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Progressivity and participation: children's management of parental assistance in paediatric chronic pain encounters

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Abstract

This article examines how older paediatric patients (10–18 years) initiate different actions, including the solicitation of parental assistance, to accomplish the task of answering clinicians' symptom questions in three paediatric tertiary care clinics. Using the qualitative method of conversation analysis to examine children's symptom accounts in 69 video-recorded outpatient intake visits, I describe four child-initiated strategies that preclude, solicit and limit parental assistance in the interactional environment of having difficulties in providing an answer. These strategies are: children's own answer searches, children's solicitations of corroboration, children's solicitations of an answer, and children's answer completions. Supported by the clinicians' strong commitment to child-centredness, children manage to solicit parental assistance without losing the opportunity to present their own symptom accounts.

Keywords

clinician-child-parent triadic communication; chronic pain; tertiary care; childhood; patient participation

Introduction

This article analyses an overlooked aspect of children's ability to exert agency and control in paediatric encounters: how children answer clinicians' questions by inviting specific types of parental support and excluding others. Specifically, I examine how older paediatric patients initiate four types of actions, including the solicitation of parental assistance, as a means to overcome difficulties when answering questions during pain symptom accounts. Although at first glance children's solicitation of parental assistance may suggest that children are not competent respondents, I show that in fact they actively organise their symptom presentations by (1) deciding when to preclude or request assistance; (2) orienting to the preference for progressivity (*i.e.* the interactional pressure to complete the activity of answering, and moving along with the progress of the medical interview); and (3) using specific interactional strategies that simultaneously invite parental participation and limit it. Unlike previous research that has focused on how parents take over the role of respondent, I show that children can involve parents while maintaining their role as primary informant of their own symptoms, as well as managing the rights and responsibilities associated with this role.

Providing clinicians with symptom information, a fundamental aspect of the 'patient' category (Byrne and Long 1976, Heritage and Robinson 2006, Mishler 1984, Roter and Hall

1992, Stivers 2007b) is not easy: it involves accounting for the visit, assessing what information is medically relevant (Heritage and Maynard 2006), transforming one's experience into medically discrete symptoms (Kleinman 1988, Mishler 1984), and ultimately, managing one's self publicly (Goffman 1959). For children with recurrent non-malignant pain, this task is even more complex for two reasons: the difficulty of articulating an account out of long and complex medical histories of multiple (often misdiagnosed and mistreated) pain symptoms and the time pressure to produce this account before the clinician shifts to the parent or the parent takes over (Carter 2002, Clemente in press, Clemente *et al.* 2008, Nutkiewicz 2008). Thus, although the strategies identified in the present paper are neither restricted to children nor to chronic pain patients, children's competence as symptom informants is even more noteworthy in the particular context of paediatric chronic pain treatment. More generally, my research suggests that clinicians can promote children's participation, and can access their symptom accounts directly in three specific ways: by building upon children's strategies for acting as symptom informants; by addressing the challenges associated with increased patient involvement in medical interactions; and by turning difficulties into opportunities for children to practise 'being a patient'.

Background

Paediatric communication is a dance of three partners (Gabe *et al.* 2004, Pantell and Lewis 1993, Bates *et al.* 2002a), even while one is momentarily silent. Yet researchers frequently adopt a dyadic approach, analysing separately communication between the doctor and parent and that between the doctor and child (Bates and Meeuwesen 2001). This dyadic framework leaves unexamined a fundamental aspect of paediatric encounters: the communication between the child and the parent, whether it is parental control of child talk (Aronsson and Rundström 1988, Bates and Meeuwesen 2001) or the negotiation for response to clinicians' questions (Stivers 2001). My analysis of children's management of parental assistance while answering clinicians' questions provides further evidence that no aspect of paediatric communication can be analysed as an isolated dyadic exchange, whether between child and clinician, parent and clinician, or even child and parent.

Children's limited participation has been described across numerous paediatric settings and conditions, including emergency care (Wissow *et al.* 1998), acute and routine outpatient care (Aronsson 1991, Stivers 2001, Bates *et al.* 2002b, van Dulmen 1998), family therapy (Cederborg 1997, Tannen 1983) and chronic illness (Beresford and Sloper 2003, Pyörälä 2004, Silverman 1987, Young *et al.* 2003). Some authors have reported that parents take the interactional floor and reduce children to the status of passive bystanders or 'non-persons' (Aronsson and Cederborg 1996, Cederborg 1997, Pyörälä 2004, Strong 1979), but other authors have observed higher levels of children's participation (Silverman 1987, Stivers 2001). Socio-historical and cultural changes in perceptions of children's competencies and expectations (James and Prout 1997, Meeuwesen and Kaptein 1996, Pufall and Unsworth 2004) help to explain different degrees of participation. Despite these differences, two findings recur across studies: children participate less than parents, and infants and young children participate less than older ones.

In this paper, I situate children's participation, turn-by-turn, in the specific circumstances within which children's actions occur. The investigation of children's social actions 'from within', reveals 'the procedures by which participants themselves organise and make sense of their activities in a given social context', as well as how 'those empirical circumstances', or 'arenas of action', can be both enabling and constraining in terms of children's capacity to display social competencies' (Hutchby and Moran-Ellis 1998: 10).

The child-initiated actions examined here manage multiple risks that threaten children's role as primary informants of their symptoms. When a child does not answer in a timely fashion or displays difficulties in answering, a parent often answers (Stivers 2001). Parents face a dilemma: to wait to see if the child, the selected respondent, eventually answers, or to answer the question themselves and thereby move the interaction along (Stivers and Robinson 2006). Stivers and Robinson illustrate how participants often resolve this dilemma by prioritising the progressivity of the interaction: the non-selected speaker overrides the primary rights of the selected respondent in order to complete the activity at hand (*i.e.* answer the question). However, as I show here, parental override is not always the default outcome; the children themselves may initiate courses of action to retain, affirm, and take upon themselves both the rights and the responsibilities of answering.

My study makes a number of contributions to the study of childhood and 'patienthood', at the intersection between the interaction order (Goffman 1983) and other social systems, particularly the family and medicine. First, I advance research that approaches childhood as socially constructed and not biologically determined (James and Prout 1997) by providing a data-driven analysis of children's own ways to exert some agency and participate in their own healthcare. Instead of focusing on how adults encourage or discourage children's participation (Clemente *in press*, Clemente *et al.* 2008, Stivers 2007a, Tates *et al.* 2002a), I focus on what children do to overcome these limitations.

Secondly, I advance research on patients' contributions to the medical interview. With the growing interest in patient-centredness (Mead and Bower 2000, 2002, Stewart *et al.* 1995), this analytic 'spotlight' on the patient (Drew 2001) complements research that has focused primarily on clinicians' patient-centred behaviours.

Thirdly, my spotlight on how the child patient incorporates and limits parental participation in the pain symptom account manifests the theoretical and clinical complexities of Seiffge-Krenke's 'one body for two' problem (1997): the permeable boundaries between the roles of parent-caregiver and child patient with different sets of knowledge over one ill body. I show that the category of patient (with its associated practices, rights, and responsibilities) cannot be unequivocally equated with one person. Furthermore, these findings underscore the importance of providing children with opportunities to learn through participation (Rogoff *et al.* 2003) and to practise 'being a patient' (Stivers 2007a), so as to promote proactive patient behaviours that will facilitate their transition to adulthood and to taking responsibility of their own healthcare.

Finally, the detailed analysis of the socially organised give-and-take between parents and children when answering clinicians' questions underscores the need to take into account the semi-autonomous character of the 'interaction order' (Goffman 1983). Analyses of paediatric medical encounters should include the fundamental interactional practices with which social life is organised. In the present case, this involves examining how participants orient their actions vis-à-vis the dilemma of sequence progressivity, that is, of the 'nextness' and contiguity of an answer after a question (Schegloff 2007). Under these interactional pressures, I illustrate how child patients not only manage to accomplish the task of answering, but also to reaffirm their primary rights as pain symptom informants.

Data and methods

The analysis presented here is based on 69 video-recorded outpatient intake visits at three tertiary care clinics in the US, specialising in paediatric pain, gastroenterology, and neurology. The data also included child and parent self-reported-measures and semi-structured parent and child interviews that were collected at the time of recruitment and six

months later. Parents completed IRB-approved written informed consent forms and children provided written assent. Findings from the other study components have been reported previously (Bursch *et al.* 2006).

Patients (64% White), 46 girls and 23 boys, 10–18 age range, mean of 14.3 years and median of 14 years) had complex medical histories of multiple pain symptoms over extended periods of time (an average of 48 months prior to their tertiary care visit, with 41% of patients presenting multiple pain diagnoses). Patients had been through numerous appointments: they averaged 19 medical visits within the last 12 months, and 51 per cent of all patients had been seen previously by at least six different doctors. In the majority of intakes (88%), patients were accompanied solely by the mother.

Eight clinicians (75% White), five women and three men, 34–64 age range) participated in the study. All the clinicians were physicians, except for a clinical psychologist who worked in tandem with a physician in the pain clinic and was present in 23 intakes (45% of pain intakes).

The qualitative findings reported here are based on an examination of the opening and history-taking phases of the medical interaction (Byrne and Long 1976, Heritage and Robinson 2006), and were analysed using conversation analysis (Goodwin and Heritage 1990, Heritage 1997). Conversation analysis looks for practices in social interaction that evidence systematic communication design. To be identified as a practice, particular elements of communication conduct must be recurrent, specifically situated, and attract responses that distinguish them from related or similar practices. A central feature of this analytical approach is grounding the analysis of the practices used to perform a social action (*e.g.* using the words ‘ear infection’ to suggest a diagnosis during problem presentation) through the examination of responses of other participants (Stivers 2002). Conversation analysis has been widely used to study communication in medical settings (Heath 1986, Heritage and Maynard 2006, Maynard 2003, Peräkylä 1995, Silverman 1987, Stivers 2007b, West 1984).

Results

When a clinician asks a question of a child patient, a default organisation of participation is set in motion: the clinician and the patient engage in mutual gaze, and the other participants often remain silent and look either at the clinician who has asked the question or at the child who is expected to answer. In selecting the child patient as the respondent for a question, the clinician displays to both child and parent a preference to hear from the child. Embedded in the action of asking a question of the child are the expectations that the child knows the answer, is capable of answering, has rights to answer, is motivated to answer, and will do so immediately after the clinician’s question.

In this section, I analyse children’s departures from this default organisation of participation as children deal with difficulties in providing answers. In particular, I identify four actions children initiate in the service of answering: answer searches, solicitations of corroboration, solicitations of an answer, and completions. In an answer search, children display having problems, but do not seek (yet) parental assistance with the production of an answer. Instead, children use this strategy to buy some time while they attempt to answer on their own. Children also solicit parental assistance either to corroborate or give an answer. Finally, in the context of a parent’s answering, children carry out a number of different actions, such as accepting, rejecting, modifying, or simply outlasting the talk that a parent has produced to assist with the task of answering. In doing so, the child displays his/her right and responsibility to bring to completion the task of answering which s/he was originally

asked to do. The following child-initiated actions are three among other departures from the 'default' sequence of clinician asking child a question and child answering it: children also ask parents to expand their answers or claim insufficient knowledge with an 'I don't know'; clinicians either pursue an answer with the child or shift to the parent; or parents self-select to provide unsolicited answers.

Answer search

The expectation that an interlocutor will answer, and will do so contiguously and without delay, is a cardinal presumption of asking a question (Heritage 2007, Sacks 1987, Schegloff 2007, Stivers and Robinson 2006). In my data set, the paediatric clinicians' strong commitment to having the child present his/her symptoms at the beginning of the medical encounter is expressed by giving long periods of time to children to produce an answer (Clemente *in press*, Clemente *et al.* 2008). Additionally, parents, as in other paediatric encounters, allow children to try to respond first (Stivers 2001). However, the time that the child has to produce an answer is not unlimited: all participants display an orientation to time limitations. Clinicians may intervene with a second pursuit question or a repeat to deal with assumed problems of understanding; and parents, guided by clinician's child-centred waiting, may turn to look at the child to check for the cause of the delay.

More importantly, the children themselves display an orientation to the accountability of their non-response: children produce non-lexical speech perturbations following clinicians' questions, such as 'um', or a 'thinking face' gesture (Goodwin 1983, Goodwin and Goodwin 1986), or both, in order to display that they are trying to answer but do not have an answer yet. Non-lexical perturbations are typical of word searches and other forms of self-initiated repair (Schegloff 1979, Schegloff 1984, Schegloff *et al.* 1977), in which the speaker signals to the other participants that although s/he has interrupted his/her production of talk, s/he is *not* (1) giving up his/her role as speaker, (2) abandoning the production of talk, and (3) inviting other participants to help with the word search. During a 'thinking face' gesture, participants interpret gaze aversion (*i.e.* the speaker looks at a middle distance indeterminate point or modifies the positioning of his/her head to avoid mutual eye contact) as signalling that there is a reason to wait. With these vocal and non-verbal displays, the current speaker initiates a new and distinct activity – involving recollection, estimation, or search for a word in the service of resuming his/her talk.

In Extract 1, an 11-year-old boy embodies the activity of searching for an answer non-verbally with a 'thinking face' gesture. In her symptom elicitation, the clinician tries to determine whether the child suffers from two different types of headache, as diagnosed by previous clinicians, or only one type, as the child claims. In lines 1–3, the clinician announces that she is abandoning her questioning about the two headaches and begins to elicit the headache symptoms. (The patient in each case is identified as PAT, the parents as MOM/DAD, and the clinicians as DOC, or DR1/DR2 if two are present.)¹

After the clinician's request to confirm if pounding is one of his headache symptoms, the boy immediately engages in a 'thinking face' gesture (line 7). The boy withdraws his gaze from the clinician, avoids looking at his parents, and poses his gaze on no particular object in front of him. In the absence of non-lexical perturbations, his non-verbal 'thinking face' gesture makes it clear that he is actively engaged in answering. The patient indicates that there is no need for his parents or the clinician to initiate additional courses of action to deal with the delay, such as additional questions, prompts or unsolicited answers.

¹For transcription conventions see Jefferson 1974.

In Extract 2, we find a combination of multiple non-lexical perturbations and a complex choreography of gestures and body movements that include eye rubbing and covering, head lowering and raising, middle distance stares, playing with one's hair, and symmetrical hand movements. In line 1, after an extended period of social talk and a discussion of the patient's medical records, the clinician starts asking a 12-year-old boy questions about how his pain symptoms began. The boy answers the clinician's questions (lines 5 and 9), but does not launch an elaborated pain account.

When the clinician asks broader questions (lines 12 and 14), which are more burdensome and less likely to be answered (Clemente *in press*, Clemente *et al.* 2008, Stivers 2007a), the patient displays serious problems in framing a response. The child's delays, pauses, and non-lexical perturbations are punctuated by his constant movement of hands and head. With this complex non-verbal and verbal word searching behaviour, the child displays both that he is having difficulties and that he is actively engaged in trying to answer. Despite his numerous difficulties, he does not seek assistance from his mother. He only gives up his role of primary speaker at the clinician's explicit request for permission to talk to his mother (line 31). As Extract 2 also shows, the child's ability to engage in answer searches is contingent on the clinician's and parent's withholding of their own talk. In this sense, children's answer searches must be considered as collaborations, in which the child searches for an answer and clinicians and parents permit him/her to do so. ¹Insert hyperlink SuppMat1

Solicitation of corroboration

Independently of whether the child engages in his/her answer search, children may initiate other actions in the service of answering clinicians' questions: soliciting parental assistance to corroborate a tentative answer that the child is producing, or to give an answer. We will first examine children's corroboration requests.

In a solicitation of corroboration, a child puts forward a candidate answer to be confirmed or disconfirmed by the parent. Children rely on gaze to initiate corroborations and occasionally use a final turn 'right?', a full-fledged question, or try-marked intonation (Sacks and Schegloff 1979). There are two types of corroborations: partial and full. In a partial corroboration, the child solicits corroboration of a single component of his/her answer, often inviting a parent to confirm a reference to a person (Enfield and Stivers 2007, Sacks and Schegloff 1979), place (*i.e.* location of a symptom or place of a medical appointment), time (*i.e.* date of a medical appointment, and onset or duration of a symptom), or medication. In Extract 3, a clinician asks a 16-year-old girl about recent changes in her leg pains (lines 1–3). The girl produces a first component of her extended answer and then runs into difficulties.

In lines 8–9, the patient first looks away from the clinician into a 'thinking face' gesture, and then looks at her mother to solicit corroboration that 'two: mo: nths a: go:?' is the appropriate description of when her leg pains returned. With the try-marked final upward intonation of her tentative reference, the patient solicits corroboration for that temporal reference and not for the other components of her answer. After mom corroborates it, the patient returns her gaze to the clinician and completes her extended answer (lines 11–12).

An example of a full corroboration can be found in Extract 4 below. A 13-year-old girl is answering questions regarding the periodicity and duration of her abdominal pain episodes. In line 1, the clinician asks the girl if her abdominal pain also occurs on weekends. After some initial non-lexical perturbations, the girl gives an extended answer, explaining to the clinician that pain occurrence depends on whether she is going somewhere or staying at home (lines 3–6).

As she approaches the last part of her turn, the girl, who had been facing the clinician, begins to turn her head to her right, where mom is sitting (lines 5–6). As the girl says ‘that’ she makes eye contact with mom, who has been looking at her throughout the entire answer. As soon as mom produces her minimal form of agreement (line 7), both mother and girl disengage from each other, abandon the brief period of mutual gaze, and return to look at the clinician in front of them. The clinician unequivocally selects the girl as the respondent for his next question (lines 11 and 15), and the patient continues in her role of primary informant (lines 12–13).

Solicitation of an answer

In a solicitation of an answer, the child invites a parent to assist collaboratively with the production of an answer. In contrast to the corroboration requests discussed above, here the child contributes less (*i.e.* the child does not produce a candidate answer to be corroborated) and requests more (*i.e.* the child invites the parent to produce an answer, but retains the right to accept or reject it). Soliciting an answer can be done non-verbally, primarily relying on gaze, or in a combination of gaze and talk. Once again, we find two types of solicitations of answers depending on whether children solicit parental assistance with only a component of an answer or a full answer. For instance, a clinician asks a 14-year-old girl with cerebral palsy about the origin of her chronic back pain (data not reproduced here, [?insert hyperlink SuppMat2](#)). The girl engages in a partial solicitation in the midst of her telling and asks for her mother’s assistance only in naming the specialty of one of several doctors to whom she refers in her elaborated answer. Together with partial corroborations, partial answer solicitations are examples of solicitations within the boundaries of a turn of talk: the speaker grants another participant conditional entry into his/her own uncompleted turn (Goodwin 1986, Lerner 1996).

Full answer solicitations, on the other hand, take place at turn boundaries (*i.e.* before an answer is produced). In Extract 5, a full solicitation is done exclusively non-verbally, as in most solicitations in the present study. An 11-year-old girl with pain in multiple sites of her body comes with her grandparents to the clinic. In line 1, the clinician formulates a question about the approximate time for when her pain was worst. The clinician pursues an answer from the girl after her silences and incomplete answers (lines 2–5).

In line 10, as the clinician attaches a second, clarifying question to her initial question ‘What month’, the girl abandons mutual eye contact with the clinician, and turns to look at her grandmother (GMA). Without much delay, her grandmother answers the question looking at the girl and not at the clinician (line 11).

Answer completion

Children carry out different actions to limit parental participation during and after soliciting assistance, including accepting, rejecting, clarifying, modifying what a parent has said, and continuing with his/her own talk before the solicitation. With these actions, a child accomplishes answer completion and exercises his/her rights as primary respondent in charge of answering. Some of these children’s actions are illustrated in the continuation of the 11-year-old girl’s solicitation analysed in the previous extract. In Extract 6 below, we see that as soon as her grandmother provides the answer ‘Before Christmas I think’, the girl abandons mutual eye contact with her grandmother, stares at a middle distance indeterminate point in a ‘thinking face’ gesture while she says A little-(line 12).

The overlap between the girl’s ‘a little’ and her grandmother’s talk occurs at turn completion (Jefferson 1984), when her grandmother adds a second and more precise temporal reference. Simultaneously, the girl’s ‘thinking face’ gesture and initial A little-indicate that she is not

about to relay merely her grandmother's first answer, but that she is assessing its appropriateness. Indeed, 'A little-' evidences that the girl is attempting to modify her grandmother's first answer or produce a different one. In this context of competitive overlap characterised by hitches and perturbations (Schegloff 2000), the girl abandons her A little- and moves to show the appropriateness of her grandmother's second answer with her full repeat (lines 12 and 15). With her full repeat, the girl manages to outlast her grandmother's talk, give her answer in the clear, and be the last person talking (Jefferson 2004). Despite the fact that the clinician has already overheard it, the girl's delivery of her answer to the clinician is a way to display her approval of her grandmother's second answer. Altogether, the girl's actions demonstrate that she is acting as primary respondent with full participant roles and not as animator or 'sounding box' of her grandmother's words (Goffman 1981, Goodwin and Goodwin 2004, Levinson 1987), as well as with rights to accept or reject answers of secondary informants, claim ownership of the sequence, and limit parental assistance.

A fundamental aspect of how children invite and limit parental assistance is found in the organisation of a solicitation. In most solicitations, the child abandons the default position of sitting facing and looking at the clinician, and adopts a transient position in which his/her body continues to face the clinician, but the head is turned toward the parent. This 'torqued' body positioning (Schegloff 1998) frames the engagement between child and parent as temporary, since the child does not modify his/her sitting so as to face a parent in a more permanent positioning. This limited nature of solicitations is observable in Extracts 3, 4 and 6 above, in which the child brings her gaze back to the clinician as soon as the accompanying adult complies with the child's request.

In addition to the ecologically embodied organisation of solicitations, children can also resort to answer completions to ensure that parents do what they have been asked, no less and no more. A child may, after producing an initial answer solicitation (*e.g.* turning to look at a parent after the child is asked to give the date of a medical appointment), pursue it with a corroboration (*e.g.* proposing 'October?' as a candidate answer to be confirmed) after a parent fails to assist with the initial solicitation.

More often, children's answer completions are structured to ensure that a parent does not do more than s/he has been asked. Children's solicitations carry important risks for their participation as primary respondents. On the one hand, children initiate a solicitation because they are having difficulty providing an answer; the child risks being replaced as primary informant if s/he does not manage to produce an answer in a timely fashion. On the other hand, by inviting a parent to talk, the child's status as primary informant is also at risk: a parent may use the invitation to disagree with the child or to do more than the solicitation specifically requested.

The clinician's selection of the child as respondent to a subsequent question is crucial in deciding who will talk after answering is completed. A key function of children's completions is to influence the clinician's selection by reinforcing that the child is the original respondent to the question, and that the child is ready and willing to continue in the role of primary respondent. In Extract 7, a clinician asks a 12-year-old boy how much school he has missed because of his stomach aches (line 1). The child initiates first an answer search and then solicits the answer from his mother (line 4).

Mom takes this opportunity to give an extended answer, which she delivers looking at the clinicians and not at her son. After some back and forth, mom concludes her answer with a summary statement prefaced with 'So' (line 17), which is acknowledged as moving to closure by the clinician's sequence shift-implicative 'Okay' (Beach 1993). After this

exchange, the child produces a second move to close, returning to his present situation vis-à-vis school (line 20), and the sequence is closed by the clinician's assessment (line 21). By returning to his current and situation the child displays that the task of answering is now complete and that the clinician is to make the next move (Robinson and Heritage 2005). The child not only indicates his willingness to relinquish the interactional floor; more importantly, the child indicates that he is the one with the rights to relinquish the floor. He succeeds in reminding the clinicians that he is ready to continue as the primary informant, and one of the clinicians selects him as respondent in the next question (line 23).

Discussion

I have identified four strategies with which older children (10–18 years) overcome difficulties in answering clinicians' questions and reaffirm their rights as clinician-selected respondents. In an answer search, a child displays that s/he is having problems answering but forestalls parental assistance at this point. In a solicitation of corroboration, the child invites a parent to confirm or reject the answer that the child is producing. In a solicitation of an answer, the child invites the parent to assist with the collaborative production of an answer. In an answer completion, the child re-positions him/herself vis-à-vis what the parent has contributed to the task of answering, and vis-à-vis his/her role of initial respondent selected to answer. Although these actions often co-occur, they are nevertheless independent phenomena.

These practices are evidence of children's ability to manage the expectations and responsibilities associated with the role of a primary symptom informant. These actions, distinct from answering but done in the service of answering, illustrate how children locally organise the symptom presentation in two ways. First, children initiate new courses of action, whether on their own or by enlisting others' support, to accomplish responses to questions. Secondly, they use these actions to manage risks to their primary respondent status. If a child does not answer in a timely fashion or displays difficulties in answering, the clinician may switch to a parent or the parent may start talking to help the child. On the other hand, if the child invites the parent to talk, the parent may go on to disagree or to contribute more than s/he has been asked. By initiating these four strategies, children minimise the risks of losing their role as respondent while actively contributing to the progressivity of the clinical information gathering.

To a large degree, these child-initiated strategies are successful because they invite specific types of parental support and exclude other forms of parental participation. When a child initiates an answer search, s/he is prospectively limiting parental participation by withholding and discouraging it. Answer solicitations limit parental participation by framing parental assistance as temporally limited: the child and parent adopt unstable positions of body torque to look at each other while continuing to orient their lower bodies towards the clinician. This transient position is abandoned as soon as the parent assists the child.

Finally, answer completions limit parental participation both retrospectively and prospectively: they frame what the parent has said as responsive to an action embedded within the child's answer, act as a reminder that the child is the original primary informant, and display the child's resumption of his/her role as primary informant (and thus, selectable to answer a clinician's next question). In doing so, children establish themselves in the position of primary informants with full rights to talk and organise talk locally, and establish parents in the position of secondary informants with *limited* rights to talk, as long as the clinician retains the child as primary respondent. A child exercises his/her primary respondent rights to ask for help if deemed necessary; to frame parental talk not as an

alternative answer, but as ancillary talk provided to assist him/her; and to sanction the appropriateness of such assistance, by accepting, rejecting, or modifying it.

Conclusion

Relying on a triadic child-parent-doctor communication perspective (Stivers 2001, Bates and Meeuwesen 2001), I have identified four practices, including children's solicitation of parental assistance, with which children locally organise the presentation of pain symptoms and manage the expectations and responsibilities associated with this fundamental aspect of 'patient role'. My description of these previously unexamined child-initiated actions sheds light on children's competence as symptom informants, within the empirical circumstances that both enable and constrain children's ability to display their social competences (Hutchby and Moran-Ellis 1998). Indeed, my analysis of children's efforts to overcome these constraints reveals that children with long and complex histories of pain symptoms not only accomplish the task of answering, but also manage risks that threaten their roles as primary informants: they discourage adults from jumping in to help them and ensure that parents do not do more than what they have been asked to do. I argue that children succeed in affirming their rights as clinician-selected primary informants because these child-initiated strategies invite specific types of parental support and exclude other forms of parental participation. At the same time, this dynamic give-and-take between parents and children shows how the 'patient' role cannot always be equated with one person: although the child is the patient, parents carry out role-associated activities (Bates *et al.* 2002a).

Children, like their parents, experience difficulties in answering (Stivers 2007a) and organise their actions with an orientation to the 'interaction order' (Goffman 1983) that prioritises completing the activity at hand and moving along with the progress of the medical interview (Stivers 2001, Stivers and Robinson 2006). However, instead of being occasions for parents to become primary informants, children's difficulties can open up opportunities for informal learning through participation (Rogoff *et al.* 2003), so children can practise 'being a patient' (Stivers 2007a) with clinicians and parents as collaborators. Since patients' proactive roles in their medical visits are fundamental to effective healthcare (Frosch and Kaplan 1999, Greenfield *et al.* 1988, Kaplan *et al.* 1989), future studies should continue to identify strategies that promote children's participation in clinical encounters across different types of care and conditions: including patients' own strategies, as well as adults' patient-centred and child-centred behaviours. Once identified, specific strategies to promote children's participation can be tested for effectiveness at the clinical level and disseminated via professional and patient education (*e.g.* brochures for chronically ill children describing methods of effective communication with clinicians). Furthermore, given that children's ability to accomplish the task of answering is contingent on clinicians' and parents' collaboration, future studies should also examine the relationship between clinicians' degree of child-centredness, parents' degree of support, children's deployment of proactive behaviours, and children's developmental trajectories. Studies should investigate, for instance, whether younger children solicit parental assistance more often than older ones, or whether children's solicitations are more related to clinicians' and parents' behaviours than to child age. At a health policy level, future studies should continue to examine the practical and ethical dilemmas of involving chronically ill children in the management of their own health (Bluebond-Langner *et al.* 2005), balancing the emphasis on promoting children's participation with an understanding of the responsibilities that increased participation places on these children as patients.

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Extract 1

Case 57

1	DOC:	Okay. Just going back to: (.) h <u>Y</u> Qu:r headache, and we won't
2		call it <u>two</u> different kinds of headaches at this moment.
3		(.) cuz: if it's the <u>same</u> to <u>you</u> :, it's the <u>same</u> .
4		(1.6)
5	DOC:	Pounding?,
6		(1.0)
7	PAT:	→ ((thinking face)) Mm: no:: it just (.) ((looks at doctor))
8		stays there.

Extract 2

Case 61

1 DOC: And what (.) ·hh tell me a little bit about the pa:in. You had
 2 whooping cough.
 3 (0.3)
 4 DOC: When you were Ni:ne?=
 5 PAT: =Yeah.
 6 (0.5)
 7 DOC: And that's when everything started?,
 8 (0.3)
 9 PAT: Yeah.
 10 MOM: Yea:h.
 11 (0.6)
 12 DOC: So what do you <remember>.
 13 (0.3)
 14 DOC: Back when you were nine.
 15 (0.5)
 16 PAT: → ((places hands under chin)) Uh ug uhm (1.0) ·hhhhh hhhhh (1.2)
 17 → ((rubs eyes)) u::h (5.0) ((pulls hair back and places hands on
 18 the top of head)) I remember (0.4) uhm (0.7) uh ·h (1.1) *feel*
 19 like I started to feel this pai:n in my back. (0.3) and (1.1) I
 20 don't really remember it that well,
 21 DOC: Uh huh.
 22 PAT: Til I went to hospital,
 23 (0.4) ·hh[hhh
 24 DOC: [And then what d'you <remember>,
 25 (1.0)
 26 PAT: → ((lowers head and places hands on the back of head)) Wuhh (0.5)
 27 uh (2.5) ((raises head and covers eyes with hands)) when I was-
 28 ((thinking face while pulling back hair)) (0.8) uh, (0.3) hhh
 29 hhhhh (2.4) hhhh ·hhh it jus-((lowers head with hands on the
 30 back of head)) (3.7)
 31 DOC: Should we let mom fill this out?
 32 PAT: ((still looking down with hands on the back of head)) Yeah.
 33 DOC: Oka:y.
 34 (.)
 35 PAT: Sorry,
 36 DOC: O::h N↑o::.

Extarct 3

Case 42

1 DOC:	So: <u>d</u> uring the past six mo:nths, <u>h</u> ave they <u>s</u> tayed the sa::me,
2	>have they been getting< <u>b</u> e:tter, or do they just kinda go <u>u</u> p
3	and do:wn.
4	(.)
5 PAT:	<u>I</u> : <u>s</u> to:pped having them for a whi:le,
6 DOC:	Mm hm,
7	(0.3)
8 PAT:	→ ·hh A::nd n::o:w like ((thinking face gesture lasting one
9	→ second)) ((patient looks at mom)) two: mo:nths a:go:?
10 MOM:	Mm hm,
11 PAT:	((patient turns head to clinician)) <u>I</u> : (.) began having them
12	again.

Extract 4

Case 26

1 DOC:	Do you have it on <u>w</u> ee:kends?
2	(0.5)
3 PAT:	U::h (1.1) it-depends. Not at ho:me. (let's say) I'm going out
4	or something, (0.8) to like (.) I dunno like a play or something
5	→ ((patient starts turning her head)) I usually get ((patient
6	→ makes eye contact with mother)) <u>th</u> at.
7 MOM:	Mmhmm.
8	(2.6)
9 DOC:	U:h hu:h.
10	(4.0)
11 DOC:	Tch so > <u>w</u> hen you go to< a pla:y or you're <u>l</u> eaving the hou:[se:.
12 PAT:	[Mm
13	hm,
14	(1.0)
15 DOC:	°You'll get (.) belly pain,°

Extract 5

Case 38

1 DOC:	·hh when was it (0.4) the worst.
2	(2.6)
3 PAT:	Probably (in the middle).
4	(0.7)
5 PAT:	Like, (0.4)
6 DOC:	A <u>b</u> out when.
7	(0.3)
8 PAT:	Uh like:, (0.3)
9 DOC:	What month.<Do you [remember about?,
10 PAT:	→ [((turns head from clinician to grandma))
11 GMA:	Befo:re Christmas I think.<Just before Christmas.

Extract 6

Case 38

11 GMA: Befo:re Christmas I think.<[Just before Chris[tmas.
12 PAT: [A little-(.) [just before=
13 PAT: [((thinking face)) [((looks at
14 [clinician))
15 PAT: =[Christmas.
16 DOC: Like-(.) after Thanksgiving.

Extract 7

Case 25

1 DR2:	So how much <u>s</u> chool are you missing,
2	(0.7)
3 PAT:	U:m,
4 PAT:	((patient looks at mom))
5	(4.0)
6 MOM:	He's missed some half days,<he's missed u-like one whole day
7	since he'd been on the medication.
8 DR2:	Mm hm.
9 MOM:	But I'm <u>p</u> ushing him to go to school.
10	(0.5)
11 DR2:	Mm hm,
12 MOM:	Cuz we took-We were off <u>t</u> wo: months (0.7) for the do:ctors.
13 DR2:	Mm [h:m.
14 MOM:	[Wh::en uh we saw doctor Bayer the first time. She pulled'im
15	out and the doctors before they had him off a week at a time.
16 DR2:	Mm h::m,
17 MOM:	.hhh hhh So we were <u>o</u> ut for over two months. hh
18	(3.1)
19 DR2:	°Okay.°=
20 PAT:	→ =Now I'm back on the-back at school and stuff.
21 DR2:	Good.
22	(0.5)
23 DR1:	Tch so u:m (.) I was <u>n</u> oticing here <u>t</u> hat you-(.) wer-have been
24	having problems vomiti:ng, did that start befo:re the <u>a</u> bdominal
25	pain or about the same time.