CREATING THE THERAPEUTIC REALITY

AN ETHNOGRAPHIC ACCOUNT OF AN OUTPATIENT THERAPEUTIC COMMUNITY

AT

A UNIVERSITY PSYCHIATRIC HOSPITAL

by

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ABSTRACT

This thesis is an ethnographic account of the daily life of an outpatient centre for the treatment of non-psychotic patients. The centre is located in a university setting and is nominally attached to a university mental hospital.

The setting is described and the case is made that it normally allows for only two categories of participant: patients and therapists. The situated activity of these two groups in structuring the setting is a major focus of the work.

The roles embodied in the two categories are described in detail and the way in which these roles interlock to create the social reality that is understood by the participants as a "therapeutic community" is set out. A belief system which is embedded in, and a determinant of each role is proposed.

The practice of "doing therapy" is described and a preliminary formulation of this practice as a situated activity which depends on the social structure of the setting is attempted.

A section which describes the observer's experiences in the setting is included as an appendix. It is argued that because the setting allows for only two classes of participant, the observer role is seen as deviant and that this leads to mistrust on the part of both sets of participants.

ACKNOWLEDGEMENTS

I would like to express my appreciation to the patients who were present in the setting at the time of my participation (or non-participation). Their acceptance of my presence in a setting in which any stranger was a source of concern and potential embarrassment was greatly appreciated and their patience in answering what I thought were sociological questions was of considerable assistance.

To the staff at Theta I must express a similar appreciation. Despite my ineradicably intrusive role which was sometimes a source of legitimate irritation to some members, I was received with a considerable degree of tolerance. The access which I was eventually given to all parts of the program, after an initial and understandable reluctance, was generous, if short lived, and the openness with which my questions were answered was a testament to the good will that I often experienced. The work of staff members at Theta is an extremely demanding one. It was apparent that the centre was a setting in which patience and affection were extended to an appreciative group of voluntary participants who frequently expressed their enthusiasm and satisfaction with a process that they saw as a significant intervention in their troubled lives. I wish to extend my warmest thanks to all those who were involved during the period of my observation.

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CHAPTER ONE

INTRODUCTION

This thesis is an account of the everyday life of an out-patient therapeutic community for non-psychotic patients who seek help with troublesome interpersonal problems. I have called the centre "Theta". My purpose in writing the thesis was to provide some ethnographic detail about the way in which therapy gets done in such a setting. It is a feature of psychiatric writing that, while there is a vast literature which describes how therapy ought to be done, there is little or no literature on how it actually gets done. That is not to propose that there is a sharp contrast between theory and practice but to suggest that the equation between the two is an unknown one.

Ethnography

An ethnographic account differs (ideally) from other accounts chiefly in two ways. The first is that it refrains from making any judgments about the details of the setting that it describes; that is,

it is not an *interested* account. The second is that it contains only material which is relevant to "the culturally significant behaviour of a particular society".[1]

It is sometimes difficult to persuade non-sociologists that the first requirement has been met. If an ethnographer watches (for example) a traffic policeman directing traffic for several days and subsequently produces a description of his behaviour which refers to his activities as "standing in the middle of the street waving his arms in the air in certain regular ways", the policeman is likely to be offended. The description depreciates the activity. The policeman knows and everybody else knows that he is not "waving his arms in the air", he is "directing traffic". The knowledge of the social order that translates his behaviour into socially meaningful activity provides it with a moral force. Garfinkel[2], in "Studies of the routine grounds of everyday activities", refers to this moral force in these terms:

> A society's members encounter and know the moral order as perceivedly normal courses of action - familiar scenes of everyday affairs, the world of daily life known in common with others and with others taken for granted.
>
> They refer to this world as the "natural facts of life" which, for members, are through and through moral facts of life. For members not only are matters so about familiar scenes, but they are so because it is morally right or wrong that they are so. 3

The ethnographer who attempts to suspend his common-sense knowledge of what everybody knows in order to make familiar scenes strange is likely to be suspect. What is he up to? How can he not see

what is "really happening"? What has he done to our world? It is just by suspending his common-sense understandings that the ethnographer attempts to discover the rational properties of everyday activities and thus remain loyal to the program of his enterprise. In order to be authentic to his own description, the ethnographer may at times display himself as being inadequate in terms of what has been indicated above yet as a person he may in fact *embrace* the presumptive facts espoused by the institution if his investment is large enough. He must, however, be on his guard against this: "For no one who wholeheartedly shares in a given sensibility can analyze it; he can only, whatever his intention, exhibit it." [4]

The second requirement is what distinguishes ethnography from newspaper reports, from exposés from gossip and idle curiosity. The details of an ethnographic account are selected to illustrate facets of "culturally significant behaviours". It is up to the ethnographer to defend his selection on these grounds and to show how the social organization is determined by and determines what facts are significant in the setting. Facts are not selected for their human curiosity value, for their shock content or for prurient interest but are selected because they are relevant to the way in which the putative social order is created. The ethnographer has, thus, this responsibility to his material: to report what is there not what he would like to be there.

The Data

The observations which form the foundation for this document were collected over a period of approximately one year. My initial contact with the institution was brought about by my desire to expand my observations of a small group. I had been studying small group behaviour by observing and participating in "leaderless" groups constituted to study group process. I wanted to continue my activity during a summer vacation. The centre was known to my advisor and he corresponded with the clinical supervisor in an attempt to gain access for me to what we both thought would be an appropriate setting.

After some initial contact with the centre in which I explained my group focus, I was permitted to attend for one afternoon a week to watch the formally constituted therapy groups which were one feature of the setting. For a long period of time I attended one day a week, first during the afternoon session and later at an evening session which took place one evening a week.

I was conscious, during this period, of the fact that the group focus which I had developed prior to entering the institution was difficult or impossible to sustain, especially as I was absent for over ninety per cent of the activities at the centre. I requested that I be allowed to attend more frequently and was eventually permitted to expand my observations to two days. Even this, I felt, was inadequate and during the last two weeks of my observation I attended full-time. The details of my experiences as an observer in the setting are set out in

Appendix I.

I believe that it is worth recording that, partially as a result of my difficulties in deriving an adequate group focus in the setting, my perspective changed quite radically during the period of my observations. I had become more interested in doing ethnography in any case and the setting was in many ways ideally suited to this enterprise. Ethnography is said to require "a long period of intimate study and residence in a small, well-defined community, knowledge of the spoken language, and the employment of a wide range of observational techniques including prolonged face-to-face contacts with members of the local group, direct participation in some of that group's activities, and a greater emphasis on intensive work with informants than on the use of documentary or survey data."[5] Theta met all these requirements.

Throughout the period of my observations I was known to everyone in the setting as an observer and attempted to be as unobtrusive as possible. I appeared in the setting as nearly as possible in the dress and style of the other participants. I took no notes during the sessions although tape recordings were occasionally available to me via the recording equipment operated by the Theta staff. In general my observations were recorded during natural breaks in the schedule and elaborated at the end of the day.

The material in the text which is written single spaced and

indented is taken from my field notes unless otherwise indicated. These field notes are unreconstructed apart from occasional corrections where I have done unusual violence to grammar or syntax. Where conversations have been included they are sometimes closely paraphrased versions of the original utterances and sometimes literal transcriptions obtained from the available recordings. The transcriptions are evident in the detail recorded which includes all parts of the utterances as nearly as possible exactly as they were heard.

My concern was with the patterns of behaviour which recurred with regular and stable dependability and which could be seen as the appropriate normal natural behaviour of the individuals in the setting and also, of course, with behaviour which was explicitly condemned as inappropriate. I used the members of the setting as competent informants about the setting insofar as they were seen by their colleagues as competent informants, and I tried as far as possible to check my observations and constructs against the subsequent behaviour which I observed. Much of the material should, however, be considered as a tentative formulation at this stage because of the restrictions that were imposed on my schedule of observations by the staff and by my own time-table.[6]

Themes and Focuses

The thesis attempts to describe the "socially standardized and standardizing, 'seen but unnoticed', expected background features"[7] of the setting. The sociological questions that I address were succinct-

ly stated by Sherri Cavan:

> What are the courses of action that have the character of taking place and being expected to take place in [this] setting as a matter of course and without question?

and:

> What kinds of assumptions would be required to generate these courses of action as regular and recurrent phenomena? 8

I proceed by describing the setting in which the activity took place and dealing with some of the dimensions of the activity in that setting. I describe the two major social roles that mature in the setting and suggest the "kinds of assumptions [that] would be necessary to generate the courses of action" that are described in the rest of the thesis. I describe the ways in which the two major roles interact to produce the features of the setting that make it recognizable as a therapeutic community. In a final chapter I attempt a preliminary formulation of the ways in which doing therapy is carried out and how the success of this enterprise is determined by the roles, beliefs and interrelationships of the participants, that is, the mutual orientation of the participants to what kind of place it is.

Anonymity

The clinical supervisor once remarked to me that there was only one Theta. The implication was that any attempt to disguise the setting was empty because it would be immediately recognizable to everybody who was familiar with the university. Of course my presence was known to the staff and the then current patient population, many of whom

expressed an interest in my work. My academic committee knew of my work and its location. All I can do is to follow the conventional practice of eliminating names of individuals. I have, however, taken the additional step of removing certain references and footnotes that might allow Theta to be identified.

Footnotes

This thesis contains three separate sets of footnotes. The references that are made to the literature are footnoted by means of superscript numbers which refer to footnotes that are appended at the end of each chapter. Throughout the text there are a number of issues which appeared to have alternative readings or which raised points which would, perhaps, have intruded in the immediate argument. To deal with these matters, I have added footnotes on the pages on which the issues came up which are indicated by asterisks.

The third set of footnotes have been included at the request of the Theta staff. This document is a sociological analysis of the institution and raises issues that the staff felt should be addressed in psychiatric terms. The points that the institution wished to take issue with are indicated by a series of superscript letters. The footnotes to which these refer are included in Appendix V.

FOOTNOTES

1. Harold C. Conklin, "Ethnography", *International Encyclopedia of the Social Sciences*, ed. David L. Sills, The Macmillan Co. and Free Press, 1968, Vol. 5, p. 172.

2. Harold Garfinkel, *Studies in Ethnomethodology*, New Jersey, Prentice Hall, 1967.

3. Ibid. p. 35.

4. Susan Sontag, "Notes on 'Camp'", *Against Interpretation*, New York, Farrar, Straus and Giroux, 1964, p. 276.

5. Harold C. Conklin, op. cit., p. 172.

6. For a discussion of a study which illustrates what an adequate schedule of observations can amount to, see (for example), Howard S. Becker and Blanche Geer, "Participant Observation: The Analysis of Qualitative Field Data", *Human Organization Research*, ed. R. N. Adams and J. J. Preiss, Homewood, Ill., Dorsey Press, 1960, pp. 267-289.

7. Harold Garfinkel, op. cit., p. 36.

8. Sherri Cavan, *Liquor License. An Ethnography of Bar Behavior*, Chicago, Aldine, 1966, p. 8.

CHAPTER TWO

THE WORLD OF THETA

Theta is a world within the world, a specialized world that is the joint creation of two groups of people: patients and therapists. In this chapter I shall describe the setting and some of the principal activities that go on in the setting. I shall attempt, in a preliminary way, to outline some of the focuses, norms and values that the two groups in the setting attend to and which provide the setting with its accountable[1] character.

Theoretical Therapy

Before I describe any of the activities at Theta, it seems appropriate to address the explicit aims and goals of the institution. The staff saw the institution as being modelled on and a natural development of a therapeutic community in another location which has been written about to some extent in the English language literature of therapeutic communities.[2] The following description picks out a few points in that

literature which appear to be relevant to the present document.

Group Focus

The focus in the literature is on group treatment and the group is described as "much more suitable as a frame of reference for the study of individual human behaviour;..."[3] This belief is explained in terms of the determinants of neurosis:

> Neurosis is anchored in the vicious circle of interaction between the neurotic individual and the rest of the group. The neurotic co-determines the reactions of the group in such a way that it provides for him the stimuli reinforcing his neurotic stereotypes.[4]

The paper goes on to argue that

> ...[The neurotic individual] is unaware of any relation between his activity and the reactions of others...5

and that

> ...an important aim of psychotherapy must be the restitution of [the awareness of the relationship].[6]

The mechanism to accomplish this is the group. The neurotic individual is seen as having a permanently distorted and invariable perception of the world which he successfully operationalizes in every social context. He sees the group

> ...in a distorted way and sees its members in roles different from those they actually play: he acts or tends to act accordingly...7

> Such an exceedingly erroneous interpretation of a group is called...a *pseudogroup*. 8

Therapeutic Process

The therapeutic setting provides a framework for the individual which allows him to act out his neurotic interaction.

> One of the main concerns is to have a group plastic enough to allow patients to reproduce the structure typical of their relations, without preventing change.[9]

The patient in the therapeutic community is assumed to reproduce his standard interactional behaviour ("to relive his neurotic vicious circle"[10]) in the therapeutic setting which provides "a broad spectrum of real-life situations in which the patients quickly reveal their typical behaviour patterns, and the others typically react to them."[11]

The therapeutic process, then, consists of observing the patient and discerning how he interacts to "...confirm [his] self-image and [his] expectations about others..."[12], that is, how the patient brings about his own "self-fulfilling prophecy".[13] When it has become apparent *what* is being done, this can be exposed to the patient in order to "...correct the 'hypothesis' of the individual about other people."[14] "A patient learns that not all persons in a certain role (as for example authority, peer, erotic partner) perform in the way he expects."[15]

It is recognised that the patient may resist the exposure of his behaviour through fear, and it is argued that the tendency to avoid the confrontation "through...anxiety-determined avoidance"[16] can be "readily seen in the therapeutic group"[17], which can address this as a relevant part of the problem.

The second stage in the therapeutic process is not so clearly explicated. It appears to involve the patient in experiments in which he can try out alternative behaviour which violates the norms of his false "hypotheses".

> [H]e can act, for the first time in his life, his activity takes the form of learning by trial and error. 18

The group is seen as a valuable resource for this experimentation.

> The patients, as co-therapists, may experiment on a much larger scale than the therapist with his therapeutic means. 19

To sum up, the theory argues that behaviour of neurotic individuals is sensibly invariant over all social situations and the centre provides an adequate theatre for the social actor to display his false assumptions and pathological deterministic behaviour which can be inexorably exposed to him. The exposure is assumed to be therapeutic for the patient, and he also has the opportunity to try out alternative behaviour in a relatively safe environment.

Other Considerations

The literature has other focuses: an early emphasis on hard work and spartan living which is less apparent in the later writing, and a continuous stress on the economy of the treatment method. It is emphasized that the centre should be wordly though isolated (the stress on isolation can be seen to decrease too and has largely disappeared to Theta itself). For example it is stressed that the work "is not occupa-

tional therapy, but genuine work in the fields, gardens and woods"[20] and that "since the patients are city people unaccustomed to farm work, this situation contributes to [the patients'] stresses, frustrations and conflicts, just as in real life."[21] Next, it is emphasized that the staff, although trained, are not traditional psychotherapists. For example, in discussing the resident "social therapists", the literature notes:

> We regard as favourable, too, that they never worked in any traditional psychiatric institution before, so that no transfer of unfavourable traits (like patronizing attitude toward patients) could take place. 22

The Physical Setting

Theta is located on the fringes of a university campus adjacent to an inpatient psychiatric hospital. The physical setting of Theta is a large timber frame house set in its own grounds. The entrance is located on a wide boulevard and is undistinguished from other entrances along the street. A sign on the gatepost announces the address and the name. The presence of a larger than usual parking lot with university "faculty and staff only" parking signs identifies it as a university-related building. There is a small vegetable garden, a brick patio and front lawn.

The building itself consists of a T-shaped ground floor and a second floor above the vertical part of the T. (See Appendix II) Below this, on the ground floor, the area is divided into an entrance, kitchen and workroom (with attached bathroom) at the south end of the T. The remainder of this area is further split up by a staircase which

leads to the second floor and a waist-level partition, both of which produce subspaces that can be organized for various purposes.

A long coat closet has been constructed behind the stairs. The largest part of the area adjacent to the kitchen has been furnished with long tables and benches and the north end of the room contains couches and chairs. There is a fireplace in the north wall.

The left-hand part of the head of the T contains essentially a single room. At the extreme west end of this room a small semi-circular stage has been constructed. It is two steps high and occupies roughly half of the end wall. There is a piano beside the stage in the north-west corner which has a sign attached to it admonishing people not to move it.

The whole south wall of the room contains windows which look out on the sunken patio and behind it to the parked cars of the Theta occupants. The end of the room opposite the stage has what was once a bar set into it. This is currently being made over into an "Audio-Visual (AV)" room and will be fitted with one-way mirror, TV cameras and recording equipment. Microphones hang from several locations in the timber-beamed ceiling.

The room is carpeted throughout and contains twenty or thirty chrome steel and black plastic stackable chairs which constitute the only furniture.

The opposite side of the T contains a smaller room (the "back room") with a storage space off it. This room is also carpeted and is scheduled to be wired for sound recording.

The second floor is divided down its entire length by a corridor. A series of individual rooms open off it on either side. These rooms have been furnished as offices for the staff, a waiting room for individual patients and a room which is currently being shelved to provide a staff library.

The downstairs space contains a minimum of "props". The small room adjacent to the kitchen has been fitted out as a workshop. It contains large rough cupboards, peg-boards for storing tools, a sturdy table and a severely neglected sink which is used for cleaning brushes and paint trays. The room is undecorated and convincingly displays an atmosphere of carpentry and maintenance. The work of doing therapy at Theta encompasses an assumption that "work is part of life" and the workshop, being the focus of work, is referred to as the "occupational therapy" (OT) room.

The bathroom adjacent to the OT room is neglected and its shower and basins have the slightly grubby unused look that a bathroom has in a house under construction.

The entrance immediately adjacent to the kitchen has a sign

posted in the window announcing that "This is a therapeutic community" and advising visitors that they should "report upstairs".

The kitchen itself contains a large refrigerator, stove, coffee machine and two walls of cupboards. The cupboards, although of rather rough construction, are newly painted and clean. Kitchen maintenance is one of the tasks of the Theta patients and the equipment and countertops are clean except where the aluminum coffee pot drips on them, and the floor here, as elsewhere in the house, is unmarked.

The part of the large room adjacent to the kitchen, besides the long tables arranged end to end, contains a large sideboard. The wall above this is hung with notice boards and the partition wall with the kitchen has a blackboard on it.

The most striking item on the notice boards above the sideboard is a medium-sized poster showing an elephant urinating. The caption reads "it never rains but it pours". Beside it, there is an old postcard addressed to "Dear Theta" with a picture of Hawaii. Beside a map of the university and a scribbled poem, there is a type-written list of rules for Theta and a timetable of the daily activities. Next to this there is a set of instructions on how to mix paint, polly-filler and cement. The whole effect is of the kind of familiar unnoticed notices that abound in all institutions.

The visitor who "reports upstairs" is presented with a series of doors, a few with neat cards on them, announcing the names of the occupants. The namecards are characterized by the use of first names instead of family names. Several of the doors are unmarked. One is split into two halves with a shelf on the lower half. A sign at the head of the stairs indicates that something to the right is the "office".

A visitor wandering around in the physical setting of this "therapeutic community" would gain very few insights into what kind of social world was created within the confines of this setting, what a "therapeutic community" amounted to, or how the activities at this institution were distinguished from the many activities that could potentially be carried on here. It could be anything from a bordello to a church. The actors have to appear before that can be resolved.

During the day, the space in Theta took on some additional aspects. As a rough generalization it can be said that the main floor area was public space and the first floor ("upstairs") was private space.[23] This, in fact, delineated the first distinction between patients and therapists for while therapists had free access to all parts of the building at all times (with deference to individual rights to individual offices), the patients had unlimited access only to the public space on the main floor and conditional access to some of the second floor space. In general this meant that they could go into the upstairs rooms only if they were invited by the occupants or with per-

mission, unless they were constituted as a work party which gave them warranted entry to any space that was going to be worked on.

The patients' treatment of the upstairs space was quite well illustrated in the use of the Theta telephones which were all situated in the "upstairs" area. When the telephone rang at Theta it was usually answered by the secretary but, in her absence, one of the staff members would answer it. In general, patients did not answer the telephone even if nobody else did, and this was seen as proper protocol:

> Somebody asked if [absent male patient] had called. He had not but it was pointed out the the telephone had rung several times before 9 o'clock and nobody had answered it.

The patients could use the telephones upstairs and showed a nice sense of the differential publicness, and indeed of the staff hierarchy, in doing so. For example, the occupational therapist was, perhaps, the most junior member of the staff and the patients that I observed generally used his telephone in preference to others. If he was in his office and another office door was open and the office observably empty, the patient would use the telephone in that room. The clinical supervisor's door was seldom if ever open and his telephone was never used by patients.

The secretary's office represented a slight departure from the rest of the space in that anybody could have business with the secretary, and this was considered adequate grounds for going to that office.

Even here there was still some differentiation between patients and therapists. Therapists regularly walked into the secretary's office to obtain records, leave work or set up the sound recording equipment which was mounted on the wall. Patients, by contrast, had only specific kinds of business that provided them with legitimate grounds for being there and were expected to state their business on arrival. In fact, the door was originally split to keep patients out. The secretary did no work for the patients but could supply them with relevant parts of their own files, Theta forms, and so forth if they provided grounds for their request.

The Theta setting, then, was divided into staff space which was restricted for patients, and patients' space to which the staff and especially the therapists had free access.

Activities

The patient population of Theta, usually numbering about twenty, attended at the centre for seven and a half hours each day from Monday to Friday. The day started at 9 a.m., except on Tuesday when there was an evening schedule and the day started at 1 p.m.

The staff kept approximately the same hours as the patients and consisted of five full-time employees plus the director of the institution and some occasional members. The staff consisted of the following people:

Clinical Supervisor (M.D.)
* Rotating Psychiatric Resident (M.D.)
* Resident Psychologist
* R.N. trained in psychiatric nursing
* Occupational Therapist
Part-time Clinical Fellow
* Secretary
Visiting Psychiatrists from other institutions.

The clinical supervisor, although he did not attend full-time, was largely responsible for the design and direction of the program while the resident psychologist acted as his executive assistant.

The Theta week was divided up into a varied program of work, play and therapy, and although the schedule changed in detail from time to time, the version of it which is shown in Figure 2.1 is representative of a typical week.

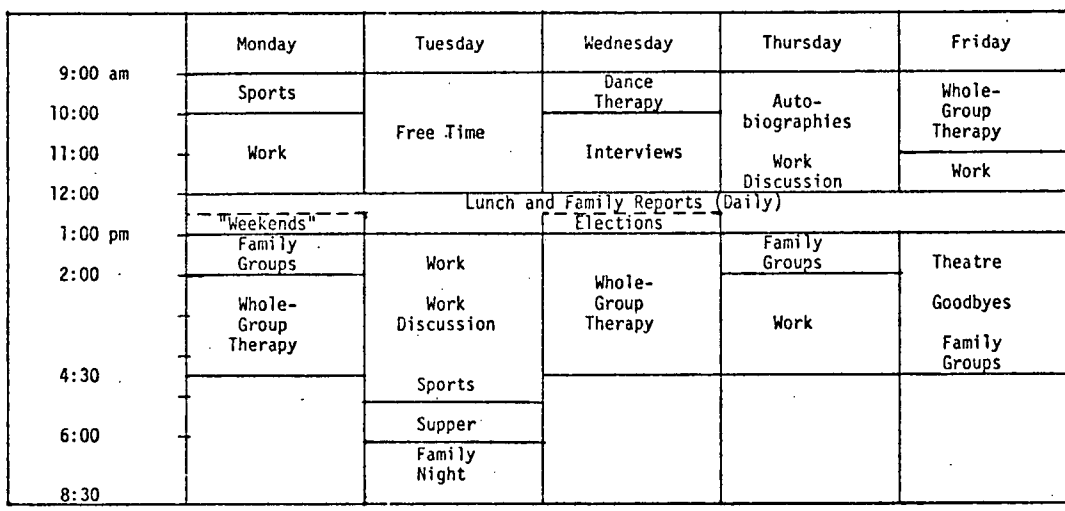


Fig. 2.1 Approximate Schedule of Theta Activities

The work which was carried on in the centre was usually directed at improving the physical amenities of the building and its suit-

* The full-time employees of Theta.

ability for its present purpose. The most common activity during the nine months of the period I attended consisted of painting. In fact the place smelled of paint almost continuously over that period of time and as the activity was intended to be therapeutic, I was going to call my description "Paint Yourself Well".

During the last few months of my observation, the patients were engaged in converting what had previously been a small bar adjacent to the "theatre" into a room with a one-way mirror which could be used for television cameras. The cameras were to be used to record the activities during the whole-group therapy which the clinical supervisor said would "improve the treatment". This room was referred to as the "Audio-visual" (AV) room. Another project that was being worked on in the later period was shelving for the staff library and the clinical supervisor's office. Other inside work that was carried out included such things as recovering worn furniture.

During the spring and summer months, work was also done on the garden. A vegetable garden and flower beds were cultivated, along with the usual clean-up chores.

The inside of the building was maintained by the patients who were responsible for carpet sweeping and keeping the stove and refrigerator clean, washing dishes and the rest. On Fridays a group of patients was assigned to prepare a meal for the whole group from food which was ordered for the purpose.

"Play" may not be a very satisfactory label for the next group of activities that I describe, because they were occasionally traumatic for some members and were at all times considered part of the therapy. This group of activities included sports, such as floor hockey, volleyball and team games of that sort which took place in a nearby gymnasium, also bowling, swimming and other physical activities. It also included "dance therapy" in which a dance instructor led the group, including most of the staff, in body movement exercises to music. Art workshops were occasionally run in which the patients constructed collages or made paintings which were expressions of their world. Finally, I would include a skit which was put on every Friday afternoon, usually by two patients who had volunteered their services, and which was always an occasion for considerable chaotic excitement and was usually very entertaining.

The therapy that was done at Theta is the subject of a chapter in this thesis and I shall only deal with it very briefly here. Therapy was generated from all the activities described above and also independently of them. For example if somebody had trouble playing games or dancing or acting in the patient play, that became a resource with which the therapists worked to reveal some aspects of the patient's problem. Therapy generated independently could be started simply by asking somebody to talk about his troubles or to report why he felt as he did about another group member.

Therapy consisted of various activities in which patients

either acted out roles that they reported, acted out roles of other people that they were involved with, spoke to each group member in turn, trying out some putative feeling that they had, or acted out their anger or aggression with another patient who usually played the role of a significant other. Padded clubs were used to express anger and hostility by harmlessly beating fellow patients in alien roles. The clubs produced more noise than pain and were anyway heavy and tiring to wield and quickly exhausted most participants. Patients were imitated and imitated each other to show characteristic behaviour and commented without reserve on whatever perceptions of each other they had. Patients were encouraged to express their feelings about each other and themselves at all times and not to conceal their good or bad impulses or opinions. In particular, patients were encouraged to engage in what appeared to be a modified form of "Primal" therapy which was referred to at Theta as "Abreaction Therapy".[24] This activity consisted of getting the patient to lie on the floor or a mattress after his emotions began to appear. In this position he was encouraged and physically manipulated in various ways in an attempt to escalate his emotional reaction to the point at which his emotions had taken over completely.

I believe that the brief sketch of Theta activities that I have given above will provide enough of a rough outline for my present purposes which are to focus on some aspects of the setting and to show more of the members' perspectives before embarking on the major task of attempting to formulate the determinants of the social order at Theta.

Structuring the Setting

Theta was constituted to some extent as a medical setting. This focus was not usually heavily emphasized and its relatively minor position in the Theta value system was pointed to when a new MD who was visiting the centre spent the afternoon paying unusual attention to the physical symptoms of patients doing abreaction therapy. She frequently checked for signs of seizure, measuring pulse and checking eye pupils and reassuring the therapist who was working that everything was under control. Apart from this being an unusual procedure (I never saw it done apart from this once), the conversation afterwards appeared to indicate that while her behaviour was not totally inappropriate, it was perhaps an emphasis that was unnecessary. This is an impression formed from the polite disinterest her comments in the after-group meeting evoked, rather than any explicit statement. The medical focus was also noticeably absent when three patients got slightly injured during a particularly vigorous game of floor hockey one day. One of the three had a leg injury of sufficient severity that made it difficult for him to walk. I drew the clinical supervisor's attention to this and he told the patient that he should go and have it x-rayed. There was no suggestion that it was *their* medical problem but rather the problem was treated the way it would have been in any lay setting.

Despite the low priority of the medical emphasis, it was present and appeared to have some consequences. There were, not infrequently, patients in the setting who considered part of their symptomology the fact that they were overweight. One such patient asked if a special

diet could be arranged for people with this problem. While this was found to be impossible (due to the intractable nature of the outside catering arrangements), the clinical supervisor suggested that people should be selective about their eating and check themselves on the weigh scales. He was told that there were no weigh scales and he was obviously astonished at this. At the meeting afterwards he asked that a scale be obtained and there was general agreement that it should be a medical scale and not just a bathroom scale which would be inappropriate to the setting. This despite the fact that it presented some problems because of the price of a medical scale which the budget would not allow. Another issue that arose at one time was what standard medical kit was available in the centre:

> A medical kit was dragged out of the back office looking as if it has never been used. [Clinical Supervisor] asked if blood pressure readings etc. were taken here. They are not. People were supposed to have a physical before they come in. It was decided that some additional equipment should be acquired: an ophthalmoscope and a neurological hammer.

The formulation of Theta as a medical setting was also observable in the qualifications that were considered appropriate to people who were being considered for the role of therapist. Several potential therapists appeared at Theta during the period of my observation. One who visited for a short period generated the following at a therapists' after-group meeting:

> [Female MD] was introduced. She is MD. She was invited to work at Theta. [Clinical Supervisor] said that she did not have any psychiatric training apart from a few lectures in the normal course of her MD training, but didn't think this mattered. Could [current alternative candidate] stay? No, it must be an MD.

Of course several members of the staff were not medically trained but it was apparent that medical training by itself was considered relevant qualification for membership in the therapist group.

The category of people who have warranted access to Theta was severely limited. In general it was restricted to two groups: therapists and patients. The efforts that are described in the appendix on the observer role to persuade me to go to the centre as a patient rather than as an observer appeared to confirm the dissatisfaction of the institution with people in the setting that did not fall in either of the two principal categories. A nurse from the psychiatric hospital applied to do her training at Theta during my period of observation and was required to attend as a patient and to follow the regular routine in entering.

> [Clinical Supervisor] said she must spend at least four weeks in the patient role. The question of when she could start was raised. [Resident Psychologist] was adamant that the routine process should be followed. She must go through the interview, group screening, etc.

Apart from the therapists and patients, there were a few visitors who came to Theta, although it was emphasized, as the Theta secretary explained to a patient one day:

> It was very important that nobody come in without permission from one of the therapists.

The most common visitors were MDs from other settings who came to Theta for an occasional afternoon or evening session. Provided that these were psychiatrists they fitted easily and naturally into the therapist role and were accepted as such by the patients, even when they were

previously unknown. I was interested, for example, in the ease with which a visiting psychiatrist fitted into the ceremonial "goodbyes" which were scheduled in the day she attended. Goodbyes were an occasion when patients and therapists alike produced a short speech, often a summary of their perception of the patient who was leaving. They were frequently occasions of considerable intimacy.

> There was the usual talk about how good people felt about people who were leaving. The unknown therapist produced some good ad hoc remarks. To [Female Patient] she said that she had been very moved by the things that people had said to [the patient] and thought that she must be a very wonderful person. To [Male Patient], who came to her about third, she said that she thought he sounded very "solid" in the changes he had made at Theta.

I report, in Appendix I, a contrast that was made between me in my observer role and a visiting psychiatrist who used to attend occasionally at the centre. The patients pointed out that she was a helper, which presumably traded on her being categorized as a therapist. They had no trouble accepting her occasional visits, whereas the occasion of the question was brought about by my being asked to explain my presence.

Any visitor, then, who could be constituted as a therapist was received at Theta without challenge. In contrast to this I was frequently challenged by new patients.[a] I used to attend lunches to introduce myself to new patients during the period of my once-a-week observation and at one lunch, after being introduced, I jokingly said that I came "so that people could know what the hell I was doing here." A new patient across the table asked, "What the hell are you doing here?" A challenge which visiting therapists were never confronted with.

In another instance a nurse from the psychiatric hospital attended for a day to observe Theta and had not apparently been authenticated to the patients. During the afternoon group meeting she was sitting in the circle of chairs when a patient, going round each group member in turn, stood in front of her. I can only reproduce a rough version which followed:*

Female Patient to Visiting Nurse:		[Name], isn't it?
Nurse	:	Yes.
Male Patient (on far side of circle)	:	Would you please introduce yourself?
Nurse	:	I'm a nurse from the hospital. I'm here so that I can see what you do here so that I can understand how our records should be kept.

The nurse's answer, although only an approximation of what she said, appeared to show that she clearly recognised the male patient's question as a challenge. Whether it was or not, she formulated her answer as an explanation to legitimate her presence, appealing to the understanding that everybody had that Theta was part of the hospital and that her business, the records, was hospital business and therefore warranted her attendance.

One night of the Theta week was designated "Family Night" and on family night patients were invited to bring their fathers, mothers, sexual partners and significant friends so that they could interact with

* This conversation is a paraphrase obtained from a recording made on the occasion by the institution. Its shortcomings derive from my incomplete record of the details of the utterances.

them. On these occasions there were often significant numbers of visitors in attendance, their legitimacy being that they were brought by a current patient of the centre and the relationship with that patient was identified. These evenings started with "introductions" in which the identity of each visitor was established. The visitors were present, however, only as instruments in the therapy of the patients and when a visitor asked for advice about some aspect of the relationship that seemed to be his problem rather than the patient's, he was told that that couldn't be addressed because "you're not one of ours".

One additional category that was recognized at Theta was that of ex-patient. Ex-patients were expected to attend at Theta one day a week, for three weeks, for "after-care" and were seen as warranted members of the patient group on those occasions. Invoking the category "ex-patient" was also seen as adequate explanation for some continued contact with the centre. There were some on-going ex-patient groups which met for several months after the formal treatment was over. An organization was also proposed that would keep some contact between former patients and the centre. Being an ex-patient was also seen as adequate warrant for entering Theta (although not, except as above, taking part in a current group). At the end of one after-group meeting

> ...two former patients were sitting in the dining room with a third person. [Female Ex-patient] explained that she had brought her mother out to see the place.

This explanation for her presence and that of her mother was accepted without comment.

That the categories "therapist" and "patient" were seen as exhaustive of all people present was, finally, illustrated by the experience reported to me by the Theta secretary. She complained to me that she felt her uniqueness very sharply. She was not an accredited member of either category set and said that she "didn't really belong to either group". She decided to go through Theta as a patient so that she could more readily identify with the patients and, presumably, have some status as an ex-patient.* b

All parts of the program at Theta were considered part of the therapy and this perspective was instrumental in determining much of the behaviour in the centre. In fact, the pervasiveness of this view among patients was the source of some troubles which were especially evident in the talk about the place and practice of work at Theta. As this problem, arising from different perspectives of what was really happening, is relevant to the constitution of Theta as "a reflection of the world" and also to the structuring of the setting, it seems appropriate that it should be dealt with here.

An important emphasis in the theory presented above, and in the talk of the Theta staff, was that Theta must be a reflection of the world. This was particularly strong in discussions about the work.

[Clinical Supervisor] said that it was important that

* It has been pointed out that the secretary's desire to attend as a patient had other dimensions than the ones I propose. It was the subject of a clinical assessment which was carried out by staff members.

> the work reflect "real life". He got very annoyed when [Female Patient] said that they were not really working but just "playing at working".

The emphasis throughout the Theta program was that work was part of the therapeutic program at the centre. In fact, it was probably this emphasis that was most persuasive in getting prople to do work that they would not ordinarily do. Whether this was the case or not, everybody was explicitly required to participate, as the introductory letter to Theta explained:

> All [the parts of the program enumerated in the letter] are elements of a unified therapeutic programme and every aspect must be attended.

While patients did, then, attend every aspect of the program, they also attended to its therapeutic focus and this produced some conflict with the usual everyday focus which was especially evident in the work part of the program.

In the first place, the work at Theta was directed by a member of the staff who was referred to as the "occupational therapist" although he was usually addressed by his first name and the label was not much in evidence. The room in which tools were kept, paint mixed, and some carpentry done was referred to as the "OT room". Probably not many people associated "OT" with occupational therapy; nevertheless, the label was there.

That the work was instigated and directed by the occupational

therapist was evident and unquestioned. When a new patient work co-ordinator* asked, at a patient committee meeting, what she had to do, she was directed to the occupational therapist:

> [Female Patient] tried to pick up some clues about what a work co-ordinator was and found he had to be in at 8:30 a.m. tomorrow to meet [Occupational Therapist].

Every time a new work co-ordinator took over from his predecessor, he was given a list of work in progress and told several times to "check with [Occupational Therapist]" about the details. I asked a work co-ordinator whether she thought she had the authority to change details of the work and she replied: "[Occupational Therapist] usually knows what he's doing". The fact that the work was directed in this way was accepted by the patients as reasonable and proper, in fact, pre-eminently a reflection of the world where decisions about what should be done are routinely made by the people in whom the authority of the institution (whether it be General Motors or the office typing pool) is rooted. When the patients' acceptance of this structure was questioned one day (because the work was generally recognized to be going badly) there was a dismayed silence followed by a long conversation with many references to the fact that the work did not reflect real life.[f] It was like asking the office typists why they didn't do something about the design of a

* At a weekly election, two patients were elected to offices designated as "work co-ordinator" and "chairman". These two officers, together with one patient elected from each of three subgroups of the patient population constituted a patient committee whose functions are described later. The three patients elected from the subgroups filled the offices of "Diary Dealer" and acted as "foreman" or "family leader" for the subgroup from which they were elected.

building whose specifications they were typing because they had grumbled about its ugliness. The therapists' perspective in questioning the acceptance was apparent and accorded with the notion that the institution must question displays of inappropriate dependence. The patients' shock appeared to derive from their being told that they should question what they saw as normal, natural authority.

The selection of work co-ordinator and foreman and the responsibilities that were expected of them showed similar contrasting perspectives. The institution's position was frequently stated that the people who filled these jobs must be trustworthy and competent. The discussions about who should be chosen showed, however, that this was almost never the case. Attention was paid to the therapeutic value of holding these positions in contrast to the "real-life" values of competence and efficiency. The issues that got people chosen as work co-ordinator, etc., were much more often things like: "Who hasn't done it yet?"; "You should do it because you say you can't do it, it would be good for you"; "It would be therapeutic for you to try and we will help you"; "You will find out about yourself if you try". On this basis, it very often happened that the people who got these jobs were the least fitted for them in a "real-world" sense and they were precisely the people that would never get chosen in "real life".

In a similar way, patients recognized that the business of being foreman, etc., was qualitatively different from holding that position in the real world. While the aggressive exercise of authority is

routinely the subject of surreptitious grumbling or veiled complaints, foremen at Theta were commonly confronted with the suggestion they were "power tripping", "pushy", or "aggressive". A family report noted:

> We talked with [Male Patient] about his being work co-ordinator. He said he liked the responsibility although he had "taken over" until Tuesday when he was a bit more relaxed. Some people commented that [Male Patient] has a tendency to power trip with his responsibility: that he didn't treat the people working as responsible workers or friends.

The difference, however, amounted to more than this. Patients expected of each other that they should care about their fellow patients and the foreman was no exception:

> It's what puts people uptight is, y'know, as if like, the only thing you're interested in is.. y'know.. the .. th'work and not the people.. y'know.. like production versus human relations.

A male patient who had considerable experience in working with foremen and as foreman himself in his regular job was criticized for not paying enough attention to his crew. He replied that he had told them what to do and could see that they were doing it, but this was not considered adequate:

> [Patient] said that she had been disappointed that [the foreman] had not gone to see how his family had been working. [Foreman] said that he had been able to see that they were working all right. [Patient] said that she had wanted him to come and see how they *were*.

In addition to the periods that were set aside for the work itself, a number of periods were set aside for work discussion. These discussions generally attended to the occupational therapy focus of the work and took the form of discussions about how people felt about each

other during the work period, how they felt about the foreman or being foreman. The clinical supervisor once complained, on being told about this focus, that the discussions "must be very unrealistic", but their being unrealistic depends on the assumption that talk about work is situated in a natural work setting. They were anything but unrealistic for the patients in the setting they were situated in. A good example of the situated meaning of talk about work occurred when I asked a work co-ordinator whether she thought that she could change the work that was set by the occupational therapist. I was trying to get at the amount of autonomy the patient committee saw itself as having but:

> She took the question as a psychological one. Could *she* do that? I found that in asking questions about the work, the questions were routinely treated as therapy questions..."I know that is my problem".

The standards of work at Theta were, of course, also determined by the setting. It was explicitly acknowledged that many people would not do the kind of work they were doing at Theta in the "real world". After a day in which the staff had complained about the work:

> [Female Patient], when I was driving her home, said that she thought that most of the trouble arose because a lot of people at Theta would not do that kind of work themselves.

The work, however, had to be done and so people judged its satisfactoriness on the basis not of professional "real world" standards nor of their own amateur do-it-yourself standards, but on the situated standards of the institution. It was pointed out that some of the work was of comparatively low quality. The objection was raised that people did not have experience in doing the work that was expected at Theta. The

foreman often knew that the work was not the best, but it was considered to be the best that so-and-so could do. One new patient that I observed explicitly checked out the institution's standards and made his own interpretation of them from the reply that he received:

> [Male Patient] said that he wondered what kind of job was expected - any old job, an okay job or a super good job. He asked [Occupational Therapist] whether he wanted an undercoat put on the shelves and when [Occupational Therapist] said "no", [Male Patient] assumed that the quality of the work was just so-so.

Patients recognized that the institution's standards were not their own but were determined by the exigencies of the situation at Theta. Thus when a set of library shelves was found to have been badly prepared by a previous patient group, the patients who were attempting to erect them continued to do so even though:

> [Female Patient] said that she couldn't believe the mess the shelves she was working on were in. She said that if she had been doing the job herself she would have junked the stuff that was there and started all over again.

The work co-ordinator, who also thought the shelves "could have been done again", recognized that this was not an appropriate reaction:

> She said that a lot of work had been put into the things already and that they now had to do the best they could.

The work was, then, recognized as taking place within the context of a setting, one in which people were inexperienced at what they were doing, had to do it, and a setting in which there was a continuous turn-over so that one might inherit somebody else's troubles and it was up to him to make the best of it.

Resources

From the patients' point of view, Theta had two resources which were in scarce supply. These were time and therapists. The two resources were interrelated in that time was still a factor when the desired therapist was present, but I shall attempt to treat them separately because there are aspects of both time, generally, and therapists' time which are of interest.

The patients recognized that the different therapists at Theta were differentially qualified to give help and valued the help of some above others. Thus, when a proposal was made to change the system of family* groups so that they would be stable throughout the patient's stay in the centre, one of the first questions that was asked was:

> I like the current therapist attached to the family very much but can we rotate the therapists?

Apart from individual patients' recognition of individual therapists' qualities, as for example in a diary entry:

> ...of course, [Therapist] is very much on top of any situation that comes up. I admire ( ) a great deal.

the whole group acknowledged the desirability of working with the clinical supervisor. Two patients remarked to me that "you usually got about two chances to work out with [Clinical Supervisor] during your stay". The clinical supervisor himself traded on this knowledge and offered his

* "Family" was the name given to the three subgroups among which the patient population was distributed. The "family" subgroups are discussed in a subsequent section.

services to the family group whose members had currently accumulated the most points in a system of scoring in which patients received points for work activities. When the scores were not available in a subsequent lunch meeting, and the clinical supervisor refused to attend with any family, there was a considerable amount of anger at the family foremen because of this lost opportunity.

In the formally constituted group therapy sessions, so-called "big group", all or most of the therapists were usually present together. As there were usually about twenty patients at Theta and only one or occasionally two patients could work at any one time in big group, time in this setting was especially valuable. This meant that there was considerable competition for the time that was available and it frequently happened that strong feelings were generated in patients who felt that they had not obtained enough group time.

> I'm very bothered that there never seems time for me to ask for help...I almost envy members in the group who are given an opportunity to work out.

> When the session was ended [Female Patient] angrily complained that she had not been given time to work, she had asked for time and had been promised it... this happened again and again...

The pressures on big-group time could be seen in the complaints of patients about time being wasted on non-therapeutic activities:

> I thought we didn't want to waste big-group time talking about business matters, that's why there's a committee.

> We're wasting so much time with dead discussion.

Wasting time was regarded as a strongly disapproved activity. Wasting time was seen as asking for the opportunity to do therapy and then not using it. A patient would ask to work and then spend the time granted to him in silence or in argumentative talk or asking questions of other patients or therapists. Even conversation was seen as inappropriate activity in big-group and, as such, a waste of time:

> [Clinical Supervisor] brought [Female Patient] up to the stage and talked with her for a while...As the discussion went on, several people became impatient with the amount of time [Female Patient] was taking up.

A patient who was granted time was expected to work on his own problem, to "let go" and be visibly making good use of the time granted to him.

Any member of the group at any point could challenge the activity on the grounds that it was "wasting time" and if he could muster enough support, the activity would be terminated. The member who had been granted time usually recognized the moral force of the complaint that had been raised and terminated his performance. In fact, that she "wasted time" was given as adequate reason for arguing against the granting of an extension to one patient:

> Several patients objected to [Female Patient] being granted an extension, feeling that it was an intrusion on their own chance to do work. [Female Patient] had wasted so much time already.

Patients monitored their own activity so as not to take up too much time in the group, as was expressed, for example, in a diary entry:

> I felt very much a part of the group today, eager to

> work on a lot of things, but don't want to feel that I am demanding too much time.

Another group activity in which the pressures of time were severe was the "family night" at which significant friends, relatives and others were brought to Theta. This session lasted two and a half hours and although there was considerable variation in attendance, it was often attended by large numbers of potential participants.

In contrast to the daily activities which were seen as therapeutic regardless of who was participating actively, there was a strong feeling among patients and visitors that attendance at family night was sufficient reason for demanding therapeutic time. Both patients and visitors were conscious that visitors had come, often from a considerable distance, not for entertainment or information, but because they could help the patient. The pressure to allow every visitor to have time was attended to by the therapists who tried to make a virtue out of necessity by proposing that those who were present for the first time could just watch. In that way they could see what kind of thing was done on family night and then have time on a subsequent night.

Even so, an attempt was frequently made to have everybody present given at least some time on the stage. One of the results of this was that it was often run on a rather rigid schedule, for example:

> [Current Patient Chairman] was keeping strict time in each group and telling them to stop when their fifteen minute limit was up.

It seems not inconsequential too, that two of the very few confrontations with the staff that I observed at Theta took the form of a refusal to stop family night on schedule because there were still visitors to be heard from.

Apart from the pressures of time in individual parts of the program, the whole stay at Theta was a highly compressed affair. The length of stay for patients was determined by the institution and was usually six weeks, with the possibility of an extension for one or occasionally two weeks at the option of the patient who only had to ask for it. That the program was a concentrated one was acknowledged by the therapists:

> [Clinical Supervisor], [in emphasizing the value of the program], said that a period at Theta was equivalent to a year outside.
>
> [Visiting Psychiatrist] said that six weeks at Theta was equivalent to six months anywhere else.

Both patients and therapists experienced the concentration of the program as oppressive. The schedule was such that the whole day was filled with activities and left virtually no time for relaxation:

> We've got the day scheduled now to the point where our lunch time's filled with discussion.
>
> I don't even find sometimes that there's time to go to the bathroom.
>
> I find that the time for the program.. to be very tight.

The clinical supervisor frequently expressed his experience of the pressures of time and explained that many of the research and experimental aspects of the program were delayed because of lack of time. Another

staff member expressed the general feeling that there was little time when I made a suggestion about some activity:

> [Staff Member] said, "we should do it"...but complained that there was never time to do the things they wanted to do, suggested more time should be spent on whole group.

Of course the fact that the days were filled with activity made the time pass quickly which caused the patients to be conscious of the fleetingness of their stay at the centre. This was most frequently commented on in their "reflections" in their diaries:

> ...only three weeks to go a long way.
>
> This week I have been very aware of the fact that there is only two weeks to go.

Patients' attention to the location of the current time in their attendance had relevance for some of their activities in the centre, and this point is addressed in the chapter on the patient role.

When one considers the amount of attention that was paid to therapy time and time with therapists, it is not hard to understand why the whole group was divided up into "families" for several periods during the week. The families were three roughly equal subgroups among which the patient population was distributed. The distribution was made fairly arbitrarily, and no attempt was made to achieve any particular balance of sexes or age groups, or to group people with "a complementary patient on whom he can show how his neurotic vicious circle works".[25] In fact, the probability of his finding a "neurotic 'complement'"[26] or of finding "others in the same role, but performing more normally"[27] in the subgroup was obviously much smaller than it was in the whole group.

The division was a puzzle to me, in addition, because there was some evidence to suggest that their constitution was counter to some of Theta's own tenets. For example, it was explicitly recognized that everything *important* should be brought into big-group. This point is made in Chapter 6, "Doing Therapy", as is the point that exploring a particular incident is not a repeatable exercise. If all matters of importance must be brought up in big-group and if discussing them elsewhere is seen as exhausting the subject, the scope of the family groups must be severely limited. In fact, much of the family group time that I observed was taken up with talk of a sort that would have been considered "wasting time" in big group.

The families, moreover, were not constituted in any way different to the big group except that they had less members. Although there was a foreman, later called "family leader", he appeared to have no function when the family was gathered for "family meeting". It was not the case that the families attempted to reproduce the roles of the nuclear family in order to explore those role relations.

One thing about the family groups was apparent, though, and that was that they had fewer members than the big group. The thing that this provided above all else was greater opportunity to work (the families all met in separate locations) and greater access to the therapist. When all the members were present in the big group, the activities were generally directed by one or two therapists, so in a sense the remaining staff members present were "wasted". In the family groups, the

therapists were distributed among the families and every therapist was working.

The fact that some therapists were valued more highly than others was adequately accommodated by the rotation of the therapists among the different families. When a highly valued therapist came to a particular family, every member of that family had more opportunity to work with him.

The establishment of family groups can be seen, then, as a natural response of the institution to the pressures of group time and the demands for access to therapists. Although it may have involved some contradictions, it appeared to provide a way to distribute Theta's valuable resources in an equitable and manageable way. It can thus be seen as a kind of "fiscal" policy rather than a therapeutic policy. With the whole group divided into subgroups, each with a therapist assigned to it, three times as many people could work simultaneously and each person had, presumably, three times as much opportunity to have access to the therapist.

Values

Many of the Theta values are embedded in the roles of the two principal participants, the patients and the therapists, and, as such, are discussed in the chapters on those roles. In this section I would like to introduce some of the values that are encapsulated in the patients' system of beliefs and which are a determinant of the role.

First of all, Theta was seen as a serious place which should be taken seriously and not someplace that one went to because it was fashionable, or "in" to do so. Moreover, it was not a place that was one of a series which one could try in a career of going to currently fashionable growth centres. Theta was a unique institution and could not be treated in any other way.

One patient who was being interviewed by the current group was almost excluded because it was suspected that he was not taking the place seriously enough:

> You said somethin' about tryin' this primal thing before 'n now you're gonna try Theta, it's like a faddish thing: now I'm into this, now I'm into that... it seems you're not taking it seriously. Do you wanna change your life or just try another thing?

and again:

> D'you realize how super-heavy this is here? It's a really serious thing, it's not something you do... just because it's a far-out thing to do...

Patients in the setting who said that they would "go on to other groups" if they did not succeed at Theta were assured that they would not succeed. The expectation that there were "other groups" available was seen as a way to avoid doing the necessary work at Theta to achieve what the patient wanted to achieve. The notion that a series of groups existed was seen as effectively neutralizing all group work because it could always be put off to the next group.

Theta was seen as a place that required commitment and the

absence of this was adequate reason to refuse entry to any new patient. This is further discussed under "Patient Role", but it can be said that lack of commitment was always available as a transformation of any apparently counter-productive activity at Theta.

> The first foreman said that the group was not working well. [Female Patient]'s lateness was cited as an example of the lack of commitment of the group.
>
> ...again raised the objection about [a patient] refusing to be chairman. This was made out to be lack of commitment to the group.
>
> [Male Patient] was only digging with one hand. This was seen as showing his lack of commitment.

To be accused of lack of commitment was to be accused of a serious breach of the Theta ethic and was often accompanied by a demand that the accused patient demonstrate his commitment by doing something for the centre in his spare time. This was referred to as "making up a commitment" and involved writing poetry, making some artifact or painting a picture which could be brought to the centre for display.

Theta was seen as a place in which the traditional moral judgments were suspended. Patients regularly exchanged reports of behaviour that in the ordinary course of events would call for moral judgments on the part of the hearer. Those ranged from descriptions of what would conventionally be received as "bizarre" sexual practices, matters of marital commitment, accounts of aggressive, even violent, behaviour, etc. It was not so much a matter that they were indifferent to these descriptions but that they were certain that anybody's moral decisions were his own business and nothing to do with therapy.[h] The necessity of speaking

about one's feelings had priority and as those feelings frequently involved guilt about conventionally proscribed behaviour, the speaker had enough troubles without adding retrospective moral judgements to his burden.

On one occasion, an attractive woman who was a significant member of the current group reported that she would continue to be a prostitute after she left Theta. Although the group was apparently dissatisfied with this state of affairs and several people said they could not understand it, the strongest comment that was made was that it was "a waste". Instead, people questioned the girl about her other activities such as professional dancing and modelling, and made much of her potential in those directions.

Summary

In this chapter I have attempted to set the scene in a preliminary way and to introduce some of the matters that constitute the "seen but unnoticed regularities that constituted the everyday scene which members in the setting saw as the normal natural features of Theta. Some of the theoretical underpinnings of a separate institution that Theta owed much of its inspiration to have been discussed and the physical arrangement of the centre has been described.

I have introduced the participants whose activities produced the therapeutic reality and described the scope of those activities. The setting typically allows for only two categories of participant: patients

and therapists. These categories embrace particular values, some of which generate pressures which lead to institutional structures such as the families.

One aspect of the program, the work, has been described as a situated activity in which members attend to the immediate context in seeing how "work" should be done and what it means in the Theta setting.

In the next two chapters I shall attempt to develop my theme by describing in detail the roles embedded in the two categories of participant in order to elaborate the way in which these roles were created and sustained.

FOOTNOTES

1. The word is Garfinkel's. In discussing "What is ethnomethodology?" he describes its meaning as "...observable-and-reportable, i.e. available to members as situated practices of looking-and-telling." Garfinkel writes that the practices "...consist of an endless, on-going, contingent accomplishment; that they are carried on under the auspices of, and are made to happen as events in, the same ordinary affairs that in organizing they describe;..." Harold Garfinkel, Studies in Ethnomethodology, New Jersey, Prentice Hall, 1967, p. 1.

2. To protect the anonymity of the institution the references cited in footnotes 3 through 22 and 25 through 27 have been eliminated from the published version of the thesis. The corresponding items in the bibliography have also been eliminated. These references are available from the author who will supply them under certain circumstances provided the appropriate guarantees are received that the institution's anonymity will be preserved.

23. For a discussion of the use of space in mental hospitals see Erving Goffman, *Asylums*, Garden City, N. Y., Doubleday (Anchor Books), 1961. Goffman deals with space in terms of parts of the institution that were "off-limits" for patients, parts which were, what he calls "surveillance space" and parts called "free spaces". The character of Theta made "free spaces" relatively unnecessary as the patients were able to leave at the end of the day. The private space that I identify is roughly equivalent to Goffman's areas that were "off-limits".

24. The practice of primal scream therapy is described in Arthur Janov, *The Primal Scream*, New York, Dell (Delta Books), 1970. Janov addresses himself to the theory supporting his enterprise in *The Anatomy of Mental Illness*, New York, Berkley (Medallion), 1971. I have not attempted to compare abreaction therapy with Janov's descriptions to see how far they appear to coincide.

CHAPTER THREE

THE THERAPIST ROLE

When a new patient (or a new observer) arrives at Theta, it is sometimes difficult for him to distinguish therapists from patients. The therapists wear no distinctive uniform or indeed clothing style and as not all members of the staff are present on all occasions, one is sometimes presented with a new face which may belong to either the patient group or the staff group. A not infrequent remark from a new patient is "I thought [Patient] was a therapist", or less frequently, "I thought [Therapist] was a patient". Within a few days, however, this difficulty disappears and everybody can see that the patients *are* patients and the therapists *are* therapists. In this chapter and the next, I will attempt to delineate the qualities of the two roles that make them recognizable to the occupants and to the people with whom they interact.

Therapists as a Coherent Group

The first strong determinant of the therapist role is the label itself. Given the varying qualifications which people that occupy the role have, it could be said that the only thing they have in common is that they are all labelled therapists. This certainly identifies them as a coherent group for the patients.

The coherence of the therapist group is partly formulated in terms of a contrast with other groups in or related to the setting and with the world in general. This kind of we-they contrast is most evident with respect to the patient group. The way in which the patients' world was working was a recurrent theme at staff meetings of the therapists which regularly took place at the end of therapy sessions. The very meeting itself, with the therapists as warranted participants, was of course a significant matter in formulating them as a coherent group. There were, however, visitors at these meetings: for example, I was permitted to be present and other authorized visitors who had attended the preceding session were usually present along with the secretary. It was never the case, however, that any patient was present at these meetings and this sharply differentiated them as a group from the therapists. This exclusion of patients was heavily emphasized on any occasion when a patient knocked on the door of the meeting room. When this happened, usually because some matter had to be attended to by some therapist, the therapist solicited would leave the room and shut the door behind him before talking to the patient, reinforcing the privileged status of the people in the room. The way in which the patients' world was working

was, of course, subject to troubles of various kinds: resistances and other types of counter-therapeutic behaviour, unsatisfactory organization which should be revised, and so forth. These troubles and the good aspects of the patient world were uniformly discussed in a way that made it clear that it was *their* world that was having troubles and organizational changes, and not the joint world of Theta.*

The second contrast that was made was between the therapist group at Theta and the staff at the neighbouring hospital to which the centre is nominally attached. The hospital staff were reported not to "understand what we do here". This was evident on one occasion on which a staff member from the hospital spent a day at the centre as a result of the discovery of some inconsistency in the way statistics were kept at the two centres. In the discussion after the group the clinical supervisor asked the hospital member whether she could understand the difficulties in meeting the hospital's demands:

> The nurse from the hospital talked about integrated systems for record keeping. [Clinical Supervisor] and [Resident Psychologist] explained why they could not be used at Theta. "You can never predict what is going to happen here."

The hospital demands for standardized records was an issue that came up from time to time and was a source of minor irritation to the Theta staff. The we-they contrast was nicely illustrated one day when the secretary:

> ...reported that she had had an argument with (some common enemy) at the hospital for sending over incomplete charts.

* I am not suggesting here that the therapists were uncritical of their own behaviour, only that they made the contrast.

There was considerable amusement among the Theta group at having caught the hospital in this shortcoming. [c]

Of course, whatever feelings the therapist group had that the hospital did not really understand what they were doing was multiplied tenfold with respect to the rest of the world. On one occasion on which I had a disagreement with the therapists in which I attempted to reinforce my demands for more observation time by presenting a letter from my thesis advisor, one of the complaints that was made was that my advisor did not understand what went on at Theta. This was formulated as a reason why his intervention should be discounted.

The most exclusive meeting at Theta and the one which most clearly defined the therapists as a coherent group was the "feelings meeting". The "feelings meeting" was a weekly meeting at which the therapists were supposed to ventilate whatever tensions or hostilities had been generated among themselves. Both the secretary and I were excluded from these meetings although, as is recorded elsewhere, I actually did get to attend one and part of a second. The therapist label was a necessary and sufficient condition for being admitted to these meetings. A therapist who attended at the centre on one afternoon a week was readily admitted on his own request but despite the fact that I attempted to argue that I might have feelings about the therapists, the clinical supervisor, smiling (as I thought at my clever ploy), said "no, we would exclude you from that".

The therapist group socialized with one another to some extent and while I know nothing of their activities outside of being invited to a few of these events, it was clear to me that they did not socialize with the patients. On one occasion, I was invited to attend a "Theta Christmas party". I went along fully expecting to see both patients and therapists present but found that the party was for current and past staff. There was eventually a joint party but it was known as "the patients' party". This event was attended by the current staff and had the same kind of atmosphere as a school dance at which staff and pupils are rather self-consciously negotiating a temporary suspension of their usual distance.

Creating and Sustaining a Hierarchy

Although the Theta staff was clearly organized as a coherent group with stable boundaries, this did not mean that everybody within the group had the same status. It was quickly apparent to me that there was a fairly well-defined hierarchical structure within the group. My own first application to attend at the centre was made to the clinical supervisor and this was seen as entirely understandable and appropriate. That the clinical supervisor was the proper person to deal with in matters demanding an administrative decision was acknowledged by all members of the staff. The resident psychologist who was nominally the senior full-time staff member (the clinical supervisor only attended on a part-time basis) told me on several occasions on which she disapproved of my activity that I "should see [Clinical Supervisor]". When she told me one time that they were all interested in what I was finding out about Theta,

she added parenthetically, "[Clinical Supervisor] too", presumably to add weight to what was about to be formulated as a request to report about my findings.

The forms of address that were used among the staff further constructed the clinical supervisor as the most important staff member. The other members of the staff, whether they were MD's or not, were addressed by their first name. In contrast, the clinical supervisor was commonly addressed as "Dr. [Name]" or "Dr. N". In fact the only member of the staff who addressed him by his first name on all occasions of their interaction was the resident psychologist. This itself nicely placed her in a privileged position in the hierarchy. This position was carefully nurtured and when I once, in conversation with her, referred to the clinical supervisor as "his nibs", this drew an immediate blank look which I took to be rejection of this conspiratorial form of reference that would have placed me in a position of quasi-equality with her. The clinical supervisor was always referred to as "Dr. [Name]" or "Dr. N" in conversation with the patients who addressed him in the same way.

The resident psychologist was acknowledged to have a position of authority in some similar ways. When I presented myself for an irregular day's attendance during some free time I had over the Christmas break, I was told that she had been unhappy about this and this was apparently a matter of some consequence. It had not been enough that I had cleared the day with the therapists who were on duty that day. Again I

was referred to the clinical supervisor but on the instructions of the resident psychologist:

> [Resident MD] and I talked about my coming another day. [Psychiatric Nurse] said that [Resident Psychologist] had been slightly annoyed - I "should ask [Clinical Supervisor]".

The resident psychologist's location in the structure was acknowledged by the resident MD in a conversation about the silences which occasionally occurred in group:

> [Resident MD] said she would like sometimes to let the silences go on, but [Resident Psychologist] didn't like that.

The resident psychologist also asserted her position in formal ways, as for example when she wrote a memorandum to the occupational therapist which my notes record as "the-ship's-not-tight-enough kind of letter."

Because of the passing consideration of Theta as a medical setting, the status of MD's was, to some extent, the traditional one in a hospital setting, and so the resident MD and clinical fellow were treated with somewhat more deference by the resident psychologist than might otherwise have been the case.

Managing the Helping and Caring Appearance

The Theta brochure had a picture on its front cover of three stylized figures facing left. The front one was seated on the floor, the second bent forward with hands laid upon the shoulders of the first and the third stood with hands in the same position. The intended effect appeared to be one of loving contact, growth and interdependence. The

brochure itself talked about:

> openness and honesty, people helping people, intensive group therapy for 6 to 8 weeks, taking responsibility for self and others.
>
> ...we provide support and share problems and suffering...

The series of interviews that formed the induction process is described in more detail in the next chapter, but some aspects of the interviews are relevant to the creation of the helping and caring appearance. The letter which was given to the patient at the pre-orientation interview announced that

> "On our part, we shall be with you through all these phases and commit our efforts to help you to work through your difficulties.

The pre-orientation interview itself gave the patient the first opportunity to tell what his troubles were. The account was received with careful attention and the attendant therapist might ask a few questions to elaborate some details. The general appearence was one of sympathetic interest in the patient's problems. The next stage in the intake process was an individual interview at which the patient, once again, got a sympathetic non-judgmental hearing. The therapist asked questions about each aspect of the problems that the patient had described and made out a "problem-list". This was a list of items from the patient's story that were recorded under various prescribed headings. The preparation of the list created the appearance of a first analysis of the problem into its individual elements and the patient was asked to assess the elements by attributing a score to each one on a 1 - 6 scale.

The list also helped to formulate the problem as the individual's own unique problem while the whole process emphasized the interest that the centre had in getting at what the patient's trouble really was.

Some aspects of the helping and caring appearance were apparent in behaviour which was absent in the presence of the patients but which appeared when the necessity of sustaining the necessary appearance was removed. Erving Goffman[1] has developed the notion of what he calls "front region" and "back region" behaviour in connection with the presentation of particular kinds of performances in social interaction. Goffman uses the term "front region" "to refer to the place where the performance is given".[2] He goes on to argue that "[t]he performance of an individual in a front region may be seen as an effort to give the appearance that his activity in the region maintains and embodies certain standards".[3] A "back region", by contrast, is a place "relative to a given performance, where the impression fostered by the performance is knowingly contradicted as a matter of course".[4] Goffman says that "[h]ere the performer can relax; he can drop his front, forego speaking his lines, and step out of character".[5]

The contrast between the behaviours can be instrumental in illuminating the appropriate front region behaviour in terms of the absence of behaviour which appears in the back region, or vice versa.

During the interviews and throughout the patients' stay at Theta, care was taken to maintain an air of disinterested acceptance of

whatever the patient reported as his activities in the past. Thus, moral judgments were suspended and the patient was encouraged to report whatever reprehensible (in his own view) actions he might have engaged in. The bland acceptance of reports of prostitution and "bizarre" sexual behaviour that characterized the front region was emphasized on one occasion by the speculation that a woman who had, apparently, three lovers, was a prostitute.

In another instance, the routine acceptance of homosexuals was in strong contrast with a small performance upstairs after a particularly trying day of therapy. Two therapists were discussing the (very evident) frustrations of trying to get a homosexual man to confront an issue that they thought was important to him. One produced a vivid caricature of his highly idiosyncratic way of getting angry, a noticeably absent feature of therapist (although not always patient) behaviour in the front region.

Apart from moral neutrality, other dimensions of the helping and caring appearance were emphasized in a conversation in the back region which would have been inappropriate in the front region. Many of the patients at Theta exhibited an extreme dependence on the therapists. While this was attended to as a matter to be addressed in therapy, the fact of their dependence was rarely if ever presented as a trouble to the therapists. The patient was, rather, led to make decisions for himself with the support of the therapists. It would have been a serious breach of the therapeutic code to tell the patient that you "couldn't

stand his dependence". For example, on a parallel issue, I was once mildly admonished by a therapist who said "it wouldn't do to tell her that she is masochistic". This attitude was pointed up one day when I was surprised to hear two therapists' reaction to a telephone call from a one-time patient at Theta"

> [Ex-patient], it sounded like, wanted something like personal discussion with [Clinical Supervisor]. [Resident Psychologist] did her best to discourage her - "What did she want from [Clinical Supervisor], etc." ...[Male Therapist] said afterwards that he got really annoyed with people like [Ex-patient] who were dependent and [Resident Psychologist] agreed.

It should be emphasized that these incidents are not included to represent the therapists as insincere or "phoney", which I do not believe they were. They are included to illustrate behaviour that would have been inappropriate in parts of the setting so as to point up what behaviour *was* appropriate there. A comparison could be made with irreverent remarks about one's boss which might make it impossible to sustain the role relationship if made in public but which may be, and commonly are, made in private however well-disposed one may feel towards the boss.

Apart from front and back region performances, other aspects of the helping and caring appearance could be seen in some of the activities of the therapists after therapy sessions. Whenever therapy was done at Theta, particularly abreaction therapy, and the patient was seen to be suffering, the therapists made a point of embracing the patient after the event. In fact everybody who had been involved with the patient who had

been doing therapy, usually hugged him after the event, but there often appeared to be a special quality about the therapist's interaction which suggested that he empathized with and cared for the patient in his experience. Apart from this demonstration of sympathetic understanding, the therapist was usually physically close to the patient at times of emotional stress. As is described later, the patient was usually lying on the floor and it was the practice of therapists to touch and caress the patient and to encourage other patients to touch the person who was doing the work. Therapists explicitly directed people to gather around in a close circle and occasionally lie beside the patient or instructed somebody to do so.

Therapists were available to patients during the usual hours that Theta was open although they did not encourage people to indulge in unscheduled consultations. The expectation was rather that people would bring their problems into the family group of which they were a member and which was usually attended by a therapist. One formal interview was scheduled at the mid-point of the patient's stay at the centre and was eagerly sought after by the patient who frequently reported it as a significant event in his therapeutic career. Patients were not encouraged to contact therapists outside the hours that the centre was open but were actively encouraged to appeal to each other for help if help was needed. The group was represented as the most powerful resource that was available for providing help during these periods.

Therapist Beliefs

Peter Berger and Thomas Luckmann, writing on "Society as Objective Reality" argue the following:

> If the integration of an institutional order can be understood only in terms of the "knowledge" that its members have of it, it follows that the analysis of such "knowledge" will be essential for an analysis of the institutional order in question. It is important to stress that this does not exclusively or even primarily involve a preoccupation with complex theoretical systems serving as legitimations for the institutional order. Theories have to be taken into account, of course. But theoretical knowledge is only a small and by no means the most important part of what passes for knowledge in a society. Theoretically sophisticated legitimations appear at particular moments of an institutional history. The primary knowledge about the institutional order is knowledge on the pretheoretic level. It is the sum total of "what everybody knows" about a social world, an assemblage of maxims, morals, proverbial nuggets of wisdom, values and beliefs, myths and so forth, the theoretical integration of which requires considerable intellectual fortitude in itself, as the long line of heroic integrators from Homer to the latest sociological system-builders testifies. On the pretheoretic level, however, every institution has a body of transmitted recipe knowledge, that is, knowledge that supplies the institutionally appropriate rules of conduct. 6

The therapist beliefs which are set out in this section are not exhaustive of the total belief structure which determines the activities of members in the setting but I would like to propose that they are relevant to the determination of some of the Theta reality, especially "doing therapy" which is discussed in chapter 6. Some of the beliefs which I posit are derived from incidents and examples in the preceding section and some require further elaboration which does not appear until later in the work.

It should be noted that the beliefs that are set out are not intended to represent therapists' avowed theoretical beliefs about therapy. This point is made in the quote above and must be heavily emphasized. The beliefs that are set out below are, I would propose, matters which therapists must take for granted in order to sustain the social reality which characterizes this setting. They are my perceptions of the tacit belief system which is implied in the activities at Theta. The beliefs are as follows:

1. That anyone can and does have problems that (provided the problems are not subsumed under certain categories and provided certain conditions are met) can be treated in the therapeutic setting.

2. That patients have problems that are beyond their own capacity or comprehension.

3. That patients are competent reporters on their own problems.*

4. That problems involve emotional states.

5. That patients can have emotions without being aware of them and that rage, hate,,hurt, jealousy, fear, guilt, pain, loneliness, sadness, love etc. are universals of experience and relevance to everyone's problems.

6. That emotional states have reliable and deterministic indicators such as facial expression, body stance,

* It is not intended to suggest that patients are competent to provide adequate *therapeutic* formulations of their troubles, only that they are competent reporters on the troubles they experience. There is an unfortunate tension in my use of the word "problems". In general I use it rather loosely as a label for the troubles that patients experience. This is done without any intention of distinguishing source from symptom. A therapeutic use of the word might require that this distinction be carefully preserved.

and more explicitly, laughter, crying etc. but with the caveat that the indicators for some individuals may be related to states in idiosyncratic relationships which are themselves detectable.

7. That troubles are "inside" in the sense that they are part of the personal internal experience of the actor and must be brought "outside" in order to be corrected. That is, they must be reified in verbal or visible behaviour.

8. That verbal behaviour may be "just acting" and that this is qualitatively different from "doing therapy".

9. That emotional distance can be reflected by physical distance, and that other emotional dimensions can be objectified in drama, exercise, work, dance, games, art etc. where they can be detected for therapeutic purposes.

10. That certain kinship categories are always relevant to emotional problems, in particular "father and mother" and that other categories such as "sibling" may be relevant.

11. That relationship categories such as "spouse", "lover" etc. are relevant to emotional problems.

12. That patient sex categories are irrelevant in determining their qualifications for membership in the group and are relatively unimportant as far as their adopting roles in therapy i.e. that female patients can adequately play male roles.

13. That patients know the roles embodied in the relevant categories well enough to produce a display of these roles that is adequate for all practical purposes in evoking the emotions related to the relationships.*

* It has been pointed out that staff members were well aware that role playing might fail and did fail to produce an adequate display and that they proposed the role playing in the hope that something useful would come of it but knowing that it might be unsuccessful. It was the case, however, that role playing was a frequently proposed activity and it appeared to be believed that the incidence of success was high enough to warrant an almost daily demand that it be attempted. Rather than belabour the "belief" with probabilities and possibilities, I have added this footnote in recognition of the staff's clear knowledge that this and indeed *any* therapeutic tactic could fail.

FOOTNOTES

1. Erving Goffman, *The Presentation of Self in Everyday Life*, New York, Doubleday (Anchor Books) 1959.

2. Ibid. p. 107.

3. Loc. sit.

4. Ibid. p. 112.

5. Loc. sit.

6. Peter L. Berger and Thomas Luckmann, *The Social Construction of Reality*, New York, Doubleday (Anchor Books) 1967 [Copyright 1966].

CHAPTER FOUR

THE PATIENT ROLE

The patients are the raison d'etre of Theta and the patient role is the second determining role at the centre. The patient comes to Theta because he has troubles in the world and frequently reports that he "had to do something" or that Theta is his "last chance". A not untypical explanation was:

> I.. I feel that my problems are are really bothering me and I can't go on in the space I am any more, eh.. it's gettin.. I feel ups an' downs 'n it like ehm.. some days I feel better about the progress I *have* made.. about dealing with them and other days I.. et's ehm.. there's nothing happening at all and eh.. I've just come to the point that I jus wanna.. I can't live with myself like this without bein' able to do somethin' about it because I'm unhappy with.. with where I'm at..

Patients were recruited from the nearby hospital and by referrals from doctors who have heard about the centre. I have done no study of the recruitment process and know little or nothing about it. There seems

to be some evidence that many patients came to Theta because they heard from ex-patients that it was a good place to be. Patients, then, frequently came to the centre highly motivated and well disposed to the program.

The patient role had to be learned and this process took place over a series of interviews and in the first few days of the patient's residence at the centre. Although the interviews were important in learning the role, I have chosen to describe them under the heading "getting in" * because the main focus for the potential patient at that stage is gaining acceptance as a patient. The section on "learning the patient role" which follows this I have reserved for describing the learning work that went on after the patient had been accepted. In fact the learning process was probably about evenly divided between the two stages.

Getting In

The potential patient's first contact with Theta was at a pre-orientation meeting. The meeting was held in one of the smaller upstairs rooms and was usually attended by more than one candidate for admission. A member of the Theta staff was present and it was reported that the current patient "chairman" sometimes attended: [Psychiatric Nurse] reported that the "chairman used to attend" but with the suggestion that her non-attendance was a matter of oversight rather than policy. She

* It should be noted that this description deals essentially with a successful entry. The institution's screening process is not discussed because little or no data was obtained on that aspect of the centre.

did not, however, rush out and get the chairman, and the matter was left as a practice that had not much importance.

Each candidate was given some typewritten information and asked to read it, in particular a letter which was referred to as the Dear Friend letter. "Dear Friend" is a sufficiently unusual form of greeting as to adequately identify the document and appeared to have the desired mixture of sufficient generality for a form letter along with some indication of the attitude that the clinical supervisor wished to foster.

The letter emphasized commitment and responsibility, the fact that the patient came of his own choice, and at the same time the group focus of the community. It could be the subject of a detailed analysis in itself, but suffice it to say that it appeared to create an impression of structure:

> group therapy in various forms, such as verbal groups, activity groups, e.g., gymnastics, various sports such as volley-ball, swimming and outdoor activities such as walks and outdoor games, as well as work-gardening, housework, carpentry.
>
> ...therapy through...modes such as art work, music, theatre, games and dancing.

along with professional competence:

> individual therapy will play a lesser role as we believe that the combined complex programme we are offering to be [*sic*] superior for people with your types of problems - *the present state of knowledge in Psychiatry substantiates this*. [emphasis mine]

and:

> All these are elements of a unified therapeutic programme..."

"...[P]eople with your types of problems..." appeared to indicate already an understanding of what "your types of problems" were and, presumably, confidence in the relevance of the program.

The "dear friend" letter, along with the Theta brochure, were the first resources that the potential patient had for determining not only what Theta amounted to but, to some extent, what he himself amounted to. The brochure told him that Theta was "*not* for people with a history of serious mental illness" and the letter told him that he was going to "do more than get relief from [his] immediate symptoms". Both references along with the initial welcome to the "health sciences centre hospital" implied that the new arrival was to be a "patient" and there was explicit reference in the letter to "patients and staff". Although the brochure invoked a more neutral category: "member", the frequent references to the "health sciences centre hospital", to "mental illness" (whether "serious" or not) clearly prescribed the role the new participant was to play: that of "patient" doing "therapy". The participant had only the most diffuse and non-specific knowledge of what this amounted to unless he had friends who had been through the program (a not uncommon circumstance). A female patient told me that she thought it would be a "rap session".

After the patients had time to read the introductory literature, the staff member asked if there were any questions. There might be some curiosity about the more esoteric details of the brochure, for example patients might confess that they did not know what "kinesic therapy" or

"Gestalt" was. The fact was, however, that the patients at this point usually had very few questions and were shortly asked to explain for the first time their reasons for wanting to come to Theta.

The potential patient took this as an invitation to display a set of descriptions of his previous or current feelings and autobiographical events which could be understood as representing a problem for him. This required that he select from the events of his life an appropriate subset which could be seen to be relevant to his self-formulation as somebody who needed help. Every candidate for admission was able to produce some subset which he saw as relevant for this task, and the staff member treated whatever list that was produced as relevant to the question that had been asked.* [9]

One feature of the account that was given of the problem was that it had to have current relevance. It was not enough that the patient had troubles in the past and he now wanted to review them and dis-

* It has been pointed out that this allows for any kind of description to be presented as a relevant list of problem items. The staff at Theta, of course, were not prepared to accept *any* description as an adequate formulation of the problem, and had clear priorities and theoretical focuses that they attended to. The staff member asked questions to probe for parts of the biography that had been omitted and to elaborate parts that were described. The point that I wish to make is that despite the logical possibility that the patient could talk about anything at all, in the interviews that I observed he appeared to have a good grasp of what *was* an appropriate subset, and the subset produced was seen to be relevant to the question.

cover some interesting psychological fact about them, but they had to be related to recent feelings or activities that drove the patient to appear at Theta.

> A female patient, after speaking about "contributing factors" in the past, told about two extra-marital pregnancies that she had "not got over yet".
>
> A male patient said that the problem of his shyness had been bad since he had given up drugs. He used to be into a lot of "heavy drugs" and had quit. "That's when the problem got really bad". He was a jazz musician and was having great trouble meeting "the public". He was "uptight" and it affected his playing.
>
> A male patient said he had "too much going right now and [he couldn't] take care of any of it."

After the pre-orientation interview, the patient took away a second form letter referred to by the heading: "Self Description". He was invited to write a brief summary of himself under nine headings. The headings and suggestions for the self description are shown in Appendix III. They were designed to ensure that the patient's self description addressed all matters that were of importance to the institution. The patient brought this "self description" to the next encounter with Theta which was an individual interview conducted by one of the staff members.

The "self description" was used as a resource by the staff member during the individual interview to formulate a list of specific problems to be treated at Theta. A female staff member told me that the self description was "very useful" during the individual interview. It was difficult to do interviews and they took much longer if it was

not available. The staff member read through the self description and selected items from it that he wrote down on a Theta form referred to as the "problem list". The headings on the "problem list" were the same as the headings in the self description form. The patient was invited to select a number from 1 to 6 for each item which indicated how severe a problem it was. This problem list subsequently became an institutional artifact* and was used to assess the progress the patient was making in the institution. [i]

I do not have a complete record of an individual interview, and the interpretive work done by the staff member in selecting items from the autobiographical account for inclusion in the problem list is thus not available to me. One feature of the process which was evident is that the staff member treated the self description as a true account of the events of the patient's life. She also assumed, once again, that the account was a relevant account. Although she might ask questions to elaborate the items that were described, she knew that there were a whole collection of events, incidents, relationships, feelings and the like which were not described. The selection depended on the patient having an impressive amount of knowledge about social relationships, kinship structures, what it was to be healthy, both physically and mentally, what parts of his education and work history were relevant and what persons were significant in his life.

* This word has a slight pejorative sense in some contexts, which I do not intend. I can find no adequate synonym.

When the patient came out of the individual interview, he had been made aware of what facets of his autobiography were of sufficient interest to the institution to be included in the problem list. He also knew what items of his report had been explored and what items had been passed over. It was now available to him to attend to the explored items as psychologically significant. He might begin to be aware of the fact that his problems had a different slant to what he thought they had. The process was further refined in the last step of the entire procedure: the group interview.

The group interview took place on a Wednesday following the individual interview (usually the next Wednesday). The potential patient came to Theta at nine o'clock in the morning and took part in any activity which preceded the interview. Dance therapy was often scheduled at this time, although if there were a great many interviews or the dance instructor failed to show up this was truncated or abandoned.

The patient group along with a number of the staff members and former patients attending for "after-care" gathered in the theatre. They formed their chairs into a large horseshoe shape and the potential patients to be interviewed sat at the focus or sometimes at the end of one leg of the horseshoe.

The interview started with the current chairman (of the patient group) asking the potential group member "why [he wanted] to come to Theta" or "What's brought [him] to Theta". There followed for

a third time a display of autobiographical details and feelings that amounted to good reasons that anybody could understand for wanting to come to Theta.

The good reasons frequently started with general statements like "I'm depressed" or "I suffer from depression", "I can't relate to people", "I can't get close to people". Sometimes the descriptions turned on events, like "I tried to commit suicide" or "My marriage is breaking up (or has just broken up)".

The group then questioned the interviewee about the details of the events that led to his arriving at Theta. A tradition had grown that vagueness in reporting troubles was unsatisfactory and the details of the troubles had to be elaborated. The group would ask the interviewee "what form [his] depression [took]" or "what are your relations with people", also "what people" and what their current status was, i.e., were they living together, was he living with his parents, how often he saw them, etc.

In the event that the patient had tried to commit suicide, the group would want to know what means he had used and what events had led him to decide to do it. Where a marriage was said to have collapsed, the members would want to know the current status of the collapse: separation or divorce, and if separation, whether trial or terminal, temporary or permanent.

As each aspect of the subject's explanation was elaborated, further elaboration was demanded until the group felt that it had understood for all practical purposes what the features of that part of the problem were. An illustration of this aspect of the interview can be seen in the group's pervasive interest in drugs and alcohol.

Every patient was asked about his use of drugs and alcohol. The patient might readily admit that he was "into the drug scene" or he might admit the he "used to be into drugs", that he "drinks quite a bit" or was a "heavy drinker for about three years". The group generally asked questions to establish the precise dimensions of the problem and then went on to decide on the basis of this report whether the description amounted to "a problem". The criterion for this appealed to a normative standard that would constitute a large percentage of the drinking population as problem drinkers and was a reflection of the extreme seriousness with which the patient group viewed drugs and alcohol.

> [Female Patient] said she had a "slight drinking problem". Several people wanted to know what that amounted to. About a bottle of wine per day. Would she make a commitment to stop drinking today? A long argument ensued. [Female Patient] said she didn't see why <u>today</u> ...[Female Patient] pointed out that there were other drugs: eating (especially for her), coffee, T.V.; why single out alcohol. [Male Patient] said that this was the worst problem and everybody, many group members knew it. After much struggling [Female Patient] reluctantly agreed to go along with the ban and made the commitment.
>
> The next problem was "drugs" - would she give a similar commitment? She had explained about asthma. She occasionally took Librium to cut off a serious attack and anyway used [Spray]. There was a ong discussion about whether she could continue with these or not. [Resident M.D.] suggested that her outside (re-

ferring) M.D. had known about the drugs and intended, by sending her to Theta, to have her drop them. [Resident M.D.] eventually agreed to check into this.

The Draconian severity of the drinking and drugs standards is further illustrated by the following extract from a patient interview:

FP 1: * How much do you drink now?

I : Uhm..very rarely; if I have a beer.. I drink beer because I like the taste and I mean.. myself and my friends we make our own eh//

FP 2: But how much do you drink, like how much a week or//

I : Three or four bottles.

FP 2: Well, how do you feel?

MP : I wouldn't call that a drinking problem.

FP 2: I wouldn't either. It's been a long time.

FP 3: D'you go to bars often?

I : I'm not a pub-type person.

FP 1: Wha.. what about drugs?

I : Ahm.. I don't smoke that much any more, I've cut down quite a bit ahm//

MP 2: Would you stop?

I : Sure, very willing to

FP 2: and you don't take tranquilizers or anything?

I : No, I.. I'm on some medication now but it's eh.. because of.. of eh [2 seconds] an-infection-I-have [very quietly] and it should be over in about a week.

FP 4: Is it antibiotics or somethin'?

I : Ahm.. "Tetracyclin"

* FP = Female Patient MP = Male Patient I = Interviewee

FP : How much dope do you smoke?

I : I've had a eh.. an ounce of ehm.. hash for over six months, seven months

FP : S.. so you don't ( )

I : No

FP 2: OK, so (reads series of questions from protocol.)

Another patient interviewed generated the following field note:

> More talk about drugs and alcohol with the next girl. [Interviewee] was admitted from the in-patient side. When asked about the drug commitment, she explained about a bad back - result of an accident. She was taking 292's. Two per day, plus sleeping pills. [Resident MD] said the hospital MD must be aware of her dependence on 292's and asked her to refrain from using them while she was at Theta. [Interviewee] reluctantly agreed to do so, although she said that some days she could not get out of bed without them.

The therapists at Theta occasionally remarked that the standards that the patients demanded in some things were more severe than those demanded by the institution, but the interviews that I observed suggested to me that the standards were a joint production of patients and staff. Why the standards were so rigid and why the subject of drugs and alcohol was of such pervasive concern to the patients is not clear to me. I could propose that, from the patients' point of view, the reason was related to the commitment demanded of the patients by both group and staff. It was pointed out on one occasion that the patients had to depend on the group for support now instead of relying on chemicals. It may be the case that, as argued elsewhere, the attraction of escaping from therapy was a siren song for patients at Theta. The desire to escape was sometimes large and threatening and drugs and alcohol

represented a way of escaping from the rigors of therapy without being physically absent. For this reason they had to be heavily censured.*

When the patients had decided that they had determined the facts about the potential member to their satisfaction and had obtained an assurance about drugs and alcohol, the patient chairman read a set of standard questions to the interviewee which were prepared by the staff. The questions that were asked are presented in Appendix IV and were usually read with ritualistic solemnity while the group silently watched the interviewee. Provided that every question was answered in the negative or the affirmative, whichever was appropriate to the question, the group interview was over and all that remained was a vote which was taken in the presence of the candidate, on whether he should be admitted or not.

The matter of admitting or refusing a patient was a serious business for the patient group. If they admitted him then he was going to be with every one of them until they left Theta unless he dropped out. Dropping out, as I argue elsewhere, was a very threatening business for the remainder of the group and if the new patient showed signs of lack of commitment, this had to be carefully considered. On the other hand, if the patient was refused, this was seen to be consequential for him. The patients in the group knew how urgently they themselves had wanted to get in and assumed that the new patient, at least possibly, was in the same position.

* From the staff's point of view, the use of drugs and alcohol was seen as being counter-therapeutic.

I was present for one group interview at which the group found themselves presented with a potential patient that they believed to be in need of therapy but were reluctant to accept as a group member. They discussed at great length the possibility of not voting on him so as not to hurt him by a refusal. They attempted to get an assurance from the therapist present that she would arrange to have him admitted someplace else. When the therapist explained that she could not guarantee to do that, that they "must decide", they voted the patient in, despite clear evidence that they thought that he was not a suitable candidate for the centre.

When the vote was being taken, it was the practice of the group members who voted against a candidate to present their reasons. "Yes" votes were occasionally accompanied by cautions or arguments against "No" vote arguments, but were more commonly given without comment. "No" votes were almost always accompanied by an explanation.

There was a strong feeling that the explanations that accompanied "no" votes must "make sense". For example, the following incident took place during one vote:

MP 1:* You remind me so much of myself (laughter). I have to vote no (gasps and crescendo of laughter and protest) Yeh

FP 1: How does that make sense?//

MP 2: I don't understand that at all//

MP 1: It doesn't make sense but I//

* MP = Male Patient FP = Female Patient

FP 2: I don't understand that either

MP 1: I got such a feeling that he.. he's holding back.. agh-h [very emotional] I don't know, It doesn't make sense but this is the feeling I've got 'n it doesn't

FP 3: So do you think he can make it?

MP 1: I dunno I eh get the feeling that.. it isn't really.. yeh I think he can make it, I'll change my vote yes.. sorry.

"Making sense" was not a question of formulating a logical argument but of giving reasons that everybody could understand as relevant and important. The one reason that above all others was seen in this way was that the candidate was "not committed". If a group member said he voted "no" because he "didn't see the commitment there", this was accepted as an adequate reason without any further explanation. A variation on this theme which elicited no protest can be seen in the following:

FP : I'm gonna have to vote no because I have very mixed feelings like [Patient]. To me I think you think that this is really a faddy trippy thing to do and I don't feel that you're going to contri.. give of yourself and let us help you in ( ). I'm sorry.

Patients were admitted on a simple majority of the group members, former group members and therapists present, and provided the decision was favorable, the committee chairman followed the vote with the ritualistic greeting "welcome to the group".

Learning the Role

The reason I have devoted so much space to the section on "getting in" is that it was during this period that the patient picked up many of the norms and values that related to the patient role. Before I proceed I would like to write a brief summary of these norms and values.

The patient frequently saw himself as coming to a haven where there was structure, security and expert help, dispensed by a professional staff interested in his problem. The setting was a medical one and the basic role he was assigned was that of a patient doing therapy. The problems that beset him had been noted and analyzed into discrete elements and he knew what parts of his story had been of particular interest to the institution. The group interview had been rigorous and his acceptance had not been automatic; in fact, in some cases it might have been marginal. He was therefore a privileged member of an exclusive group. The group had emphasized commitment and he was aware that his continued acceptance was conditional upon his demonstrating his commitment. Drugs and alcohol had been heavily emphasized and he knew that the group had rigid standards with which he must comply although he did not know, yet, what these standards were, except in the most general terms.

The day chosen for new patient interviews included a family meeting and a whole-group therapy session under the direction of the clinical supervisor. The luncheon included a patient committee elec-

tion. The new patient was thus presented with a considerable spectrum of the Theta activity and proceeded, at will, to participate, albeit tentatively. For example, the patient, once admitted by the group, had the privilege of voting on the candidate who followed him and was expected to do so. He also had the privilege of voting for committee members at lunch time although it frequently happened that new patients pleaded ignorance of the candidates and did not vote. In fact a tentative tradition to offer new patients this excuse was growing during my attendance. The new patient was judged, therefore, to be competent to assess the stories of potential patients (which apparently required no special skills to assess) but not to assess the qualifications of committee members with whom he had not yet become acquainted.

The new patient attending to the luncheon talk might learn that there were something called "commitments" and a practice of "making up a commitment". He might hear talk about punctuality, diaries, families, family night, working out, and all the rest of the concerns that made up the routine daily life of Theta. Somehow he had to find out what all these references amounted to.

Towards the end of the lunch there would be a call for "family reports" and several members of the group would read a short written summary of the events of the previous day's family activities. The patient would learn that the "families" were Theta subgroups and would begin to get some idea from what was worth reporting which activi-

ties were valued and which activities were censured in these settings. He would learn that some members of the group had the status of reporters and, in the subsequent committee report, which activities of the whole group were "news".

After the reports had been read there was an election which, he might learn, was not taken very seriously,* although it had the form of a regular election. He would note that the qualifications for certain elected positions appeared to depend on other positions having been held: for example, that so and so could not be chairman because he had not been work co-ordinator. He would learn what were considered good reasons for refusing office and the attention people paid to the length of time patients had been at Theta in considering who should be nominated: for example, that someone ought to be nominated because it was his "fifth week". This pointed also to the assumption that everybody should occupy at least some of the positions during his stay at Theta.

The new patient was assigned to a family during his first day,** and after the lunch he joined this family for the first time. He found, in the family group, that members could elect to work on a problem and that all members of the family were expected to contribute observations about that problem. The new patient quickly found that his

* This is discussed in a subsequent section.

** The methods of assigning patients to families were in a state of flux during my period of observations; sometimes it was done by lot, sometimes arbitrarily. There was talk of "bargaining" for new members.

opinions, experiences and observations were considered equally with other family members, although he might have reservations about expressing them. One patient who made a remark in her first family meeting prefaced it with "maybe I'm outa line..." and was quickly reassured on the point.

The whole-group therapy session started immediately after the family group was over. It appeared that the whole-group therapy session was organized to provide the new patient with a display of what was currently considered as "doing therapy". Of course "doing therapy" was the reason the whole-group was assembled on this occasion, but it normally tended to be a heavy session and the clinical supervisor frequently told new patients that the "first day is the worst". The new patients were spectators at this session and were rarely expected to work. The work that was done during my period of observation usually involved abreaction therapy and the new patients were able to see the emotional dimensions that were demanded during therapy.

New patients frequently reported this afternoon therapy session as a frightening experience. They could see that the emotional displays were orchestrated and approved by the therapists present, but often remarked afterwards that they couldn't see themselves doing the same thing. They observed the reactions of the veteran group-members as the therapy proceeded and attempted to adopt what appeared to be appropriate postures and expressions. They joined the group surrounding the patients who were "working out" and made themselves as inconspicu-

ous as possible.

After the session was over the new patients were asked what they thought of their first day at Theta. It was at this point that they admitted their fear or perhaps even distaste of the activities which they had observed. This was then taken as an opportunity for the staff to order the reactions of the new patient so that he now saw what had happened during the day as the normal approved and proper activity of doing therapy.

> At the end [Clinical Supervisor] brought the new patients up to the front. [New female patient] said she was frightened by what had happened in the morning: "Everybody at each other's throats". [Female Patient] said it wasn't usually like that. [Second new patient] said she could not see herself doing what [Patient who had done therapy] had done. [Male Patient] said it was very different from what he had expected. He would come because he "had to".

The notion that the first day was the worst was evoked to assure the new patient that however shocked or dismayed he was at what he saw, this shock and dismay was something he should accept because what had happened was therapy. Moreover, strong reactions were completely proper, even desirable. In one incident reported again later in another context a patient was very upset by the first afternoon's therapy session.

> [Clinical Supervisor] brought the new patients into the centre where they sat on the mattress [which had been used in the preceeding therapy]. He asked them individually what they thought and went on to explain that the first day was the worst. Some said they were scared or very scared. [New Female Patient] said that she thought it was a bad sign that she broke down on the first day. [Clinical Supervisor] said it was a good sign - some people took weeks to achieve what she achieved, some never did.

The patient, then, had come to observe some of the Theta activities and had heard some of the Theta talk. What he had not understood, he had probably asked a patient about who would have told him "the facts" about that activity. He had participated in an election and learned some of the preoccupations among patients. He had seen a family group and had watched therapy being done. He reactions to this had been checked and interpreted in the light of the Theta culture. The new patient now left the setting to return for full-time activities on the following Monday with some expectations of what was going to go on and how he should behave in the setting.

Time and the Patient Role

It has already been argued that time was experienced as oppressive at Theta. Time, however, had other references for the patients in the setting, some of which were instrumental in determining behaviour.

The current point in a patient's career through Theta was frequently located as a relevant factor in determining what should be done. Thus a patient who was in this "first week" was not expected to be available for any office on the patient committee, whereas a patient who was in his "fourth week" was under considerable pressure to occupy some office if he had not done so yet. In selecting between alternative candidates for chairman, too, the fact that "it's his fifth week" was frequently cited as good reason that someone should be chosen over an alternative candidate who had a longer time left to him.

Patients in their fifth or sixth week used this fact as a resource to demand "big-group" time over patients who were less advanced in their careers. The location of the current point in a patient's career at Theta was also seen as a source of trouble:

> One of the reasons for people being antagonistic to [Female Patient] was that she was a bad example. Somebody said that they knew that she had been there for six weeks and apparently had not changed at all. That was really threatening.

Role Relations Among Patients

The patient population was treated by the therapists as a uniform group insofar as no special privileges (apart from the group time discussed above) were extended to patients of any class or seniority. Patients occupying the various positions in the patient committee were also treated uniformly with all other patients apart from being required to give certain reports which they prepared.

The only variation from this among the patients themselves was that patients of longer standing were sometimes seen as forming a minor subgroup of "old hands".

> [Female Patient] was asked who was making demands on her. She identified [the four most senior group members].

Despite this, the group saw itself as essentially a society of equals. This was perhaps emphasized in the elections of committee members which was operated as a means to let everybody have a chance, rather than as a seriously competitive enterprise. A frequent call on

election day was "who hasn't been chairman?" This was done even though the clinical supervisor was in the habit of lecturing the group on the importance of the chairman.

> [Clinical Supervisor] asked who was dissatisfied with the chairman. He said the chairman was very important to the group: could be a centre of group resistance. The group chose the chairman. If the chairman was not good, the group was not good.

The essentially ritualistic emphasis of the election can also be seen in the fact that although the election was carried out with a show of rules of order, nominations, voting and the rest, it was the source of jokes which tended to emphasize the emptiness of the formality.

> [Male Patient] made a joke during the election. He said he wanted to know what [nominee's] position on drinking was. After her election [Female Patient] said that she was going to forbid drinking.

This joke depends for its force on the consequentiality of questions asked of candidates at real elections. If the candidate's position on drinking (for example) is going to affect the people he is going to have administrative power over, his answer to the question is clearly going to be important. The question asked in this context emphasized the fact that the chairman was going to have no such power. In fact the candidate did not even attempt to answer it. She just smiled.

The selection of other positions at Theta followed a similar pattern. For example, in selecting the work co-ordinator on one occasion, the group were discussing the relative merits of the three candidates in the usual terms. The clinical supervisor happened to be present:

> Halfway through the elections [Clinical Supervisor] interrupted to say that the work co-ordinator should be competent. It was pointed out that nobody was really competent. It was also pointed out that he should be enthusiastic. [Clinical Supervisor] agreed. Some votes now went to [Male Patient] but the group insisted on having its candidate - [Female Patient], self-confessed incompetent.

Despite the attempt by the clinical supervisor to influence the process, the group attended to its own priorities in selecting a patient to fill the role.

It was a noticeable feature of the committee's work itself that it was reluctant to make decisions that had not been checked out by the whole group, even in relatively trivial matters such as renaming the foreman "family leader".

> An early discussion today was about what the foreman should be called. The committee decided "family leader" and then had great doubts about whether they could choose that one. The group had chosen "family head" and [some other name]; could they change that? Families had suggested these names and points were to be awarded [to the family whose suggestion was selected].

The committee saw itself, then, as having very little power to influence the process even in the most trivial way and was mostly concerned with reporting the day's activities. Even this was seen as a relatively empty process. The feeling was that "you don't have to listen to the committee report anyway because you were there".

The therapists made attempts to reduce the emptiness of the committee's activity by having the members select people who ought to be working. I was at a committee meeting immediately after this had been

suggested (or re-emphasized, perhaps) and it was obviously a trouble for that committee:

> After they [the committee] had discussed the day's happenings for about two hours they found that they had produced a description of the day (just what the resident psychologist had objected to at lunch). They then started to produce a list of "who should work on themselves", "who was not contributing to the group", "who was contributing especially well"... It was clear that the committee felt very ambivalent about their judgments because [Female Patient] was proposed as a candidate for both the delinquent list and the honor list... The list of people who should work on themselves got so long eventually that the committee decided to pick one name. They eventually came up with [Female Patient] "more because she pisses me off right now than anything else". There followed a careful composition of just the right phrase - "the committee recommends that [Female Patient] needs to work on her problems". They were clearly delighted with this.

It seemed that the unvarying triteness and vacuity of the published comments and recommendations about fellow patients:

> "[Patient name], tell us what you're feeling."
> "[Patient name], work for yourself."
> "[Patient name], let us see your anger [or warmth or...]"
> "[Patient name], what's happening with you?"

were far from documents of the lack of imagination, perception or ability of the Theta participants, but rather deliberate cliches to escape the difficulty of making public judgments about fellow group members.*

Abdicating the Role

The most direct way of abdicating the patient role was by ab-

* Group members regularly and willingly made judgments in therapy sessions and in lunch time talk but it was always tacitly assumed that they were "for right now" and could be and usually were revised within the period of the interaction. The public judgments did not have this quality of being corrigible.

senting oneself physically from the scene. This was a not infrequent occurrence at Theta. People just stopped coming either temporarily or permanently. Absence was always a concern for the patient group as well as for the therapists. It was apparent that in a setting in which the major sanction was discharge, voluntary absence was particularly threatening to the whole institution. Any unexplained absence immediately generated an inquiry into the absent patient's whereabouts: "Had he phoned?" Some member of the group was assigned to telephone the absent member if he had not. If it was not possible to contact him by telephone a number of group members would visit his address to see if they could find him. Even the absence of a patient on the first regular day of her attendance was an important issue, so that it was not a question of concern for fellow patients whose troubles were well known; any absence was a threat.

I was in the room on one occasion when a new patient who had failed to arrive on the first day was telephoned. The patient who called produced a long, clever and forceful argument for the new patient to attend. In the course of this dialogue she dealt with difficulties like the new patient denying that she wanted to change: "You don't have a desire to change? We won't let you fail", and fearing that she would lose her identity: "Part of your identity, but what kind of part is that? You'll replace it with something more positive". The patient-caller acknowledged the attractiveness of absence from the setting: "It's not an easy place to be but it gets easier; I've considered leaving but I just didn't".

Apart from patients who failed to arrive at the centre, patients occasionally absented themselves or threatened to absent themselves from the room in which therapy was being carried out. Once or twice threatened absence brought the threat of discharge from the clinical supervisor which certainly tested the patient's sincerity in the action as well as the power of the group to generate a commitment to stay at Theta. Apart from the concern of the therapists at this kind of absence, it was clearly a patient's concern too:

> The day ended with a long discussion on the question of absences. This is a big problem at Theta at the moment. [Patient] led the "hard-line" movement: he said that if people said that they were going to leave, they should be told to go. The problem of formulating a satisfactory rule was discussed at length. ...[Female Patient] was cited as a case in which the device was used to get attention. [Male Patient] said that he thought that [another patient] had done the same thing on Tuesday. [Patient] protested. The difference that was identified was between "I'm going", followed by action, and "I'm feeling like leaving and I wonder what is causing it". The second was identified as good behaviour, the first was bad....The discussion included a lot of talk about intention. If someone said that they were leaving and then headed for the door, they intended to leave. Someone objected to this on the grounds that they might be looking for attention or they might not have any other way of expressing their anxiety.

The concern about absences, then, appeared to be very serious among both patients and therapists. That physical absence was treated more gravely than other kinds of detachment such as being silent or perhaps participating in a way that directed attention away from oneself (being conspicuously active as a co-therapist for example) was evident. The concern of the therapists was, of course, obvious. Absence removed the patient from the strongest threat of the institution, that of discharge.

For the patients it seemed entirely reasonable in that everybody probably felt the need to escape at some time and when somebody actually did it, it became that much more realistic.

The only valid reason for absence from the setting was sickness. The sick role was invoked by a large number of patients during my stay at the centre and I was aware of the frequency of sick absence after a patient had been involved in a "heavy" therapy session. The incidence of "one-day flu" was so high at one stage that the staff instituted a system of individually identified drinking cups to reduce the apparent infectiousness of the disease. The staff was aware, of course, of the ease with which a patient could claim that he was sick and attempted to find remedies for this:

> At lunch there was some talk about [two patients]. [Clinical Supervisor] asked what was happening with them. It was explained that they were sick. [Clinical Supervisor] asked what temperature they had. Nobody had asked. [Clinical Supervisor] said that people should know "details" when someone was sick.

The patient group were also well aware of the potential power of the sick role explanation in absences and distinguished to some extent between "known to be sick":

> I enquired where [Patient] was and was told that she had been injured on the previous day playing floor hockey.

and "reported sick" when the patient's immediate past history might be searched to see if there were reasons to suspect that he was malingering:

> [Absent Patient] had been put on probation in her family on the previous day. When she had not come in today [Female Patient] had called. She said that

> she was sick. [Female Patient] was somewhat discouraged. She said that she doubted if [Absent Patient] would come back.

I observed one other method of abdicating the role while I was at Theta and that was by redefining the problem so that the setting was now inappropriate. A female patient had identified her shaking and excess weight as aspects of her problem. These were characterized as symptoms by the institution and considerable time was spent in attempts to get beyond these symptoms. She was questioned frequently in group about aspects of her past and current life in an attempt to find the source of her troubles but was highly resistant to any attempt at detailed exploration. As she proceeded through her stay at Theta, it became apparent that she was not prepared to entertain the notion that her troubles could have sources beyond the observable symptoms. In fact, she combined a natural difficulty with the English language with a devastating ability to misunderstand the questions. The net effect of this was that she blocked the inquiry and was the source of considerable frustration to her family and the group as a whole. After about three weeks, she decided that her problem was merely a weight problem. If this was the case, of course (from her point of view), Theta was an inappropriate place to be and she in fact left shortly afterwards.

Patient Beliefs

Parallel with the therapists' beliefs, there is a system of patients' beliefs which are instrumental in determining patient behaviour

in the setting and in their seeing what goes on at Theta as sensible, reasonable and understandable. These beliefs, like the therapists' beliefs posited in the previous chapter, are neither defended nor used in this section, but I hope to show in the two succeeding chapters how the social reality that is created at Theta depends on the beliefs of the two groups and their mutual dependence. The belief system which I propose exists as follows:

1. That Theta is a special place where one can explore one's troubles in ways that are not available outside the setting.

2. That it must be taken seriously and requires commitment on the part of its members.

3. That therapists are helpers and hence that they are motivated to improve the patients' well-being.

4. That they are professionally qualified to observe and interpret behaviour and that this gives their observations and interpretations a special status which is not accorded to lay observations and interpretations.

5. That the therapists' presence in the therapeutic setting is assurance that whatever comes up will be "handled" in a way that is not threatening for patients and is "safe" for the patient involved.

6. That reciprocity of confidences is suspended in relations between patient and therapist and that while the therapists should properly know all about the patient, the patient should not expect to know anything about the therapist except that he is a therapist.

7. That the social structure of Theta is properly defined by the therapists who may properly propose, question or redefine any activity at any time on the grounds that it is or is not therapeutic, therapeutic effectiveness always being sufficient grounds for any rule, interdict or activity without further explanation.

8. That although therapists' observations may confirm one perspective over another, they will be essentially neutral in any interaction among patients and will not take

sides in disputes involving patients.

9. That both therapists and patients will suspend their traditional moral judgments.

10. That the group at Theta is more important than any individual in the group and hence that behaviour invidious to the group must be suppressed. Further that commitment of all members to the group and to whatever is therapeutic is essential to the therapy of every member.

11. That patients should show their emotions and express their feelings about other group members.

12. That patients should have goals.

13. That time is a valuable resource and should not be wasted.

14. That suicide, whether attempted or threatened, is of immediate and pressing relevance to patients' well-being and should be attended to.

15. That alcohol and drugs are serious threats to the individual that should be abnegated and must be interdicted in cases of questionable dependency.

One is tempted to add "et cetera"[1] after a list which cannot, of course, be exhaustive. The beliefs that I have set out above and in the chapter on the therapist role appear to be some of those most frequently and clearly evoked and form the warp and woof of the unique moral order of Theta.

FOOTNOTES

1. The problem of providing an exhaustive set of norms or rules in "accounts" has been addressed by Garfinkel. See, Harold Garfinkel, *Studies in Ethnomethodology*, p. 3. Garfinkel argues that "Whenever a member is asked to demonstrate that an account analyzes an actual situation, he invariably makes use of practices of 'et cetera', 'unless', 'let it pass' to demonstrate the rationality of his achievement." and "The definite and sensible character of the matter that is being reported is settled by an assignment that reporter and auditor make to each other that each will have furnished whatever unstated understandings are required.

CHAPTER FIVE

THE RELATIONSHIP BETWEEN THE THERAPIST ROLE AND THE PATIENT ROLE

In a sense therapists can be no therapists without patients and patients no patients without therapists. The idea of a special class of professionals labelled "therapists" with a specialized discipline labelled "therapy" depends on the corresponding idea of a special class of people labelled "patients" on whom therapy can be practised. Without therapists and therapy, patients are mainly part of a large group of people with unorganized diffuse troubles. It is only when they enter into a relationship with therapists that they can properly be called patients.*

A special feature of the relationship between therapists and patients is their different relationship with the institution in which they

* Of course once the relationship has been identified they are patients for everyone to see. Once labelled patients are patients not only for therapists but for fellow patients as well.

meet. The institution is, for patients, a "special place", a sanctuary to which they have come for a limited period of time. It is different in many ways from their everyday world and despite the assumption of the institution that Theta should be a reflection of the world, it is recognized by the patients for what it is: a setting within but different from their outside world. In fact it is this special quality that provides its usefulness for them. In contrast to this perspective, Theta *is* the everyday world of the therapists. It is their place of business as members of one of the helping professions. They are not there for a limited time, they are "always" there. For this reason, it is seen as proper for them to have a special part in determining what should go on there, in providing stability and continuity in what is seen by the patients as a stable and continuing institution, specially constituted to give them help.

Making the Difference Visible

It can be said that *every* activity at Theta works to construct therapists as therapists and patients as patients. The two preceding chapters could now be discussed all over again to show that all the actions of therapists were seen as appropriate to their role by patients and allowed by patients as such. Similarly patients' actions could not be successfully operationalized without the tacit assistance and approval of the therapists. The items that are discussed here, then, are a few of the more visible minor matters that have not already been incorporated in the discussion of the separate roles.

It has already been noted that the absence or lateness of a patient was a matter of concern for both patients and therapists. In fact, even when the matter was reported by the patient there was some residual concern that he might be malingering. In contrast to this, therapists who were late or who reported sick were seen as having good reasons for being late or absent and, if sick, were assumed to be genuinely so. Therapists occasionally took days off or left early and in fact did all the things that employees of any institution do, without any more comment from either patients or their fellow therapists than is usually accorded this kind of behaviour.

Formally constituted group meetings were occasionally attended by the clinical supervisor at times when he was not regularly scheduled to attend. On these occasions he could arrive during the proceedings and leave before they ended without generating any comment then or later.

During group meetings, patients who engaged in private conversations were usually challenged and invited to share their comments with the whole group but this activity was seen as entirely appropriate for therapists.

The therapists could also interrupt the proceedings and it was seen as their right to decide that some process that was currently in progress should be discontinued. For example during one "weekends" session at which patients reported what they had done since the previous Friday the contrast between patient interruptions and therapist interrup-

tions was evident.

> [Female Patient] spoke last, was first interrupted by [Patient] who was "shushed" by [Male Patient]. [Female Patient] resumed. [Clinical Supervisor] arrived and after looking at the table...started to talk in a loud voice about charting. Several people seemed uncomfortable - he had interrupted [Female Patient]'s "weekend"...[Female Patient] eventually got a couple more sentences in but was interrupted again by [Clinical Supervisor]. He wanted the charting started - it was about 12:50.

The proceedings of formal groups was interrupted on another occasion when the therapist decided that it would be appropriate to introduce some music during an afternoon group.

> During much of the last part [Clinical Supervisor] was attempting to operate the intercom. He kept buzzing and saying "hello". At first there was no reply, then a buzz in return. The activity was the total centre of attention. He was saying, "let's have some music" or some such. After a second buzzing, there were gales of laughter.

This behaviour from a patient would not have been tolerated by either patients or therapists.

That the behaviour that was expected of therapists and patients was different was nicely illustrated in one after-group meeting at which a therapist was telling the (therapist) group about the activity in that afternoon's family group.

> [Resident Psychologist] also reported about [Name] - she had been "going on" in family. [Resident Psychologist] had let her go on. [Clinical Supervisor] misheard and thought [Resident Psychologist] was talking about [staff member with almost identical name]. He was obviously very surprised that [Staff Member] would do this.

Therapists were clearly expected not to "go on" in the setting but were expected to reserve their emotional problems, complaints, etc., for the

feelings group constituted for that purpose.

Another aspect of the contrast between therapists and patients was visible at a group interview at which a candidate for Theta exhibited signs of behaviour which simulataneously constituted him as somebody with serious problems visible at the group interview reported in Chapter 4 in which the candidate for Theta exhibited signs of behaviour which simultaneously constituted him as somebody with serious problems and somebody that it was not desirable to have at Theta. The insistance of the therapist that the group make a decision resulted in the candidate being admitted despite the patients' clearly stated opinion that he should be elsewhere. No patient's argument could have carried the weight of the therapist's demand that the patients vote and no patient was asked to intercede on his behalf after the therapist refused to do so.

The points that have been made above illustrate, in part, the patient belief in the control of the therapists. Their understanding that they could and should assume the security of the patients in the setting is illustrated by an incident concerning patients' focus on suicide. Although the Theta brochure declared that the centre was "*not* for people... presently suicidal as other programs are more useful" (emphasis added), it quite frequently happened that patients who had recently attempted to commit suicide were included in the group. There was occasionally though, talk or threats of suicide among the members. This talk was treated as a serious matter that the therapists *ought* to attend to. On one occasion their apparent non-attention was a source of annoyance to the group.

> Several people objected to [Therapist] on ground he invoked feelings about suicide and then terminated the session - source of [Patient's] annoyance. [Patient] was supported by [several other patients] in her protest: allusions to therapist's responsibility.

The therapists' behaviour was open to criticism from the group on any occasion on which they violated what was seen as the norms of their role by the patients. For example, the possible partisan behaviour of a therapist during a session was the object of a long discussion at lunch one day.

> There was quite a lot of talk about "Family Night". One of the issues was whether [two therapists] had "taken sides" in some of the interaction. An item was that [the therapist] had said that [Male Visitor] had to seduce his [girl friend who is a patient] every time he met her..."It wasn't fair to support [Male Visitor] just because he was a European too."

The patients appeared to be agreed that therapists should not "take sides". There was a lengthy discussion as to whether, in fact, this was a case of it.

Control and Democracy

The business of managing the proceedings during actual therapy sessions is largely dealt with in the next chapter where I attempt to show that every detail of the patient doing therapy is managed by the therapist. Likewise, the rest of Theta time, apart from the detailed production of therapeutic behaviour, was almost totally managed by the therapists.

The day to day business of the centre followed the schedule which is illustrated in Chapter 2 (Fig. 2.1) and this schedule was a production of the institution which revised it from time to time as circumstances demanded. The patients had no input into the production of this and consulted it with the same uncritical curiosity that a schoolboy consults his class timetable. "What we should be doing now" was written down for them and displayed so that they could know it.

Although the formal questions asked of new patients in the group interview may have formed a relatively small part of that total process, the formal questions were always asked and had to be answered in the prescribed manner. The formal questions were prepared by the institution and the reading of them was part of the *duty* of the chairman.

The patients' interpersonal relations were prescribed by the institution. Apart from the strict taboo against sexual relations, there was a curious ambivalence about the institution's attitude to relations in general among the patients.

New patients who had just been accepted in the group interview were routinely told that they were now "part of the group" and as such were expected to call group members if they needed help between the day of their interview (Wednesday) and the day of their starting at Theta, which was the following Monday.

Now it is known that a member of society does not turn to "just anybody" when he is in need of help. Sacks[1] has shown with respect to suicidal persons who seek help that there are rules which "provide from whom help may and may not be sought."[2] The rules provide for collections of paired relational categories which invoke certain rights and obligations concerning the activity of giving help. Furthermore, these collections are ordered sets; people seek help from the one at the top of the list first, and proceed from there in strict order. It was clear that new patients did not see the members of the current patient group as belonging to "classes whose incumbents are proper to turn to"[3] just because they had been told they were, for example:

> [New Patient] reported sipping beer all day every day between intake [Wednesday] and Monday. [Male Patient] and eventually everybody took her up on this. She had made a commitment to quit drinking... Why hadn't she called somebody? She said that she wouldn't have called anybody from Theta even if she *had* had the numbers, because she didn't know any of them.

The staff members at Theta, who might have been seen to be in an appropriate "paired relational category" to the patient were not available to be called.

After the patient had spent sometime at Theta, the other Theta patients appeared to be placed in a high position in the class whose "incumbents are proper to turn to" and patients frequently called each other for help.

The danger now arose that the patients would form subgroups outside the centre which would act to prevent the troubles being brought into the setting.

> [Female Patient] was jumped on towards the end of the session. [Patient] said that she had been feeling suicidal and had called [Female Patient]. [Clinical Supervisor] was extremely angry with [Female Patient] for not reporting the incident to the group. She said that she had thought it would be "betraying a trust".

The failure to report this incident has obvious dimensions other than subgroup formation. In fact, however, [Female Patient] did mention the incident to a staff member and it was known to a few patients. The outrage that descended on the female patient appeared to suggest sharp limits to the amount of helping that the institution expected of the patients outside the setting.

Patients who socialized outside the setting were expected to report this activity in subsequent talk at Theta. The Monday lunch meeting was regularly constituted as a time to talk about "weekends" and any social activity that had taken place over the weekend was normally reported there. There was, however, no other formalized occasion for this and weeknight meetings quite often did not get talked about. Staff members occasionally asked if anybody had "seen anybody" the previous evening and were frequently asked if this was allowable. The clinical supervisor in particular usually answered that it was "not forbidden", it was a matter of choice; he did not "recommend it". The line, then, was drawn between "socializing" which was mildly proscribed and "asking for help" which was, rather ambivalently, approved.

The point that appears to come out of the ambivalent attitude of the institution toward patients' interaction outside of the centre is that too much activity of this kind could potentially form powerful alliances among the patient population which could effectively reduce the control of the institution over its charges. The most powerful alliance that could be formed was an explicitely sexual one and the strong reaction of the institution to sexual alliances was further evidence of their discomfort with activity that was outside their control.

The first patient, for example, to be discharged for this reason during my period at Theta had had sexual intercourse with a patient who was in her last week at the centre. Despite the fact that she was no longer present in the setting, the male patient, who had a week remaining, was discharged. It could be argued that the female patient was scheduled to attend for "after-care" (which she did not, in fact, attend) but there was at least one instance in which a homosexual couple were allowed to overlap their respective periods so that they were both present on the after-care day.

A second patient who was discharged was present in group concurrently with his sexual partner.

> Just before family groups I was upstairs when [Staff Member] came up with all the rest of the staff. [Staff Member] was quite excited, said that there was a piece of excitement - [Male Patient] had slept with [Female Patient] the previous night. [Female Patient] had reported it in her diary. [Staff Member] said that one of them would have to go now.

Although the group was extremely angry with (particularly the male) participant, they appeared reluctant to discharge either one. It was argued, for example, that there was "a difference between going to bed with someone and having a love affair". The clinical supervisor, however, insisted that one of the two must leave. He said that [Male Patient]'s actions had damaged the whole group. This had a visible effect on several of the patients, one of whom remarked that he was not "prepared to sacrifice [his] own therapy for [Male Patient]." The opposition to the discharge continued and the clinical supervisor eventually said that [Male Patient] could be readmitted at a later date, but must wait at least three months. This was transparently a token gesture to reduce the heat, because he remarked to me afterwards that

> ...[Male Patient] could not get treated in this group. There should be places where people like him got treated. He might do better in the hospital.

The combination of intransigence, threat, and apparent conciliatoriness eventually had its effect and the group decided to discharge the male patient. The female patient was allowed to stay but was admonished not to see the male patient again; it would "interfere with her treatment".

Now it was generally the case that patients currently at Theta were engaged in some sort of sexual relationship outside the centre, and at least a few patients were involved with former patients. (As I have remarked, patients not infrequently attended as a result of recommendations from their friends.) The explanations that were given (for the rules) in the centre were either explanation by fiat: "it damages the therapy",

"it interferes with the treatment", or were characterized by the kinds of inconsistencies that have been discussed above. Why the relationships which originated at Theta were so severely censured is thus a puzzle which it seems only possible to explain in terms of control.[e]

I would like to propose that the control involved was control of the boundaries of intimacy within the centre. Much of the activity at the centre involved people in intimate emotional and physical contact. Some of the non-verbal games involved bodily contact, and bodily contact was encouraged during and after abreaction therapy. The disclosure of intimate personal details about one's former life was a routine part of doing therapy. In the light of all this activity it seems eminently reasonable that the boundary should be clearly defined. I speculate that the strong taboo against and strong reaction to sexual intercourse was a clear statement of the precise boundaries of that intimacy which made it "safe" to practice what might otherwise have been threatening behaviour.

The next dimension of control I wish to discuss is time. It has already been said that the lateness of therapists was not an issue in the centre, while the lateness of the patients was. Punctuality was heavily emphasized at Theta, although it was not uniformly enforced. Punctuality in the morning was strictly monitored and a system of fines and "commitments" was levied against people who arrived late. Punctuality

in other parts of the program was available as a resource to find that patients lacked commitment or were "slacking off":

> The afternoon meeting started about 2:10. [Resident Psychologist] made this an issue: she said that people were getting slack about starting times.

At these times it was never an argument that the group often started a few minutes late, but the lateness was accepted as a bad sign. The patients themselves addressed themselves to the same issue:

> [Female Patient]: Enthusiasm is at a all-time low...nobody comes on time, no one enforces the rules.

Apart from punctuality, the patients were required to spend the full day at the centre and were generally forbidden to leave early unless there were very special extenuating circumstances which were known from the time of their first admission.

> [Male Patient] left early so as to be in time for his job. He was told to make other arrangements so that he didn't have to leave early.
>
> At lunch a girl asked to leave early Tuesday so as to get to [Theatre] on time - was refused by another group member.

The fact that the patient in the first example above was not allowed to leave early to go to his job leads to another dimension of the control question. The institution expected that people would devote their whole time to Theta during the six-week period of their stay and generally asked them if they could support themselves during this period. "Moonlighting" was frowned upon and the patient above, for example, was questioned very closely about his necessity to work during the evening hours:

> [Male Patient]'s job was the next subject. He explained that he drove taxi until 2 a.m. He was asked if he was tired the next day. He said "no" again. Somebody asked if he was just passing the time. He smiled and said "yes", he was "just passing the time". He was asked why he didn't need the money, explained he was eligible for unemployment insurance. It was suggested he had a "thing" about working. He said he did. People asked how he worked at Theta. The foreman said that he worked well.

This patient was eventually persuaded to stop working his shift because it "interfered with his treatment".

In general the patients made almost no decisions about anything at Theta [*d] and, as can be seen in the work of the committee, saw themselves as having little or no power to affect the procedure. Therapists exercised their authority in explicit matters such as the schedule, and on occasions such as when the group made recommendations as to who should work. The patients' choice might be followed or not depending on the judgment of the therapist. The therapists also exercised control in more subtle ways such as, for example, when they voted first on occasions on which they wished to have the weight of their opinion behind a particular decision:

* An obvious exception to this was the group decision to admit new patients. I feel somewhat ambivalent about this point because I never saw the group refuse any patient. I inquired about this and was told that "we nearly refused so and so" but could find no case of an actual refusal. Some votes regularly went against new patients which was, perhaps, a safe way to exercise some autonomy provided it was apparent that the votes would not influence the process. The only occasion on which I saw the patients attempt to influence the procedure (discussed in the text), the attempt was frustrated by a therapist. I neglect minor matters like the patients deciding on the menu for the lunch they cooked, choosing material for chair coverings and the like.

> The group voted on whether [Female Patient] should stay or not...The chairman asked [Male Patient] to vote first. He said he voted "no" and gave his reasons....[Clinical Supervisor] said there was no time to go around with everybody giving reasons and that it should just be a hand vote. He asked for a show of hands of people who thought that [Female Patient] should be allowed to stay. He immediately raised his own hand as did [Resident Psychologist]. The few people who had originally objected to [Female Patient] staying voted against her but she was allowed to stay by a large majority.

During the early period of my observations the family groups were arranged so that their members were picked by lot on Wednesday. There was discussion about this arrangement in the therapists' after-group meetings during the period when a point system (discussed below) was being worked out. The author of the point system was in favor of having the family groups stable throughout the patients' stay and persuaded the other staff members of the advantages of this system. The patients were asked if they would agree to have the family groups changed to the new system and said that they would not. After further persuasion, however, they agreed to let them run two weeks instead of one. About a week after this, it was decided that the family groups *would* remain stable but that families could "bargain" for members from other families. What the "bargaining" would amount to and how it would be effected was not explained and I did not see any done during the remainder of my observations. The talk about "bargaining" did, however, produce an illusion of flexibility which sweetened the pill enough to make it swallowable.

Sanctions and Rewards

It was an interesting paradox at Theta that while the final sanction available to the institution was that the patient could be discharged, one of the primary tasks was to keep the patient in. This meant that a nice balancing act had to be continuously accomplished. If the threat of discharge loomed too large, this reduced the patient's commitment to the centre, whereas if it was taken too lightly it was no longer effective in achieving the control that was needed.

In the light of this balancing act, the need to have the patient heavily committed to the program is apparent and this provides an effective explanation for the extremely heavy emphasis

Once the patient was thoroughly committed to staying at Theta, the threat of discharge became very weighty. Actually, very few people were discharged during my stay. The cases that I have already reported stood out as exceptional events. One patient was discharged for coming to the centre smelling of drink:

> They confronted him and [Female Patient] confirmed that she had smelled it too. [Male Patient] said that he had been drinking the night before. [My informant] said that everybody was very angry with [Male Patient]. I asked her who had suggested that he leave, she said she thought it was [Resident Psychologist]. They had had a vote. Only one person voted against it. She said that only a couple of people had been positive but they *needed him to leave*.

The notion that the discharge was cathartic for the whole group appeared on two of the three occasions that I was aware of a patient being discharged. On the first one a staff member told me:

> ...it was necessary for [Male Patient] to be discharged to cleanse the group. He said the group had been much better since [Patient] left.

This suggests that an attempt was made to offset the traumatic feelings associated with the responsibility of voting out a fellow-member by representing it as an essentially therapeutic act.

The *threat* of discharge was much more widely apparent than discharge itself.

> [Female Patient] hurt, annoyed, sulky, declared she was going home. [Clinical Supervisor] told her she could not go, he would discharge her. She eventually stayed.

The threat was not often used as explicitly as this and was more often embedded in the implications of a system of probation. Patients who had transgressed against the rules of Theta were "put on probation" with the implication that discharge would probably follow if they did not reform. This was often enough to produce a change in behaviour and seldom resulted in actual discharge.

Patients who had transgressed against the rules were sometimes fined small sums of money, for example when they were late in the morning or absent without cause. A system of "make-ups" was also in effect in which patients were expected to make something for the centre such as a picture or some art or craft object or occasionally to write a poem. The make-up had to be negotiated with the group but was generally considered

as a rather minor matter. It was only when the group became dissatisfied with the member that they looked to the make-ups to see whether, in fact, they had been done and what form they took. This was then available as further evidence (perhaps) that the patient lacked commitment or was not taking the business seriously enough.

The institution itself started a system of rewards and sanctions in the form of points which were given for good or bad performance in the work at Theta. Although the official document describing this system predicted that "[The] direct effect [that is, the effect on the individual patient] will probably be quite negligible"[2], the document argued that the system would "[increase] the group members' awareness of being part of the group (family here)...[and] the group members' concern for other members' disturbing behaviour which could otherwise be 'kindly' [sic] tolerated." Also, "It certainly increases the attention paid to the rules of the game, that is, increased [sic] discipline."[5]

The group members treated the point system as another artifact of the institution which ought to be "taken seriously" but which generally didn't appear to mean very much apart from that. To be fair, it should be said that the system was still being worked out at the end of my period of observation but already the kind of attention that was paid to the system could be seen. For example a family that had very few points one week had a lot of absences. Far from motivating the family to browbeat their absentees, the absences were seen as adequate explanation for

the low points. A Patient remarked "that's really good for only two members". [referring to the number of accumulated points].

Insofar as it had developed, the achievement of high points had no payoff. The clinical supervisor tentatively started to offer himself to the family group with the highest number of points for family meeting, which caused a certain amount of interest but in general the point system was being treated for what it was: an artificial, misleading (insofar as members could see that there were "good reasons" for low points) and irrelevant (from the patients' point of view) artifact of the institution which, like the charts, had to be attended to because the institution considered it useful. The commitment and control that the system was supposed to influence was well established without the system and the success or failure of the families was apparent without the points which either reflected it:

Clinical Supervisor: Which family has the highest score?

Patient : Family 3.

Clinical Supervisor: I thought so.

or if it did not was viewed under the auspices of what everybody knew was the explanation for that.*

* It has been pointed out that the fact that there was no apparent payoff produced a useful therapeutic paradox and that in any case the point system did produce an observable change in the commitment of the group to punctuality and attandance. My failure to produce an explanation in sociological terms is characteristic of the fact that it is not always possible for the observer to discern all the dimensions of any activity in a setting and in this case I was unable to find any explanation in terms of the perspective I had developed.

Before I go on to the next chapter, I would like to review some of the matters that I have attempted to draw out in discussing the way in which the patient role and the therapist role meshed.

I have argued that Theta was "home base" for the therapists and a special place for the patients; a place, moreover, in which the activities were rightfully directed by the therapists. I have attempted to show that this difference was apparent in attendance, time keeping, and in the authority that patients expected therapists to exercise. I have attempted to show the wide range of activities in which the authority vested in the therapists was exercised.

The control the institution exerted over the proceedings could be seen in the schedule of activities, in the conduct of interviews, in the activities of patients within and without the setting, and in the ways in which patients interacted with each other.

Control was backed by a system of rewards and sanctions, the most powerful of which was discharge or the threat of discharge. This sanction was especially effective because of the strong commitment that was generated in most patients.

I have attempted to show that the principal feature of the interrelationship was that the authority of the therapists was seen as appropriate authority which should be accepted without question in all

Theta activities whether the usefulness of those activities was immediately apparent or not.

FOOTNOTES

1. Harvey Sacks, "An Initial Investigation of the Usability of Conversational Data for Doing Sociology", *Studies in Social Interaction*, ed. David Sudnow, New York, The Free Press, 1972.

2. Ibid. p. 40.

3. Loc. cit.

4. "The Rationale of the [Theta] Marking System", In-house Memorandum.

5. Ibid.

CHAPTER SIX

DOING THERAPY

The central purpose of Theta is to provide a place in which therapy can be done. The centre is designed to give assistance to people who have neurotic problems and the ways in which it is organized are designed to facilitate the treatment of these problems. The actual activity of doing therapy depends on the way the patients are formulated as patients and on the way the therapists are formulated as helping professionals. The parts of the thesis which have been developed so far are intended to provide the foundations for a description of the principal activity of the centre and in this chapter that activity is discussed.

I shall attempt to show how the roles of patient and therapist and the relationship between them are used as resources to allow the busi-

ness of doing therapy to be carried out. I shall attempt to use the patient and therapist belief systems to show that therapy is a rational activity that depends on the beliefs embedded in the two roles : I shall attempt also to show (at least by implication) that the commitment and control that the institution demands and exercises are necessary to the activity.

Some Features of the Therapeutic Activity

The Theta ethic was that everything that went on in the setting was therapeutic. It was the case, however, that some activities were considered more important than others and among all the activities at the centre the "big group" was primary. A perennial complaint of therapists was that important matters were not brought up in "big group" and the Clinical Supervisor frequently made references to it as the most important activity at Theta:

> [Male Patient] said that he had been annoyed with [Male Patient] in family but had said it there. [Clinical Supervisor] said he should say it again because everything must be brought into big group. This was the summit - the highest form of Theta activity.

I have argued in a preceding section that the reasons for forming the smaller, "family" groups appear to be related to the necessities of distributing Theta resources rather than their therapeutic effectiveness. In any event, no therapy that was carried out in the smaller groups was neglected in big group and I focus most of my attention in this chapter on that setting.

The Clinical Supervisor once agreed rather "half in fun and whole in earnest" that therapy (and particularly abreaction therapy) was a "kind of exorcism". The force of this metaphor appears to be that it focuses on the peak therapeutic activity at Theta which was the generation of strong emotional reactions: "abreactions". I am not attempting to argue that this was the primary therapeutic *focus* but that it was the activity that was valued by patients and therapists alike as the summum of "doing therapy" while I was at the centre.

This activity was referred to as "working out" and people who did it were said to be "on the mat". Patients who resisted this activity or who were unable to "let go" when they were "on the mat" were frequently seen not to have benefitted from their period at Theta, even though they might have participated in "blind walks", "role playing", dance, theatre, families and the rest. As this may be a rather controversial point, I would like to cite some of the evidence which has led me to make it.

First of all there was a marked contrast to the reaction among therapists after a session in which one or two patients had "worked out" and sessions in which no one had done so. Sessions in which patients had "worked out" were described as heavy but good sessions. The therapist who had worked most directly with the patient was often tired but was frequently congratulated on the "good work out" that had occurred.

At one session a new patient reacted to the abreaction of a patient who was "working out" by herself crying, which was a fairly common occurrence. It often happened that behaviour of this kind was used as a resource to get the second patient to "work out" at the same time. This was not, however, usually done with new patients. At this session the new patient was taken by a visiting therapist who was unaware of her new status (it was the patient's first day). The visiting therapist attempted to lead her into an abreaction which scared her considerably as she had not yet seen enough of the centre to absorb the norm that this behaviour was useful. Her lack of commitment to this norm was explicitly stated after the session when she said that she thought it was a "bad sign" that she had "broken down on the first day". My field note further records:

> [Clinical Supervisor] said it was a good sign. Some people took weeks to *achieve what she achieved.* Some never did. [Female Patient] reinforced this - she hadn't been able to do it at all.

The abreaction, then, was an achievement for patients: something to be desired. This was readily observable among patients who frequently talked of "really wanting to work out". It was also observable among patients who had "worked out" in the sense that it was "news": [Female Patient] came up to me as I entered and said she had "worked out" on Wednesday, obviously delighted with herself. It was "news" too in that it was recorded on the daily report by the patient committee who would report that they had worked with a therapist but "didn't get into anything" or "nothing came out" when their activity did not lead them to a workout.

The patients' attitude to abreaction can be seen, finally, in their attitude to the different therapists in the setting. Of the five regular staff members at Theta, only two ordinarily did abreaction therapy. It was sometimes remarked that [Staff Member] was good but did not "work out" with people or that [Staff Member] was good in family because he or she made people work. That the two staff members who did abreaction therapy were more highly valued may have been attributable to their greater all-round skill and experience, but it seemed to be the case that at least some of the attitude was attributable to the particular kind of therapy they did.

Doing therapy, then, at its most highly valued level, involved the patient in the display of strong emotions and in behaviour which, while extremely threatening to new patients, was eagerly sought by completely socialized members of the group. In fact, "working out" was the acme of group involvement and had some of the qualities of an initiation ceremony which provided a warrant for fully-fledged membership in the group.

In a setting in which therapeutic activities are valued above all others, the therapist is valued above all others as the dispenser of therapy. Although the ethic was that everything was therapeutic, the most clearly acknowledged therapeutic periods were when a therapist was present. The therapist's absence was frequently the cause of complaints,*

* Therapists were not often absent but on the occasions on which they were, the frequency of complaints was high.

for example this extract from a patient's conversation about the activities of his family group:

> "...there was an opening there...we..we were...weren't qualified.. just didn't know how to handle it. Eh..if a therapist had been there 'n if we had had more time, I think we could have fairly significant progress there.

A stronger statement was made by a male patient at the end of a session in which there had been a fair amount of acrimony. I was waiting outside the door and he burst out of the room with: "Where are all the goddamn therapists?" The anger and indignation in the question are evident. Actually one of the staff was present at the meeting and this illustrates another detail of the therapist's attributed qualities which I shall discuss below. "Where are the therapists?" was a common question when the group was assembled and nothing was happening. It was asked on occasions on which therapists were present but unnoticed and the work of the group had not started, as well as on occasions on which the therapists were late. The occurrence of this question as a reaction to lack of activity points to an important feature of "doing therapy", that is, that it is an activity that is, like all other activities, properly directed by the therapist. In the discussion of therapeutic activity that follows in the rest of this chapter, a characteristic of the activity is that it is negotiated with, sanctioned by, produced by, managed by and (at least optionally) terminated by the therapist. There is, of course, co-operation on the part of the patient but the therapist is the impresario.

To return to the angry question about the therapists' absence,

this seems to me to point to another dimension of the therapists' presence in the setting while therapy is going on. The therapist's presence is assurance that the situation will not get out of hand, that is, he not only properly *does* control the activities in "doing therapy" but that he *can* control them. In the absence of therapists, therapy is seen as a difficult and potentially dangerous task. The quotation recorded on the previous page was followed by a further one in which the patient sets out the dimensions of the problem seen by the group members: "...this is like amateurs trying to do an appendectomy, it just didn't work and we had to leave it...". I watched at least one event which pointed to the troubles of attempting to "do therapy" without the protection and direction of the therapists. The incident occurred on a family night on which the scheduling had been such that when the end was announced by the therapist a patient who had brought a friend had still not had an opportunity to do therapy. The patient protested that she wanted to work but the therapist declared that there was no time. He went on to explain that he believed that the patient's problem was better worked on in the regular group. The explanation was so transparently ad hoc that nobody present appeared to believe it and it was explicitly disputed by one patient who proposed that the group should continue. The therapists all left and went upstairs. The self-appointed leader started to do a fair imitation of the therapist at family night but it was clear that there was a lot of anxiety among some of the members. It very quickly became apparent that the interaction between the patient and her guest was not going to

"go anywhere" and more and more people began expressing their concern about the group. About fifteen minutes after the "coup", a male patient said "It's just like the therapist said, [Female Patient] would be better off in group". Five minutes later the therapists returned and announced that the session must end because they had to lock up the building. The group broke up with considerable relef.

Emotions

I have attempted to demonstrate above that the summum of doing therapy is abreaction therapy and would want to argue that much of therapy involves emotions as at least one if its dimensions. It seems appropriate, therefore, that I should discuss how emotions appear to be understood and talked about at Theta.

The most frequently discussed emotions at Theta were anger-hostility-hate, occasionally jealousy, with closeness* as a probable second. It seems not inconsequential that anger-hostility-hate are emotions that are most readily acted out while loneliness, sadness, fear and guilt, to name a few others that were reported, are less available for this mode of treatment. This seems reasonable in a centre where the treatment tends to be action-oriented rather than talk-oriented. One could speculate, too, that "closeness" is available for demonstration

* Closeness was never defined and appeared to have physical as well as emotional dimensions. It was used to indicate the attachment of friendship and comradeship as well as interpersonal intimacy and can perhaps be seen as the opposite of anger-hostility-hate.

via the non-verbal methods which were used at Theta whereas love, tenderness etc. is not. This is, of course, pretty speculative and anybody who has seen Marcel Marceau would probably disagree with the last part.

That anger-hostility-hate were believed to be the emotions most relevant to doing therapy appeared to be supported (at least negatively) by a statement made by a female patient who complained to the group: "I want to gain from therapy and I can't if everybody is going to be so nice". It was routinely the case that patients' experiences were searched to find someone at whom they were angry so that the anger could be ventilated in the group and phrases like "[Patient] expressed anger at her father" were commonplace in the daily reports of the committee. Like "working out", they were "news", whereas "[Patient] cried" or "[Patient] expressed loneliness, sadness, fear or guilt" were not part of the stock of cliches that produced the "business as usual" character of the daily report.

Recognizing emotions is part of the task of doing therapy. Both patients and therapists attended to the usual indicators of laughter, tears, facial expression, body posture and the rest but in addition to this, both patients and therapists acknowledged that recognizing emotions could be a problem. Emotions might not be what they appeared to be. For example, when a female patient started to cry at one group meeting the therapist said "that's how you express your anger" and a few moments later the second therapist at the meeting reiterated "when you're

angry you cry, you must have some feelings, I saw it". Not only might emotions not be what they appeared to be but they apparently could be present without the owner's knowledge. A female patient wrote after reading her autobiography to the group "I was happy that no hate feelings appeared for Dad". It was regularly assumed that if someone recounted being in a situation in which anger was appropriate, then they had been angry even though they weren't aware of it.

Emotions are infectious and one person's emotional outburst may trigger emotions in another. This was especially true of abreaction therapy when one or several spectators frequently started to cry while the principal actor was "working out". The reaction that was attended to was always the same. It was not the case that anybody searched to see if anger had invoked anger or hate, hate, but whatever emotion was being expressed, the searched-for reaction was tears. It was known, of course, that people could be having reactions that were not so apparent but this was not attended to among patients. On one occasion a therapist remarked to me after a session that I was "feeling something". Although the therapists' "feelings meeting" (which I did not attend) was scheduled at the time, the therapist told me to come upstairs so that I would not have to spend the rest of the day suffering. This attention to my reaction was, perhaps, generated by the knowledge that I had a vested interest in not displaying emotions and so I was subject to closer scrutiny for more subtle signs of having been infected.

Finally it was frequently the case that an attempt was made to

demonstrate emotional dimensions by physical distance. Enough has been written about group ecology in the literature of non-verbal communication to make it unnecessary to argue for the significance of physical distance in group settings. At Theta it was assumed that an equation could be made between emotional "closeness" and physical closeness. On Family Night, families were routinely asked to demonstrate the way they felt about each other by arranging themselves on the stage, for example:

> [Female Patient] appeared to be very frustrated with the whole process and eventually rearranged the chairs (under [Male Patient]'s request) to express how she felt about her two parents. She put her mother beside her father and herself outside the circle.
>
> [Male Patient] was asked how close he felt to members of the group and he said that he felt equally close to all of them. He was invited to place them at the physical distance he would like to have them and placed them in a circle around him...[Resident Psychologist] asked him if he would like people to be closer to him and he said he would. [Resident Psychologist] then asked people to show how close they would like to be to [Male Patient] and there was an immediate move to surround him. [Male Patient] said that he felt that [Male Patient], who was well outside the circle, should be closer. [Male Patient] said he didn't want to be any closer.

Categories for Therapy

The patient population at Theta, during my period of observation, was usually predominantly female. No attempt was made to redress this imbalance by making special efforts to recruit male patients and it appeared to be believed that the sex category was irrelevant to therapy. The categories "Patient" and "Therapist" are, of course, sexually neutral, and both category classes contained male and female members who were, in principle, treated uniformly without regard to their sex status.

The irrelevance of sex categories was further evidenced in that the same therapy was done on patients regardless of their sex and even sexual problems themselves were discussed without apparent reference to the individual sex involved: women's sexual problems were treated essentially in the same way as men's even though some of the male *problems* discussed were sex-specific.

In role playing the imbalance of the group sometimes presented some problems in that there were frequently insufficient men present to fill the roles required. The clinical supervisor frequently remarked that the person a patient chose to play some male role "could be a woman" and apparently believed that their actual sex category was relatively unimportant to the activity.

Occupational categories, too, appeared to be completely irrelevant to the therapeutic activity. I was frequently conscious of suddenly becoming aware of the occupational category of some patient (for example when I found out that one of them was a policeman) and being surprised to notice that in general I had no idea what people did in their ordinary lives. In a few cases categories like "housewife" were alluded to as part of the problem in the sense that the patient did not feel fulfilled in that role. There was also occasionally some talk about what kind of work people would do after they left the centre, but as far as doing therapy went, there were no differentiations made in the kind of treatment that was administered that rested on occupational categories.

Some relationship categories were considered universally relevant for therapy. The most noticeable of these were "father" and "mother" which were sex discriminated, and "sibling" which was not except in so far as the names used were inevitably discriminatory. Every patient was asked about his or her father and mother and was asked to explain his past and current relationship with them. This occurred in the various pre-admission interviews and was carried into the therapeutic setting as a routine and ongoing preoccupation. Patients were assumed to have strong feelings about their parents and their siblings.

Other categories that were considered relevant were "homosexual", "black" (which was formulated as a problem-relevant category by a West Indian patient) and "religion". That someone was "homosexual" was taken by the patient population to be an adequate reason for his coming to Theta without any further explanation and it was always available as a possible category that could be invoked to explain feelings and behaviour, even though the patient did not himself invoke it.*[j] The patient files that were prepared for the institution routinely recorded the patient's religion. The rather random list that appeared: Protestant, Lutheran, Mennonite, Roman Catholic, NDS (?), None, Nil, seemed to indicate that it had not much significance. It rather seemed that every-day stereotypes had as much force as any therapy-relevant consideration or sheer classifacatory schema.

*This assertion is disputed by the institution who deny that homosexuality *by itself* was enough to get the patient accepted. A staff member told me that doubts about sexuality, or fears that one might be homosexual might be considered but that homosexuality, even if that was declared to be the problem, would not be accepted as such.

The clinical supervisor once asked, on being told that a patient had a mother problem: "Is she Jewish?" It was the case, however, that patients were sometimes asked if they had "religious conflicts". I never saw this used as a resource in doing therapy.

Roles and Therapy

The most important resources in doing therapy are the patient and therapist roles. These have been formulated to make the practice possible and the practice itself depends on the beliefs embedded in these roles which have been set out in the relevant chapters.

The therapists' assumption that anyone can have problems allowed them to accept whatever formulation of the problem the patient presented as evidence of actual trouble and his presence in the setting could be seen as reasonable and understandable in the light of the belief that his problems were beyond his capacity. No further enquiry was conducted to find if the patient was malingering and there was no suspension of belief in the story the patient told. The attention that was paid to the patient's story was evidence that he was considered a competent reporter and this was a determinant of what was counted as troubles in the therapeutic setting.

The attention that was paid to emotional states and particularly to the emotions generated by fathers, mothers, siblings, husbands, wives and the rest were determined by the understandings that these were relevant matters for doing therapy, and their invariably being involved

made them essential elements of the activity which was carried out.

The patient belief that Theta was a special place was essential in that he had to be able to behave in ways which would conventionally be disallowed. The ways in which he behaved had to be prescribed under the auspices of a characterization which eliminated the possibility that he was "throwing a tantrum" or "being a cry-baby" or "disturbing the peace" or whatever characterization might have been put on the behaviour in another setting. As the therapists were, presumably, the people who "really knew what was therapeutic", it was entirely reasonable that the behaviour should be directed by them. They were, moreover, characterized as helpers, which was both necessary and sufficient for the behaviour they suggested to be pursued. This was especially so as the behaviour was sufficiently removed from what is conventionally received as reasonable to be extremely threatening to the actor.

Categorizing the therapist as a professional helper immediately invoked special roles and rights to which professionals are due which included the assumption that when you take your problem to him you describe it to him but he does not reciprocate with information about his own troubles. It further located him as a proper person to take troubles to, a specialist on troubles whose specialist training qualified him to deal with troubles.

The patient and therapist roles, then, allowed the business of going to therapy to get done. In contrast, there were a few roles

that were either deliberately or unconsciously invoked which blocked or interfered with doing therapy. The role of worker which was implicit in the discussion of work in Chapter 2 tended to have this quality; that is, it was to some extent incompatible with doing therapy. In similar ways the role of player (in the sports) and of actor in the Theta dramas had to be suspended before therapy could be done. In fact, as I shall show, the therapy that revolved around these activities was carried out after they were over, when the group reconvened to view what had been going on in the light of its therapeutic relevance.

Another role that I saw invoked to prevent therapy being done was that of comic:

> [Male Patient] put in a tremendous performance and had most people in the room in fits of laughter. A compulsive attention-seeker with a good sense of his audience...[He] really had control of the group for a while.

This role in which the proceedings are treated as essentially non-serious, seems to preclude the kind of business which is understood as therapy from being transacted at Theta. This so much annoyed the therapist in charge that he remarked afterwards:

> ...that he thought [Male Patient] might be suffering from "minor brain damage" from some fall he had when he was a youth. He said that [the patient] "lacked the ability for abstract thought"...

The essentially emotional character of the therapeutic process also tended to make the intellectual role incompatible with it. One of the ways in which this could be seen was in the pejorative use of

the term "intellectualizing". Any attempt to explain or interpret the process on the part of the patient rather than just to experience it was open to the challenge that it was "just intellectualizing" which was seen as a worthless and counter-therapeutic activity. This term was not, however, applied to therapists' interpretations which were accepted as having a different status to that of the patients' comments.

The business of doing therapy itself involved patients in the playing of certain secondary roles such as the parents, siblings and other significant figures in the lives of patients who were working:

> [Clinical Psychologist] asked [Patient] to select some people who could stand in for her father, her mother, her uncle and her grandparents. [Patient] selected A as her mother (some people referred to her as the group mother and she was frequently chosen as mother in these tableaux), B as her father (the group has currently only three men B, C and D. D is new and unknown and C is gay and small. B is large and hirsute and is chosen to play almost all male roles at the moment.) [Clinical Supervisor] frequently says that people can "choose a woman if you like". [Female Patient] used to get chosen for any and every role.

Once the role players were chosen, the patient would give them some minimal information about the kinds of people they were supposed to represent and then attempt to address them as those persons. Being a reasonable facsimile of some person was not always successful as for example:

> [Female Patient] was playing the role of [the patient's] mother and did not seem to have much idea of what a woman who had been brought up in an Austrian convent would be like.

> [Male Patient] tried to talk for K's father but it sounded very much like the performance he had given with M. He was pretty well at a loss as to how a reserved upper-class Dutch autocrat would behave.

The success or failure of the enterprise depended on there being either some correspondence between the role-players in terms of stereotypes or in terms of the role-player producing a display of his own (say) father's behaviour and this being similar to that of the patient's. Making the failure explicit was a way to stop the activity:

> [Two patients] were persuaded to arm-wrestle on the floor. This was a stand-off too. N said very matter-of-factly that she thought she was arm-wrestling with [Patient] and not with her father. [Patient] got up and started a round-robin to find out what people thought of her.

In general, the more successful role playing was, not surprisingly, by patients of people that they knew intimately. This often produced noticeably different characteristics from those displayed by the patient.

> After some time [Clinical Supervisor] asked her to sit on a chair and pretend to be [her lover]. She did this and her demeanor immediately changed. She became less defiant and more subdued.

The creation of the second role in a relationship such as this frequently led people to understandings of how the two roles fitted together.

Patients were also asked to play themselves in roles which had been discerned as part of their spectrum of behaviour and sometimes to carry on a dialogue between two apparently contrasting roles that they espoused:

> [Resident Psychologist] asked [Patient] to speak to [Herself]. The demanding Y to the real Y. Y said she would be making it up, but tried anyway. [Several patients became engaged in the role playing, some speaking on behalf of one Y, some interacting with Y.] Y actually was playing at least two roles herself, a nasty, vindictive role: "What're you going to do now?" in a minor 5th sing-song voice, (I'm the king of the castle); "I'm not going to let you". Meanwhile the other Y roared at her, big voice, "You aren't good enough for the group"; "The group won't let you stay"; "you can't make it".

Patients did not always choose the roles they were to play themselves and the group could suggest roles that they thought the patient should try out:

> A was told to choose a surrogate husband and chose B...[Clinical Supervisor] suggested that people show the relationship between the two non-verbally. After a few suggestions [a patient] came up with the following: She should put her arms around his neck and hang there. [Clinical Supervisor] told her to take this position. A tried it and definitely didn't like it. She "felt funny".

That patients felt uncomfortable in roles they were playing was often taken as a sign that the role was psychologically significant for them. This applied to incidents like the one immediately above where the patient was assumed to have discovered something about herself, but also to incidents in which the discovery was less deliberate. For example, if a patient in the patient play felt uncomfortable in the role he was cast in, this was made a resource for doing therapy on the presumed aspects of the patient's life that that role encapsulated.

Learning What's Wrong

It has already been said that whatever the patient reported as troubles were assumed to *be* troubles for him. This meant that the list of what could count as the source or symptom of neurosis was, in principle, inexhaustible. If this is true, there can, in principle, be no standard decision procedure for determining what is really wrong or discerning cause from symptom. The list of troubles that was generated during my stay at Theta ran from amputated limbs and physical deformity to not being able to open mail or pay bills.

The first formulation of the trouble too, was not always sustained during the period that the patient was in the centre and things that had not been suspected as a trouble could be found to be a trouble in the course of the treatment.

> How is your original problem? Wasn't it something to do with loneliness?
>
> I asked [a patient who was filling in numbers on her chart] why she had changed "Roman Catholic" from 6 to 5 [which indicated that it was more serious]. She said she thought she had problems that she didn't know about at the beginning.

It was also always open to the therapists to propose that what had first been formulated as the problem was not really the problem at all but only a symptom of the problem.

> A accused B of withholding some talk about his wife. He fears she will leave him if he admits he has had homosexual relations. [Therapist] suggested that that was not really his problem and he asked for help in formulating his problem.

The resources that the centre used for discerning the dimensions of the problem were all the activities that were engaged in. These activities, such as dance, theatre, work etc. were routinely scrutinized to see whether they had elicited feelings in the patient that could be used to discover the real trouble.

> Q was questioned about why she had not participated in the whole of the dancing. She said she hated that kind of thing...R said he hated that kind of thing too. He said he had an absolute horror of it.
>
> S said that he had been told to participate less [in the play] and so he had not participated at all. The group picked up on this as something he habitually does.
>
> T said she had felt "really uneasy in the role" [in the play]. She felt that she was "under attack"...She said the part was "very real", she didn't feel she was acting. It was "scary".
>
> V [who had been working extremely hard on rebuilding the AV room] was asked why he worked so compulsively. Was he "dependent" on the work?

In fact, any incident or talk or behaviour at Theta was available to be treated as part of the patient's pathology. When a patient objected to part of the proposed points system, this was examined under the auspices of the therapeutic model to discount her objection:

> [Patient] said that she didn't like the idea of introducing competition into Theta. She thought that competition was "very destructive". This was immediately formulated as part of her problem. It became "very interesting" that she had objected to this.

Through this process along with the initial work which is done at the interviews, the patient comes to see many aspects of his life under the problem heading. As time passes in the setting, the patient usually begins to integrate all the various parts of the troubles that have been empha-

sized into a pattern of trouble.

The discovery of a pattern of trouble often coincided with the construction by the patient of his autobiography. This document was written by the patient during the first two weeks of his stay at Theta. There were no particular ground-rules for its production; people made of it whatever they thought an autobiography ought to look like *in the setting.*

The situated character of the autobiography was mainly evident in that it tended, perhaps, to emphasize the unhappy aspects of the patients' lives and tended to be another document which found good reasons why a patient had the troubles he did. In fact, there was a fair amount of confusion between autobiographies and self-descriptions and it was routinely pointed out at the pre-orientation interview that the self-description was <u>not</u> an autobiography, but that that would come later. The two documents were seen to be somewhat similar.

That the autobiography frequently led the patient to discover that there was a pattern to his life was amply evidenced in the Theta diaries:

> In typing my autobiography over the weekend, I kept wishing I had done it before. There's something about writing it all down which exposes the patterns in a way which haphazard thinking doesn't do.

> I got very depressed tonight writing my autobiography and letting my feelings come to the top regarding my family...I can also see a pattern emerging from my Dad towards me like his mother to him and it scares me.
>
> I keep seeing more and more things I do wrong and have done wrong in the past...
>
> ...autobiography...I feel very anxious when I see what stupid ways I chose to live my life.

This discovery that there was a pattern to the patient's behaviour appeared to be viewed by the patient with mixed feelings. While the discovery that he had been living his life in "stupid ways" was frequently accompanied by some depression, it was also accompanied/or shortly followed by a period of hope and optimistic expectation. It seemed as if the pattern, while depressing in its discovery, produced the expectation that, now that it was known, it could be cured.

The "high" that patients experienced in their second week at Theta was frequently followed by a low. It was as though the experience of discovery accompanied by optimism was followed by a wave of pessimism generated by feelings that cure was impossible. I checked this observation with the resident psychologist who said that she had noticed the same pattern. This tentative observation is supported by some evidence from patient comments:

> For the first time since I arrived, I am scared that I cannot get better... The problems that I have overwhelm me sometimes. Where do I start? How does one deal with such a large thing as guilt?...

> I have been depressed for quite a few days now...
> I don't notice any change in myself...
>
> The confusion is back again just as strong as
> ever, the future looks uncertain again.

I have not had the opportunity to explore this changing perspective in enough detail to allow more than a tentative formulation. It is, however, a sufficiently interesting point that seems worthy of additional study, particularly for Theta staff who might wish to adjust patient schedules in accordance with the mood-phases of the patients' experience.

Correcting It

Actually the division of the process along the lines that I have used is highly artificial in that the process of discovering the real trouble would itself have been therapeutic. It is mainly the tentative conclusion that the patients experience the process as having two phases that has led me to make the division. In this section I shall discuss some of the procedures that were used and some of the troubles that were encountered in doing therapy.

The selection of the person who should do therapy on any particular occasion was achieved by a number of devices. The simplest and probably the commonest one was for the therapist to ask "Who wants to work?" It was then up to anybody who felt that their troubles were pressing to

ask for group time. It has already been pointed out that only a few people could work on any particular occasion when therapy was being done and it was assumed that everybody's problems were not equally pressing at all times. The therapist in charge would sometimes ask "What do you regard as most important?" or "Who needs to work the most?".

If a number of candidates for work were identified, the selection could be influenced by the length of time the candidate had left at Theta, so that candidates in their last week were seen to have priority over candidates who would have a subsequent opportunity on some other day. Candidates who were visibly in emotional states were selected over candidates who were not, but apart from these priorities, the selection appeared to be quite arbitrary: "Therapist picked A to work for no apparent reason".

The selection of the patient who should work could be made on the basis of some interaction that went on at the beginning of the meeting:

> [Patient] stated that she had objections to the use of primal scream therapy. She didn't want it for herself. Several people..said that [Patient] resisted all forms of therapy which she denied...She got quite angry with some of the men. [Clinical Supervisor] brought [Patient] up to the stage and talked with her for a while.

or in another instance:

> Patient : I understand, but I started to say something and B put me off.
>
> Therapist : Tell him now

Patient : You pissed me off.

Therapist : Go closer and tell him.

If either patient in an exchange of this kind became emotional during the exchange, he was selected as someone who should be working and therapy proceeded from there.

Once a candidate had been selected and had started to work, the rest of the group were no longer potential candidates until the work with that patient was completed.* They now became resources with which to do work with the selected candidate. The group could be used to play the roles that have been previously described or they could be used as fellow group members on whom opinions and feelings could be tried out for example:

> [Clinical Supervisor] asked J what he thought of people at Theta. He said he had no animosities if that is what he meant. [Clinical Supervisor] indicated either/or and asked him to go around and say what he felt about each member...
>
> D said that he didn't give a shit. Hung his head. Looked uncomfortable. [Clinical Supervisor] asked him to go around and tell people, naming them, that he didn't give a shit about them.

No response was required of these kinds of comments although group members often appeared to feel an obligation to take a turn in the potential

* How it was known that the work was completed could be the subject of a separate study. The activity could be terminated by the schedule: therapy stopped at certain hours and although it occasionally ran slightly overtime, the schedule was recognized as having priority over the immediate activity. Therapy could be terminated by the therapist declaring it to be over or deciding that the patient was "just acting" and giving up the attempt to work with him. Therapy could be terminated by the elicitation of inappropriate responses like laughter or by the failure to elicit any response at all.

conversation after they had been addressed. The therapist, however, would sometimes invite the other group members to express how they felt about the patient who was working:

> Next [Clinical Supervisor] asked everybody to do what they wanted to D. Several girls went up and kicked him in the pants. The group gathered around him and pushed him from side to side.

The reaction of group members to unresponsive patients has already been recorded insofar as they were seen as wasting time. The reaction reported above was another which was sometimes generated under the circumstances and one which had the tacit support of the therapists present who did not interfere with it.

> M said she felt alone and sad. She was questioned about what she was going to do about it. She went around and told everybody in turn that she didn't trust them. After a couple of rounds she got to A who said that she was doing the same thing that he had been doing. He said he wasn't going to let her. He started to push her around and the whole group joined in pushing her from side to side and shouting "come on M".

The purpose of this activity was to generate emotion. The test that useful work was being done was that the patient had noticeably lost control of his emotions which could then be worked on. It didn't seem to matter whether the emotion elicited was anger or tears but it should appear. If the first appeared, then the patient was given one of the Theta padded clubs and invited to pound some second patient to work out his anger. If the second patient was playing a role, the anger was assumed to be directed at the person whose role he was playing.

> After a few minutes of dialogue [Resident Psychologist] went and got the boppers and invited A to tell his father how angry he was with him. A said he was worried about this and was afraid that he would go at [the second patient] with his fists.

This patient had no trouble distinguishing the person he was going to fight with from his father before the incident started, but it was assumed that his *anger* would be directed at the father-image embodied in the role performed by the other patient.

As soon as it was apparent that the patient had achieved a state in which his emotions had gained ascendency over his intellectual control he was usually invited to lie down on the floor or on a styrofoam mat that was available for the purpose. This was the signal for all the group members to gather around him, kneeling or sitting. Usually the therapist who was directing the session would kneel at his side facing his head.

It did not always happen that the patient's emotions *had* in fact completely taken over, but if they had not, the work which was to follow was seen as more difficult. A therapist reported of one marginally successful event, "We spent a lot of time fighting his mind".

When the patient was on the floor, the therapist encouraged him to breathe rapidly, sometimes accompanying his instructions with a kind of artificial respiration in which he stimulated the breathing by alternatively pressing and releasing his lower chest. This was explained as a means to get him to "hyperventilate".

While all this was going on the patient was encouraged to speak, or failing that to make any sound that he felt like making. The therapist and the group members fed him lines that they thought would be appropriate

such as "leave me alone" or "don't leave me"; "I hate you"; "I want you to love me". The patient had the option of repeating the phrases as they were given to him or dealing with them as "conversational" items which could be responded to. The therapist, meanwhile encouraged him to "let out that sound", or to repeat an apparently significant phrase or to do so "louder".

Patients were seen as having physical manifestations of their troubles and one of the tasks appeared to be to get the trouble "out" in a literal physical sense.

> D...appeared to be unsuccessful despite some pretty impressive shouting crying and several determined efforts to vomit. [Therapist] described this afterwards as a block and said he had got D to spit out the mucous that collected. [Clinical Psychologist]: "good".

In another context the clinical supervisor described a patient as having a pain which started low down in his body and gradually worked its way up as the therapy proceeded.

The abreaction therapy usually continued until the patient had exhausted his repertoir of shouting, crying, cursing, and sounds and was himself tired. Some of the ways that therapy was terminated have already been mentioned. In general it appeared to be negotiated jointly between patient and therapist with the therapist having the option not to discontinue the activity if, in his judgment useful work could be done by continuing. At the very least the therapist had to consent to the ending for it to be successfully accomplished. After the process was over the patient

who had been working was warmly hugged by the therapist and by all members of the group of people who had surrounded him, all of whom would have been holding some part of his body throughout the event.

There were a few reports of patients' reactions to this process in the diaries, some of which appeared to be favourable:

> I had a workout today. I still feel physically drained but I don't remember too much about what I said. It feels like a plug got pulled in my brain and let the dirty water out. All that's left is the ring in the tub. It is strange, a lot of things came out I have not thought of in years. Old feelings and fears.

The same patient wrote of a second "workout":

> Tonight I feel much better - worked out today. For some reason my headache disappeared for a while although it came back later.

Another patient, however, reported a less favourable reaction:

> I felt very defeated also today after my session on the mat. Felt worse than I have for weeks.

That doing therapy could be unsuccessful in its immediate reaction was, of course, one of the hazards of the process and one of several troubles that the process had for patients. Some other troubles that were encountered are discussed below.

Troubles

One of the first troubles that could be experienced by patients was not being able to "do therapy", not being able to "get into anyting". This usually meant that no emotional reaction had appeared to whatever therapeutic procedure was being practiced which was sometimes found to be

evidence that it had been a failure. Patients reported being aware of troubles that they had but not knowing how to do therapy on them:

> J said to M that she was really annoyed with her because she wasn't working. M said that this was true, she had things to get out but didn't know how to do it.

Even when they had directions or suggestions as to how to do it, some patients complained that they could not comply with them:

> H was told to talk to J and to tell him to leave her alone. Somebody went and got the boppers. H objected. She didn't want to hit him. She wanted to be friends. J bashed at her half-heartedly. H said she couldn't hit J and let the bopper hang limply by her side.

It has already been said that some role playing did not come off and this was a source of trouble insofar as the illusion that the patient was beating his father dissolved into the realization that he was beating his fellow patient.

> When R was working out about his mother... he stopped after a few minutes and said "I don't think he means what he's saying".

This diary report of an incident in which a male patient was playing the role of another male patient's mother occurred when the female who started playing the role got tired and the male patient took over for her. The incident was a source of trouble for both the therapy and for the role player who reported that he:

> ...had mixed feelings about this. First I felt really good that he knows I don't think like that and second it automatically put me on the defensive to tell him I was playing his mother, not my own.

The danger of the therapeutic reality slipping away and being replaced by some other interpretation which would make the participant look ridiculous was always present at Theta. The activity had to be carried out under the auspices of the appropriate understandings in order to be sustainable. Thus when a patient was unable to see the procedure in the appropriate light he found himself ridiculous:

> [Clinical Supervisor] asked who she would pick as her father. She said "R". She was invited to use the boppers with R. R said he didn't want to do it again. [Clinical Supervisor] asked him why not. He said he felt like a spectacle when he did it. There was some talk about what it was to be a spectacle. Was M a spectacle on the floor? R said "no". Another patient said she could appreciate what R meant. [Clinical Supervisor] said he was there for therapy, he was not supposed to "enjoy" it.

Although he did not have to enjoy it to be able to do it, he did have to believe in the appropriate reality. The fact that he did not made him a "spectacle". In fact, the patient left Theta shortly after this incident.

Another trouble that occasionally interfered with the business of doing therapy was the experience that recreating troubles that had already been ventilated was something that could not necessarily reproduce the feelings associated with them. This was experienced in "big group" when a patient was invited to report on some incident with a view to working out the problems associated with it in this highly valued setting:

> [Clinical Supervisor] went on to ask for the new patients to come up one at a time, P was first. P had been having some reaction to the group members already. She identified J and D who she had had a row with a couple of days previously. P could not find anybody that she felt strongly about at that minute.

> [Resident Psychologist] said that there was some "important group business" [The group was reported to be working poorly]. R said he had been annoyed with J in family but had said it there. [Clinical Supervisor] said he should say it again...R made a half-hearted attempt to resuscitate the issue but it didn't get off the ground.

In fact, the feeling among patients appeared to be that attempting to reproduce an event of this kind ought not to be done:

> [Clinical Supervisor who had been absent on the previous day] asked H to show how she would tell M to leave her alone. Several people pointed out that she had done that on the previous day.

Apart from the troubles that doing therapy could have in the setting, it could occasionally have troublesome consequences. The patient in the above field note went home to tell M to leave her alone after rehearsing the scene at Theta. She returned the next day with a large bruise over her eye that she received when she acted out the scene that she had rehearsed in the safety of the centre.

Although not an exhaustive description of the process of doing therapy, the sections above have attempted to bring out some aspects of the activity in the light of the Theta culture. The assumption of the centre that everything at Theta is therapeutic has been described and the emphasis on abreaction therapy has been detailed. The patients' attention to and involvement in this aspect of therapy has been documented.

The role of the therapists in doing therapy and in providing direction and protection has been set out and it has been shown that the process of doing therapy cannot be sustained in the absence of the therapists.

The part played by emotions in doing therapy has been discussed and it has been argued that certain emotions are attended to above all others. The emotions that are most frequently developed lie along the dimensions of anger and closeness and are most accessible to the therapeutic procedures used at Theta.

The categories that were used in doing therapy have been discussed and the place of roles in the activity has been delineated. In particular, the two principal roles at Theta, that of patient and therapist and the belief systems embedded in these roles, have been proposed as major resources for doing therapy. Other roles played by the patients in the process have been discussed.

It has been argued that patients experience their passage through Theta as having two phases. In the first, the patient discovers a pattern of behaviours that he often sees as of long standing. This discovery is accompanied by optimism. The question of how the pattern will be changed follows the discovery and may be accompanied by a corresponding depression. The actual work of formal therapy itself has been described as well as some troubles deriving from the activity.

Throughout this chapter and the rest of the study I have attempted to show that the activities at Theta can be seen as situated in and determining of the environment that members understand as a therapeutic community. I have attempted to point to the situated activity of the participants as having the moral force referred to in the introduction.

If I have been true to my ethnographic aims, I will have described the culture as it is seen by members in the setting. As an ethnographer I will have reported what I found without reference to what I felt about the finding, independent of personal ties or enthusiasms that I developed but remembering that my first loyalty was to my ethnographic account. Of course any enterprise must, to some extent, fall short of the ideal and this no less than others will have offended against the principles (not to say the best practice) of the ethnographic ideal in major and minor ways. That, however, is a shortcoming of this work and not of the ideal which attempts to discover how the social order is created and sustained.

APPENDIX I

THE OBSERVER ROLE

As a naive observer, arriving at a therapeutic out-patient centre, I suffered from all the usual anxieties of the new patient with the additional problem that I knew that my role was not going to be defined for me. Although I had some vague beliefs about how observers behave in settings, I was very conscious of not knowing how *this* observer would behave in *this* setting or what would be expected of him. I had been told that I would be expected to participate but how much? And what was my participation supposed to consist of? My previous group experience seemed ill-suited to formulating any suitable role and the role of non-participating observer was repeatedly discussed at Theta.

Negotiating a Role

I have already described the categories of therapist and patient as exhaustive of all the usual roles that are prescribed in the centre. Now while it was clear that I could not be a therapist, one im-

mediate possibility was that I could go in as a patient. This role was suggested to me by the clinical supervisor when I first proposed that I should expand my observations from the rather casual weekly visits that I maintained during the first several months of my contact, to full-time observation. In subsequent negotiations, the clinical supervisor pressed fairly hard for me to become a patient. I refused to do this because (apart from a reluctance to expose myself in a way that would, I felt, be very demanding emotionally) I was convinced that the perspective that I wanted to develop was better seen from the sidelines. If I was involved in the process I thought that I would not be able to attend properly to what was happening. I did not want to write an account of my experience and influence at Theta; I wanted to write about how the people there jointly created their own reality.

That my role was deviant was clearly recognized by the patients as well as being a concern of the staff. The same demand (that I be a patient) was frequently made of me by other patients. I once defended my stance on the grounds that my time was limited but a patient dismissed this on the grounds that it was a "rationalization", a common pejorative description at Theta. The fact that my role was seen as deviant is further evidence of the exhaustiveness of the "therapist" and "patient" labels and I have described some of the incidents that seem to illustrate this below.

Having rejected the role of patient, I was the object of a certain amount of suspicion from both therapists and patients. This led

to my activities being circumscribed in various ways. I was required to attend on a fairly rigid schedule which I negotiated with the clinical supervisor. The schedule of my visits to the centre had always been a matter of some concern to the staff. The explanation that was given was that I "upset the patients". At one point I changed from coming on Wednesday afternoon to coming on Tuesday evening without much immediate comment. When, however, I arranged to come on a day that I was free over the Christmas holidays, not only was that irregularity a source of annoyance to the resident psychologist, but my previous change became evidence of my unpredictable habits of attendance. I was asked to renegotiate my schedule with the clinical supervisor.

My new schedule allowed me to attend at meetings of the whole group, formally constituted for the business of doing therapy. When I departed from this to come to a Monday lunch which I had been attending at the patients' request, I was again in hot water. I should only attend when the clinical supervisor was present.

I eventually negotiated a period of time during which I was allowed to attend full-time at Theta and at the end of this period was granted an extension. I was careful to be present during all the scheduled hours at first, but as time went on I found I was able to be more selective. My extension was granted with good grace and there were no more incidents about irregularity. It was still the case, however, that when I was leaving and casually mentioned that I still felt my time had been too limited, the clinical supervisor said once again that I should

have been a patient.

The role of observer is a very difficult one. Apart from minor incidents like not knowing if I was a "visitor" at an early meeting that I observed (it turned out that I was not) one never really knows quite what to do. There is considerable pressure to participate in the group process, not the least of which is to let people know that you are human. I have at least one doodle on a sheet that was drawn to show my neighbour that I *was* bored and human: "We learn from Horace Homer sometimes sleeps". [Byron: *Don Juan*]

The pressure to participate when someone is "working out" is enormous. It was felt immediately by new patients who invariably joined the group on the floor and made some gesture to show that they were involved. I frequently did the same. Another device that I used was to lean forward on a chair just above the group, resting my elbows on my knees. In general I participated as little as possible after some initial mistakes (see "Troubles" below) and was well-accepted by most patients who showed a very sympathetic understanding and tolerance of my position: "I know you can't be involved because that would affect the interaction". In fact my occasional lapses from the role were frequently challenged:

> "What are you doing now? You seem to be participating some of the time!" I said that I did participate somewhat in the families and in some things like the dance therapy. I would continue to participate as little as possible. I said I was involved and did feel many of the emotions that other people felt but believed that my role was not to participate any more than I could

> help. [Female Patient] said: "Okay, we'll just play it by ear".

I think that field note describes the stance I eventually adopted which allowed me several things. I participated enough to satisfy the institutional requirement that everyone must do so. I was, hopefully, reasonably unobtrusive and at the same time, indulged myself in a gratifying display of "I'm really human y'know".

Troubles

One of the early troubles I had was in overdoing my participation. On several occasions I got carried away with the certainty of my Laingian insights on Family night. On one particularly bad occasion I spent the evening making fairly wild speculative guesses in role playing with patients and visitors. This caused a considerable amount of dissatisfaction with both therapists and patients. The clinical supervisor told me that the patients had put me in a psychodrama and the patient chairman told me that the patients were upset with me. It was at this point that I was asked to come to Monday lunches so that the patients could get to know me and what I was doing.

A persistent trouble in a setting in which you are an identified observer is trying to explain what you are doing:

> A male patient sat beside me and after sitting in silence for some time, asked me what I was doing. I told him my M.A. thesis was in Sociology and talked obscurely about the social construction of reality in a way which didn't mean much to me and must surely have meant much less to him.

Apart from the irritating vagueness and unsatisfactory obscurity of such

talk, there is the pervasive idea that you are treating the people you are observing as things. On another occasion I noted:

> The next question that was brought up was - did I treat the patients at Theta as objects to be studied? I had to admit (after much hesitation) that I did. I tried to explain that as much as they treated me as "just sociologist", so much I treated them as "just objects". This did get some response eventually. By the end of the lunch I was getting quite a lot of support.

This explanation, in terms of "bad faith" was so successful (and, I hope, genuine on my part) that I regularly reproduced it whenever the question arose.

I made a point of being as straight-forward with patients as possible. I asked them whether they would allow me to read their diaries and sensing that it was a sensitive issue, said I would give them a week to think about it before I pressed them for an answer. I suspected at the time that there would be considerable resistance to this but in the event only two people refused me permission. In fact the two people who refused were confronted on their refusal by the other patients who seemed to see it as a part of their neurosis. I did not read the diaries I was refused and if I had been refused a significant number I would have been without some valuable information on "patterns".

A more serious trouble arose when I arranged to have my thesis advisor write a letter to assist me in expanding my period of observation. The letter was written in fairly strong terms as I was anxious to put pressure on the clinical supervisor because my time was rapidly running

out. The clinical supervisor was extremely angry and expressed his total dissatisfaction with the letter in the strongest terms. The issue came up on a day on which the staff's "feelings meeting" was scheduled and I got to attend my first one. I was invited to present a written interpretation of my advisor's letter there and then, which I did. The staff members' reaction to the letter was generally more moderate and after some discussion in which I found support from the clinical fellow, the matter was settled but there were a few moments when I thought I might be excluded entirely.

Another fairly serious incident involved a patient who left Theta prematurely. I had spent a few minutes talking to her before her final group. During the group meeting she was confronted by both patients and therapist on a matter unrelated to my conversation. She had already expressed misgivings about Theta in group (and to me) and after the group meeting she left the centre and did not return. In searching for a reason, the clinical supervisor said that I had provided a warrant for her leaving by giving her tacit support. The observer had "great influence". This incident was cited on several occasions as a reason for limiting my free access to the setting although the clinical supervisor eventually admitted that she might have left anyway and had discussed doing so.

Finally, during the early period of my attendance, an incident occurred which I was totally innocent of but which shook me at the time. During a group meeting a remark was made by the patient to my left which

was attributed to me by the therapists present. The therapists were sitting several seats to my right in a straight line. The remark was one in which I appeared to support a vocal and troublesome minority over an issue of what kind of therapy should be done. Despite my denials, I was confronted over this incident in the clinical supervisor's office. I presented my field notes for the evening which contained some evidence that there were other sources for the therapists' annoyance at me that night (I had stayed behind to watch a minor rebellion on the part of the patients when all the therapists left), the best I could get was a grudging admission that 'maybe he [the patient] was throwing his voice". I suddenly had some insight into what it must be like to be accused of witchcraft - there is no defence and any attempted defence is constituted as evidence of guilt.

Distrust

The kind of paranoid feeling that I had that night was some part of my early experience at Theta. Because my role was deviant and because I was there on sufferance, I frequently felt that I was being suspected of some activity that would result in my ejection. I think, however, that there may have been some distrust on the part of the staff as well, so with the serious intention that it may help some other observer to know he is not alone but with tongue slightly in cheek, I add this somewhat whimsical commentary.

Staff Distrust

The staff at Theta were perennially concerned with "what I was finding out". This was often explained as an attempt to understand my role. The staff was quite capable of deciding what parts of the Theta process I should be watching:[k] big group was "more interesting" for me, but apparently quite mystified as to what I was "doing". My field notes have fairly frequent references like the following:

> [Resident Psychologists] said again she was interested in what I was doing, wanted to hear me say what I was finding out: [Clinical Supervisor] too - I should give a talk.

All this was couched in terms of how valuable my comments would be to Theta. My problem was that I didn't think I had anything that was of value to Theta at the time and had only the most vacuous and esoteric details to talk about. I had no penetrating visions and certainly was not in the process of formulating an expose as the staff may have suspected. Of course my paucity of ideas made me evasive and compounded the problem. The possibility that this was distrust and not the disinterested curiosity it claimed to be may be supported by the fact that the clinical supervisor insisted that I give him written assurance that I would submit a draft of my thesis to him (which I readily agreed to do). He said he would add comments which should be included in the final document.

My Distrust

My distrust derived from what I saw as my very insecure role at the centre. As I said, I felt that I was there on sufferance. I was aware of the suspicion and mild antagonism of some of the staff members and realized that almost anything I did (or did not do) could be made a problem for the patients, the staff, or the institution. My being dismissed would have been highly consequential for me as I had a considerable amount of the time invested in the field work and had no alternative subject on which to write my thesis.

A number of incidents will illustrate some of the dimensions of the problem. In the incident reported above in which the patients decided to continue the group after being told to stop, I decided that I should continue to watch the group. The group continued for about twenty minutes during which time I was conscious of some misgivings that my decision would be interpreted as a sign of lack of neutrality or divided loyalty. When the therapists returned to break up the meeting once and for all, I was sure that the psychiatric nurse was unusually cool to me.

On another occasion I thought I detected some irritation from the resident psychologist when I gave her some information about immigration services that I had obtained for a female patient. Immediately after this she told me about an incident with a patient that I thought was significant. I recorded the whole event as follows:

> [Resident Psychologist] came up and I asked her to give a message to [Female Patient] about immigration information. She seemed mildly resistant to this. As we were about to leave and go downstairs, she told me that [Male Patient] had been discharged because it had been found out that he was having an affair with one of the other patients..... I wondered whether [Resident Psychologist] had told me all this because I had asked her to give a message to [Female Patient]. It was a rather unusual kind of conversation for [Resident Psychologist] who has been fairly formal with me so far. The other possibilities seemed to be that it was just a piece of gossip, or that [Resident Psychologist] told me by way of making some sort of gesture of welcome after my alienation of a couple of weeks ago.

This kind of feeling occupied me throughout my stay at Theta. It was not confined to therapists for I noted after giving a female patient a ride into town one day "[Female Patient] seemed somewhat cool to me after I drove her home - which may have been a kind of seduction and consequent betrayal of the group".

The worst incident occurred one day when I so far stepped out of my role as to offer to "push" with a male patient. He was having trouble expressing emotion and I thought he might be able to do something physical better. I had the idea that what he really wanted to do was to push everybody away and offered myself as a guinea-pig. We placed our arms on each other's shoulders and leaned against each other. He was very strong and pushed me around without any trouble. Not only that but he wanted to continue to push me around the room long after I had decided the activity was well past its termination point. Nobody interfered and I suddenly had the fantasy that no therapist would bail me out at all because

I deserved whatever was coming or some such. Actually my activity was praised after the group meeting and I was in no danger. Bit, in an atmosphere of uncertainty, distrust expands to dimensions far beyond its rational boundaries.

Observer as Deviant

In describing the observer as deviant I am appealing to a model of deviance along the lines of Becker's "outsider".[1]

> All social groups make rules and attempt, at some times and under some circumstances, to enforce them. Social rules define situations and the kinds of behaviour appropriate to them, specifying some actions as "right" and forbidding others as "wrong". When a rule is enforced, the person who is supposed to have broken it may be seen as a special kind of person, one who cannot be trusted to live by the rules agreed on by the group. He is regarded as an *outsider*.

I was explicitly recognized as " 'outside' John" by one patient writing in her diary and frequently as "observer John" which was a style of label that was unique in the setting. But my outsider status was more than just a nametag. On one of the first lunches that I was invited to so that I could explain my role, a contrast was made between me and one of the other occasional visitors to Theta who was a psychotherapist. The contrast turned on the fact that the psychotherapist was present as a helper, someone who was of value to the patients, while I was of no value to them. This question of my value came up on several separate occasions when I was being questioned by patients about my role and was an issue that I rarely heard raised in any other context (although it was occasionally raised at group interviews when a potential patient seemed to be unsuitable for admission).

Even when I was clearly recognized as a potential resource to some member of the group, it was usually the case that the member avoided taking advantage of that fact. One patient explicitly acknowledged my similarity to her father and wanted to "work on feelings about him". Despite this she chose a female patient to represent him in the ensuing role playing. I asked her afterwards why she didn't pick me and she said that she "didn't know she could do that".

It hardly seems necessary to say that my behaviour contrasted sharply with everybody else's in the setting. I was not usually expected to vote at Theta elections but was occasionally questioned about why I would not. The questioning itself was undoubtedly the best indicator of the deviant character of this refusal but on one occasion it was made the object of a joke. A patient in the "family" group which followed the election asked who she thought should work and said that she thought I should. She said I had refused to vote and she thought that that was part of my "problem". On another occasion a patient committee was making up a list of patients who "needed to work". After a long discussion in which almost everybody in the group was included in the list until it became completely unmanageable, I was added for light relief. This was clearly a joke and was the cause of considerable merriment among the members who decided that it was an excellent idea. When the "serious" business of writing out the formal version of the report was undertaken, my name was omitted.

When it came to my last day at Theta, I was invited to participate in the "goodbyes" ritual and was happy to do so. I went around the group and spoke to each person, telling them some of the things that I had wanted to say for some time. This was quite uncalculated and was of course a violation of the usual procedure in which each patient says a few words to the person who is leaving. Somebody said "he's doing it all wrong" but a second patient said "I know, but that's okay". I completed my round with tolerant resignation of the fact that everything I did there was unusual.

Becoming Accepted

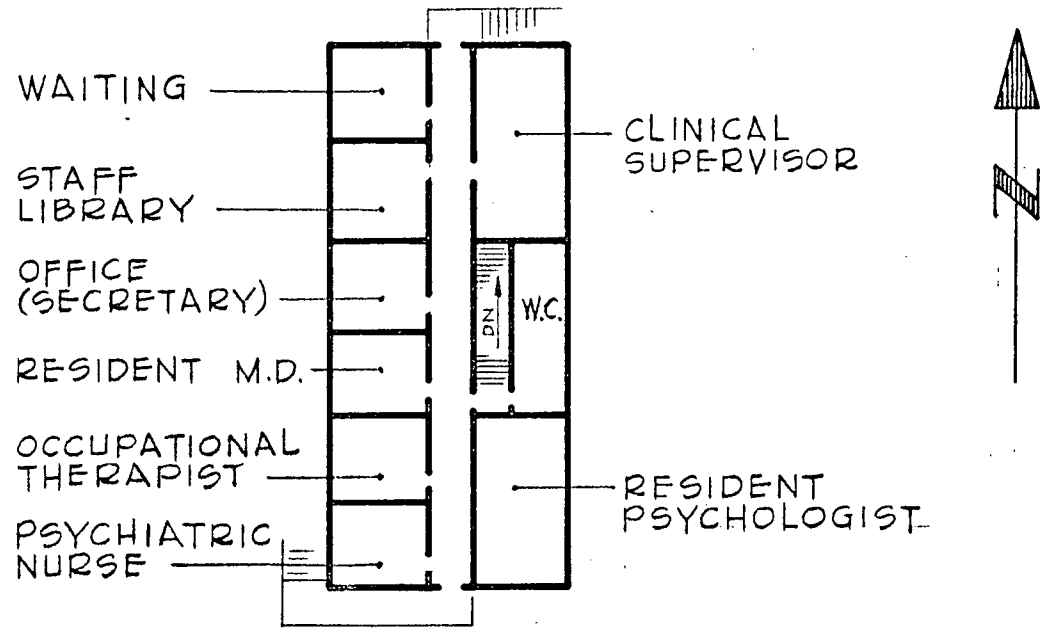
The sections above, while they contain references to the recognition of the deviant character of my role, show too the amount of acceptance that I had at Theta. In general the patients appeared to find me very little trouble which fact was explicitly acknowledged by the clinical supervisor towards the end of my stay. My introductions to new members contained references to me as "a trouble maker" in tones that clearly indicated that I was not and matter-of-fact phrases like "John...comes Tuesday nights and to lunch Mondays...sociologist with sociology department at [University]". These were accepted as adequate explanations of my presence in the setting on most occasions.

Despite my occasional troubles with the staff (and theirs with me) I was generally treated with consideration, friendliness and, eventually I believe, understanding tolerance of my "difficult role" as it was characterized by one therapist. I was allowed to stay at the Theta

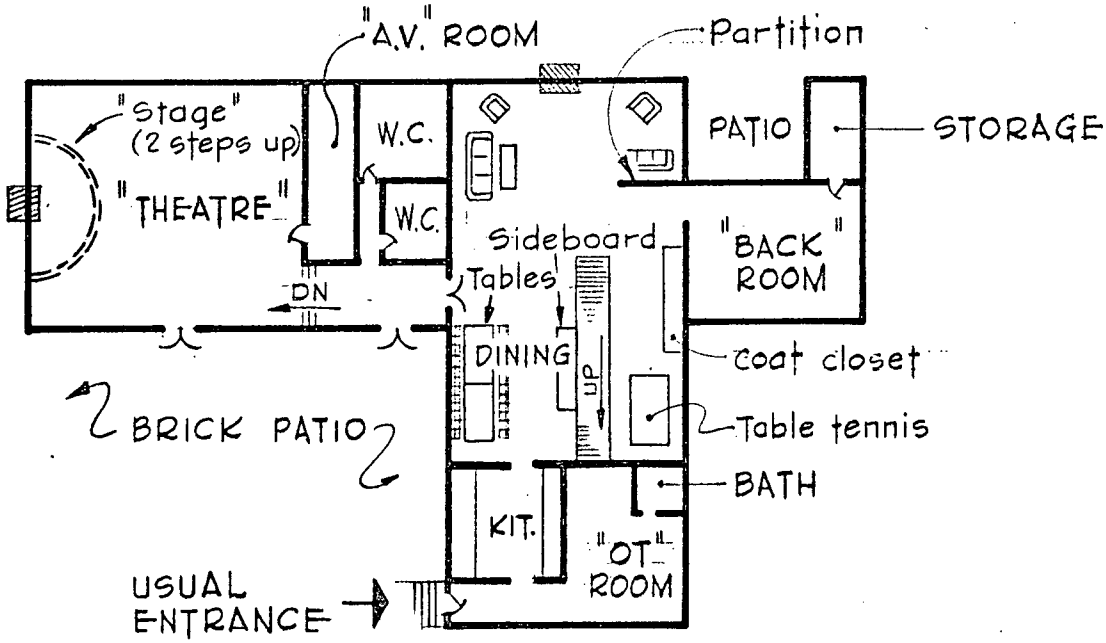
house after hours to listen to tapes of sessions and invited into the homes of staff members. I ended up with a considerable amount of empathy for the work that staff members were doing, with *their* "difficult role" that they put themselves in.

FOOTNOTES

1. Howard S. Becker, *Outsiders: Studies in the Sociology of Deviance*, New York, Free Press, 1966 [copyright 1963], p. 1.



SECOND FLOOR



MAIN FLOOR

FLOOR PLAN OF "THETA"

HEADINGS FOR SELF-DESCRIPTION FORM

1. Mental and Physical Health -- (for example, headaches, afraid to be alone, etc.) History of symptoms and treatments.

2. Personality Changes Desired -- What would you like to change about your personality? (for example, shyness, short-tempered).

3. Education and Work -- Describe your education; short history of work: Complaints about work situation (ability or interest to work).

4. Sexual Partners, Marriage, Children -- Short history of your dating and love relationships. Describe your present relationship (marriage) and any problems in it. Relationship with children. Short history of your sex life -- including complaints, worries, deficiencies, abnormalities.

5. Life Style -- What would an observer say about you and your household if he could observe you for one day? Friends? Sports? Usual week-end activities? Any harmful habits? (for example, eating problems or over-eating, lack of sleep, heavy smoking, drinking, prescribed and unprescribed drugs, etc.).

6. Philosophy of Life -- Religion and other beliefs about the world, mankind, community, sex relations, astrology, etc.

7. Family -- Briefly describe your childhood in terms of your relationships with your father, mother, brother(s), sister(s) and important others. What are the present relations?

8. Physical Health -- General health, past serious illnesses, surgery, injuries, pregnancies, abortions, menstrual difficulties, etc.

9. Hope -- What do you think has been causing your problems? What hope do you have that:
   (a) your mental health can be improved?
   (b) you can change your personality?
   (c) you can change your life situation?

APPENDIX IV

STANDARD QUESTIONS TO BE ASKED COLLECTIVELY OF PERSONS APPEARING BEFORE THE GROUP FOR ADMISSION

1. Are there any health or other physical problems that would limit you in any way from participating in fairly strenuous sports and swimming?

2. Do you have any commitments, appointments and the like that would fall in the next six weeks of your stay in the group?

3. Do you have or have you had a habitual use of any drugs or alcohol? If so are you prepared to completely abstain during your stay at Theta?

4. Are you prepared to return after six weeks for three successive Wednesdays for after-care?

5. Are you willing to make a sincere effort to encourage significant persons in your life to come on Tuesday evening to the group?

6. Do you understand that your commitment to the group allows for no exceptions, nothing holding back, no time off, that it is a <u>total</u> commitment?

7. Are you prepared to write an autobiography, starting out the first week for presentation as early as the Tuesday of your second week?

8. Are you aware that failure to follow the rules and neglect to contribute may result in probation and, if not corrected, discharge?

APPENDIX V

FOOTNOTES ADDED BY THE INSTITUTION

Introduction by the Author*

The footnotes which follow have been prepared by the clinical supervisor of Theta in accordance with an understanding which was developed during my observation period.

In order to ensure that the meaning of the document not be inadvertently altered, the footnotes of the clinical supervisor have been typed exactly as received except as follows:

1. The page numbers which referred to the draft have been altered so that the reference now pertains to the corresponding section or quotation in this final version.

2. Minor typographical errors have been corrected where the intended word was clearly apparent (for example "they" for "the"). These corrections have been indicated with square brackets.

Where the text of the final document differs from the draft, the fact of

* The footnotes begin on page 184.

this difference has been indicated. The original text to which the footnotes refer has been retained in the notes to preserve their complete sense.

I do not wish to comment extensively on the notes which must be judged on their own merits although I shall draw the reader's attention to a few points where I feel that the notes raise issues which, apart from not bearing directly on this document, appear to me to be errors of fact which it is necessary to correct.

That I do not address myself to the notes in detail should not be taken to indicate that I agree with all or any of the points raised. Many of the comments stem from the difference in perspective between myself writing as a sociologist and the clinical supervisor writing as a psychiatrist in a setting in which he is an interested participant. I am not, as the clinical supervisor appears to believe, totally ignorant of the psychiatric theories that "serve as legitimations for the institutional order"(quote from Berger, in text, p. 63). Most descriptions of psychiatric settings, however, buy into those theories and it was essential to my ethnographic account that I adopt an indifferent posture to that theory. The clinical supervisor's comments appear to indicate that I have been successful in at least that part of my enterprise.

To address the question of "systematic error of observation and interpretation", (as the clinical supervisor characterizes my ac-

count), It is up to the clinical supervisor to make his case. I can only assume that the notes are intended to do this. I leave it to the reader to judge the success or failure of the attempt. As I have said, I believe that some of the comments derive from our different perspectives; some appear to me to be simply differences of opinion about the *meaning* of observations. Some of the criticisms are, however, made of fragments of the document lifted out of context and do not appear to give the reader the proper sense of what was intended by the full ethnographic account. For example, the treatment of my description of the clinical supervisor's intervention in the patient-committee election appears to discount all the material on the emptiness of the elections. In fact, I would suggest that his failure to influence the elections was further evidence of my point. The quotation that follows appears also out of context. The text describes that the patients, once again, treated it as a ceremonial rather than an instrumental occasion, which reduces the significance of their decision-making in this matter. Without wishing to belabour the point, I underscore this particular example in order to stress the importance of considering the clinical supervisor's footnotes in relation to the total text in which they are embodied.

The last question which needs to be addressed derives from the several references to promises, agreements and contracts that have been allegedly broken. Without wishing to do more than correct what could be an erroneous impression created by the statements that are made by the clinical supervisor about these arrangements, I set out below the details of the communications, meetings and conversations which appear to

constitute the subject matter of this controversy. Ordinarily a matter of this kind would have no place in this document. I have chosen to report the details of this controversy, however, because a significant focus in the clinical supervisor's commentary which follows expresses a serious concern about the probity of my own conduct in fulfilling our agreement that he should have adequate opportunity to comment on the thesis.

My intiial approach to Theta was through my thesis advisor who wrote to the clinical supervisor and introduced me. I had a series of telephone conversations with the clinical supervisor in February and March, 1973, which resulted in my coming to Theta at his request on April 6, 1973, to observe a formally constituted group meeting. I spoke to him subsequent to that group and obtained his permission to attend once a week. I was unable to continue to attend the afternoon sessions during the summer of 1973 as I had a job and asked the staff if I could come to the evening sessions which they agreed to let me do. I subsequently talked to the clinical supervisor about this change although we had not had much contact over the early period as he was rarely present at the evening meetings.

At Christmas, I attended somewhat irregularly for a couple of weeks which, as is reported in the text, was a source of irritation to some staff members. Because of this I stopped attending altogether during January so that my schedule of observations could be renegotiated with the clinical supervisor. On February 4, 1974, my thesis advisor and

I met with the clinical supervisor with a view to arranging the schedule of my observations for the remainder of my observation period. My notes of that meeting record that:

> [Clinical Supervisor] suggested that I came in as a patient, suggested that this would be less disruptive. [Thesis Advisor] and I objected that process would or might become focused on me as a deviant patient but [Clinical Supervisor] was not impressed by this argument. He suggested that if I didn't want to come in as a patient my observations would be severely limited - to maybe two days a week.

The clinical supervisor said he would discuss the matter with the Theta staff. He made a reference to my thesis at that meeting and asked

> ...that the staff be given an opportunity to read the thesis - not to suppress anything but to make suggestions. I said I would look to him for help if there was time. He said time was a great trouble.

One of the reasons that I had requested that meeting was that I had accepted a job for the coming summer which was scheduled (at that time) to start in June. I had agreed to go to Africa with a company that I used to work for. Both my thesis advisor and I presented this as a reason for requesting a more intensive observation schedule, stressing that the time I had available to finish my MA was not much more limited than before.

In a subsequent telephone conversation the clinical supervisor said that I could attend Mondays, Wednesdays and Fridays and that other times might be arranged. During the next week the schedule of my attendance was hardened and I was variously requested to attend "only when the clinical supervisor was present" and "only during big-group

meetings". In a conversation at Theta on February 13, 1974, I asked once again for more observation time. The clinical supervisor said that they "would think about that", that I "had great influence" (on the patients at meetings). On February 15, I had another conversation with the clinical supervisor about attendance. My notes record:

> ...he said that I should wait until he talked about it. About 15 minures later he came down stairs and said: 2:30 Monday, lunch Wednesday, and 9 a.m. Friday. He said I had been present for many Monday lunches already.

I was still not satisfied with this and asked my thesis advisor to intercede on my behalf. He wrote a letter (dated February 19, 1974. See Appendix VI) requesting a more extensive schedule. I, myself, wrote a letter on the same issue (see Appendix VI). It was my thesis advisor's letter of February 19 that so angered the clinical supervisor that he asked me to jot down immediatley my thoughts about what I thought it meant. My attempted explanation is also included in Appendix VI. I read my explanation out at the staff meeting of February 22. After some discussion of this issue between myself and the staff members who were present at this meeting, the clinical supervisor agreed to allow me to supplement my then current observation schedule by attending full-time for my last ten days of observation. This period started on March 6, 1974 and ended on March 15, 1974. I attended a staff meeting on March 15 which I recorded as follows:

> I went to the "feelings" meeting and talked for a few minutes. I said that I was just beginning to get some ideas about the place and was very impressed. I talked a little about the conflicts that I had seen during the last week between the individuals and the group about people leaving. The people at the meeting seemed quite

> well disposed to me and [Clinical Supervisor] said that he had not made it any easier for me himself which I agreed with. I asked for a week's extension and [Clinical Supervisor] agreed to let me stay after checking with the others who agreed readily enough.

I attended full-time from March 8 to 22 which was the last day of my observations at Theta.

The issue of the staff seeing my thesis was raised rather casually at the meeting of February 4 and was raised again at a staff meeting on Februaly 11. My field notes for that date record the following:

> Went upstairs to [Clinical Supervisor]'s office. He started by asking me to give him written assurance that he would have a copy of my *draft* of my thesis - "in case it got forgotten what arrangement had been made". [Emphasis added]

The letter which my thesis advisor wrote on February 19 states:

> We sincerely welcome your suggestion that the first *draft* of his thesis be shown to you, and, indeed we would be eager to have you discuss it with your staff so that your collective reactions can be integrated with the final version. [Emphasis added]

As far as I know this is the only statement giving the "[promise] in writing" that is referred to in the clinical supervisor's text.

In the light of the reasonably cordial discussions that were taking place at that stage of my contact with the Theta staff, I fully expected that the staff would have some input into the final document. Of course they could have no input until they saw what the document looked like and it was certainly never my intention to spring a finalized version on them, as this would have frustrated the purpose of

their getting it in advance.

In accordance with my perception of the agreement between us, which I have documented above, I submitted a copy of the first draft to the clinical supervisor on June 14, 1974, the same day that I submitted it to my thesis committee for comment. As my time had by now become extremely pressing due to my rapidly approaching departure for Africa, I asked everyone concerned to give me their reaction to my draft as quickly as possible and scheduled a meeting with my committee on June 20.

The clinical supervisor wrote on June 17 to say that the draft was incomplete. There was no suggestion in this letter, included in Appendix VI, that he was surprised to receive a *draft*. I was away at the time and went to see him on June 21 to enquire about the missing parts of the draft I had given him. I showed him another copy of the last page of the document and he told me that his copy was in fact complete. The June 21 meeting was an extremely angry one in which the clinical supervisor said that my thesis had been unfair to the setting. I spoke with him again on the telephone on June 21 and realizing that he had considerable objections to the thesis, wrote him the letter dated June 23 which is also included in Appendix VI.

Despite the several pleas for discussion on the thesis contained in the letters cited above, there was no discussion between the clinical supervisor and myself. There was a discussion with another staff member which resulted in my making some changes in the document.

All the issues that had been drawn to my attention, I examined with considerable care. I had already introduced some modifications by the time of my letter of June 23 and indicated this in that letter. Some other issues were reported to me by the staff member and prompted further changes. Apart from some major revision of the introductory chapter, the changes referred to above are the only significant alterations of the original draft.

I believe that the above description details the relationship between myself and the institution in a way that will be of assistance in understanding the import of the matters in the notes about our "agreement". I believe I have lived up to the spirit as well as the letter of that agreement and that my doing so is documented in the above report.

July 4, 1974.

Notes of the Clinical Supervisor of "Theta" to the thesis of Mr. J. Brown. "Creating the Therapeutic Reality. A Phenomenological Account of an Outpatient Therapeutic Community". [Title of first draft]

1. Introduction.
2. Specific Comments.
3. Methodological Remarks.
4. Notes on the Theory of Therapeutic Community.
5. Background Information.

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1. INTRODUCTION

In February, Mr. J. Brown promised in writing that I, the Clinical Supervisor of "Theta", would receive the text of his thesis in order that I would have an opportunity to write my comments, which would be part of the thesis as footnotes. I did not hear from him until June 14, 1974, although, according to his words in February, our staff expected to hear from him much earlier. As late as June 14, 1974, he sent me the first draft of his thesis. I asked to write my notes to his final thesis, according to our agreement, but he explained that I would not have an opportunity to write my comments to the final thesis, as the defence would be on July 4, 1974, and that the final thesis would be typed on July 3, 1974. Later he informed me that the defence would be on July 9, 1974 and that "Your footnotes will be included in the final bound copy of the thesis regardless of when they are submitted. If they are avail-

able by approximately July 5, they can be included in the final form before defence..." (letter of Mr. Brown to the Clinical Supervisor of June 23, 1974).

Although I feel that the promise of Mr. Brown, made in February, has not been kept, I am writing these notes to the "First Draft" not knowing, of course, what changes Mr. Brown will make in his final thesis as a result of discussions with myself and members of "Theta" staff, or otherwise. I offered to take into account any changes he will make in the text, and that I should receive these in writing before starting to write my notes (beginning of July), but to date I have not received any of this information. Mr. Brown promised that these notes would be included, disregarding any changes he may make in his final version.

In writing these notes, I am, of course, not concerned with the evaluation of the thesis. My only concern, and I was asked to do this by the staff of "Theta", is to correct the misinformation about various aspects of "Theta", given by the author, and comment on the source of systematic error of observation and interpretation of "Theta". I will not, therefore, deal with the parts which correctly describe the institution - and I agree that there are such parts.

These notes are written in a hurry as I am extremely busy with a task of great importance for the Department. The "Specific Comments" are only a random selection of incorrect observations and unwar-

ranted generalizations and can be extended in future.

****

2. SPECIFIC COMMENTS

a [p. 28]: "Any visitor then, who could be constituted as a therapist, was received at "Theta" without challenge. In contrast to this I was frequently challenged by new patients."

Incorrect generalization: It was not only the difference o[f] roles. Mr. Brown does not see the difference in behaviour of a knowledgeable visiting psychotherapist and his. At one time, when he made remarks and gave advice, incompatible with psychotherapeutic strategy, one visiting psychiatrist remarked after the session: "What is the amateur psychotherapist doing here?" (Mr. Brown admits once - [p. 160]: "On one particularly bad occasion I spent the evening making fairly wild speculative guesses in role playing with patients and visitors". However, he is not aware to what degree his comments and behaviour ran contrary to the therapeutic strategy of the Centre). At other times, M.D. visitors, without knowledge of psychotherapy, were challenged by patients.

b [p. 31]: (Secretary) "She decided to go through "Theta" as a patient so that she could more readily identify with the patients and, presumably, have some status as an ex-patient."

Not correct. Mr. Brown distorts to prove his point. The secretary decided to become a patient, only after she decided to finish

her job and go to study. Her decision was motivated by her problems, for which she sought psychiatric help outside "Theta".

c [p. 54]: "There was considerable amusement among the Theta group at having caught the hospital in this shortcoming."

Again, Mr. Brown distorts to prove his point. The amusement was in regard to one lady in the hospital only, and the "hospital" had a similar attitude towards her as we did. Are distorted gossips [*sic*] part of "phenomenological method"? [The reference is to the introduction to the draft which has been extensively rewritten. "Ethnographic" could be substituted for "phenomenological" without loss of meaning in this case.]

d [p. 112]: "In general the patients made almost no decisions about anything..."

Incorrect. It is a pity Mr. Brown deals so superficially with the intricate problem problem [*sic*] of power distribution, where a knowledgeable sociologist could be of help. Instead of using our massive material studying this question, I will mention his own statements <u>contradicting</u> his general statement:

[p. 90]

a. "Halfway through the elections the Clinical Supervisor interrupted to say that the work coordinator should be competent. Some votes now

went to [Male Patient], but the group insisted on having its own candidate [Female Patient] self-confessed incompetent. Despite the attempt of the Clinical Supervisor to influence the process, the group attended to its own priorities in selecting a patient to fill the [r]ole."

b. One of the most serious decisions of the Centre, admitting a patient, is a group decision. [P. 81]:

"The patient was admitted on a simple majority of the group members, former group members and therapists....."

c. It is true that the therapist uses his influences, as in instances where not all means have been exhausted and the group wants to discharge the patient.

d. Although the staff is <u>against</u> the patients meeting outside the group, no strict rule is included in the rules.

e. Despite what Mr. Brown says, the patient having a function is apprehensive [*sic*] and has an opportunity to be [p. 35] "power tripping", "pushy", "aggressive".

e [p. 109]: "The reaction of the institution to sexual relations among its patient population was extremely difficult to understand. The explanations that were given in the centre were either no explanation at

all: "it damages the therapy", "it interferes with the treatment", or were "shot through with inconsistencies". And [p. 110]: "Why the relationships which originated at Theta were so severely censored is thus a puzzle which it seems only possible to explain in terms of control". [The final version of this quotation has been somewhat changed.]

Mr. Brown did not bother to ask. Here only main reason will be given. [*sic*] No patients who are in a relationship of important dependency (husband-wife, boss-employee, two co-workers) are admitted at the same time. Sexual (or love) relationship deprives the persons of flexibility for changing their behaviour; it is difficult for them to be completely open and they support themselves in their resistance. Such a love relationship is usually a symptom of resistance, "flight into love". (The mentioned patient discharged, lied for several weeks.) Experimentation in the past led to this practice; often, the other partner was admitted later. (The relationship normally turned out to be a traumatic one.) This arrangement may be given up one day, if new knowledge and techniques will allow us to deal with the complex problems, which such a re[la]tionship causes.

f [p. 33]: Mr. Brown summarizes that the work "does not reflect real life".* It reflects real life to the degree necessary for therapy, that is, showing some typical problems of behaviour (see [p. 92-93]). It is

* In this case it seems necessary to point out that the text has *not* been changed since the draft. The reader should note that the quotation cited should not have been attributed to me but was a report of an apparent consensus among patients. JB

true, however, that a 24-hour therapeutic community gives more opportunities in that respect.

g [p. 71]: "It is an interesting sociological fact that every candidate for admission is able to produce some subset which he sees relevant for this task [which he sees to be relevant to his self formulation as somebody who needs help] and that the staff member also treats whatever list is produced as relevant to the question that has been asked." [Amended in final version; see text.]

Equivalent statement [*sic*] would be about a grocery: "It is an interesting sociological fact that every shopper produces a set of demands and the store owner treats also whatever list is produced as relevant to the question "What can I do for you?"

But how [does] Mr. Brown [explain] the fact known to him that some patients are sent away from these interviews? He also missed that [the] psychiatric interview checks the consistency of statements with non-verbal behaviour and that the group interview is a further step in this checking. On [p. 73] he says again: "One feature of the process which is evident is that the staff member treats the self-description as a true account of the events of the patient's life."

Is this the "phenomenological analysis" [p.] "an essential

facticity which it does not make sense to question"? [The introduction to the draft contained references to phenomenological analysis which were removed in the final document.] Mr. Brown simply does not know anything about psychiatric interview [*sic*] (though he was once present) and continuous checking in a therapeutic community. Although mistakes cannot be excluded, they are highly unlikely. Here, something essential escaped Mr. Brown.

h [p. 47]: "Theta was seen as a place in which the traditional moral judgments are suspended. It was not so much a matter that they were indifferent to these descriptions but of the certainty that anybody's moral decisions were his own business and had nothing to do with therapy." [This has been amended in the final document although the sense has been preserved. See pp. 47-48.]

This is a wrong observation and conclusion. Not only that moral decisions have to do with therapy [*sic*], neurotic breakdown is often caused by chronic moral conflict. However, the group does not use the usual means to help the patient in his moral conflict - that is, by reproach, advice and persuasion, as they proved mostly inefficient in his previous life. Instead, the treatment is designed to modify his motivational network, so that he is able to make a decision.

i [p. 73]: "This problem list subsequently becomes an institutional artifact and is used to demonstrate the progress the patient is making in the institution." [This has been slightly amended in the final version.]

This courageous statement is based on specific use of the problem list, where a patient himself was questioned about not making progress on a problem list. But Mr. Brown, in one sentence, judges extensive work of the last years about problem oriented record [*sic*], which is now a routine part of the work in many branches of medicine, including psychiatry.

j [p. 133]: "That someone was "homosexual" was taken to be an adequate reason for his coming to Theta without any further explanation and it was always available as a possible category that could be invoked to explain feelings and behaviour, even though the patient did not himself evoke it." [This quotation has been slightly amended in the final version.]

The first statement is simply not true and is a not uncommon example of Mr. Brown's careless statements. We went through all problem lists of homosexual patients and they all suffered from neurotic symptoms and problems, such as depression, hopelessness, forfeiting uncertainty about sexual orientation, etc. Why would a happy homosexual ask admission to the demanding treatment of Theta?

The other half of the sentence is a vague generalization, which cannot be answered.

k [p. 164]: "The staff of Theta were perenially concerned with "what I was finding ou[t]". The staff was quite capable of deciding what parts of

the Theta process I should be watching....."

The sarcasm is unwarranted. Mr. Brown became a burden for Theta and we did not interrupt his stay out of charity. He evidently interprets, in his idiosyncratic way, the tactful remarks of therapists relating to which parts of the programme he would be least harmful.[*sic*]

He also misinterprets our concern with his findings. He should know that we asked every guest about his observations even if he visited only once. I asked each staff member in each staff meeting following the group session routinely about observations and personal feelings.

I could go on and on with remarks to Mr. Brown, but Mr. Brown does not give us sufficient time and I am too busy. Also, it would save time to read first a textbook of psychotherapy.

Mr. Brown looked into a complex factory through a keyhole and made hasty conclusions about everything. However, he is not even aware of it.

3. METHODOLOGICAL REMARKS

Let us imagine a student of sociology who wants to study the organization of a surgical ward, but who knows very little about anatomy, physiology, and antisepsis. As he studies a task group, he cannot under-

stand this behaviour unless he has either extensive information of the fields of knowledge in question, or unless he asks them why they are behaving in certain ways. He may also, and probably will, find some discrepancies between what they intend to do, and what they do, which may be of general interest. If, however, he neither has the necessary knowledge, nor for reasons of his own does not ask them, it would be hopeless to explain their acts (based on their knowledge and beliefs) observing their behaviour for a short time. He may obtain quite a false picture as to what is going on. For example, he may interpret their behaviour, such as not touching certain objects, going through stereotype sequences of movement - as their phobias and ritualistic behaviour. He may interpret restrictions put upon his behaviour by the team, e.g. that he is not allowed to touch certain objects which they do - as unfriendliness towards him. The same observer may study the behaviour of hunters of an African tribe and interpret their behaviour as superstitious and compulsively repetitive, only because he does not know enough about animal life and technology of tools and weapons.

It may be debatable where psychotherapy stands on the continuum of systematic knowledge between the two human organizations mentioned. Whatever the case may be the tasks of Theta are approached with the help of a conceptual framework which has its basic views broadly accepted in the field of psychiatry. I introduced, of course, the example of surgery, since psychotherapy has less prestige than surgery and the absurdity of the situation is more obvious, but it is not less absurd in the case of Theta.

The remarks just made would be irrelevant, if it were true what Mr. J. Brown writes at the beginning of his thesis characterizing his stance as a phenomenological one. He describes it [by] means of a quotation of P. Berger that phenomenological analysis "refrains from any causal or genetic hypothesis....." and says further, "That is, I describe a commonsense reality without making any judgments about members' understandings as being right or wrong but (provided I have been successful in discerning them), as, for members, an essential facticity which it does not make sense to question".* Leaving aside the question whether this methodological "stance" is a sound one, it can be shown that Mr. Brown does not keep to his promise and makes daring generalizations and interpretations, and not knowing the theory underlying the activities of Theta (and, as he mentioned in a discussion with me, even programmatically not being interested in it, nonetheless, in fact, substituting it with a commonsense view) misinterprets the activities of Theta and the behaviour of the staff, even diagnosing them psychiatrically ("paranoia")**. There is a close parallel to the imagined example of a

* The quotations are taken from the introduction to the original draft. JB

** The word "paranoia" has been eliminated in the final version. My original use of the word was not intended to be a psychiatric diagnosis but a members' categorization. I attempted to disavow the psychiatric implications of "paranoia", arguing that the word was in common use by members, but eventually recognized that the inescapable psychiatric roots of the word made its retention inadvisable. It has been replaced with "mistrust" which is not intended as a synonym. See, pp. 163-165. JB

surgical ward, as this and other misinterpretations are caused by Mr. Brown's not having even an elementary knowledge of the theory.

4. NOTES ON THE THEORY OF THERAPEUTIC COMMUNITY

I am not going to, of course, develop here the theory of group psychotherapy in general and of therapeutic communities in particular. I will deal only with the minimum for present purposes.

One of the cornerstones of modern psychotherapy broadly accepted by psychotherapists of different orientations (not only psychoanalysts), is Freud's discovery of resistance. The patient is divided in his motivation: in his treatment he co-operates in order to get better, but at the same time, with changing intensity, he tries to keep status quo of his neurosis. As Menninger says (Menninger, K.A., Holzman, P.S., Theory of Psychoanalytic Technique, Basic Books, 1973): ".....every patient, in spite of his co-operativeness and eagerness to do whatever he is told in order to "get better", is at the same time partially "on the defensive". He unintentionally but purposely, obstructs the very process upon which he counts so heavily to benefit him. He may obstruct it so effectively as to "terminate it soon after it has begun." Freud compared individual treatment to a battle where on one side of the line is the therapist and the reasonable part of the patient, and on the other is the resisting part of the patient. The conflict is only the reflection of the inner neurotic conflict of the patient. Far from being only a nuisance, the manifestation of resistance is unavoidable in treatment and its

handling is an essential part of the treatment.

This holds also for [the] therapeutic community, only the handling of resistances is more difficult, as the patients in periods of increased resistance form coalitions. The mentioned picture of a battle in individual psychotherapy holds for [the] therapeutic community also, where each patient is partly [an] ally of the therapists in achieving therapeutic goals, partly contributing to the group resistance (both his alliance and resistance fluctuating in time). The difficult and challenging task of the therapists is to handle the individual, subgroup and group resistances. This they try to do using the patients as co-therapists. The more the patients take responsibility for the treatment, the more efficient [the] treatment can be. The more they are able to do it through the patients themselves, the better. However, the patients are unreliable allies, because of their fluctuating resistances. From time to time, they try to drive a wedge between the therapists. It is almost inevitable that they succeed with a psychotherapist-beginner. Under these circumstances, a high degree of unity of therapists is necessary, strengthened by staff meetings where not only the observations of staff members, but also their emotional reactions are discussed and channelized.

5. BACKGROUND INFORMATION

Even from this short description it should be apparent that there is no place in the system for a long-time observer, unless he

takes either a therapist's or a patient's role (at least at the present stage of knowledge). Otherwise, he becomes a nuisance like a neutral person walking in the battlefield, where one side has taken into consideration his presence and the other misuses it. This happened already during the half year when Mr. Brown attended once a week only. Without any knowledge of psychotherapeutic strategy, he "played therapist" from time to time, so that one visiting psychiatrist asked after one session in surprise, "What is the amateur therapist doing here?" Several therapists (not only one, as he thinks) found his behaviour disturbing, and not only on one occasion which he is aware of.

When, in February, Mr. Brown asked to be present for longer times he was given, in the presence of the Supervisor, a choice of staying for 4 - 6 weeks in the role of a patient (what we have done in the past with new staff members for training purposes), or to be in Theta for a whole week as an observer and continue coming once a week for the rest.* Both he and his supervisor accepted the second alternative; I promised I would discuss with the staff possible extension. However, in our meeting we decided against extension,** as Mr. Brown's presence had been, even so far, an additional burden for the already overworked staff, and his stay for longer than one week was expected to lead to

* The details of the negotiations have been recorded in my introduction to this appendix. The schedule of my attendance is shown in Appendix VI. JB

** Actually, as recorded in my introduction to this appendix, I was granted an extension at the end of my first ten days of full-time observation. JB

further complications (time for patients to develop transference reactions to him, etc., which could not be analysed. So the principle of closed system in which the causal chains of interaction can be analysed (and which Mr. Brown erroneously thinks was discarded) would be seriously violated.

In the next days after the agreement, Mr. Brown put pressure through his supervisor to change the agreement (February 19, 1974): "I do not believe that John would give me a distorted version of his experience and from what he reports, it is hard for me to understand why there should be so much fuss. As you know, he will be in (Theta) for another month or so.....".

It is unfair that Mr. Brown quotes me as saying that the letter is "outrageous" without quoting this letter.* We were "making a fuss" about letting Mr. Brown stay for a month, because we would not let <u>any</u> observer who did not have an extensive knowledge of psychotherapy stay for a month. This complete lack of understanding led Mr. Brown to a systematically biased observation and he jumped to unwarranted conclusions. He never tried to understand the theory and beliefs of the staff, and as a result, he misinterpreted the staff's behaviour as "paranoia" [p. 164].** "I think, however, that there may have been some paranoia on the part of the staff as well....the fact that this was

* In view of this objection and the relevance of this correspondence to my introductory remarks to this commentary, the letter is included in Appendix VI. JB

** Again, the reader is reminded of the change in the final text from "paranoia" to the less ambiguous members' word "distrust". JB

paranoia and not the disinterested curiosity it claimed to be may be supported by the fact that the Clinical Supervisor insisted that I give him written assurance that I would submit a draft of my thesis to him.... He said he would add comments which should be included in the final document." (Mr. Brown's distortion: "draft" - instead of "thesis".)

That this was a realistic assessment and not paranoia is apparent from the fact that although this was my only condition for his stay in Theta, he has not given me his final thesis for comment to date. (As our contract was that my comments would be included in the final thesis [p. 164], I did not expect, of course, to write them to a draft, but rather to the final thesis.)

Although Mr. Brown regards us as paranoid, we freely opened our Institution, including informal staff meetings, to his observations. He even had an opportunity (in the role of a patient) to observe it uninterrupted for four to six weeks. We doubt very much whether another department, including the Department of Sociology, would allow the admission of a student to their informal staff meetings. But we may try this in the future, and ask for permission for a student of medicine to conduct a psychological study.

APPENDIX VI

SCHEDULE OF ATTENDANCE AT THETA

1973	April	6, 13, 27
	May	4, 9
	June	13, 26
	July	10, 16, 18, 24, 31
	August	7, 14
	October	2, 9, 23, 30
	November	6, 8 [First lunch attended], 13, 19, 20, 26 [Lunch], 27
	December	17 [Lunch], 18, 27
1974	February	11, 13, 15, 18, 20, 22, 25, 27
	March	4, 6, 7, 8; 11 through 15; 18 through 22.

[First draft of thesis submitted June 14, 1974.]

February 19, 1974

Dear Dr.

In accordance with your request, I attach a further copy of the current working draft synopsis of my M.A. thesis focus. This is identical with the copy given to you on February 1, 1974.

This document was discussed at the meeting of February 4, 1974 with yourself and , my advisor from the Department of Sociology. At that meeting I elaborated on my request to you to attend at to make further observations of the institution for the purpose of obtaining information for my thesis. In a subsequent telephone conversation with you on February 4 you advised me that you had discussed this matter with the staff and that it would be permissible for me to attend at on Monday, Wednesday and Friday and that other times might be negotiated. This has subsequently been further refined so that the present agreed times are Monday, 2:30 - 4:00 p.m., Wednesday 12:00 noon - 4:00 p.m. and Friday, 9:00 - 11:00 a.m. You also indicated that during my last week I could be at throughout the week.

I certainly wish to express my appreciation for whatever times you can see fit to allow me to attend. I believe it would be helpful if I set out what activities I would be interested in at times of the day other than the formally constituted group meetings.

The culture of the setting, the ways in which patients view and view what is appropriate behaviour in the setting are problematic for the new arrival. I am interested in learning how new patients become acculturated to this setting. I am interested in learning what the patients view as the "facts" about therapy and . It is not my task (or my intention) to demonstrate that they have the "facts" wrong, that they don't understand, have been misled or should have known better, but rather to discover the prevailing

...../2/...

.....Dr.

common sense understandings that determine the behaviour patients view as appropriate in the setting; i.e. that allow them to behave rationally in the setting.

In order to do this it would be of great assistance if I could be around at times, such as lunch hours and work periods, autobiographies and psychodrama preparation, committee meetings and the rest when the patients are freely expressing their opinions about, and organizing, their affairs.

I have discussed this matter at length with my committee before presenting you with this letter and Dr. has decided to write a separate letter to you, setting out his concerns in the matter.

If, after another week or so, you can see your way to discussing this matter further, I shall be happy to set out once again, a detailed schedule of whatever revised times you can allow me to be present in the setting.

Yours sincerely,

John Brown

February 19.1974

Dear Dr.

After our conversation in your home, I was hopeful that the Sociology graduate student --John Brown-- would be granted a little more access to observing your programme than seems to be the case. I fully appreciate the reasons for the hesitation expressed by at least one member of your staff, but I also feel that any feelings of reserve or apprehension should be weighed against the possible value of John's study to what you are seeking to accomplish at ... I do not believe that John would give me a distorted version of his experience of his impact upon what goes on at the Centre, and from what he reports, it is hard for me to understand why there should be so much fuss. As you know, he will only be at for another month or so, and, therefore, to those who may regard his presence as something of an irritation, they can take relief in the thought that he will only be there for a relatively short while.

Apart from these expressions of my own petulance, John and I are actually very grateful for whatever time you allow him to spend at the Centre. The concern for more observational time is tied to the problem of knowing what to make of observations taken in one context, which may can be reported differently when they are made in other settings where the interactional peculiarities are not the same. In addition, there is the problem of seeing as much as can be seen when there is only a month in which to carry on these observations.

I gather that a major problem is that some of your staff are disturbed by the fact that they are not entirely sure just when John will arrive on the scene, and that this, indeed, can be disruptive. May I suggest the following:

1- In the first week to ten days, John follow a precise schedulex(e.g., the one already proposed by you), and that during this time he attempt to develop firm ideas about what other events or settings he should be observing.

2- In the second and third weeks, he add to the observational sites and times of the first week, the further hours that he has been able todetermine that he should be at; thus, providing the staff with another precise schedule for this period, so that they are

not greeted with any unwelcome surprises.

3- That John adopt your tentative suggestion that he devote the last week of his observations to a complete daily cycle, and that he adhere faithfully to this schedule so that your staff will not then be disrupted by any unanticipated absences on John's part.

If you can agree to this sort of schedule, I believe that it will be possible for John to see enough to make an intelligent commentary on what he observes. We sincerely welcome your suggestion that the first draft of his thesis be shown to you, and, indeed, we would be eager to have you discuss it with your staff so that your collective reactions can be integrated with the final version.

Again, I am hopeful that you will find some way to accommodate John's needs so that he has a decent chance to produce something worthwhile.

From: J. Brown COPY February 22, 1974

To: Dr

Letter of Feb. 19: Request for Written Comment

Dr 's letter was written as a reaction to my own concerns about the very structured schedule of observations that had been imposed on the observations of the setting. I had expressed my concern that the only facets of that I would see were the formally constituted group meetings.

I cannot, of course, provide an interpretation of Dr. 's total perspective, which derives from his whole biography and experience with therapeutic groups. His use of the word "fuss", while it may be unfortunate, can only be understood in the total context of the letter, which I take to be an expression of his own concern that my perspective would be distorted and a plea for some reconsideration on your part. He does identify it as an "expression of (his) own petulance" and, I believe, an attempt to state his case as directly and forcefully as he thought appropriate.

I strongly urge you to talk to Dr himself, with or without my being in attendance, if you wish to have the matters he descussed explicated further. This is particularly so as I have considerable hesitation in commenting on his letter to you in his absence

John Brown.

June 13, 1974.

Dear Dr.

In accordance with our agreement, I enclose for your information one copy of the first draft of my M.A. thesis. This copy is delivered to you at the same time it is submitted to my committee.

As I understand you may wish to make comments which should be included in the final document in the form of foot notes, I would like to advise you that my committee has kindly agreed to have a meeting on this draft in about one week. The reason for the haste is, of course, my imminent departure for Africa and the fact that I am hoping to have a final draft finished before I leave. I am sure you will understand the need for any response you wish to make being submitted as soon as possible.

I shall be happy to discuss any point that you wish to make and would value your observations whether you wish them included or not. If you do wish to have any part footnoted, I would appreciate it if you would send me this copy marked up via and I shall make the necessary adjustments to the original.

Yours sincerely,

John Brown.

JB:jw

June 17, 1974

Dr. John Brown,

Dear John:

Thank you for your draft of your manuscript received June 14th. I received 142 pages which does not seem to be the entire manuscript. That is why I called Dr. , since according to your statement, both and I expected to receive the manuscript earlier.

According to our agreement, I do want to make comments included in the footnotes. However, I am extremely busy organising an , and I do not see any point in spending my time writing comments to a draft which can be changed. As soon as you provide me with a final version, I will write my comments. I expect, of course, reasonable time in which to do that. You may, of course, have comments to my comments.

If you have any questions or comments please call me, either at the office ( ) or at home ( ).

Yours sincerely,

* Meeting June 21 advised after reading last page that he had received whole document.

June 23, 1974

Dear Dr. :

Further to our telephone conversation of June 22, 1974, and your request for written assurance on several points arising from that conversation, I wish to advise you as follows.

I shall make every effort to have your comments included as part of the permanent document at the time my thesis is presented for defense. I should point out that we have revised the date of the defense to July 9 so as to give you as much time as possible to prepare your comments. As I am currently scheduled to leave for Africa on July 10, you will see that this is the latest date that I can accomodate.

Your footnotes will be included in the final bound copy of the thesis regardless of when they are submitted. If they are available by approximately July 5, they can be included in final form before the defense. If, however, they are not finished until after that date, it may be necessary to mark up the superscript letters in ink on the defense copies. Every person who attends will be given a copy of your notes.

I wish to confirm that I do not currently expect to publish the thesis outside the university in its current form. The question of what kind of publication might develop from this work has not arisen as yet. I am quite prepared to discuss any paper or work with you should the occasion ever arise, or to correspond with you about it if I am not in at the time.

I am attempting to have the final version of my thesis available by July 6 or 7. This would include your footnotes and allows two days for their insertion. This date allows approximately one week for typing and reproduction which means that my target date for having the revisions complete is June 28 or 29. As I have already pointed out, I do not expect this version to be radically different from the current version. I would like at this point to make a plea for some more constructive communication between us. If you have strong objections to some parts of the document, as you clearly have, I would urge you very strongly to consider discussing them with me or perhaps having a meeting

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which could include several members of your staff and some members of my committee. I have already examined the points that you have raised so far and find your objections to the penultimate sentence on page 140 (for example) to be well-founded. I believe the sentence is cast in an unfortunately strong form and have modified it accordingly.

Your last point concerned my report of your categorization of one sentence of Dr. 's letter about my attendance as "outrageous". I have examined the passage and am quite prepared to rewrite it so that it is less objectionable to you. In this regard, I understand you will make available a copy of the letter and I would appreciate it if this could be done as soon as possible. Once again, I believe that a reasoned discussion of points of this kind could eliminate a lot of the friction between us.

You have said that my report of the above incident is a total distortion of the facts, which at the very least indicates that there is a strong difference of opinion about the incident which (without attempting to deny its importance to you) is a relatively minor one in terms of my total document. It would be most unfortunate if matters such as this that can be discussed and possibly corrected should become instances of acrimonious discussion in the text, discussion which, moreover, is bound to lead to interpretations by readers whose particular bias may lead them to unwarranted conclusions about the motives behind the discussion. I believe that this kind of controversy can do more harm than good by drawing unnecessary attention to matters that might otherwise be received indifferently by readers who had not been involved in the issue.

On the matter of my making "psychiatric interpretations about the staff members" which, you indicated, referred to the matter of "paranoia", I have consciously striven to avoid psychiatric interpretations throughout the document. I can appreciate your objection and concern about the definitive use of the word paranoia, which has inescapable psychiatric roots. I shall add the necessary qualifications to the section to make it clear that I intend the word in its lay sense.

Finally on the issue of anonymity, I recognize that this is a serious problem. I have been extremely careful to avoid any reference to , or indeed any geographical location in the text. No name appears in any part of the document; even a local theatre which could have been identified has been characterized as "(Theatre").

If you can make any suggestion that further protects the anonymity of the setting I would certainly appreciate your advice.

I hope that this letter conveys to you my readiness to hear and

consider your opinions on parts of my MA dissertation that you consider to be controversial. I have no wish for it to become a point of confrontation between yourself and the Sociology Department and believe that this can be avoided by the suggestions I have made. My committee has asked me to tell you that they welcome Dr. 's attendance at the defense, and that a formal invitation would have been sent to you as soon as the date was finalized.

Yours sincerely,

John Brown

JB/wc

July 4, 1974

Mr. John Brown,

Dear Mr. Brown:

I am sending my Comments which according to your promise will be included in your thesis before defence.

I am also expecting, according to your promise,to have a final text of your thesis before the defence.

I waited until July 3, 1974 for either your final version or for written changes in places which I told you were distorted. Since, however, I have not received them I have to insist that my notes are published in the thesis disregarding changes you make in the final version, which you also promised me.

Yours sincerely,

BIBLIOGRAPHY

Becker, Howard S. *Outsiders: Studies in the Sociology of Deviance.* New York, Free Press, 1966 [copyright 1963].

Becker, Howard S. and Blanche Geer. "Participant Observation: The Analysis of Qualitative Field Data". *Human Organization Research.* ed. R. N. Adams and J. J. Preiss. Homewood, Ill., Dorsey Press, 1960.

Berger, Peter L. and Thomas Luckmann. *The Social Construction of Reality,* New York, Doubleday (Anchor Books) 1967 [copyright 1966].

Cavan, Sherri. *Liquor License. An Ethnography of Bar Behavior.* Chicago, Aldine, 1966.

Conklin, Harold C. "Ethnography". *International Encyclopedia of the Social Sciences.* ed. David L. Sills. The Macmillan Co. and Free Press, 1968, Vol. 5.

Garfinkel, Harold. *Studies in Ethnomethodology.* New Jersey, Prentice Hall, 1967.

Goffman, Erving. *The Presentation of Self in Everyday Life.* New York, Doubleday (Anchor Books) 1959.

Goffman, Erving. *Asylums.* Garden City, N. Y., Doubleday (Anchor Books), 1961.

Janov, Arthur. *The Primal Scream.* New York, Dell (Delta Books), 1970.
The Anatomy of Mental Illness. New York, Berkley (Medallion), 1971.

"The Rationale of the [Theta] Marking System". In-house Memorandum.

Sacks, Harvey. "An Initial Investigation of the Usability of Conversational Data for Doing Sociology". *Studies in Social Interaction.* ed. David Sudnow. New York, The Free Press, 1972.

Sontag, Susan. "Notes on 'Camp'". *Against Interpretation.* New York, Farrar, Straus and Giroux, 1964.