Agenda setting with children using the 'three wishes' technique

Abstract

The National Health Service (NHS; UK) offers initial screening appointments for children referred to Child and Adolescent Mental Health Services (CAMHS) to determine clinical need and assess risk. Conversation analysis was utilised on 28 video-recordings of these assessments, lasting approximately 90 minutes each with a multidisciplinary team. This paper focuses on the agenda setting strategies used to establish relevant goals with children and adolescents; specifically, the technique of offering 'three wishes'. For example, "*if you had three wishes, what would you like to make happen?*" In cases where children initially volunteered an assessment-relevant wish, they tended not to articulate further wishes. Non-assessment-relevant wishes (i.e. fantasy wishes, such as being "rich") were treated as insufficient, with many approaches used to realign establishing assessment relevant goals. Where responses were not institutionally relevant, practitioners undertook considerable discursive work to realign the focus of the three wishes task to assessment relevance. In these cases, the wish responses were treated as irrelevant and tended to be dismissed, rather than explored for further detail. Such work with the children's contributions has implications for engaging children and child-centred practices.

Introduction

During their lifespan, approximately one third of children and adolescents experience an emotional, behavioural or neurodevelopmental difficulty (Merikangas, Nakamura, & Kessler, 2009), with global prevalence ranging from 10-20% (Kieling, et al., 2011). In the UK, mental health services are provided by the National Health Service (NHS) and young people are seen by child and adolescent mental health services (CAMHS). CAMHS is a service provided for those who experience emotional, behavioural or neurodevelopmental difficulties (Karim, 2015), and assesses, diagnoses and treats individuals, using approaches including pharmacological and talking therapies. Typically, access requires a referral from the General Practitioner (GP) for assessment.

In CAMHS, a multidisciplinary approach is taken for assessments and treatment (Karim, 2015), usually including psychiatrists, clinical psychologists, community psychiatric nurses, occupational therapists, and other psychological therapists. At the initial assessment, parents/guardians typically accompany children (Hartzell et al, 2010), and other close family members may also attend. The invitation to the whole family allows for practitioners to ascertain a broader understanding of the child's difficulties from different perspectives. The function of the assessment is to screen for difficulties (Parkin, Frake & Davison, 2003), by identifying any immediate risk of harm

to the child/adolescent or others, to develop an initial formulation of the presenting problems, and to consider what might be the next steps (Mash & Hunsley, 2005). During assessments, the agenda specifically relates to the institutional requirements for information-gathering, and thus questions put forward by practitioners tend to be focussed around these requirements (Thompson & McCabe, 2016).

In relation to family-centred practice, it is important to account for the views of children/adolescents and their family, to ensure that services meet the needs and expectations of the families involved. Evidence suggests that greater engagement with children/adolescents in therapy predicts better outcomes (Chu & Kendall, 2004). In assessments it is therefore common to use techniques such as using Subjective Units of Distress Scales to elicit feelings (Kiyimba and O'Reilly, in press), asking children to describe their 'three wishes' to set goals, and drawing family trees to understand relationships. However, there is little empirical evidence to examine these strategies, and research has indicated that children/adolescents can feel peripheral to the assessment process (Ross & Egan, 2004), feeling professionals do not always engage them sufficiently or take their views seriously (Buston, 2002).

A contributing factor could be that practitioners who are involved in assessments may have had little formal training in assessing children (Grigg et al., 2007) and may

struggle to elicit relevant answers (Stivers, 2001). Thus, it is possible there may be room for improvement in practitioner expertise in how they question children/adolescents to inform decisions and how they implement available techniques to facilitate this.

Aims of the paper

Despite the crucial gatekeeping function of initial assessments, there is little empirical evidence to guide practitioners. Problematically, there is little qualitative research on assessments to help inform best practice (Hartzell, Seikkula, & von Knorring, 2009). Therefore, the objective of this study was to take an inductive approach to analysing video-recordings of assessments to better understand these interactions. Specifically, we were interested in how goal-setting was achieved collaboratively to examine child-centred practice and child engagement. We aim therefore to examine an engagement technique commonly used whereby the child/adolescent is asked to describe 'three wishes' to give insight into their expectations and understanding of the setting, and to provide a platform for goals.

Method

A qualitative approach, specifically conversation analysis (CA), was adopted to

interrogate the data and address the aims. We focused on understanding the initial goal-setting interactions between practitioners and children/adolescents who were participating in assessments. We recognise the notion of adolescent can have specific meanings, we use this concept throughout to reflect the technical terminology used in the Child and *Adolescent* Mental Health Service, from which our sample was drawn.

Participants and data collection

Purposeful sampling was used to gather data from twenty-eight consenting children/adolescents together with family members in a UK CAMH service. Urgent referrals and acute cases were excluded. Participants were typical of the population attending the service, ranging from 6-to-17 years (Mean 11.21, SD = 3.10), with 36% female and 64% male. Twenty-seven young people attended with mothers, eight with their father, and six also had their maternal grandmother with them. In some cases, siblings or extended family members also attended. All but one family were seen by two practitioners, consisting of qualified and assistant clinical psychologists (5), consultant, staff-grade and training-grade child and adolescent psychiatrists (10), occupational therapists (4), psychotherapists (2), community psychiatric nurses (5), and a learning disabilities nurse (1), with some having medical students or student nurses observing. Each assessment appointment was approximately 90 minutes, and resulted in a data

corpus of approximately 2240 minutes, which meets sampling adequacy parameters for this approach.

All initial appointments were video-recorded, and these recordings constituted the naturally occurring data corpus. Naturally occurring data is defined as that which occurs regardless of a researcher's involvement (Hutchby & Wooffitt, 2008; Kiyimba, Lester, & O'Reilly, in press). The use of naturally occurring data for this kind of analysis has the advantage of demonstrating actual clinical practice rather than simply generating retrospective reports, such as those that may be gathered through interviews (Potter, 2002).

Data analysis

CA was utilised for several reasons, including its inductive focus and attention to details of interaction as they occur in a real-world setting. Further, CA is a rigorous methodology for studying talk-in-interaction (Atkinson & Heritage, 1984), which aims to minimise ungrounded interpretations due to its observational focus on directly observable characteristics of the data (Drew, Chatwin, & Collins, 2001). It has grown in popularity for studying health interactions due to its use of using naturally occurring data. The benefits are that CA can illuminate actual practices between doctors and

patients (e.g., Peräkylä, 1997; Pilnick, & Dingwall, 2011), as well as between mental health practitioners and their clients (e.g., Peräkylä, Antaki, Vehviläinen, & Leudar, 2008; O'Reilly, Karim, Stafford & Hutchby, 2015).

In CA, the process of analysis begins with familiarisation with the data through repeated listening/watching and reading transcripts. To capture important paralinguistic features, such as volume, pauses, and emphasis etc., a detailed transcription system is used (Jefferson, 2004). The symbols are outlined in table 1. Further, the analytic process is emic and data-driven as analytic claims are evidenced through the data. Typically, co-analysis between researchers is used to identify emergent patterns and to promote methodological rigour.

INSERT TABLE ONE HERE

In our study, following these procedures, we gathered a corpus of extracts that were identified as sharing features relevant to the aims of the study; that is collaborative goal setting. In our case, these were data extracts from early in the assessment in which goal setting was conducted. Specifically, we sought to ascertain whether there were recurrent or systematic patterns of communication within the extracts (Drew et al., 2001), which could provide insights into agenda-setting. In this process, we identified a re-occurring

technique that practitioners referred to as ‘three wishes’, which became the focus our investigation. At its simplest level, this was a question-answer sequence, which within CA literature is part of a larger category referred to as ‘adjacency pair’ sequences (Schegloff & Sacks, 1973).

Ethics

The study was awarded full ethical approval from the UK National Research Ethics Service. All procedures proscribed were adhered to, including age-appropriate information for all participants, provided up to three weeks before attendance with the appointment letter. Written consent was collected before and after the appointments from all participants, including practitioners. All transcripts were anonymised.

Findings

Broadly, the ‘three wishes’ question was a way of asking what matters most to the child, and thus (albeit obliquely), what might be the goals for the assessment. This approach recognizes that the question itself was situated, in the sense that it was asked by a practitioner in a mental health assessment of a child/adolescent referred by the GP. Our analysis demonstrated that depending on the different types of responses offered by the

child or adolescent in the first-turn-position after the question, this appeared to dictate the trajectory of the kinds of next turns that were provided by the practitioners:

1. When the child offers their first wish, in their next turn the practitioner treats this as sufficient and the talk moves to talk about the child's difficulty.
2. When the child offers a first wish, in their next turn the practitioner pursues that line of questioning seemingly treating it as insufficient.
3. When a child offers a first wish, in their next turn the practitioner treats that wish in a dismissive way.

We note, that treating the wish as insufficient and dismissing the relevance of it often occurred together, and while discursively perform slightly different social actions, they were frequently combined by practitioners in their treatment of the wish.

The following two extracts demonstrate the first category of responses from children and adolescents in answer to the 'three wishes' question, which are characterised by their nature of being treated as sufficient by the practitioner.

Extract 1: Family 1

This extract is a good example of how the adolescent's response to the three wishes was treated by the practitioner as sufficient and relevant.

Clin Psy: ↑if you had three wishes(0.66) what
Clin Psy: ↓would you like to make happen
Adol: ↑my OCD'd ↓go (0.38) away
Clin Psy: °yeah°
Adol: erm (6.60) dunno (7.13)↑er (0.37) dunno
Clin Psy: ↑ok well main ↓thing (0.34) is that e- er
the OCD g↓oes awa:y (0.46) you you
↓feel you would be a lot happier
Adol: ((*nods* [*head in agreement*))]
Clin Psy: [ri:ght] (.) ↑excellent

* Adolescent is 13 years old (F)

In Extract 1, the practitioner (in this case a clinical psychologist) began by asking the adolescent a hypothetical question '↑*if you had three wishes….*' With no hearable pause between the question and answer, the adolescent responded with what can be heard as an institutionally relevant first 'wish'. Thus, the adolescent appears to have oriented to the nature of questions and answers as being situated. Notably, in doing so, the adolescent made relevant the potential reason she had come to the assessment, which was her '*OCD*' (i.e., Obsessive Compulsive Disorder) (line 3). Further, the use of a diagnostic label, that is, a technical mental health concept, marked the talk as

particularly relevant within this context. Following this response, the child engaged in several false starts, which included lengthy pauses (ranging from 0.37-6.60 seconds), perhaps indicating some trouble in the talk, as she had been asked to identify three things and only offered one. Conversation analysts have noted that lengthy pauses may mark trouble in talk (Jefferson, 1989; Speer, 2001).

The practitioner's response repeated the child's initial wish, wherein the OCD '*goes away*', perhaps serving to reinforce/emphasise the adolescent's initial wish. The responses from the clinical psychologist in the first and third turns are semantically and intonationally in agreement –as if indicating that the 'right' kind of answer has been provided. This is then extended by noting "*you ↓feel you would be a lot happier*", with the adolescent nodding to display agreement. The psychologist did not ask any further questions about the wishes or about the goals for the assessment. A similar structure can be seen in Extract 2, where again an institutionally relevant response was proffered.

Extract 2: Family 3

Psychiatrist:	can °you tell me these wishes ↓what
	they are°
Adol:	um (5.80) s↓top being °naughty°
Psychiatrist:	stop being ↓naughty (0.25) why

Adol: um (0.51)°I dunno°

Psychiatrist: °s↓orry°

Adol: I d↑unno

Psychiatrist: ok but one of your ↓wish is to stop

Being ↓naughty

Adol: yeah

Psychiatrist: o↓kay:

* Adolescent is 13 years old (M)

As in Extract 1, this example also demonstrates that the first answer to the three wishes question is something that could be considered relevant to the business of a mental health assessment. The adolescent offered one wish that was treated as sufficient and heard to be a 'reason' for attending the assessment. Similar to Extract 1, the adolescent initially only offered one wish. The subsequent trouble in the talk, marked by the pause (0.51), seems to indicate that the adolescent was having difficulty producing the requested additional two wishes. Nevertheless, the first wish was treated as an answer that was a relevant basis for further questioning; in this case 'why' was posed, indicating that the 'wish' was being treated as appropriate to the current institutional business but reasons for it were sought. However, he did not give an answer to this reason-seeking question, apart from '*I dunno'*. The usual conventional requirement in conversation is that when a question is asked, an answer becomes immediately relevant

and required (Sacks, 1992). However, where a question may be difficult to answer, 'I don't know' can provide a way of fulfilling the social and conversational obligation to respond to the question without directly answering it (Stivers & Robinson, 2006). The psychiatrist treated this response as 'incomplete' (Stivers & Heritage, 2001), and continued to reiterate the last point on which they agreed. This is seemingly a way of re-establishing shared knowledge, by reflecting that the adolescent's 'wish' was to stop being naughty. The '*okay*' from the psychiatrist following this statement also semantically indicated sufficiency.

The first two extracts illustrate how adolescents provided responses to the three wishes question that were treated as sufficient and institutionally relevant answers, thus mitigating the need for additional wishes. However, the following extracts show how some answers were either treated as insufficient and therefore pursued or were dismissed.

Extract 3: Family 6

Psychiatrist:	if you had three ↓wishes and you could
	wish for absolutely anyth↓ing in the whole
	wide w↓orld
Child:	°Yeah°

Psychiatrist: what would you ↓wish for?

Child: em: (7.91)↓for JLS to live at my h↓o:use

Psychiatrist: ↓Ok

((*all laugh*))

* Child is 9 years old (F)

It is typical amongst mental health practitioners to prefer the use of open questions, as it is understood that these are likely to elicit fuller responses from children (DeVoe, 2002). Generally, across the extracts, the participating children/adolescents offered relatively short responses about their wishes, even when institutionally relevant. Here, in Extract 3, this institutionally irrelevant set of wishes resulted in more detail being elicited, with the psychiatrist asking additional questions, as well as inviting further wishes. In everyday conversation, it is unusual for pauses to be longer than a few milliseconds (Sacks, 1992), but in therapy talk, the allowance of longer pauses is often used deliberately to allow the client more time to consider their response. Here, the child paused for nearly 8 seconds in considering her primary wish. The treatment of this wish was different from the earlier extracts, as all parties (practitioners and her mother) laughed at this response.

Extract 4: Family 6 (continuation of extract 3)

Psychiatrist: ↓so JLS em we can try ↓that one – I don't
think that's ↓gonna happen but what are
the other two ↓wishes and you can wish
for anyth↓ing ( ) and you're dreaming
big ↓which is good
Child: to ↑sing on a st↓age (0.88) in front of lots
and lots and lots of ↓people
Psychiatrist: uhuh
Child: em: an:d to:: (4.04) em:
Psychiatrist: can I give you an opt out ↓clause you can
say (0.54)↓I'll think about the ↓third wish
and keep it 'til later (5.02) if you don't
want to waste it on ↓something quick

After the first wish was responded to with laughter, it was also then quickly dismissed by the psychiatrist as something impossible. Thus, the psychiatrist pursued the agenda further by asking what the child's next wishes might be, leaving a further opportunity for an institutionally relevant wish. Interestingly, after the child had 'used up' two of the allocated wishes and was displaying thinking about the third, the psychiatrist interjected with a suggestion that she 'save' the third wish so that she did not "*waste*" it. There is a clear judgment here about the validity or relevance of the wishes offered thus far, as well as an attempt to subvert the child's responses at this point.

Extract 5: Family 6 (continuation of extracts 3 and 4)

Child:	I ↓know I wanna be rich
Psychiatrist:	ah o↓k well that's pretty good because then
	↓that gives you lots of other wishes doesn't
	it (0.63) a very sensible use of ↓wishes
	young lady okay
	(2.04)
Psychiatrist:	two things I just want to ↓ask you about
	(0.26) one i:s (0.37) you've obviously
	↓come here today with your ↓mum yeah
	what were ↑you hoping we ↓might be able
	to do for ↓you
Child:	↓don't know ((*shrugs*))

After the child ignored the offer from the psychiatrist to 'save' her third wish, she responded with *'I wanna be rich'*. The psychiatrist favourably evaluated her final wish and finished his turn with ending intonation of '*okay*'. He then took the conversational floor to (re)introduce the idea of agenda/goal setting from a more direct approach, by overtly asking the child about her hopes for attending the session. It is recognised that

questions often convey within them certain presuppositions that oblige preferred kinds of answers (Hayano, 2013). In this case, there was a presupposition in the question from the psychiatrist that '*we*' might be able to help. Asking children about what they understand to be the reason for their attendance at a mental health assessment is commonly done to encourage the child's engagement in the process (Stafford et al., 2016). This can be heard as taking another approach to the topic of agenda setting than the three wishes technique. However, this more direct approach was still met with a response from the child that did not move the co-construction of a shared assessment goal any further forward. A similar example is offered next.

Extract 6: Family 22

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Psychiatrist:    a magical wish (0.44) [what will y]ou ask for
Child:                                 [(money)]
                (0.58)
Psychiatrist:   [(you ha you ha] you've d[one it]
Clin Psy:      [we did actually]         [(look) a]
                 little b[it at this]
Child:                  [my mum to 'ave a job]
                 (1.04)
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* Child is 11 years old (M)

What is interesting about Extract 6, is that the two ‘wishes’ that the child presented following the three wishes question were to have money and for his mum to get a job, related wishes with a similar goal to be more financially viable. However, both wishes were ignored, as the psychiatrist and the clinical psychologist took over the conversational floor in overlap with each other. Instead, as we will see in the following extract, which is a continuation of Extract 6, an alternative goal was offered by the clinical psychologist, thereby orienting more strongly to the institutional context and the goal-setting agenda being pursued.

Extract 7: Family 22 (continuation of extract 6)

Clin Psy:		so w wh what wo (.) what Colt you was
		saying earlier about if we could change
		↓things or we could help you to ↓change
		things (0.75) then (.) >one of the things<
		was (0.23) wanting to go back
Child:		woah ((*tower falling*))
Clin Psy:		to the s:pecial (0.34) school that (0.38) Colt
		went to be[cause]
Psychiatrist:		[ah]

Clin Psy: (0.25) there (.) there was (.) clear
boundaries and clear consequences and they
helped him to not be ↓naughty is what Colt
was saying

Here the alternative assessment relevant goal offered by the clinical psychologist was presented as something that Colt (the child), had talked about earlier – i.e., to go back to the special school where there were clearer boundaries that helped him manage his behaviour better. Once again, where the three wishes technique did not initially *work* as an institutionally relevant goal elicitation device, another approach was taken, and the 'wishes' that the child has already placed on the metaphorical table were dismissed or ignored. Both practitioners talked about what the child's three wishes could have been, and framed them as goals. In effect, they reframed what the three wishes question was about, reconstructing how they wanted the child to respond that was more assessment-relevant. We can clearly see again that there was a preference for an institutionally relevant response; indexically tied and appropriately situated for these questions. We can see this evidenced again in the following extract, where once more a wish was provided which did not conform to the agenda-setting exercise.

Extract 8: Family 13

Registrar: okay you've got three wishes what would
you wish to [see]
Child: [a million po]unds
Registrar: [no (.) a million po]unds ok[ay]
Psychiatrist: [ahh] [I] would ↓like
th[at wish:]
Registrar: [I'd love th]at as well
(0.38)
Registrar: yeah o↑k (.) what else?

* Child is 8 years old (M)

In Extract 8, after presenting the three wishes question, the child's first response was '*a million pounds'*. This was followed by some lighthearted interaction about how they (the practitioners) aligned with that wish and would also like a million pounds. The use of the phrase '*I'd love that as well'* relates in conversation analytic terms to what is known as 'tying'; a phrase used to refer to the indexing of content from previous turns to the current turn (Sacks, 1992). In this case, '*that*' indexed the '*million pounds'* from the child's turn. After this rather dismissive response, the registrar then asked, '*what else?'*; as if implying that such a wish could only be a dream, not achieved. Thus, this served to differentiate fantasy from reality in the context of the child's mental health.

Again, the child did not seem to understand that the question was not really aimed at eliciting his wildest dreams about having lots of money, but that there was a fundamentally more sophisticated underlying premise to the question. A premise which related directly back to the relevance of who was asking the question, when it was being asked and in what institutional context. In this sense, the child's answer was treated as dispreffered and an effort to elicit a different, better or more relevant response is evidenced with '*what else?*'

Extract 9: Family 13 (continuation of extract 8)

Child:	two million pounds
	((*practitioners laugh*))
Registrar:	oh a third one I think (I know) what you're
	gonna say (0.45) is it three
Psychiatrist:	is there anything you would like (0.22) is
	there anything you would like to change?
	(0.68) at home
Child:	hum ((*shakes head at the same time*))
Psychiatrist:	nothing?
Registrar:	↓no
Doctor:	okay (.h) so you are okay?

(0.39)

Notably, in Extract 9, the laughter after the child's second wish of two million pounds seems to indicate that it was treated as a 'bit of a joke' – again not sufficient, not appropriate, and certainly not *the right kind* of answer. At this point, the psychiatrist stepped in to be more directive and to give a clearer framework to the child about what kind of answer might be sufficient. He specifically directed the child to think about what he would like to change '*at home*'. Yet, this more direct approach, offered as a clarification to the three wishes, was not successful in eliciting an assessment-relevant shared goal.

Discussion

Using CA affords the opportunity to study assessment interactions and the sequential patterns within talk. CA is valuable in demonstrating how the process of assessments is achieved moment-to-moment and turn-by-turn. The specific investigation of how shared goals are established in child mental health encounters is not something that has been investigated in this way before. Bearing in mind the fact that children/adolescents vary considerably in terms of their presenting difficulties and developmental needs, the data

indicates that there was some consistency with regards to the sequence of turns following the three wishes question.

This approach to analysing data demonstrated that there were three types of interaction where the three wishes technique was displayed. First, the child/adoelscent offered a wish that was treated by the practitioner as sufficient, and the further two wishes were not pursued. Second, there were occasions where the child/adolescent offered a wish and the practitioner treated the response as insufficient. In other words, the three wishes technique was extended and the full three wishes pursued. Third, the practitioner treated an initial wish by the child/adolescent in a dismissive way. These three types of interaction demonstrate that the implicit agenda of goal setting was not always interactionally achieved. Thus, because the situated objective of the three wishes technique was not always oriented to by the child/adolescent, the practitioner needed to make the agenda more explicit.

The goal setting aspect of the agenda is a crucial part of the appointment, as it directs the focus of the task. In this context, the questions presented by mental health practitioners tend to relate to establishing the goals and pursuit of detail about them (Thompson & McCabe, 2016). People normatively account for the context and relationship in which the question is asked to offer a relevant answer. For example, if

asked ‘how are you?’ by a cashier at the supermarket or a GP during a consultation, the person asked is likely to account for the situation and the person asking in their choice of response. Thus, not only is an answer conditionally relevant after a question is asked (Heritage, 2010), but also an *appropriate* kind of answer is relevant, depending on context and relationship. It is normatively expected that adults have an understanding about the appropriateness of types of answers to questions asked in a mental health setting. Additionally, parents are likely to be familiar with the function of the assessment. However, children/adolescents are not typically initiators of the appointment (Wolpert & Fredman, 1994) often do not know why they are there (Stafford et al., 2016) or misinterpret the function of the assessment (Bone et al., 2014). Arguably, they do not have the contextual information that enables them to consider what kind of answer is appropriate and relevant to the institutional agenda.

In relation to the use of the three wishes technique, the question ‘if you had three wishes what would you wish for?’ could be taken as a straightforward request for wishes. In this setting, however, the subtler interpretation of the question would focus on identifying wishes relevant to mental health. What our data illustrates is that at times children/adolescents did not attend to this nuanced expectation. Notably, there may be a range of reasons, such as the child/adolescent may not see themselves as having a problem and thus this was not central to their responses, or they may be under review

for a condition which means they interpret the question more literally (e.g., autism), or may have a specific language disorder. Regardless of the reason, what is important is that in some cases, practitioners abandoned the three wishes exercise to take a more direct approach to goal setting, seemingly treating it as a strategy that had not functioned in the way expected. Arguably, this may have left some children confused about why they were being asked about their wishes in the first place.

There is an assumption that techniques like the three wishes are helpful for eliciting shared goals, yet this is not based on empirical evidence. The benefit of drawing on naturally occurring data to examine in situ practices is that the actual interactions can be scrutinized in detail. CA examines this kind of data, as it specifically allows for sequential analysis of questions and answers. As noted, our analysis shows that children/adolescents do not appear to have always accounted for the contextual setting in which the three wishes question has been asked. Understanding this may be of benefit to practitioners involved in frontline assessments. Specifically, if children/adolescents do not know the reason for their attendance, they have little basis for contextualizing the exercise.

Indeed, practitioners do frequently ask children if they understand why they are attending the appointment, but do not always provide sufficient clarity for those that do

not know (Stafford et al., 2016). Notably, we argue that the three wishes technique can be a useful exercise for goal setting, but some care needs to be taken. In other words, offering three wishes provides a basis for children to be encouraged to orient to their setting by offering more than one opportunity to do so, and in cases where this happens on the first wish allows the practitioner to abandon the other two and focus on the first and institutionally relevant wish. However, we argue that the technique is arguably more effective if practitioners first establish that children and adolescents understand the function of the assessment and the reasons why they are there for it to be most effective, to help them understand that the question is tied to the context and thus one wish may then be sufficient for the goal setting task. On this basis, one solution could be to ensure that they are provided with sufficient information about the purpose of the assessment prior to the goal setting component. Additionally, while asking about 'three wishes' may be generally understood to be something within a child's domain, especially in targeting the suspected problems encountered by the child in the context of the assessment, it is necessary to account for the child's competences in communication. Skills in communication such as reading facial expressions, intonation, syntax, as well as context and the intention of the speaker may have relevance to the interpretation of the question. This may be especially complex for questions with subtle context-bound agendas like the three wishes question. Such acquisition of pragmatic skills is often

variable and developmentally tied and practitioners could bear this in mind when goal setting.

In conclusion, ongoing attention is being given to improving the communication skills of practitioners at all levels of experience with the use of empirical evidence. Greater attention to the specifics of interaction through the training environment has potential to further improve practice. Although experienced practitioners often utilise effective communication techniques, translating and conveying these practices to trainees can sometimes be difficult. An understanding of the phraseology and subtleties of questions can highlight the need to examine other aspects of speech in more detail. We recognise that mental health practitioners representing different professional groups conduct assessments in different ways and that the use of questions, such as three wishes, are not utilised by all. Nonetheless, where practitioners do favour the use of these kinds of engagement techniques, we suggest that the relevance to the child and the goal-setting agenda are considered carefully.

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