

## The role of objects in understanding children's participation in paediatric rehabilitation

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This article will present a consultation with a nine-year-old boy, his parents and professionals at a paediatric rehabilitation unit in Norway. The empirical case illustrates how the boy's participation appears when toys and equipment is used, and also when the conversation proceeds during the consultation. The case is analysed by investigating the child's participation through how the interaction between the different persons takes shape, and how toys and equipment are used in the consultation. The application of role theory and a materialist approach focusing on the use of objects illuminates the boy's participation in different ways, thus providing relevant information about how the child's participation affects professionals' decisions in regard to the child.

**Keywords:** professional's work; children's participation; paediatric rehabilitation; actor network theory; role theory

### Introduction

Attention to and acceptance of children's rights to be more involved in decisions that affect them have evolved over the last few decades. This acceptance comes from various directions, of which three to be mentioned are; the growing influence of the consumer reflected in the term *user involvement*; the *children's rights agenda*; and the understanding of the *child as a competent social actor* (Alanen 2010; Franklin and Sloper 2006; Kellett 2010; Lightfoot and Sloper 2003; Sinclair 2004). Furthermore this acceptance is shown by a growing debate on children's right to be heard and to take part in decision-making, models for children's participation, how to capture children's experience, and the importance of user involvement, in addition to some user-centred designs in developing assistive technology for children (Alanen 2011; Fraser and Lewis 2004; Frauenberger 2011; Gallacher and Gallagher 2008; Graham and Fitzgerald 2010; Greene and Hogan 2005; Kellett 2010; Marti and Bannon 2009; Percy-Smith and Thomas 2010; Shah and Robinson 2006; Ulvik 2009).

Compared to research on children's participation in general, little research has been conducted in relation to disabled children's experiences of participation (Martin and Franklin 2010). The United Nations Committee on the Rights of the Child voices concerns about children belonging to marginalized groups or disadvantaged groups, and whether they are met with obstacles in exercising their right to participate and be heard in decision-making processes (General comment no.

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12-2009). Research shows that professionals involve children with impairment in a range of decision-making arenas, although the involvement of children at a higher strategic level than in practical work is still rare (Franklin and Sloper 2006). Other studies show a gap between how professionals, parents and children experience involvement (Young et al. 2006). In Scandinavia there is a lack of qualitative research that documents experience of participation in decision-making in paediatric rehabilitation, as well as of documentation on what takes place in consultations at the specialist level for children and youth (Bolin, Lindén, and Persson 2003; Connors and Stalker 2007; Eriksson and Granlund 2004). Research exploring children's experience mainly covers participation in school, experience from test situations and the experience of having a disability (Asbjørnslett and Hemmingsson 2008; Bjorbærkmo and Engelsrud 2011; Coates and Vickerman 2010; Connors and Stalker 2007).

The last 20 years of activity and research regarding children and young people's participation is influenced by the United Nations Convention on the Rights of the Child. Studies and activities concerning the right to take part in decision-making, the right to be heard in decisions, and models for participation reflect the human rights discourse (Lansdown 2010; Percy-Smith and Thomas 2010,3). The concept of participation is defined as the right to be involved in matters that affect one's life. Participation in this tradition is often described in terms of degrees of participation, as in Hart's ladder of participation (Shier 2001). Important improvements have been made concerning children and young people's collective right to participate (Tisdall 2010), but a criticism of the perspective is the sequential and hierarchical thinking of participation, as being culturally biased, and not sufficiently child-initiated (Malone and Hartung 2010). The criticism addresses important methodological questions on how to capture the child's point of view, which will be addressed below.

The concept of participation is also influenced by childhood sociology, where children as competent actors are explored as social participants (Alanen 2011; Bjerke 2011; Gallacher and Gallagher 2008; Ulvik 2009; Sinclair 2004). Participation is seen as an interaction, both passive and active, and the question is *how* the child participates. Participation is not necessarily studied as a right within the social perspective, but more as an action in itself.

As part of acknowledging the child as a social actor with competence and a right to be heard, there is the concept of *giving children voices*. Major questions concerning voice are: What affects the voice of the child, how are children given voices, how are they articulated, and how to study children's voices. This implies critical thinking on the role of context, power relations such as adult/child, reflexivity of the researcher on his/her influence on the situation, and also how the concept is socially constructed (Gallacher and Gallagher 2008; Holland et al. 2010; Kellett 2010; Robinson and Kellett 2004; Spyrou 2011).

In relation to health care and rehabilitation, using the International Classification of Function, Disability and Health, participation is defined as involvement in life situations (Law 2002). The goal for professionals working in accordance with this model is to facilitate participation in daily life for persons in need of rehabilitation. Standardized forms and conversations on daily-life activity are used as working tools. A criticism of this model is the lack of inclusion of personal experience (Asbjørnslett and Hemmingsson 2008).

Depending on the research questions, children's participation can be studied in different ways: Talking with children about experiences, observing interactions, or

even including the child as a researcher. In paediatric rehabilitation there is a need for information on how professionals get access to children's experiences, and how children are involved in decision-making. There is a need for information on the ongoing interaction and decision-making process during consultations. What happens in a consultation at a paediatric rehabilitation unit will be explored in this article.

Paediatric rehabilitation is used in this article with reference to people with congenital or early acquired disabilities. The word *habilitation* is used in Norway, although *paediatric rehabilitation* is more commonly used internationally (Tetzchner et al. 2008). An often used definition of habilitation and rehabilitation in Norway is 'a time limited and planned process for measurements and goals, where different actors cooperate to enable persons with disabilities to attain and maintain maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life' (The Norwegian Ministry of Health and Care Services 2012).

### ***Purpose and scientific value***

The purpose of this article is to enhance opportunities for involvement during consultations for children with impairments, and to contribute to professional practice on children's participation. The article aims to contribute to the discussion on participation more generally, and to the discussions on disabled children's right to participate in decisions concerning their own lives.

The scientific value of this study is to discuss the empirical findings in relation to the chosen theoretical perspectives. By analysing how the interaction at play is governed by expectations and practical use of the room and objects (materials) at the place of consultation. Through an analysis of the relationship between ideas and the pragmatic use of the material, the discussion on participation becomes relevant. The analysis is inspired by Goffman's 'Interactional Rituals' (Goffman 1959, 1967) and Actor Network Theory with special emphasis on the objects as actors (Latour 2005; Latour and Woolgar 1986; Law and Hassard 1999). The article also discusses the usefulness of combining these perspectives in order to understand how the interaction at play can be said to create meaning for those involved.

### **Method**

The article will present a consultation in a Norwegian setting in which a physiotherapist, a doctor and a nurse examine a nine-year-old boy at a paediatric rehabilitation unit. This was his first time at this particular unit, although he had been evaluated by doctors several times before at other medical centres. The boy had no diagnoses, although he presented problems with motor precision and concentration, and had nutritional problems at a younger age. The professionals described this case as difficult because it was uncertain what the problem was. At the time of writing, 36 consultations have been observed. This consultation was chosen because it gave me the opportunity to follow a child and professionals over a full day, for cognitive testing, physical evaluation (described in this article), the evaluation meeting between the professionals and the concluding session with the parents. This kind of consultation is not regularly scheduled. In addition, the way in which the boy's participation was attended to, and the lack of communication from the professionals

to the parents and the boy on the relevance of play during the consultation, I found interesting and relevant for the discussions on participation and giving children voices.

Observation has been applied to gather information during the consultation. Group interviews were carried out to gather information on how the professionals understand their work.

During the consultation I was positioned at a distance from the professionals, parents and the child. Notes were taken during the observation about their positioning and movements in the room, what kind of equipment they used, what they talked about, and the behaviour acted out. After the consultation the physiotherapist shared with me her thoughts about the consultation, and I could ask her questions, thereby making my role more participatory than just observing. During the evaluation meeting I observed, sitting alongside the professionals and writing down what they talked about. At the beginning of the consultation the participants often looked at me, but this behaviour soon disappeared. Although they were aware of my presence, it probably does not have serious implications for the consultation. The professionals were aware of my presence, and said that they thought about it but forgot it after a while. Two of the professionals express it like this:

You are just there and do not participate in the conversation, so I forget that you are there. . . . I don't think it has that much influence, but it did in the beginning  
When you attend there is an extra stress factor, especially if there is a new patient. It is different if it is a patient we already know . . . but then I forget it.

The professionals are made familiar with my presence through several consultations and informal discussions about the purpose of my presence.

The professionals' description of their work and understanding of children's participation are from two group interviews. Six professionals attended the group interviews: one doctor, one nurse, one psychologist, and three physiotherapists. Questions on differentiation of tasks, delegation, how they define their work, and children's role in decision-making and participation were put to each of the professionals in the group. The interviews were tape-recorded.

The purpose of using participant observation is to get closer to the work of the professionals, as well as to describe what the professionals say and do in situations not structured by the researcher (Fangen 2010). Observation is suitable for investigating the interaction at play and the relevance of using equipment and toys in the room. In combination with group interviews, it is possible to investigate the professionals' understanding of what they do. The consultations are carried out by professionals with specialist competence, therefore observation is suitable in this context. The method was chosen to capture the discrete interaction between individuals, as well as how persons related to the material things in the room in which the consultation was conducted. The data is primarily presented in the form of descriptions of the consultation, with reference to the group interviews and conversations with the professionals.

### **Ethical considerations**

Conducting research at hospitals in general has been thoroughly considered by the regional Ethical Committee. Filed information, diagnoses and patient conditions are considered highly confidential. The research project involves observation and

participation at a paediatric outpost rehabilitation unit. Children are considered to be particularly vulnerable (Regional Ethical Committee), and disabled children even more so (Martin and Franklin 2010). The purpose of conducting observation is to gather information on professional work with children and to observe how children participate. This involves children, and it affects them both while being observed and by being represented by the researcher in journals and books. As already mentioned, this requires the researcher to be reflective about the choices made in the presentation of the child. Concerning consent, the parents and the child are informed about the project by their physiotherapist before the consultation, and they receive information and a letter of consent to read and sign at home. The professionals talk with the children before the consultation to hear if they have been informed about the research project, and if they feel fine having an external person observing the consultation.

Children must be protected from dilemmas of confidentiality (World Medical Association, 2008), i.e. the child should not be worried whether the professional can recognize and dislike their thoughts about the consultation; therefore the boy was not interviewed after the consultation. The study is approved by the Regional Ethical Committee of Southeastern Norway.

### **Empirical data and choice of theory**

The first step in the analysis of the consultation was to trace how relationships were connected and what made what act. The observational material is organised according to routines, professional task solution, and use of space, use of equipment, play, and planning. These categories were often replicated by the professionals in practice and in conversations and interviews. Two conditions seemed to structure the consultation and had an impact on both the ongoing conversations and the professional conclusions made after the consultation. These were the professionals' routines and roles and the boy's use of toys and equipment. In theoretical terms, the roles and statuses can be seen as an ideational dimension and the play and use of objects and equipment as a practical or material dimension, which were perceived as appropriate for further interpretation of the consultation. The relation between ideas and practice for understanding the event became relevant as an analytical focus for the consultation. During the interaction at play, the parents and professionals revealed some level of uncertainty as to the expected behaviour of the child in this situation.

With regard to the professionals' work concerning play, Goffman's theorizing on face-to-face interaction, obligations and expectations of roles (Goffman 1967, 1959) is very reflective and thought-provoking. Goffman's theory problematizes the relationship between society's understanding of individuals or groups, and the opportunities of showing one's identity (Goffman 1975). In paediatric rehabilitation, a child's opportunities to articulate identity, such as competence in different activities, personal likes and dislikes, is very much dependent on the adults' understanding of the child. How the conversation is conducted and what is taken notice of by the adults in the consultation can help illuminate the understanding of the child. Goffman is further concerned with the symbolic dimension of interaction, or that interaction is acted out on the basis of expectations and obligations related to roles and status, and thereby makes sense. According to Goffman, the role of authority linked to status is important in this process; as the way professionals and

patients relate to each other in encounters is a confirmation of status by showing appreciation and an ability to handle the encounter (deference and demeanour). The relation between deference and demeanour is of special interest in this case. Deference refers to the appreciation of a person's status, usually indicated by some form of politeness or salutation. Demeanour refers to the person's handling of a situation where an aspect of personal self reveals itself. Deference and demeanour can occur in the same situation. In the following case the way this relationship occurs and affects the situation is discussed. Central to Goffman's theories is the actors' adjustment to situations in order not to lose face, or to maintain harmony. This theoretical perspective seems fruitful in the case in question for the analysis of the boy's way of acting. The concept of avoidance is a strategy to avoid discussions or actions that can disturb the effort not to lose face, and is often seen in connection to deference. It is interesting to investigate to what extent this kind of 'face work' is at play and how it affects the common understanding of the situation. The last point can be further elaborated on by the distinction Goffman makes between front-stage and backstage, where the consultation with the child and the parents can be seen as front-stage, and the professional evaluation after the consultation as backstage.

Symbolic interactional theories are commonly used in health and social sciences (Svensson 1998; Levin and Trost 2005); however, some reasons will be mentioned for choosing Goffman and not symbolic interactional theories, which also are concerned with symbolic dimensions. Like Goffman, symbolic interactional perspectives and studies refer to situation, symbols, interaction and present happenings. Goffman's theories differ when it comes to analysing the diffuse aspect of social interaction - the relation between expectations and roles. Like Goffman's theory, symbolic interactional theory goes beyond the situation itself by referring to expectations that people bring with them into the situation. The 'face work' or the possibility to act out competence is ascribed to the situation. Goffman's theories are more about the representation of roles and statuses as social values, and less about personal need for acceptance, and inner motivation that can be associated with symbolic interactional theories. The former is in line with the analytical aim of this article.

Goffman's theory is concerned with what the actors use (props and stages) for displaying roles as a signal to the recipient. However, in order to investigate the ongoing interaction and pay attention to the material dimension, the play and the use of objects and equipment need more attention. In the tradition of Actor Network Theory, objects are seen as actors with the ability to act. Actor Network Theory is concerned with the importance of literally tracing relationships, showing what leads to what and including how objects also work or affect actions (Latour 2005; Strathern 1999). Including objects as actors differs from the construct of actor used in role theory which refers to human subjects. The acting part of the actor is referred to as *actant* (Elgaard Jensen 2005). Objects can make people act, and objects are also a part of making the articulation of identity possible. It is the process of *translation*; when the actant is strengthened and clearly seen, that makes objects significant. In the analysis of the consultation, focus will be on how some objects may influence the conclusion. In this tradition of Actor Network Theory, culture or society are analysed as practice, and do not offer a pattern on which action converses (Knorr-Cetina 1999). In this tradition there is no difference between actors and network. Actors, both human and non-human, make up the network and there is nothing external to the network that can explain the interaction at play. The object of study is the relationship (networks) as it is acted out (Latour 2005). Latour does not reject

that ideas are working in encounters, but the object of study for the researcher is how persons and objects appear in the network of relations. Objects in this tradition are not a result of how we use them intentionally, but are as they appear. Children's use of objects might not always be intentional, but the adults around them can make the object relevant for seeing and acknowledging how they make use of the objects. Thus, applying the theoretical perspectives from both Goffman and Latour may render valuable insights and understandings of the interaction at play. Goffman is interested in practice and in a person's use of the material around them, in addition to the ideas governing the understanding of encounters. Objects do not have the same appearance as persons in Goffman's work. Using Latour implies seeing how objects make action an integral part of the interaction. Applying Goffman's perspectives implies revealing the ideas at work in interaction. I find it interesting to work with the two traditions, and to investigate the relation between ideas and practice.

In the research field of disability and assistive technology, perspectives from Actor Network Theory have yielded important insights into how technology makes the articulation of identity possible, while also highlighting the interdependency between technology (objects) and persons for a decreasing disability or increasing ability (Moser and Law 2001). Studies of technology and science in the tradition of Actor Network Theory are extensive (Law 1999) and are used differently, although objects seen as actors and the tracing of the network of relationships are two of the main concepts of the theory. Actor Network Theory is a reminder of the role of objects' in a situation, and the perspective overcomes the distinction between persons, objects and artefacts (Strathern 1999). Use of toys and equipment directs attention towards the child's communication and actions in the following case.

In the following, tracing is used to describe what happens in a consultation, including the use of objects in the room. This implies investigating how the use of object works, parallel to analysing the action at play with reference to the constructs of deference and demeanour. The two analytical perspectives also invite a discussion on how different meaning systems can work together in encounters.

### **Consultation at the paediatric rehabilitation unit**

A paediatric rehabilitation unit within regional hospitals supplements the community services with competence and assessment of children and adolescents with physical and/or cognitive impairment. Several professional disciplines are involved in the consultations offered to the children and their families. Before presenting the case, some background information about the unit and about the professionals' perceptions of children's participation is provided.

#### **The unit**

##### ***Understanding of the child's participation***

Based on interviews and informal discussions with leaders and employees at the rehabilitation unit, there seemed to be an overall awareness of including children in the conversations during consultations. 'Children's participation' is part of the rehabilitation unit's weekly agenda at the staff meetings. Children's participation is

understood both as their right in different contexts and as their way of taking part in daily life. For example, in the group interview where participation is a topic the doctor says:

As you might know, participation is a theme that we discuss at the staff meetings . . . participation in the consultation. . . . But children's participation can be seen in different ways. One thing is participation in the actual consultation, which we are talking about here and now, but I think that the participation in the consultation ought to increase the child's participation out there . . . to give the child good functioning out there (in daily life). I actually find participation in daily life more important to focus on.

Later in the conversation one of the physiotherapists also underlines the psychosocial dimension of participation by saying:

Participation is about identity; how one wants to take part (in daily life). . . . How can we as professionals contribute in this matter? There are possibilities for us to explore this matter even though our work is in the field of medicine

The physiotherapist group often discusses how to get better at including the child as an active participant in the consultations, and they discuss ideas on how to improve children's participation in collaboration with researchers. The physiotherapists perceive play and movement as an articulation of competence, and they use play as one way of measuring physical movement and capacity. One of the physiotherapists expresses:

To explore and play with the child is a good way to collaborate with the child and to get information about how the child functions

One of the other physiotherapists says in a conversation before a consultation when we talk about measuring children's abilities:

Body impairment is central in the consultations with the physio and the doctor. There has been a tradition for this focus. Our strength as physiotherapists has been in the matter of body impairment, but we have moved more towards function, and embedded in this is the perspective of participation in different environments (daily life).

In the following case, this understanding will be described.

### ***Allocation of tasks between doctor and physiotherapist***

Observed in the consultations, the doctor and the physiotherapist perform different tasks. The physiotherapist usually welcomes the patient and the parents at the entrance, starting with an informal talk with the child and the parents that often addresses the child first. Upon entering the examination room, the doctor sits down while the physiotherapist arranges equipment, toys and chairs in the room and then also sits down. Arrangement of the room is commonly done by the physiotherapist. The doctor starts the conversation by asking the child: 'So, how are you doing? Have you done some new activities since the last time we met?' They then talk about physical functioning, school and leisure time. The physiotherapist often plays with and examines the child while the conversation is taking place, and becomes involved

after a while with supplementary questions. Objects for the child to play with are taken out and arranged by the physiotherapist and the consultation ends with the doctor summing up with some conclusions. The doctor then shakes hands with the parents, and sometimes the child as well, and leaves the room. The physiotherapist then often sits down with the family and talks for five more minutes. When a child needs multiple testing and assessment, involving several professionals, they all gather for the final discussion after the consultations are completed. In regular consultations, only an informal conversation is carried out by the professionals involved in the consultation. The diagnoses are made by the doctors and the physiotherapist reports to the child's local healthcare service centre. The physiotherapist describes it in the group interview as:

In a way we have arranged some sort of organisation of our tasks, but we do alternate from time to time; but usually the consultation starts with the doctor asking questions to the child and the parents... it's formal stuff and it is about information- giving.

Earlier on in another consultation she says: 'We [physiotherapists] prepare the room for the consultation'

And the doctor describes after a consultation: 'I do medical examinations, and I have several consultations every day, therefore I have to leave the room first'

## **The consultation**

### ***The room***

Whereas the physiotherapist meets the family at the entrance, I have already met the parents and the child earlier in the cognitive assessment, and they confirm my presence and are thus familiar with me being part of the consultation. The consultation room is big, with enough space for inventory, equipment and toys, but without giving a feeling that the room is overcrowded. There are stripes lined up on the floor for children to walk on when testing balance, in addition to medical equipment, scales for measuring body weight and measurements for body length. There is an 80 x 100 cm sized table on the right side of the room towards the corner, as well as chairs alongside the wall on the right side and around the table. On the left side of the entrance, there are two wall bars, a wall mirror with a hand bar attached to it and a trampoline underneath so that the children can jump and hold the bar at the same time. In the left corner of the room there is a bench used for examinations that can be lowered or raised as needed. Behind the bench there is a big foam mattress, and alongside the wall there are cabinets for equipment, blankets and toys, while in the middle of the room there is space for some thin rubber mats and large balance balls.

When the boy enters the room, he immediately approaches the trampoline at the side of the room. The parents take their place at a good distance from one side of the table, and the doctor and physiotherapist take their seats on the other side close to the table. The nurse first sits down beside me on the bench by the window, but then changes her mind and takes a chair and places herself closer to the others behind the doctor and the physiotherapist. The parents are seated throughout the consultation, as is the nurse. The physiotherapist switches between sitting, standing and playing with the boy. The doctor is seated throughout the consultation except when examining the boy together with the physiotherapist. The boy plays with the different items in the room and does not use the chair unless one of the adults tells him to sit down. I am seated on the bench behind them throughout the consultation.

The use of the room is prominent at the beginning of the consultation, as the boy explores the space and the objects in the room. The room, equipment and toys give him the opportunity to show an activity level, exploration and competence that are in accordance with the centre's policy, described above. The professionals want the children to explore and show their competence as an integral part of the evaluation, even though this is not explicitly stated to the child and the parents. Parallel to the boy's activity, there is a communication going on about where to sit, which is ceremonial (Goffman 1967) in character and devised with a combination of expectations and obligations on how to behave in a situation such as this. The doctor and the physiotherapist sit down where they usually sit in other consultations, and the physiotherapist tells the parents in a friendly way to sit down and points toward the chairs opposite the doctor. At the same time she arranges the things in the room, and prepares for the examination.

The nurse dwells on where to sit by looking at different places to sit down, which she explains, is related to how she wants to communicate her status as an observer. She says to me: *I am just here to observe, and where should I sit?* [asking herself] I understand this in the sense that the nurse does not have the same obligations as the doctor and the physiotherapist in this particular situation. After they have all sat down, the mother addresses the boy by telling him to take off his shoes and sit down.

Analytically this interaction may demonstrate the interchange between displaying respect for those involved and respect for the encounter – the actions show mutual deference, or what Goffman describes as 'appreciation is shown to the recipient.' This form of ritualised performance is most prominent in this sequence and much time is spent showing deference to the situation and the persons involved. At the same time the demeaning dimension of the ceremonial play is seen in the context of the handling of the situation, and the professionals performing their routine. The concept of demeanour articulates the relation between handling a situation and presenting oneself, and in this case it is the boy that is of main interest. The mother's request to the boy to sit down is an action by the parents that prepares the conversation to start. The formal conversation about the boy begins when the doctor starts asking questions and the scene is set for evaluation of the boy. They start to talk, but without paying attention to the boy, hence confirming the parents as his spokespersons. The deference towards the parents and their status as those who best know the child reveals an understanding of the parents' voice as being crucial for achieving an understanding and description of the child. Nevertheless, the child is also seen as an explorer, and it is interesting to see how the boy's way of participating is noted and handled later on in the consultation.

### **The doctor**

The doctor lays the notebook and copies of different journals on the table, and browses through the pile while asking questions about the content of the journals. Notes are also taken, and the mother answers some questions about nutrition and the boy's age when they first suspected something unusual was going on with him, with further questions being directed toward the parents. The doctor is leaning forward at the table on his elbows with his shoulders raised towards his ears, looking straight at the mother, appearing familiar with the situation. The boy does not receive much attention, and plays by himself or with the physiotherapist when they talk about him, although he looks toward them quite often. I am struck by the thought that he is listening to what

they are talking about. For example, when the mother talks about his eating habits, his weight and nutritional problems, the boy plays with a stick that he hits the balance ball with, making a loud noise. The nurse comments positively on his eating habits, while the mother continues, 'He does not eat meat, but he eats vegetables. We used to give him a smoothie, but he got fed up with the smoothie . . .' and the boy then interrupts, 'No, I'm not fed up with the smoothie!' The mother barely hears what he says, and continues to talk and comments instead on the noise he is making. She says that he can get a bit uneasy when he enters a new room because he wants to check things out, and she assures everyone that he can be quieter. The professionals comment on neither the mother's nor the boy's information. The mother looks at the doctor, the physiotherapist and the boy. No one says anything.

The starting sequence of the conversation is primarily between the doctor and the mother, as the boy's opinion is not requested at this point. The physiotherapist and the nurse do not ask many questions, which is both part of the routine and of the role that the doctor has in the conversational sequence, or as the physiotherapist says in the group interview, *the doctor usually starts first . . . and it is about formal things*. To interrupt would be to exhibit an improper demeanour, and the mother deals with the boy's interruptions by excusing them. The professionals do not confirm her excuses, creating a silence and a change of topic in the conversation.

Showing deference can take the form of using avoidance, meaning to create distance in order not to violate the 'the ideal sphere,' or to avoid painful or difficult discussions (Goffman 1967). The mother commenting on the boy's behaviour can be seen as such use of avoidance; stopping the boy from interrupting the conversation or violating the ideal sphere, which underlines the asymmetrical relationship between the mother (adult) and the boy (child). But the boy resists. The professionals use avoidance (avoiding a difficult discussion) by not responding to the mother's comments on the boy's behaviour. There is no investigation of the child's interruptions and he is therefore not fully given a chance to present more of himself.

These two ways of using avoidance indicate how the interaction at play is centred on deference more than on actually giving the boy a chance to present himself as competent. It shows the absence of an articulated common understanding of the child's behaviour. Interruptions and different reactions from children during a consultation are common and are commented on by the physiotherapist in the group interview:

. . . how children react to adult conversations in the consultation varies . . . and we have to deal with the parents and the child. . . . It is difficult and interesting how to take care of the parents and the child in a consultation.

The statement describes the challenges of these consultations.

In the context of paediatric rehabilitation, children's play and noise is actually welcomed as part of the physical evaluation. Noise is therefore not necessarily perceived as improper behaviour. The boy expresses himself by making noises, exploring the room and objecting to his mother's information. What happens in the play, the noise and objections are acted out as a change in the conversation, which also creates a change in the involvement of the professionals. The objects work as an actant for the boy, and according to Latour (2005) objects can constitute, alter and change orders of practice. The physiotherapist's role and the boy's play warrant further investigation.

### **The physiotherapist**

The physiotherapist sits by the table and listens while the doctor asks questions, but she looks at the boy quite often, and she sometimes gets up and finds things for the boy to play with. She finds the balance board that he is playing with and gets a chance to register his balance control. The physiotherapist smiles at him and they laugh together. She listens to what the mother and doctor are saying, but when the mother comments on the boy's activity level in the situation, the physiotherapist reacts by asking the boy, 'Do you think the cocoa is lukewarm now, maybe you can sit down and drink it?' He sits down, although not for long, before he starts to play again. He takes a ball and throws it at a target spot, and the physiotherapist adjusts the target spot so that it is easier for him to throw at it. He then starts to play with some other things, and the others in the room are now all watching him, while the mother starts to talk about what he likes to do. The boy seems very concentrated on his activity, but when the mother describes how fond he is of Star Wars, and that he remembers all the names of the characters in the television series, he responds, 'No, I do not remember all of them . . .' [silence]. The doctor and the physiotherapist ask about friends, and direct the questions toward the mother. The boy is now playing with Lego, and she says that he has a lot of friends, 'He is not a leader, but he is a gentleman.' The boy interrupts, 'No, I'm not a gentleman [pause], but yes, I have had a lot of friends since I was a child' [silence]. The mother says that he is fond of building Lego but has a problem with the small bricks, though the boy disagrees by shaking his head. Still, the mother insists, 'Yes you do!'

The objects (toys) are more significant in this sequence, which focuses more attention on the boy. The physiotherapist makes the balance board available for him. They interact, have fun, and the physiotherapist simultaneously observes his motor function. The mother refers to this as a high activity level. The boy finds the ball, and the physiotherapist plays ball with him. His play skills and interest are discussed by the adults with objections from the boy. The boy seems to correct what they are saying as he has another story to tell (Gubrium and Holstein 2009), but none of the adults take into account his actions and resistance or try to investigate his own understanding of ability and competence. Playing with the toys and equipment gives the boy a chance to articulate himself, and a chance to show skilful handling of the play situation, which works as an actant. The objects are made relevant, but not so strongly that they initiate a discussion in the present situation, and theoretically speaking the process of translation is not thoroughly completed. The case can be further explored:

The physiotherapist turns towards the parents and asks about his daily activities (ADL) and how he manages them. The mother answers that he manages rather well, but that he has some problems with doing up buttons. The doctor and nurse also ask about activities at school, and the nurse asks the boy if he can swim. He says yes, though the mother corrects him, 'No, you cannot swim.' After that, no more questions are asked about swimming. The mother talks a lot about how he generally pays attention to things around him and that he is observant in traffic, and the boy suddenly comments, 'Can you please stop all this chatting. I am tired of it.' The mother responds by saying, 'But this is why we are here.' There is silence until the physiotherapist says, 'There's a lot of adult talk here.' The boy responds, 'Yes, and therefore it's good that I'm not supposed to be here for too long. . . .'

The physiotherapist and the doctor demonstrate different ways of relating to the boy and the parents. The physiotherapist is more active with the boy than the doctor, though in the background of the conversation. As described above, physiotherapists

at the rehabilitation unit describe play as being very informative, and it is often observed that the physiotherapist provides the child with toys to play with during the adult conversation. In the present case, the physiotherapist makes toys, balance balls and mattresses available, in order to give the boy the opportunity to demonstrate his abilities. This action supports the evaluation process while simultaneously being a way of accepting the boy as an active and explorative child.

The use of objects offers opportunities for the boy to present himself, or his abilities, and he can articulate a voice in this interaction. This can be seen using Goffman or an Actor Network theoretical description. The way the physiotherapist organizes the play by speaking in a low voice, using a balance board in the background and keeping an eye on the ongoing conversation between the adults, illustrates the responsibility of taking care of many things at once in the situation. In terms of Goffman's theory it shows respect for the other adults and the situation. At the same time it can be seen how the Lego, the balance ball, the stick, the mattresses make it possible for the boy to demonstrate an ability to solve tasks, creativity and task management, it affects the content of the conversational comments and objections, and helps the physiotherapist's physical evaluation of the boy. It shows the complex interplay between the material (objects and use of room) and different ideas regarding how to handle the situation right.

### **Physical examination**

After a while the physiotherapist stops helping the boy on the balance board, and joins the doctor in the conversation. The boy is casting a glance around the room for more things to play with, and starts to build a castle with all the foam objects and mattresses in the room. The professionals comment on his creative constructions and are impressed. While the boy plays, the doctor and the physiotherapist agree to perform the physical examination assessment of muscle strength, flexibility and movements, as well as weight and height measurements. They agree only to focus on his legs, and perform the examination of his legs on the foam mattress where he is playing. They inform him that they will examine his legs, and they look at his legs and feet, commenting to each other on various aspects of the positions of his legs/feet, which may help explain his balance problem. His ankle joints are hypermobile, and the doctor asks the father if the boy often twists over on his foot. The father says no, but says that the boy has problems standing straight while ice skating. The doctor says 'hmm' and nods as a sign of agreement and understanding of what the father says. When examining the boy, they ask, 'Does it hurt, is it uncomfortable?' The examination is done quickly, and they tell the parents that they will be served lunch in the family room and meet again at 1 p.m. for a summarizing closure of the day.

### **Discussion between the professionals**

As a matter of routine after the consultation, the doctor, nurse, psychologist and physiotherapist all sit down to evaluate and make preliminary conclusions. In this case, the cognitive and physical disabilities cannot be diagnosed, and the professionals find it difficult to set goals for the boy. Both the results from the cognitive test carried out earlier the same day and the psychologist's conclusions are given significance. The psychologist wants to conduct more tests on memory capacity, and they talk about his interruptions and creativity with the objects in the room, giving more significance to this than what the parents said. They agree that the boy seemed to function very well in the consultation, and that this is probably the case in his daily life as well:

The doctor: ‘ think it is about time to accept the boy the way he is. . . I think we can discard diagnosing, and concentrate on how to compensate for his difficulties in daily life.

The physiotherapist: I felt I got really good contact with him. I think he was very creative, with positive energy.

The nurse: He eats as his peers do.

The interesting aspect of this sequence is that the professionals talk about the positive aspects of the boy’s behaviour that are not communicated in the consultation with the boy and the parents present. Considering the consultations as the main event for the evaluation, Goffman’s distinction between the front-stage and back-stage is suitable for analysis, with the different professionals’ arguments presented with fewer restrictions in the discussion between the professionals (backstage) than in the consultation (front-stage) (Goffman 1959). Comments on the boy’s behaviour related to his use of objects were avoided in the consultation, but made relevant and evaluated positively in the discussion between the professionals. Using the actant perspective in the investigation of how the objects are used, the objects make it possible for the boy to demonstrate balance, competence, creativity and reflection. These abilities are discussed and given a relevant and strong meaning in the conclusions of the professionals, even though this was not obvious in the consultation. The importance of this argument is firstly that people relate to objects (toys and equipment) in creating and displaying identity, and secondly that the power of objects to make articulation of identity possible in the context of paediatric rehabilitation should not be overlooked.

When dividing into backstage and front-stage, it is also important to underline the continuity between the two stages. There is a continuity of professional performance, even though less formal, where each professional argues from their particular point of view. Another continuity that is carried forward from the consultation to the professionals’ discussion is the failure to let the boy expand on reflections of own competence.

The day ends with a summary meeting between the professionals and the parents. The boy is in a separate room. The psychologist is given the role to start the summary, since the cognitive test has yielded more concrete results than the other parts of the examination. When it comes to the boy’s physical functioning, the doctor is given the role of summarizing their conclusions on behalf of the physiotherapist and the nurse, with the doctor repeating much of what has been said during the day, including the psychologist’s findings.

### **Summarizing discussion**

Various aspects of relationships have been articulated in the consultation. Through investigation of what has taken place, giving attention to face-to-face interaction and the use of objects, the child’s participation becomes illuminated differently. Sociologically the material shows different forms of *taking part*: in the conversation; in the physical assessment; and in play and interaction with objects and equipment. The child’s participation can be seen as fairly active in relation to the type of action. The adult use of avoidance is demonstrated several times during the consultation. Avoidance is part of the deference, or the conduct to avoid difficult situations or questions. There is a high degree of deference in the consultation, and less focus on discussions of the boy’s articulation of his abilities and skills through his use of toys

and equipment (demeanour). Analysing the use of object and its ability to act or give action (actant); the object stimulates the boy to demonstrate various abilities (demeanour), which is important for the professional's evaluation. It can be asked if this focus on deference and use of avoidance is a hindrance to more attention being paid to expanding on the boy's articulation of identity in the situation. The interaction constitutes the asymmetrical relationship between the adult and the child in the situation. This asymmetrical relationship is also demonstrated when the boy's objections to the adults' comments on his play are handled with avoidance instead of letting the boy articulate more of his abilities.

Communication of the perceptions of the boy's behaviour to the parents, and also the exploration of the boy's own perception of competence and problems are absent. The boy is not asked if he finds the conclusion to be in accordance with his experiences or needs. And therefore no shared understanding is negotiated. Even though some of the boy's activities, especially the interaction with objects shown during the consultation, are inscribed in the conclusion, this does not mean that his voice has been listened to.

These findings underline the difference between the concepts of participation and children's voices (Kellett 2009). Kellett's (2009) arguments for Lundy's perspective on children's voices comprises four parts: Children must be given the opportunity to express a view (space), which must be facilitated. Further, the view must be listened to (audience), and the view must be acted upon as appropriate (view). It is hard to see that the boy's view has been fully taken care of. The boy's voice in the consultation seems to be layered with adult voices.

The boy does not have speech problems. Many of the consultations carried out at the rehabilitation unit are with children with severe speech difficulties, but these children also have a voice. Lundy's perspective gives association to the spoken word, but the perspective is still relevant for children with impairment and speech problems, if one includes non-verbal communication. To *give voice* refers to various forms of communication, and implies how the child is given an opportunity to be heard and seen (Komulainen 2007; Moser and Law 2001). Moser and Law argue for the importance of non-verbal communication when talking about children's voices. In the context of paediatric rehabilitation where many of the children cannot verbally speak up, it is highly contextual and situational whether the *voice* or the *participation* is foregrounded or not. Working with or doing research on children with impairments thereby challenges the discussion on the relationship between participation and children's voices.

Divergent meaning and a lack of common understanding between professionals, child and parents have been mentioned several times in the analysis. It is therefore relevant to reflect on representation. Relationships, or how we relate to each other and to objects, can be seen as a representation of collective and individual understandings (Sansi 2007; Schneider 2003, 2006). How relationships to people and objects are formed and used by individuals or groups varies according to context, time and history, and the different forms of relationships and the objects involved are understood to possess a capacity to give meaning for those involved (Cohen 1989; Geertz 1973). Relationships and objects can be interpreted differently according to the expectations one has of the encounter, the relationship, the context and what type of experience one has with the use of objects, as it is possible for different understandings or meanings to be working at the same time in a situation. For example, two crucial conditions affect participation in the consultation: the first is the setup or routines with differentiated tasks for the professionals to perform,

whereas the second is the object's role in affecting the interaction at play. The meanings of these two conditions seem to be understood differently by the professionals, the boy and the parents. For the parents, it is the formality that is acted out in the encounter and an expectation of being evaluated for a short period of time, in which the management is about showing the best or familiar behaviour of the boy. The analysis reveals a lack of communication to the parents that the boy's activity level is evaluated as positive, though in the discussion between the professionals after the consultation, the boy's activity is discussed as being appropriate for the situation.

Children can be viewed as opportunists who explore and exploit objects and spaces according to what is offered to them (Osnes, Skaug, and Kaarby 2010), which is what the boy did. The policy at the rehabilitation unit is to give the child room to express himself/herself, both verbally and through play, with the professionals also noting the child's interaction with the parents. The use of objects such as toys and equipment gives the child an opportunity to communicate his/her ability (Moser and Law 1999). The physiotherapist makes the toys available for the boy, and provides an option to use the objects and thereby show parts of his identity to the adults. According to the professional, it has been traditional up until today for the parents to be the primary information-givers on behalf of the child, which is very much in accordance with society's view on the parental care-giving role. Adequate equipment that helps the professionals to measure function, set goals and make diagnoses is important, but this is not explicitly communicated.

Toys provide a means to have fun, learn and explore, and are strongly connected to socialization. To play, whether with or without toys, is considered important for physical, emotional and cognitive development (Anderson 1986; Osnes, Skaug, and Kaarby 2010). In paediatric rehabilitation, we have seen that toys and play are used to evaluate function and abilities, which is in accordance with the Norwegian National Strategy of Habilitation and Rehabilitation, 2008–2011. Some aspects of how it is used are described above, although the play in this specific context goes beyond the fun or socialization element; it may be used during evaluation of function. Formal situations such as the case presented are not associated with playing and being noisy, and it can be difficult for parents to know what the proper behaviour is for the child to act out and for the parents to display.

The limitation of the study is that this is one encounter, with particular professionals and a boy of a specific age with a family who may give different outcomes. It is also a limitation that for reasons of confidentiality the boy was not interviewed after the consultation. Another limitation concerning method is my presence as a researcher in the consultation, and that I impact on their performance as professionals in the situation described. However, this case still highlights aspects of child participation which may have implications for other consultation settings involving children.

## **Conclusion**

Using participant observation, professionals' work with children in a consultation at a paediatric rehabilitation unit has been investigated. By means of this qualitative approach and by tracing what leads to what in the consultation, the child's participation is elucidated. Routines, roles and use of objects in this scenario appear to be important for understanding the work of professionals with the child. Applying

role theory in the analysis reveals how and when the child is in the background of the consultation, and often alienated from it. At the same time, materials such as toys and equipment facilitate the child's articulation of his competence and ability, which has an impact on and is expressed in the professional conclusions following the consultation process. By discretely looking into the different relationships at play, it has been revealed that the child's participation is as much a result of how he uses the objects in the room as of how he is verbally included in the conversation. However the professionals do not communicate how they understand the child's play and exploration. In addition it is observed that further exploration of the boy's understanding of his own competence is not carried out, and this calls for awareness and further elaboration on how children's competence is explored both in research and in practice. More generally, further investigations, both qualitative and quantitative, on several consultations are needed to get a broader picture of how objects may be used in consultations in paediatric rehabilitation.

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