

Self-rating via video communication in children with disabilities – A feasibility study

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Children with disabilities face different barriers hindering them from having their voice heard in real-life interviews in research and in health services. Factors relating to the child and family e.g. physical inaccessibility, lack of transportation and lack of privacy has been mentioned as barriers. Video communication tools may have the potential to reduce barriers and additionally, may have some advantages over telephone, SMS, or chat interviewing since it allows the combination of spoken language with forms of augmented and alternative communication e.g., body language, sign language. On the other hand, the video format may contain cognitive and communicative barriers restricting participation in interviews with children. Therefore, in this study the aim was to explore the feasibility of administering a self-rating instrument via a video communication tool to children with developmental disabilities.

Seventeen children with developmental disabilities, born 2007–2009, were recruited from the ongoing longitudinal study of mental health and participation in children with developmental disabilities (CHILD-PMH). The Picture my Participation (PmP) was used as an example of a self-rating instrument to explore the feasibility of interviews via video communication in research and Zoom was chosen as the video communication tool. All pictures of the PmP were inserted into PowerPoint slides and arranged in a Talking Mats-manner, meaning two slides per activity, one with the response options relating to attendance and one with the involvement response options. Instead of having the children pick up, or drag, a picture and placing it under the favoured response option, as when guiding children through self-ratings in PmP in real life, the children were instructed to mark the response of their choice using the annotate function within Zoom or if possible and if they preferred, they could just tell their response.

The findings showed that overall, the children answered the questions. A visual inspection of the PmP responses did not reveal any distinct problematic patterns. Most difficulties that arose during the interview were related to the PmP instrument rather than the video format per se. Some children preferred using icons instead of drawing lines in the annotate function, and some preferred to answer verbally. Interviews were completed in 35.3 minutes on average (range 22-60) which is somewhat longer than the estimated 30 min approximation of the time needed for interviews IRL. However, no time was required for traveling either for children or professionals. Thirteen children used a computer, three a mobile phone, and one child a combination of both, due to technical problems. There were a few technical issues during the PmP interviews e.g. some children struggled to find the annotate function in Zoom, however, all parent-child dyads were able to solve the problems that arose.

In conclusion, interviewer-guided self-ratings of participation through video communication may be a feasible procedure, in children with developmental disabilities, from age 11, and may increase these children's chances to contribute their experiences in research and clinical practice. As the interviewer do not directly perceive the same things as the child and can only control parts of the digital environment, problem-solving thus become more dependent on the child's (or parent's) ability. Before offering video communication in a larger project or in clinical practice, it is recommended that the procedure and necessary applications are tested and practiced by all data collectors, on different types of devices.