Children's claims to knowledge regarding their mental health experiences and practitioners' negotiation of the problem

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Abstract:

Objective: The objective was to identify how children knowledge positions were negotiated in child mental health assessments and how this was managed by the different parties.

Methods: The child psychiatry data consisted of 28 video-recorded assessments. A conversation analysis was undertaken to examine the interactional detail between the children, parents, and practitioners.

Results: The findings indicated that claims to knowledge were managed in three ways. First, practitioners positioned children as 'experts' on their own health and this was sometimes accepted. Second, some children resisted this epistemic position, claiming not to have the relevant knowledge. Third, some children's claims to knowledge were negotiated and sometimes contested by adult parties who questioned their competence to share relevant information about their lives in accordance with the assessment agenda.

Conclusion: Through question design, the practitioner was able to position the child as holding relevant knowledge regarding their situation. The child was able to take up this position or resist it in various ways.

Practice implications: This has important implications for debates regarding children's competence to contribute to mental health interventions. Children are often treated as agents with limited knowledge, yet in the mental health assessment they are directly questioned about their own lives.

1. Introduction

In this article, we explore the dynamic negotiation of 'knowledge' in child mental health assessments, attending to how the positioning of children as 'knowledgeable' reframed who had the rights to claim that their version of the proposed problem was accurate. Indeed, the assessment context is one where issues of knowing, rights to demonstrate knowledge, and rights to formulate descriptions inherently generate local sensitivities, and can have extra-interactional consequences in terms of diagnosis and access to further treatment. This context is particularly pertinent as these interactions have multiple members, including children. For the practitioner, therefore, there is a need to balance a child-centred assessment against establishing a credible version of the presenting problem.

Most research on child mental health has examined patients/families already known to services. There has been little research exploring initial child mental health assessments [1] and virtually no qualitative work on these encounters [2]. The initial assessment, an inherent aspect of any health institution, serves to collect information, engage with the family, and determine future need [3]. These assessments are designed to investigate whether the child has a mental health disorder that requires specialist mental health input. The initiative arguably reduces waiting times, increases patient satisfaction [4], and functions as a gateway to specialist services.

The institutional character of child mental health assessments is characterized by knowledge elicitation by practitioners and the production of information by families about potential psychiatric conditions, with the goal of producing diagnoses and implementing interventions [5]. These assessments are complex encounters, particularly as practitioners work with multiple family members and the patient during a single session [6]. While assessments typically aim for the practitioner to establish a definition of the nature of the presenting 'problem' in order to ascertain whether further service contact is indicated, contestation and/or explicit disagreement between the various parties about what this 'problem' might actually be is likely. For example, children may resist practitioners' attempts to access their mental health experiences, thereby hindering the progress of the activity [7]. Children themselves are rarely the main initiators of attendance [8], which has been argued potentially to affect their engagement with the therapeutic process [9]. Alternatively, family members

may attempt to resist clinicians' accounts of the presenting problem, although this may in turn be resisted by the practitioner [10].

What becomes of particular interest is the manner in which matters of knowledge are managed and negotiated between participants in such assessments, where practical consequences for children and families are predicated upon the professionally-sanctioned version of the 'problem' [11]. Broadly, institutional talk is typically characterized by asymmetries both in terms of interactional organization and knowledge [12]. In the examined assessment context, the fundamental institutional aim of which is to elicit information about a child's life and experiences, such asymmetry may be especially pertinent for three reasons. First, it has been broadly described that children are typically afforded only a 'half-membership' status to the group in which they are interacting with adult members, and are not considered to have full interaction rights [13]. Second, the specific children in these interactions are present in this context because there has been some level of recognized historical concern about their behavior, emotional wellbeing, communication and/or development. A range of studies in different contexts have consistently demonstrated a number of ways in which individuals categorized as such may demonstrably not be afforded comparable interactional rights as other speakers on a moment-by-moment basis [14][15]. Third, in these initial assessments, the children (and families) are the individuals whose experiences and 'problems' are *being discussed*, and therefore it would be socially expected that they might possess primary rights to describe these themselves uncontested [16]. Given that this context brings (at least) these three sets of partially conflicting issues together, it might be predicted that complex interactional matters may arise during these sessions in relation to children's positioning to take the conversational floor, the manner in which their epistemic rights to share about their state of affairs are negotiated, and the extent to which their version of events is received as accurate and/or reliable.

Given this backdrop, we investigate how this particular group of children was treated as social agents with rights to 'know' within the context of an assessment. We explore tensions of symmetry and asymmetry between adults and children, considering how children's positioning to convey 'knowledge' about their condition was treated as fluid. Our analysis was informed by the question: What are the conversational practices that practitioners and children use to build their own and their co-participants' knowledge status, and how do these practices bear on the achievement of institutionally relevant goals?

2. Methods

The data consisted of video-recorded initial mental health assessments at a Child and Adolescent Mental Health Service (CAMHS) with 28 families and each appointment lasted approximately ninety minutes. CAMHS is a UK specialist mental health service for assessing, diagnosing, and treating childhood mental disorders. Typically, children are referred for assessment by a General Practitioner. Children in the study had been referred for a range of potential problems, including behavioural, neurodevelopmental, emotional, and psychiatric disorders. All but one family was seen by at least two practitioners. All 29 practitioners within the team participated, including consultants, staff-grade and trainee child and adolescent psychiatrists, clinical psychologists, assistant psychologists, community psychiatric nurses (CPNs), learning disabilities nurses, occupational therapists and psychotherapists. Some sessions included medical students (1) or student nurses (2).

The study is representative of general attendance to CAMHS, with 36% of the children being female and 64% male. The age of the children ranged from six to 17 years (Mean = 11.21, *SD* = 3.10). Most children attended with their mothers (27), with seven also having fathers attend (one child attending with only their father). Six were additionally accompanied by their maternal grandmothers, and in some cases another family member and/or professional known to them.

2.1. Data analysis

Conversation analysis (CA) was utilized, as this pays close attention to the details of interaction. CA is a well-established approach to the study of talk-in-interaction, and takes naturally-occurring data as its focus [17]. The basic premise is that the researcher inspects recorded data to see how the participants in a scene display their own understandings of what they are doing and saying, as evidenced in the organization of their talk. This is facilitated through the production of a detailed transcription, conforming to the guidelines of Jefferson [18] and by the use of video-recordings so that non-verbal behavior (such as the child nodding in confirmation) and other paralinguistic features (such as the child smiling) can be transcribed and analysed.

2.2. Ethics

Approval was granted by the National Research Ethics Service (NRES: UK). Information was posted to families with their appointment letter up to three weeks prior to attendance. At the appointment, consent/assent was taken from clinicians, parents, and children, before and after attendance. Consent forms for children were age appropriate (different forms for different age groups) and time was taken before the appointment to verbally go through the child information sheet and the consent form with each child. Parents facilitated this process where needed. Consent was also taken from all parties at the end of the appointment to ensure that they had not changed their mind after they experienced the assessment. This was a mechanism to manage any misguided expectations about the appointment prior to attendance, and was particularly important for children.

3. Results

Analysis revealed that practitioners' directed questions to children and/or parents, with these questions being designed in ways that simultaneously positioned children as 'knowledgeable' (to varying degrees) on their own state of affairs whilst in some instances challenging the children's accounts of their experiences and circumstances. Accordingly, the rights of the children to own and display their knowledge unfolded through these question-answer sequences. Analysis explored how the positioning of the child as knowledgeable functioned to frame and reframe who had the right to tell the 'true' story.

In conversational terms, particularly in relation to question and answer sequences, speakers occupy different positions on an epistemic gradient from more knowledgeable (K+) to less knowledgeable (K-) regarding the matter at hand [19]. In our data, three patterns of epistemic gradient were evident following practitioners' questions. First, some children were treated as being in a K+ position, and responded accordingly by asserting some knowledge. Second, some children were treated as being in a K+ position, but alternatively moved to take up a K- position. Third, there were instances in which the K+ position of the child was negotiated, treated as flexible or even contested by the adult participants. These three analytic findings were consistent across the full data set with a large sample of each of the three types of knowledge positioning in each family. Due to space limitations, we selected illustrative examples and present these extracts to highlight how this was achieved in practice. Taken

together, these patterns indicate the complexities of interactions where multiple agendas may be at play. For instance, a practitioner must navigate both the need to establish whether further assessment is needed and practice in a child-centered way.

3.1. K+/K+ - child treated as an epistemic agent and then takes up the knowledgeable position

The practitioners most commonly employed questions to elicit information from children, and these took many different forms including (but not limited to) yes/no interrogatives, declaratives, and wh-prefaced. Questions are themselves a form of social action designed with a primary function to seek information [20], and in health these questions can be sensitive in nature [21]. In the data, practitioners treated children as holding epistemic rights to knowledge about their own lives and directed questions toward them. Particularly pertinent were situations whereby the child was positioned as K+ in terms of their own experiences, thoughts, and feelings.

INSERT TABLE 1: EXTRACT 1 HERE

Here, the practitioner treated the child as having privileged access to his thoughts in that it was only the child who could address the question *'what do you think will happen'* (line 1). When an individual's thoughts, feelings or experiences are addressed by speakers, that individual is positioned as the epistemic authority (K+) on such matters [22], which is the case here. Notably, the open-ended narrative style wh-prefaced question required the child to conceptualize the thoughts in the present tense, asking the child to comment on their thoughts regarding what '*will happen'* if the child failed to touch things. This child, while taking up the K+ position, never volunteered additional details, resulting in sensitive details regarding the child's thoughts being actively pursued by the practitioner (lines 4/6/9). Hence, while the child took up an epistemic right to speak for himself regarding his thoughts, it was the practitioner who directed the trajectory of the knowledge revealed and thus the pursued agenda. It should also be noted that the above discussion relates to the anxious, ostensibly unusual beliefs which have brought the child to this assessment in the first place, as demonstrated by the practitioner's emphasis on '*think'* in line 1. This may be further reflected by the lack of positive evaluation from the practitioner following the child's answers, in spite of the child's K+ positioning.

INSERT TABLE 2 = EXTRACT 2 HERE

Similar to extract one, the practitioner's initial question positioned the child in the K+ position by making reference to recent events and framing the topic as the words of the child *'you said'*. Its open-ended style, based on information provided by the child, allowed the opportunity for the child to frame their knowledge of the event in their own words. In this case, the uptake from the child treated the question as a direct elicitation of knowledge and provided a straightforward information response which aligned with the practitioner (line 9). However, following some multi-party repair work, which in itself can be challenging (i.e. seeking to correct a misunderstanding) (lines 10-12) the practitioner ultimately treated this response as insufficient; marked by noting the child's *'smiling'* (line 14). Hence, although the child's epistemic rights were grounded in experiential claims about her motivations at the time (constituting a K+ position), the legitimacy of the response was challenged by the practitioner, with '*was that really some- what you wanted to ↓do'* calling for an account of the initial response. Also, the practitioner replaced the word '*hoping'* with '*wanted*', further calling for the child to account for whether suicide was something that was truly '*wanted*'. Yet, this challenge was not fully accepted by the child, as she continued to assert her epistemic authority to know about her experiences and motivations regarding the knife (line 19). As such, the legitimacy of the original claim was made evident with the K+ position originally granted being maintained.

3.2. K+/K- Child treated as an epistemic agent but takes a K- position in response

In contrast to the above, there were instances whereby the practitioner treated the child as having epistemic agency, but the child responded by declining to take up that position in various ways. Consider extracts three and four. In both instances, the two children responded in a projected K+ position with assertions that they could not remember the answer to the prior question. Given that these questions indexed personal matters and therefore positioned the children as holding epistemic authority, "can't remember" responses powerfully worked to resist the practitioners' trajectories of questioning:

INSERT TABLE 3 = EXTRACT 3 HERE
INSERT TABLE 4 = EXTRACT 4 HERE

While these extracts both demonstrate a child being placed in the K+ position but then taking the K- position accounted for in terms of an inability to remember, there are some key differences between them that illustrate the parameters of variability of this phenomenon. In extract three, the child's response followed a long, qualified question turn which included an account for its own asking (lines 1-4) and was designed to establish a subtle topic shift from what has preceded. Despite being positioned as K+ the child's response was relatively minimal and rendered pursuit of further detail difficult, particularly given that it provided a response to only the final part of the practitioner's long question [23]. This difficulty is reflected by the subsequent laughter from the practitioner, signaling some trouble with the response [24] and hence the child's K- position. In talk, such voluntary laughter functions to manage any interactional trouble, with episodes of shared laughter being a highly ordered event which has been coordinated by the participants [25]. Conversely, in extract 4 the practitioner's question was one that sequentially followed a prior response by the child, and therefore represented a further pursuit of the present topic which necessitated a building up of knowledge, rather than new knowledge specifically. Here, while trouble was indicated by the child through the significant pause and prefaces of *'well'* and '*eh'* (line 8), the child's ultimate adoption of the K- position was less minimal than in extract three and, notably, invoked the mother's epistemic agency to comment on the history. By doing so, the child maintained the progressivity of the interaction (i.e. the progressive flow of the conversation), while the *'not remember that much'* (line 8) appealed to a reading that it is the finer details that were not being recalled, rather than the generality of the incident. Hence, the child was able to exert agency and control in the encounter [26] and, potentially, inoculate against accusations of stake in the version being presented [27], while allowing the clarification sought by the practitioner to be provided by the mother.

A key characteristic of both extracts was that the nature of the questioning from the practitioners required a level of retrieval of memories from periods in the child's history. In both cases the practitioner was requesting information from when the child was younger and the implication from this is that the events could be 'factually' provided, i.e., a correct answer. In the case of extract 4, interestingly, the practitioner offered the child a choice of two alternatives with an 'either/or' designed question [see 28], and the uptake of a K- positon meant that the factual recall of the event was provided by the mother. Thus the orientation in

the responses to these historical recall questions, was that it was the detail that was not recallable, due to the age of the child at the time those events occurred.

3.3. K+ negotiation – child's K+ position is treated cautiously

The nature of the multi-party interactions and the relative status of the child's knowledge position within these interactions meant that some questions offered by practitioners could be answered by either the child or parent, or collaboratively built by multiple parties. In these instances, the child was cautiously positioned as a K+ epistemic agent, and equally other members of the interaction displayed rights to qualify, build, or disagree with the response provided. Hence, when a K- position was adopted by the child, when the legitimacy of their account was queried, or when a response failed to conform to the normative/expected response, the progressivity of the interaction was often maintained by other parties. While it is fairly typical for parents to step in and answer practitioner questions when a child fails to respond in a timely manner [29], here, parents also intervened to indicate responses as inadequate, inaccurate, or incorrect. Such challenges to claims of knowledge, when considered sequentially on a turn-by-turn basis, indicate complex boundaries of epistemic authority [30].

INSERT TABLE 5 = EXTRACT 5 HERE

In lines 1-3, the practitioner can be seen to treat the child's knowledge position cautiously. Notably, this initial question consisted of three parts (two wh-prefaced and a declarative), with no transition relevance place (i.e. the point at which one speaker completes their turn and another takes up a turn) [31] between each part for the child to take the conversational floor and respond with a competent answer. The first part referred to enjoyment in the past, *'what things did you enjoy doing together when you were little* (lines 1-2)*'*; the second part asked about the competence to recall the enjoyment, *'what can you remember'* (line 2); and the third part was a declarative question with an inference built in that connected to the previous two parts of the question, *'you look like you like mega blocks?'* (lines 2-3). This declarative by its linguistic nature required the child to confirm or disconfirm the observation. At this juncture, the sequentially expected move would be to address the last part of the turn [23], but the statement in line 2 does not clearly project for any particular kind of subsequent response. Accordingly, with no response initiated from the child during the pause following

this statement, a more straightforward question, *'did you like mega blocks when you were little'* (line 5), was produced for the child, positioning the child in a K+ position related to the current activity. In response, the child neither took up a K+ nor K- position; rather, the child was presumed to display difficulty in ascertaining the meaning of the question, as evidenced in the mother's reformulation of the practitioner's original question. Thus, the mother took responsibility for the progressivity of the interaction, treating the child as being in a K+ position and able to provide knowledge to the practitioner regarding his past preferences. At the same time, the mother also positioned herself as K+ when the child apparently answers inadequately, stating *'I know'* (line 12). Ultimately, even when the mother offered a more detailed reading of the child's play in lines 16-19, her use of the interrogative tag *'didn't ya'* positioned the child to respond in the K+ position sequentially following her response. Hence, she still treated the child as possessing epistemic authority in spite of the practitioner's earlier caution.

INSERT TABLE 6 = EXTRACT 6 HERE

Extract six illustrates a different route through which a K+ negotiation played out through a discussion of the child's visits to the grandmother. While the child offered a K+ response (lines 2-4) following a wh-prefaced question, the response itself was arguably problematic as it evoked notions that the grandmother was 'annoyed' *'when I annoy her' (line 7)* – a quality not typically associated with enjoyment, as projected by line 1. Accordingly, the response was treated as questionable by both the practitioner and mother, who thereby collaboratively cast doubt on the epistemic agency of the child. The impact of these moves can be seen in the subsequent downgraded account of '*she does sometimes*' (line 7) by the child, but in spite of this downgrade the practitioner continued to challenge the child's response by offering information that he had acquired from the child's mother, stating: '*but you do enjoy her cuddles*' (i.e. cuddles from the grandmother) (line 13). The use of the word '*but*' accepts the prior account whilst building a counter to the child's description of his relationship, as the notion of '*cuddles*' sits in rhetorical opposition to being told to '*go away*.' Notably, the long pause and the child's subsequent statement, '*why d'you have to tell them that*' (line 15), made evident both that the information regarding the *'cuddles'* was accurate but also that the mother did not have the right to share this knowledge with the practitioner. The child, therefore, positioned himself as the rights holder of this information. In this way, multiple parties negotiated both the accuracy of the knowledge and who had the right to offer it, with

the boundaries of these rights being co-constructed by all of the involved parties, including the child.

4. Discussion and conclusion

4.1. Discussion

Through our analysis, we have highlighted variation in how the positioning of the child as 'knowledgeable' and 'an expert on who you are' served to reframe presented versions of emotional, behavioral, educational and familial difficulties. Practitioners directed their questions regarding service attendance mostly to the children directly, treating children as potentially knowledgeable regarding their own hopes and experiences even in circumstances where the *content* of their answers was not positively received. The children were then able to take up or resist this position. Nonetheless, their responses were treated differentially with their presentation of problems sometimes treated as incomplete, and, at times, inaccurate. Often their knowledge claims were challenged, negotiated, and redefined by the adult interlocutors.

4.2. Practice implications

Like most healthcare services, child and adolescent mental health practice is underpinned by the policies of child-centeredness and participation [32, 33]. Thus, professionals in healthcare settings must remain cognizant of their communicative practices [see also, 34]. Across our data, we pointed to how practitioners positioning a child as able to provide accounts left open the possibility that children were active participants in their own care. This was particularly evident in the 'K+ negotiated' category whereby the children's epistemic privilege and rights were treated cautiously by the practitioner, and in some cases challenged.

We argue that such inconsistency does not reflect a 'failure' on the part of the practitioners to practice in a child-centered manner. Rather, this points to the complexity of the interactional and institutional business at play. The practitioners' professional mandates are potentially underpinned by a dilemma: on one hand, to establish a version of the presenting problem that enables consideration of whether a child and/or family should be offered further sessions or discharged from the service; on the other hand, to enable active participation of the child in

their assessment, within contemporary discourses of child-centered practice, all of which is framed by these 'ill' children's membership statuses. As has been demonstrated in other institutional contexts, the complexity of managing such institutional dilemmas cannot be understated [e.g., 35]. This may reveal itself in some of the dynamic and delicate positioning moves taken by the practitioners, as well as the inconsistencies, in the above extracts. At the same time, in these interactions there is a child and other family members who are individually and collectively negotiating contested and morally-loaded positionings in relation to 'mental health' (and, often, family relationships). Such negotiation involves complex, subtle, and dynamic interactional processes, but in addition may not always be congruent with the agendas being pursued by practitioners. Additionally, practitioners rely heavily on questions to elicit relevant information from the children and these question designs reflect the foundation of the institutional task at hand.

For practitioners, then, our analysis makes explicit the tensions inherent in implementing child-centered work in a complex setting, such as a child and adolescent mental health service. Individual practitioners will vary in the extent to which they seek to uphold participatory rhetoric in their everyday work, but for those who espouse these principles, our identification of interaction conduct that more or less positions the child as 'experts on who they are' may enable empirically-informed reflection on clinical practices [36]. Furthermore, this has implications for broader notions of client-empowerment, which is central to mental health settings [37]

4.3. Conclusion

In our data, it is the practitioner who ultimately has rights to position the child as K+ or K- though the design of their questions. Typically, the child and family members are positioned as respondents to or recipients of these questions. Hence, these data provide a powerful case of an interactional context in which knowing, and rights to know, are of significant macro- (institutional) and micro- (sequential) social import.

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The authors declare no conflict of interest

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Tables = Extracts of data

Table 1

Extract one: Family 21 (Prac = Community Psychiatric Nurse/CPN)

1	Prac	What do you THINK will happen if you don't touch
2		something that's light?=
3	Child	= The worry in my head will come real.
4	Prac	The worry in your head [will c]ome ↓real
5	Child	[yeah]
6	Prac	(0.2) What's the worry in your head?
7	Child	Could be anythink
8		(.)
9	Prac	Give me the a a an example of one of the worries
10		that you might have
11		(0.2)
12	Child	Somebody will die.

Table 2

Extract two: Family 6 (Prac = psychiatrist)

1	Prac	so when you ↓said that you were going to take a
2		↓knife to yourself
3		(1.0)
4		yeah?
5		(1.1)
6	Prac	What were you ↓hoping would happen?
7	Child	Erm
8		(2.4)
9		f::or me to ↓actually kill my↓self.
10	Prac	Mummy w↑ould?
11	Child	No me ↓to kill ↓myself ((smiling))
12	Prac	Say that ↓again mummy would?
13	Mum	↓No for her to kill her↓self.
14	Prac	Ri:ght you're ↑smiling as you ↓say that which makes
15		me ↓think that (.) was that really some- ↓what you
16		wanted to ↓do was kill yours↓elf

17	Child	When I'm ang↓ry
18		(1.7)
19	Child	I ↓do (.)

Table 3

Extract three: Family 2 (Prac = Psychotherapist)

1	Prac	I want to ask ↓you a little bit and it ↑might not
2		↓seem sort of directly ↓relevant but just a little
3		bit ab↓out you growing(0.2)↑up (.) okay ↓cause we've
4		started talking ab↓out your family
5		(1.1)
6	Prac	and I ↑wonder if you ↓could(0.5)↑just tell me about
7		↑how things were ↓when you were (.) small ↓whether
8		you went to (0.8) nurse↑ry pl↓ay group?
9	Child	((*shrugs shoulders*))↓Can't remem[ber heh heh] heh
10	Prac	[(No) heh heh]

Table 4

Extract four: Family 27 (Prac = CPN)

1	Child	He's jus' bin starting on me .hhh again: bu:::t we
2		ha- the but we haff:: (0.5) um:: some troubles back
3		in the past.
4	Prac	Mm::
5	Child	We have (.)
6	Prac	What with this: (1.2) this lad or some other lads?
7		(2.1)
8	Child	We:ll eh I- >I can't remember that much< and I
9		even:: .hh ( ) stuff. I think y'ask mum she
10		could tell you mo::re
11		(0.5)
12	Child	[like] better.
13	Mum	[.hhh]Had some history last year with bullying, and
14		the school rectified it by separating them

Table 5

Extract five: Family 4 (Prac = Occupational therapist)

1	Prac	↓An’ what things did you enjoy doing to↓gether when
2		you were little what can you re↓member you look like
3		you ↓like mega ↓blocks?
4		(0.65)
5		↓Did you like mega blocks ↓when you were little?
6	Child	°↑uh°
7	Mum	what toys did you ↓play with when you were little
8		Jason?
9	Child	Um:
10	(1.7)	
11	Child	I:(2.0)°(I ↓didn’t play with any↓thing)°
12	Mum	I ↓know (.)
13	Child	What?
14	Mum	°↓Go on ↑see if you can ↓think°
15	Child	°I can’t think of ↓it°
16	Mum	↓you used to have I:(0.3)boxes ↓of ca:rs ↓he used to
17		line them all ↓up
18		(1.2)
19	Mum	↓on the settee didn’t ↓ya?
20		(0.8)
21	Mum:	All your ↓cars.

Table 6

Extract six: Family 22 (Prac = Psychiatrist)

1	Prac	[what does she do that you] en↓joy (.)=
2	Child	[That’s what ( )]
3	Prac	=When you (are) visiting her?
4	Child	>Tell me to go away< (.)
5	Prac	She d- she does t[ha:t]?
6	Mum	[No she] does not.
7	Child	She does sometimes when I open (.) [when I (annoy
8		‘er yeah)]
9	Mum	[When you annoy
10		‘er yeah]
11	Prac	Okay
12		(0.6)

13	Prac	but you do enjoy her cuddles?
14		(2.3)
15	Child	Why d'you have to tell them ↓that?
16	Mum	Well coz you do don't ya?