locked filing cabinet for up to 5 years after the completion of the PhD thesis.

2. Other details

The researcher, Ms Sirkka Komulainen is currently a 2nd year PhD student at the Department of Sociology at the University of Surrey. She completed her 1st Degree and Master's Degree in sociology in Manchester between 1996-2000. The researcher is a Finnish citizen (EU-member) and is fluent in English.

The police records of the researcher have been checked in Finland and the UK and accepted by ‘Children’s Centre’. She has previous experience of participant observational research with children in the nursery at ‘Children’s Centre’.

The research is supervised by Jo Moran-Ellis who is a lecturer at the University of Surrey (Department of Sociology), and by ‘Collaborative Supervisor’.

The duration of the fieldwork with ‘Team Service’: 9 months (October 2001- July 2002). ‘Team’ practitioners will receive an interim report in the end of the fieldwork period, and a final report in the end of the PhD programme (October 2003).

3. Contact details

If you would like further information, please do not hesitate to contact us!
(details withheld for confidentiality reasons)
CONSENT FORM

Title of Project: A study of 'communication difficulties' in multi-agency needs assessment for disabled children

Name of Researcher: Sirkka Komulainen

1. I confirm that I have read and understood the information sheet dated ............... for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and I may withdraw at any time.

3. I understand that the research is fully confidential and that my name or the name of the research location will not be used in the study.

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

Name of Practitioner                    Date

______________________________
Signature

______________________________
Researcher                    Date

Signature
APPENDIX 8
Dear Parent/s,

I am a post-graduate research student at the University of Surrey. My PhD research is looking at the methods of communication that disabled children use. I am conducting my fieldwork at the ‘Children’s Centre’ at the moment. My research is under the supervision of Jo Moran Ellis (The University of Surrey) and ‘Collaborative Supervisor’ (The Children’s Centre).

I am interested in how children communicate in the nursery at the Children’s Centre when they are looked after by care workers. So far I have been observing children in the nursery at the Children’s Centre. I have also observed a speech therapist and an occupational therapist working with children. However, to make the observation more accurate and less influenced by my presence, I would like to ask your permission to video-record children and care workers/practitioners together.

These video-recordings would only be used for this research, stored in a locked filing cabinet at the university, and destroyed after I have finished analysing them. Children would not be put in any risk and they would not be asked to participate against their will. The final results of the analysis would be part of my PhD thesis and possibly referred to in other publications, such as sociological journals. However, the identity of children would be protected so that, for example, their real names would not be used, and the location of the centre would not be revealed.

The purpose of the research is to help sociologists and practitioners to understand children’s communication difficulties better. This is still an unexplored area in sociology.

If you do not wish your child to be video-recorded, simply return the slip attached in the free-post envelope by the 28th February. Further information of the research may be obtained from me or ‘Nursery Nurse’. Non-participation will not affect the care your child receives, and you may withdraw your child from the study at any point you or they wish to no longer participate.

Yours Sincerely,
CONSENT FORM

I agree/ I do not agree (please circle) to my child ------------------ (name) taking part in a study of disabled children and communication conducted by Sirkka Komulainen at ‘Children’s Centre’.

If you have agreed to your child being included in the study please sign below to indicate your consent.

- I understand the study involves Sirkka Komulainen video-recording my child at ‘Children’s Centre’.
- I understand the videotapes will be securely stored and accessed only for the research and that strict confidentiality and anonymity will be maintained.
- I understand that I may withdraw my child from the study at any time and that this will not in any way affect the services he/she receives.

Signed -------------------------------

Print name -------------------------------

Date -------------------------------