MAKING SENSE OF A DIAGNOSTIC CATEGORY: A STUDY OF THE RELATIONSHIP BETWEEN THEORY AND PRACTICE

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ABSTRACT

Members of scientific disciplines and lay persons alike commonly hold the view that the practical work carried out by those very same members is theory governed. The problem undertaken by this study was to observe, in a psychiatric hospital, the practical work of psychotherapists, with the intent of characterizing the role played by theory in their work. An ethnographic approach was employed, and the research was focused on psychotherapy with patients diagnosed to be members of a single diagnostic category. The researcher began his fieldwork with the assumption that his knowledge of psychiatric theory would allow him to make sense of his observations. Contrary to his expectations, he was unable to discern the theoretical significance of the activities that he observed. This led the researcher to conclude that there was a "gap" between his knowledge and his observations. The researcher developed a number of plausible explanations for the "gap," none of which proved to be adequate. The "gap," in itself, raises a hitherto unacknowledged issue of the relationship between theory and practice. It is argued that the "gap" exists not only for the researcher, but also for any persons who would study a body of scientific theoretical knowledge, and then observe what purports to be the practical application of that knowledge. The "gap" seems to be integral to any theory-guided discipline. The study explicates, it is argued, a characteristic of scientific work. The lack of an adequate explanation for the "gap" is not a failing of the study, but rather points to the lack of a

standard which specifies what "theory governed" means. Although the study presents us with a puzzle, it does not put into question the efficacy of theorizing with respect to the accomplishment of practical work in the clinical or any other disciplines.

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I have been influenced by many social scientists in my studies and work in various academic institutions. I am unable to acknowledge individually, my debt to all of them. My Advisor, Roy Turner, stands out, however, as one who has had the most significant impact upon my thinking, and who has made an immeasurable contribution to the completion of this work. I wish also to acknowledge the thoughtful criticisms and suggestions of Adrian Marriage and Ken Stoddart who helped to shape this work by enabling me to clarify my ideas. The staff and patients of "University Hospital" provided me with the means to carry out my research; to them I am indebted. I owe thanks to The Canada Council and other institutions that granted me financial assistance. My typist, Eleanor Lowther, facilitated, in many ways in addition to her excellent typing, the production of this document. To her, I also owe thanks. Finally, I am deeply indebted to my family and most importantly my wife, Sheila Joy, who inspired me, advised me, and sustained me. To them, this work is dedicated.

CHAPTER 1

INTRODUCTION

The Perspective

Hans Strupp, in his introductory article to a major psychotherapy text, notes that psychotherapists are ". . . mental health professionals whose technical concepts (e.g., ego strength, impulse control) . . . are ostensibly scientific, objective, and value free."[1] Later in his article, Strupp points out that:

> Techniques are of course the core and *raison d'etre* of modern psychotherapy and . . . are usually anchored in a theory of psychopathology or maladaptive learning. Psychoanalysis has stressed the interpretation of resistances and transference phenomena as the principal curative factor, contrasting these operations with the "suggestions" of earlier hypnotists. Behavior therapy, to cite another example, has developed its own armamentarium of techniques, such as systematic desensitization, modeling, . . . aversive and operant conditioning, . . . training in self-regulation and self-control. . . . In general, the proponents of all systems of psychotherapy credit their successes to more or less *specific* operations which are usually claimed to be uniquely effective. A corollary of this proposition is that a therapist is a professional who must receive systematic training in the application of the recommended techniques.[2]

The above quotations illustrate a perspective which is shared alike by the psychotherapist, the social scientist, and the lay person. Members of all three groups commonly hold the view that psychotherapy is a theory-governed activity. By this, we mean an activity which is determined in a fundamental way by a body of scientific knowledge. Therefore, in the case of psychotherapy, it is alleged to be an activity which can be explained and understood by appealing to the scientific knowledge

known as psychiatric theory. Together these groups have in common the belief that the work done by the psychotherapist is governed by the canons of psychiatric theory.[3] This perspective asserts that it is these canons which provide the "rules" by which the psychotherapist carries out his/her work, and it is therefore to these canons that the therapist appeals when deciding what he/she should or should not do in the course of his/her work.[4]

Thus, we find that three different categories of people all share a common conception with respect to the nature of the work done by psychotherapists. Using the ethnographic method, this thesis will critically examine the view that psychotherapy is a theory-governed activity. Contrary to the beliefs of the lay person and the social scientist, and the claims of the psychotherapist, the researcher discovered that psychotherapy did not seem to be an enterprise that was governed by the canons of psychiatric theory. It appeared to the researcher, that psychotherapy was a practical and pragmatic enterprise which could be understood not by making reference to psychiatric or social scientific theory, which the researcher had studied, but rather by drawing upon the common sense cultural knowledge which the researcher shared with the other members of his culture. The task of the researcher will be to demonstrate the researcher's discovery, and to analyse why he was unable to make sense of psychotherapy in terms of psychiatric or sociological theoretical constructs built upon the taken-for-granted notion cited above. The research will show that the researcher was unable to bring these constructs into the research setting, the wards of a psychiatric hospital, and use them to make sense of, explain, or

evaluate what he observed. It seemed to the researcher that one could not view psychotherapy in terms of, nor as a product of such constructs, but instead, had to view it as an activity conducted in terms of what he chose to call the intuition of the therapist,[5] as the constructs did not seem to be applicable to the work that took place within the setting.[6] The research was focused, for reasons that will be discussed below, on psychotherapy with patients who had been diagnosed as "paranoid."[7]

The thesis, therefore, is an ethnographic study of psychotherapy with "paranoid" patients in a psychiatric hospital. Its task will be to demonstrate the existence of a "gap" between the researcher's constructs, and his observations in the fieldwork setting, which raised the question of a "gap" between the theoretical knowledge on paranoia cited in the psychiatric and social scientific literature, and actual instances and the treatment of the disorder.[8] The evidence of the research points, it will be argued, toward the conclusion that, contrary to our taken-for-granted notion, psychiatric theory does not determine even in a rudimentary way the nature of psychotherapists' work with "paranoids"; exclusive of their accounts of their work. We shall analyse this conclusion, and two other plausible conclusions that contradict it, with the aim of arriving at an adequate explanation of the "gap."

We shall show, however, that none of the conclusions provide an adequate explanation of the "gap." This finding, together with the discovery of the "gap," are, we assert, the major research findings of the thesis. Our findings, in turn, introduce, we claim, a larger issue

with respect to the character of the relationship between *any* body of theory and related practice in any scientific discipline. Thus our findings, derived from our study of psychotherapy, are, we shall argue, of relevance to the understanding of other scientific disciplines, as they raise unanswered questions that are common to all of them.

The analytical framework of the thesis is derived from the ethnomethodological perspective.[9] It was this perspective that both prompted me to pursue an ethnographic approach in my research, and adopt a narrative format, which I shall now begin to employ. It also ultimately provided me with the means to critically examine my observations gained from my fieldwork. I do not claim, however, that the thesis stands as an example of ethnomethodology. I view it, rather, as a work falling within the broader interactionist paradigm that derives from phenomenological philosophy, and encompasses a variety of perspectives in addition to the ethnomethodological, such as symbolic interactionism, labelling theory, and that of Erving Goffman.

The perspective of the thesis draws, in particular, upon works by Roy Turner, David Sudnow, and Jeff Coulter.[10] Turner's "Occupational Routines" paper and Sudnow's book *Passing On* helped to convince me, prior to doing my fieldwork research, that an ethnographic approach to the study of psychotherapy with "paranoids" would provide me with a more fundamental understanding of the nature of the disorder and its treatment, than the adoption of alternate positivist research strategies that utilized, for example, a survey research approach. As I had a background in anthropology, I was, to some extent, predisposed to the acceptance of this type of research design. Furthermore, adopting their

approach fitted with my theoretical orientation within sociology. I had been exposed to a variety of interactionist perspectives in both my undergraduate and graduate work in the discipline, therefore was able to make sense, albeit at a superficial level,[11] of the ethnomethodological perspective advocated by Sudnow and Turner. In his paper, Turner states that:

> . . . ethnographic studies of science, medicine, etc, will have as their pay-off *not* critiques and remedies, but some more fundamental understanding of how these activities are constituted in the first place. My theoretical interest, in advocating such studies, is to disclose, not "the social influences *upon*," but "the social structure *of*" the central events and activities of the professions and occupations. Like David Sudnow, I am advocating a concern with "the *procedural basis* of events," and "the concrete organizational foundations" of activities.[12]

It was to this task that I addressed myself, aiming to discover the "*procedural basis* of events" that made up the disorder and its treatment. Prior to, and concurrent with the adoption of their perspective, I had evolved my own theoretical perspective on the disorder, that emerged from my study of the critical literature on psychiatry and paranoia. Thus, I began with, and carried through the course of my fieldwork, two mutually exclusive orientations; one (the anti-psychiatry perspective) that was critical of, but nevertheless formulated in terms of traditional psychiatric and sociological theory, and the other (the perspective of Sudnow and Turner), which stood as an ethnomethodological critique of all other theory *including* the anti-psychiatry variety. Unbeknownst to me, I utilized throughout the course of my fieldwork a set of constructs formulated in terms of the same theoretical orientation that Sudnow and Turner, from their ethnomethodological perspective, rejected.

One may legitimately question my naivete, with respect to the contradiction within my approach, which I shall not attempt to explain at this point, as the chronology of my changing perspectives on the disorder constitutes the body of the thesis. Suffice it to say, at this point, that it was not until after I had finished my fieldwork that I came to a more fundamental understanding of the depth of the ethnomethodological perspective, and the inadequacy of my preconceived constructs. It was at that point that I went back to Turner's and Sudnow's work and the work of other ethnomethodologists, and began to utilize their perspective in an effort to make new sense of my research observations. Thus, I drew upon their work at two different points in time, and at two different levels of understanding. I am, therefore, unable to present in the introduction to the thesis a concise outline of its perspective, as my perspective changed over the course of the research, and the changes in my thinking which are documented in the thesis, became the substance of it.

Thus, to gain an understanding of the analytical framework of the thesis, one must keep in mind that it is a framework which evolved in the course of, and as a consequence of, pursuing my fieldwork, and was not formulated until after the fieldwork had been completed. The three other sources cited above, Turner's articles, "Utterance Positioning as an Interactional Resource," and "Some Formal Properties of Therapy Talk," and Coulter's book, *Approaches to Insanity*, also contributed to the development of this framework. I encountered them after finishing my fieldwork, and they helped me to analyse my data, and formulate a plausible conclusion with respect to the data.

From Coulter, I was able to derive some assistance in relating the perspective advocated by Turner in his paper, "Occupational Routines: Some Demand Characteristics of Police Work," and utilized by Sudnow in his book, to my own particular area of interest; psychotherapy with "paranoids." He helped me to reconsider the relationship between psychiatric theory and practice, which allowed me to arrive at one answer for the many problems that I encountered in attempting to make sense of my research observations in terms of my original constructs, derived from the anti-psychiatry perspective, which I brought into the research setting. Coulter defines his understanding of the relationship between psychiatric theory and practice this way:

> I have drawn a persistent distinction between psychiatry, understood as an irremediably practical and pragmatic affair, and psychopathology, understood as a theoretical enterprise that aims to rationalize the experiences with insane members of a community in scientific terms.[13]

It was this analysis, developed by Counter in his book, which helped to give me the means to rethink my research experiences and observations. Rather than relying upon my original constructs; i.e., theoretical explanations of paranoia and psychotherapy formulated in terms of common sense beliefs, I began by utilizing his perspective to conceptualize the disorder and its treatment in terms of an alternate understanding as to the nature of these "phenomena." Coulter argues forcefully in his book that the practical work of therapists which we know of as psychotherapy,[14] is not guided by the tenets of psychiatric theory, but rather is organized in terms of the therapists' social stock of knowledge (common sense knowledge, folk wisdom, etc.).

Coulter's analysis provided me with the means to focus the perspective advocated by Turner and Sudnow upon my area of research interest. By drawing upon his work, I was able to evolve a perspective which seemed to allow me to make sense of my research findings, and account for the "gap" that I had discovered between my constructs derived from the theoretical literature and my research observations. He raised for me the question of reconceptualizing one's understanding of the relationship between psychiatric theory and practice, which led me to reconsider my insights as to the "*procedural basis* of events" that made up psychiatric practice. Coulter expresses the perspective that I drew upon this way:

> . . . the idea of a psychiatry without cultural reference is like the idea of conceptual thought without language--in both cases, the latter is partially constitutive of the former, and could in no sense be considered a fetter upon it. We should not be so readily tempted into harbouring a common view that sees ordinary cultural knowledge as always defective; commonsense cultural knowledge and standards are not all of a piece, but are accommodated to particular sorts of work, and enable us to do that work (the tasks of psychological assessments amongst others) adequately and routinely.[15]

I encountered Roy Turner's other works ("Some Formal Properties of Therapy Talk," and "Utterance Positioning as an Interactional Resource") subsequent to my study of Coulter's book. From his articles, I drew a conclusion that I had begun to consider initially as a consequence of my research experience, and subsequently as a result of my study of Coulter. Psychotherapy with "paranoids" might not, I began to see, be a theory-guided activity, as it may derive its direction from the therapist's common sense rather than his/her psychiatric theoretical knowledge. This new view was a radical departure from my previous views

which had been formulated (according to the commonly held view that psychotherapy is a theory-governed activity) in terms of my constructs that I had derived from my study of the psychiatric and social scientific theoretical literature on paranoia. The perspective from Turner's work that I drew upon is best summed up in his own words:

> Thus, it may well be the case that a component of psychiatric competence is the ability to "discover" retrospectively in routine utterances the therapeutic motivations taken to govern their production; but nonetheless it is necessarily also the case that in the course of conducting the psychiatric interview the therapist exercises those conversational skills he possesses as a member of the culture, competent to talk to other members and be understood. It does not matter, of course, that the therapist may have principled grounds for breaching conversational rules: the recognition and production of breaches are dependent upon the very same competence which provides for the recognition and production of talk which observes those rules in the first place.[16]

I was influenced later by the work of other researchers which led me to reject my conclusion discussed above, and subsequently raise and reject two other plausible conclusions. I, in fact, came to see that there is a basis, in the quotation cited immediately above, for arguing that psychotherapy is a theory-guided activity. By now, it may be apparent that the perspective of the thesis evolved with the passage of my doctoral work, and it is the evolution of the perspective that constitutes the body of the thesis. I am, therefore, presently unable to offer further details as to the nature of the perspective of the thesis beyond the brief comments noted above, as its substance, to reiterate, derives from a documentation of my changing views as to the nature of paranoia and the character of its treatment; the culmination of which is the thesis perspective.

Two further points, however, need to be clarified at this time. First of all, the thesis is not meant to stand alone, as an autobiographical account of one individual's study of paranoia. I believe that the experiences and observations that I write about, as they pertain to my changing perspectives on the disorder, have a wider relevance. I am arguing that they have broader import, as I assert that *anyone* who studied the literature on paranoia and then conducted an ethnographic study of its treatment in a psychiatric setting would arrive at the same conclusions as I did. I make the assumption that the thesis stands not as a mere piece of reflective self-exploration. Rather, I see it as a sociological work formulated in terms of, and grounded in, a body of sociological knowledge. Thus, I am asserting that it furthers our social scientific knowledge of the larger issues, specifically the question of the relationship between psychiatric theory and practice, and the question of the relationship between *any* body of scientific theory and related practice, that were confronted in the course of documenting my own personal research experiences.

Finally, it is important to note that the thesis is not intended to stand as a critique of psychiatry. Contrary to the purpose of some research in this area, which is oriented toward finding examples of the misuse of therapy or "poor" therapy, the thesis will not try to develop such common sense normative perspectives. I argue that what is of sociological interest is the analytical depiction of the activity which we know of as psychotherapy with "paranoids," rather than common sense judgements of it.

The Development of the Perspective

The perspective of this thesis evolved from a process of rethinking my understanding of the field of mental disorder and psychiatry. My interest in this area had its roots within my family. A relative of mine was a psychiatrist, and I had frequent opportunities to discuss with him and his friends who were also psychiatrists, topics that I studied in my undergraduate work in sociology. I found that I often had a differing interpretation of human behaviour from that held by these psychiatrists, and I became aware of the significant distinction between a sociological and a psychiatric analysis of phenomena. In the discussions that I had with the psychiatrists, I felt at a disadvantage as I had not studied the psychiatric literature, nor had I first-hand knowledge of what psychotherapy actually was. I realized that the psychiatrists themselves were not well versed in sociological knowledge, but to them this did not seem to be too important, as they felt that ultimately all human behaviour had to be accounted for in terms of the psychiatric viewpoint. Thus, it seemed that this view asserted not only an alternate explanation of human phenomena, but also an explanation that did not really accept a sociological level of analysis. The experience that I had of being exposed to this viewpoint made me decide to gain more knowledge of the field of mental disorder and psychiatry.

In my first year of graduate work, I did a reading course in the sociology of knowledge which focused on the works of Sigmund Freud and theorists influenced by him.[17] I was interested in exploring the psychiatric literature which gave recognition to concepts such as culture and society, as I wanted to find the common ground between a

psychiatric and a sociological perspective. It seemed to me that the two perspectives could possibly offer complementary interpretations of human behaviour. As I became more familiar with the literature, I began to develop an interest not only in the common ground between sociological and psychiatric thinking, but also in the sociological study of psychiatric theory and practice. I became interested in analysing psychiatry as a phenomenon in our society composed of both a body of theoretical knowledge and a practical activity; psychotherapy. Thus, rather than looking for elements in psychiatric thinking that provided a link with sociological perspectives, I now began to focus on a sociological analysis of psychiatry. My new interest stemmed from my original need to know what psychiatry "really was all about," but also was influenced by the advent of the anti-psychiatry literature.[18] There was a current interest in analysing the field of psychiatry, and the psychiatric profession was coming under increasing attack by critics who claimed that it was a mechanism of social control. Some of this literature made sense to me, as it appeared to provide an analysis of psychiatry which exposed the nature of psychiatric theory and practice, and seemed to reveal the influence upon society of the practice of psychotherapy. Thus, I explored a body of literature which provided a new viewpoint on psychiatry, and I began to decide that I would undertake to study the field of psychiatry for my doctoral research.

Prior to entering a doctoral program, I applied to the Canada Council for a fellowship, and an examination of my application form may provide a useful means of documenting my particular research interests and theoretical perspectives at this point in time. On my application

form, I outlined my program of study and research. I proposed to study ". . . the relationship between psychoanalytic theory and the influence upon society of the practice of psychiatry."[19] I wanted to combine my previous interest in the sociology of knowledge with respect to the psychiatric theoretical perspective (i.e. the psychiatric viewpoint), with my more recent interests in psychiatry as a practical activity, and as a profession which allegedly was involved in serving a political purpose as a mechanism of social control. Thus, on my application form I wrote:

> I am interested in relating the political critique of psychiatry to psychoanalytic theory. Psychoanalytic theory will be analysed both as a world view which has possibly oriented the direction of psychiatric practice toward social control, and as an ideology which possibly has served as a justification for the practice of social control. The aim of the research will be to establish whether there are elements of psychoanalytic theory which are related to the practice of psychiatric therapy as a mechanism of social control, and to identify these elements.[20]

I proposed to examine the elements that made up psychoanalytic theory, as I wished to specify how its intrapsychic and biologically based concepts such as the model of instincts and repression denied the possibility of explaining mental disorder in terms of the effects of the environment upon the individual, as no recognition appeared to be given to the influence of socio-economic variables. Thus, it seemed to me that psychoanalytic theory oriented psychotherapy toward a role of social control as it provided for the practice of adjusting a disturbed individual to his/her social world regardless of whether that social world was the source of his/her disturbance. Therefore, at this point in time, I believed that one could understand the nature of psychiatric practice if one had an understanding of psychiatric theory.[21] It seemed

to me that psychotherapy was a theory-governed activity, and therefore that the body of theoretical knowledge known as psychiatric theory in a fundamental way determined what a therapist did or did not do when he/she practised psychotherapy. This idea was basic to my perspective on psychiatry, and from it I was able to develop my analysis of the political critique of psychiatry. If psychotherapy was a theory-governed activity, then one must look for explanations of the alleged practice of social control in the nature of the psychiatric theory, not in the practical activity of psychotherapy, as this activity merely reflected the tenets of the theory. In my doctoral research I planned therefore to do a critique of psychiatry, documenting how one could account for psychiatric practice in terms of psychiatric theory.

Having developed what seemed to be a sound theoretical perspective, I pursued my doctoral studies using this perspective as a focus for interpreting the material that I studied. As I gained more knowledge of mental disorder and psychiatry, I refined some of my ideas and decided to concentrate my work on the diagnostic category paranoid state, as this diagnostic category seemed to lend itself to sociological analysis. I did not, however, find reason to change my view that psychotherapy was a theory-governed activity, and thus I still sought to do a critique of psychiatry, analysing psychiatric practice in terms of psychiatric theory. My subsequent applications to the Canada Council for renewal of my fellowship continued therefore to stress this approach, and I maintained it within my Ph.D. thesis proposal. In my proposal I wrote, for example, with respect to the significance of my doctoral research that:

> The proposed study should make a contribution to our knowledge of how psychiatrists "bring off" their psychiatric encounter with the "paranoid," and how this accomplishment is related to . . . their psychiatric understanding of "paranoia" and mental illness. This knowledge would in turn enable us to develop further insight into the relation between the practice of psychiatric therapy and the exercise of social control.[22]

It was not until I began to do research in the field, that my theoretical perspective began to lose its relevance to me. It is my purpose at this point in the thesis to note briefly why this process took place, and to outline briefly how a new theoretical perspective evolved. The data which documents the actual process of transition in my thinking and other topics touched on at this time, will be dealt with in the main body of the thesis. The material that is being discussed in this section of the thesis has been presented in order to establish the background to, and therefore give a firmer understanding of the evolution of the theoretical perspective of the thesis.

My fieldwork was conducted in a psychiatric hospital in which I adopted the role of a non-participant observer. I spent time in the hospital observing the interaction between the staff and the patients, and in particular spent time observing therapy sessions in which patients who had been given the diagnostic label "paranoid" took part. At last, I was able to have the opportunity of witnessing at first hand the practical activities of psychiatry. I felt that now I would be able to understand what psychotherapy "really was all about," as I would be able to use the knowledge that I had gained from the psychiatric literature to make sense of what went on in the wards and in the therapy sessions. My understanding of the events and activities that I experienced and observed in the hospital however, did not turn out to be what

my theoretical perspective had led me to expect. After being in the setting for some time and trying to make sense of my observations, I began to realize two things. First of all, I became aware that the work done by therapists did not seem to be structured in terms of psychiatric theory. The second thing that I came to realize was that I did not seem to need to make reference to psychiatric theory in order to make sense of what therapists or patients said. I therefore began to go through a process of re-evaluating my original perspective, and by the time that I had finished my fieldwork, I questioned whether this perspective could be used to explain the data that I had collected. In the months that followed I mulled over my data, and I slowly began to see that the material that I had collected might be explained in terms of a perspective which contradicted my original viewpoint. I became aware that psychiatric practice might not be a theory-governed activity. Thus, my thinking was transformed, as I realized that one might not be able to analyse psychiatric practice and draw conclusions about its influence in society by making reference to psychiatric theory. Instead, I came to accept the premise that one had to view psychiatric practice in terms of common sense cultural knowledge, rather than seeing it as a product determined by a body of theoretical knowledge. I concluded, for example, that one could not argue that a therapist's understanding of and interaction with a "paranoid" patient was determined by the therapist's knowledge of psychiatric theory. I eventually rejected this position, and then adopted and subsequently rejected two other explanations of my research findings. Thus, the perspective of the thesis evolved through a process of rethinking my views.

It is also necessary to discuss the role played by my research methodology in facilitating the transformation in my thinking. The ethnographic method was employed in the field, and at the outset of my fieldwork I assumed that I would be able to utilize this approach to gather data which would document how psychiatric theory governs psychiatric practice. Thus, I entered the research setting with my previously discussed preconceptions, and I assumed that the observational data that I gathered would serve to confirm my ideas. As it turned out, however, my thinking underwent a transformation, and it was the ethnographic method which enabled me to make this transformation. Had I adopted a different methodology such as a survey research approach, it would have been difficult to overcome my preconceived ideas, as these ideas would have been formulated within the methodology in such a way that the methodology would have produced data that I myself had generated out of the setting. Using such an approach, I might have developed questionnaires, interview schedules, rating and attitude scales, etc., which would have provided me with a means of getting data from the setting which made sense in terms of *my theoretical perspective or preconceived construct* of what was going on in the setting that I was studying. This approach would not, however, have provided me with a picture of what actually transpired on an everyday basis for members in the setting. I would have made a basic error which has been noted by Jeff Coulter this way:

> One must avoid treating action-in-accord-with-a-rule as action-governed-by-a-rule, since one can easily bring some course of observed activity under the auspices of a rule like formulation without such a formulation expressing the state of knowledge of the member doing the activity.[23]

Roy Turner has aptly described this process in terms of a metaphor. He argues that ". . . such studies proceed by the assembly of 'snapshots' of the social world."[24] As these "snapshots" provide only selected glimpses of what is happening in the research setting, one may, he argues, readily assemble "snapshots" to illustrate one's particular preconceived constructs. What I wish to point out is that the unstructured approach of the ethnographic method did not provide me with the means of engaging in this practice. In contrast to other approaches, this method allows for what Turner, again using his metaphor, calls ". . . a continuous and un-edited videotape of social phenomena."[25] Thus, *any and all* activities that I observed in the setting constituted my data. This denied the possibility of assembling "snapshots," which would serve to confirm my preconceptions. I was, therefore, able to view psychiatric practice as a continuing activity which gave me the opportunity to discover that my original constructs could not explain the data that I was collecting. The constructs that I ultimately did adopt as a result of this experience form the theoretical perspective of the thesis.

The Choice of a Diagnostic Category

Prior to doing my fieldwork I developed, as was previously noted, an interest in the diagnostic category paranoid state (DSM-11-297).[26] In particular, I became concerned with "paranoids" who had persecutory delusions. This interest stemmed from my reading of the psychiatric literature in which I found that this diagnostic category was distinguished from other categories such as schizophrenia by a number of

important features. It was pointed out, for example, that there is little evidence of a physiological basis for the disorder.[27] Nor is the "paranoid," unlike the "schizophrenic," seen to be desocialized. Norman Cameron claims that the "paranoid" has organization and contact with reality, describing their condition this way: ". . . both in perception and in action the patient is not nearly as desocialized as are other psychotic persons."[28] The Diagnostic and Statistical Manual of Mental Disorders notes that the core of the "paranoid's" disturbance is not a mood or thought disorder, but rather a delusion which may be composed of both complex and logical thinking.[29] Persons diagnosed to be "paranoid" are seen to share the characteristic of asserting coherent versions of social reality which contradict the commonly held "normal" versions. They are seen to have a sustained relationship with the social world which is characterized by a disagreement with other members of the culture, as to the nature of that world. One psychiatrist describes the disorder this way: "thus the main single factor that is emphasized in the existence of a belief or beliefs held to be false by the examiner or evaluator."[30] The literature acknowledged that there was a social component common to the behaviour of the "paranoid" which is not always present in the behaviour of others seen to be mentally ill. Thus, it seemed to me that this diagnostic category was particularly suited to sociological research.

After reviewing the literature on paranoia, I concluded that it not only was a disorder suited to sociological research, but also that it was particularly suited to an analysis in terms of my theoretical perspective.[31] It seemed to me that psychotherapy with "paranoids"

illustrated most clearly the relationship between psychiatric theory and practice, and how this relationship could be understood in terms of the concept of social control. My reasoning proceeded as follows. Psychiatric theory accounts for paranoia in a number of ways such as a faulty intrapsychic structure, or a disturbance of interpersonal relationships, and excessive use of projection. These theoretical explanations of the disorder have in common their denial of the possibility that the delusion of the "paranoid" may in fact be a "logical" response to the present or past life situation of the individual. They do not allow for the chance that the "paranoid" individual actually is responding to real persecution. Instead, these views assume that the beliefs of the individual have no basis in reality, and that the roots of the individual's disordered thought and behaviour are to be found within the individual. Thus, it seemed to me that psychiatric theory, which I believed governed psychiatric practice, would direct the therapist to search for defects in the individual who was diagnosed as "paranoid," rather than looking for experiences in the life of that individual which would account for feelings of persecution. It seemed clear that, as the theory did not allow for an alternate explanation of the "paranoid's" feelings, the therapist whose work I assumed was governed by this body of theoretical knowledge would not have grounds for accepting the "paranoid's" claims of persecution. I therefore believed that therapy sessions with patients diagnosed "paranoid" would follow a particular form. I thought that the interaction between the therapist and the "paranoid" would be an encounter in which two contrasting versions of reality would be asserted. I believed that the

session would be dominated by a reality disjuncture; the "paranoid" expressing his/her delusion, and the therapist offering a competing explanation of the patient's beliefs. I took it that the therapist made sense of the "paranoid's" behaviour in terms of his/her theoretical understanding of paranoia, and therefore would not honour the patient's account, as this account would be seen as having no basis in reality. I assumed that the therapist would interpret the patient's account as stemming from some fault in the psyche of the patient, and would therefore set about to convince the "paranoid" that his/her beliefs were mistaken. Thus, I believed that therapy sessions with "paranoid" patients focused on a well-defined disjuncture between competing versions of social reality, and proceeded along a course in which the therapist negated the "paranoid's" version and imposed his/her own upon the patient.

This pre-fieldwork analysis of the diagnostic category, paranoid state, which I developed, fitted well with my perspective on the relationship between psychotherapy and social control. I felt that therapy with "paranoids" highlighted how psychiatric theory determined psychiatric practice in such a way that the practice could be viewed as a form of social control. Since the theory made no provision for accepting the account of the patient as true, the therapist, relying on this theory, would simply invalidate the "paranoid's" account. One version of social reality would be imposed at the expense of another. It was the act of invalidation, which I assumed took place, that I saw to be of importance. The theory-based negation of the "paranoid's" account served, I believed, the function of social control as the therapy would

adjust the disturbed individual to his/her social world despite the fact that this social world might be the source of the disturbance. Thus, I believed that psychotherapy might be serving the function of social control rather than liberation, and I thought that my research would explain and document this process.

Having developed my analysis of paranoia within the framework of my theoretical perspective, I then integrated it into my research design. Using the ethnographic method, I planned to gather data which would illustrate how psychotherapy with "paranoid" patients was linked to psychiatric theory, and could be viewed as a form of social control. Utilizing my analysis of this disorder, I decided to compile data from four cases which had been diagnosed to most closely approach the diagnostic sub-category "true paranoia" (DSM-11-297.0). This decision was based on my assumptions about what happened in therapy sessions with "paranoid" patients. I assumed that the diagnosis of "true paranoia" was reserved for cases in which it is perceived by the therapist that there is a more clearly defined reality disjuncture between the therapist and the patient, than for example in cases given the diagnostic label paranoid schizophrenic. By observing this type of case, I believed that it would be easier for me to identify such a disjuncture. It followed therefore that it was in these cases of "true paranoia" that the invalidation of the "paranoid's" version of reality would also be most apparent. Thus, my analysis led me to believe that the observation of psychotherapy with "true paranoids" would most readily reveal data which supported my preconceived constructs.

Upon entering the research setting, I found, as has already been briefly noted, that my constructs did not fit with what I was experiencing and observing. First of all, I discovered through discussions with some of the clinical supervisors of the wards in the hospital that only one patient in the previous two years had been diagnosed as a "true paranoid." This did not deter me, however, as I felt that even if I did not get the opportunity to observe psychotherapy with such a patient, I would still be able to locate the same processes happening (albeit in a less clear form) with patients who had been diagnosed as suffering from some other form of "paranoid" disorder. As it turned out, I only was able to locate one patient whose diagnosis fitted into the Diagnostic and Statistical Manual category number 297, paranoid states.[32] It is necessary at this time to point out that there is considerable disagreement within the psychiatric literature as to the correct diagnosis to make in cases of "paranoid" disorders. We find, for example, one psychiatrist noting that: "until the various paranoid conditions can be differentiated by characteristics other than clinical features, the primary value of designations such as paranoid personality, paranoid state . . . is to facilitate communication."[33] What, however, was important to me was that if a patient's diagnosis included a reference to some form of "paranoid" condition, then this was a patient who the therapist perceived to possess a certain set of characteristics, and according to my perspective, the therapist would set about treating them in terms of their theoretical understanding of the condition.

I came to discover, however, that the activity which ensued in therapy sessions and on the wards with "paranoid" patients did not make

sense in terms of my constructs. The analyses and theories of paranoia discussed in the psychiatric literature seemed to have little to do with how therapists actually understood and what they actually did with "paranoid" patients. My data, which illustrate this finding, will be presented later in the thesis, but suffice it to say that my constructs did not agree with the data that I was collecting. To put it briefly, the therapists did not seem to rely upon psychiatric theory in their work with "paranoid" patients, and I did not have to make reference to my knowledge of the theory in order to make sense of their work. Thus, I could not locate examples of the processes such as invalidation and reality disjunctures, which I assumed I would find, taking place.

I did not reject, however, my choice of diagnostic category. In the period that followed my fieldwork as I was developing new perspectives, I realized that the focus on paranoia, which I had developed because of my original perspective, could still be of use. I became aware that the data which I gathered on the work done with these patients, highlighted my new perspectives on psychotherapy. Although I also interpreted work done with non-"paranoid" patients in terms of my new perspectives, it was the work done with "paranoids" which most clearly revealed what seemed to be a "gap" between the theoretical knowledge on psychiatric disorders cited in the psychiatric and social scientific literature, and actual instances and the treatment of these disorders.

The Research Setting

The psychiatric hospital in which I conducted my fieldwork is a voluntary admission psychiatric institution which is located on a university campus. The hospital is owned by the university in which it is located, and is administered by the university's department of psychiatry. The hospital is located in a modern structure built during the late 1960s, which also houses the faculty offices and teaching facilities of the department of psychiatry, two day-care programs, a child and family clinic, a psychology clinic, and a basic science research wing. There are three in-patient wards in the hospital, each of which has twenty beds, and there is also an out-patient clinic. Two of the wards are designated as longer-stay wards, while the other ward and the out-patient clinic are integrated ". . . to form a combined evaluation and assessment unit with crisis-intervention and short stay intensive care. This assessment unit has back-up services from all the other programs including the longer-stay wards."[34]

The most recent statistics available (at the time of my research), which were given to me by the hospital administration, indicate that in 1974 there were 922 admissions to the facility, and that the average length of stay was 24.16 days. The patient population does not reflect the location in which the hospital is situated, as the hospital does not cater to the health care needs of the university community, which are met by a separate facility. Rather, the patient population is diverse, and reflects the make-up of the general population of the city in which the hospital is located. Patients are generally admitted upon referral by their physician, although some patients seek admission by

themselves. The hospital information booklet notes that:

> Admission to University Hospital is usually done by having an "assessment interview" in our Outpatient Clinic where the person is seen and then either sent to one of the three inpatient wards or put on a waiting list. Sometimes he is referred to an alternative resource within the community or, perhaps, one of our Day Care programmes.[35]

An administrator of the hospital pointed out to me that the type of patient admitted to the hospital in recent years had changed, owing to the advent of community mental health clinics. She noted that less problematic cases, which previously were admitted to the hospital, were now being seen in these clinics. This led, she explained, to a higher percentage of problematic cases being admitted to the hospital.

A patient information pamphlet which is given to patients and their families, describes the hospital this way:

> The purposes of the Hospital include teaching and research as well as patient care. There are three in-patient wards of the Hospital. Each ward functions independently of the other wards and as an individual community. The community is made up of the twenty patients on the ward and the team of doctors, nurses, psychologists, social workers and occupational therapists.
>
> It is the belief of the staff of the Hospital that each person who comes to the Hospital seeking help has individual needs and problems. Although one method of providing such help is through consultation with a doctor, there is also much to be gained through working on problems in a group setting. In order to facilitate this process, group meetings are held on each of the wards. At times the entire community meets together and at times small groups of patients meet with staff.[36]

The description notes a number of characteristic features of University Hospital. As it is a hospital attached to a department of psychiatry of a university, it is oriented not only toward the treatment of patients, but also toward research and the training of students. The hospital also maintains what may be termed a "progressive" as opposed to a "traditional" treatment program for patients. Wards in the hospital

are called therapeutic communities, and the personnel working within them are called treatment teams. Although patients are assigned a primary therapist and a primary nurse, the treatment program of the hospital emphasizes the involvement of patients in the activities of the ward community and with the other members of the treatment team.

University Hospital is atypical of other psychiatric institutions in its area, because of its research and training orientation, and its team treatment and ward community approach to patient care. It also is characterized by its modern and un-hospital-like appearance. On a number of occasions I heard individuals who live in the city in which the hospital is located, refer to it as the "psychiatric Hilton." The first time that I visited University Hospital I did experience the feeling of being in a hotel. I did not have the impression of being in a hospital or a psychiatric facility, as the floors were carpeted, the furniture was modern and stylish, the walls were wood panelled, the lighting was not harsh, background music was playing, and none of the staff wore uniforms. Thus, unlike my experience in visiting other psychiatric facilities, I did not have an immediate sense of being in a medical setting.

During the course of my fieldwork my impression of the hospital changed, and I lost all sense of the setting being of a non-medical nature. I also found that characteristics which supposedly defined the hospital did not become obvious to me. I did not, for example, throughout the period of my fieldwork, encounter anyone who was doing research in the hospital of either a medical or a social scientific nature. I assume that work of this type was going on, but on no occasion was I

aware of it. I was, however, well aware of the student training programs in the hospital, as I had contact with psychiatric residents, fourth year medical students, student nurses, and social work students. I therefore concluded that the work done on the wards was oriented much more toward student training and patient care than toward research. I also found that I did not become aware of the concept of a ward community to be of major significance on the wards, although my impression may stem from a lack of data on this topic. By contrast, however, the team treatment approach was readily discernible on the wards. I discovered that I was able to gather verbal and written information about patients whom I was interested in not only from their primary therapist and nurse, but also from other hospital staff, as these individuals also had ongoing contact as team members with the patient.

Access to the Research Setting

Before I could carry out my fieldwork in the hospital, I had to gain the permission of two committees; the Faculty of Medicine Committee on Research Involving Human Subjects which was a committee from my university, and the Research Committee of the hospital in which I planned to do the research. I shall discuss the procedures that were involved in obtaining permission to do my research, as such a discussion is informative of the response of a psychiatric institution to a request that it allow itself to be studied, and also may serve to highlight the differences between the official policies with respect to legal matters and to the welfare, rights, and privacy of the subjects studied, and the actual ongoing practices that may affect these factors within the

hospital. My experience was that I had to participate in an extensive screening procedure and commit myself to a series of rules before I was allowed to do my research, yet when I got within the research setting, I found that the work that was done there was not always organized strictly in terms of these official policies. It is my purpose at this point to describe the procedures that I had to follow in order to gain permission.

The first step that I took to gain entry to the hospital was to contact the Head of the hospital, and to explain my interest in doing research there. This procedure was facilitated by my personal acquaintance with the Head through my relative who was a psychiatrist. Thus, I had a helpful means of initially establishing contact with the institution. The Head gave his tentative approval to the study, subject to its approval by the two committees, and appointed one of the hospital psychiatrists to assist me in working out the details of my research plans. At that point, my relationship with the hospital as a prospective researcher changed, as the Head left the city for the duration of my negotiations with the committees, and I thereby lost the advantage of this personal input to the proceedings.

My next task was to write a research proposal for each committee, and I consulted with the psychiatrist who had been appointed by the Head on how to go about doing this. He was helpful in giving suggestions as to the content of the proposals, and it seemed that there would be no difficulty in gaining approval for my proposed work. I prepared the proposal for the committee from my university according to a standard format defined by the university. This proposal which was

called a "statement of protocol" was an outline of the procedures that I would follow in order to ensure the welfare, privacy, and rights of the subjects studied. I did not have a format to follow for the other proposal, but the psychiatrist had informed me that it was necessary to include an outline of not only the steps that I would take to ensure that my research procedures were ethical, but also an indication that they would not interfere with the normal functioning of the hospital. I then submitted the statement of protocol to the research administrator of the university committee, thinking that it was logical to get the university's permission first to proceed with my work, and then to gain the approval of the hospital. The administrator informed me that the protocol required a letter of permission from the hospital Head and the signature of the psychiatrist who was my appointed advisor. I contacted the psychiatrist about this, and he was not prepared to sign for me as the Head was out of town. He suggested that I contact the Acting Head of the hospital, which I did, and I found that I was in the position of being an unknown outsider. The Acting Head had not been previously informed of my identity and my plans, and to him, I was just anyone off the street who abruptly was asking for a letter of permission to do research in the hospital.

It was his opinion that I should get the hospital's approval, which he defined as his own and the clinical supervisors' approval, first before I submitted my statement of protocol to the university committee. I got in touch with the psychiatrist to discuss my problem, and found that he now felt that my attempt to gain access to the hospital had to be put off until the Head's return, and also that he

felt that his responsibility for and involvement with my work was minimal. Thus, it seemed to me that my position in relation to the hospital had been transformed. Lacking the personal contact with the Head, I no longer had the means to easily effect an entry to the setting. I decided to check with the Head of the university committee in order to establish the exact nature of the letter that was required, as it was not clear if it committed the person who signed it to accept responsibility for my work. This individual informed me that the signature was not an acceptance of responsibility, but rather relieved the hospital of liability for my work. He suggested that I again contact the Acting Head, and explain the meaning of the letter, and added that he would also speak to him. Thus, I contacted the Acting Head once more. After some discussion, he agreed to read my research proposal, and suggested that I make copies of it for the clinical supervisors. The next day the Head of the hospital committee informed me that a meeting had been set up for me to get together with the committee the following week. The Acting Head also contacted me, and let me know that he would discuss my proposal with the senior staff of the hospital, and that if the Hospital Research Committee found my work to be acceptable, then I would not have to anticipate any problems in gaining approval from the university committee. At this point, I again sensed a change of my status, this time from that of "outsider" to one who has some legitimacy in requesting access to the hospital. I believe that my identity and the background of my request had become known to the Acting Head and the other senior staff, and this, I assume, accounted for the change in my status.

One month after I began the process to negotiate my entry to the hospital, I met with the Research Committee of the hospital at a meeting that had been especially called to discuss my proposal to do research. Present at the meeting were the chairman of the committee, the Acting Head and clinical supervisors of the hospital, the psychiatrist who had been appointed to assist me, and three other administrative staff of the hospital. I arrived at the appointed time, and found that the meeting was already in progress; the committee members having met earlier to discuss my proposal. I was introduced to the members, and the chairman then asked me to "take the hot seat." The way he phrased his request fitted the way that I felt at that moment. It is an unusual experience to attend a meeting in which the majority of the participants are psychiatrists, and in which the discussion focuses on oneself. I was asked first by the chairman how I arrived at my topic. I was then asked by other members how I planned to gather data, and what was my understanding of the paranoid form of disorder. A discussion then evolved on the difference between a psychiatric and a sociological perspective on mental disorder. The clinical supervisors seemed to be interested in finding out what ideas I had, coming from a sociological background, on the nature of psychotherapy and paranoia. The chairman and the Acting Head focused their remarks on outlining the procedures that I would be required to follow in carrying out my research.[37] The clinical supervisors expanded the discussion beyond the technicalities of these procedures, and questioned me as to how I planned to put into practice these regulations. Thus, I was asked how I would manage to gain the consent of the patients and also the therapists.

By the end of the meeting, I felt somewhat burdened by the extensive list of regulations to which I was committed. Not only was my work to be governed by the rules of the university committee, but also by those of the hospital committee. In addition to the rules of ethics pertaining to the therapists' and the patients' welfare, rights, and privacy, which I was bound to follow, I also was committed to follow regulations with respect to legal matters, and to non-interference with the functioning of the hospital. I felt the responsibility of making sure that my work would not breach any of these rules and regulations, and I also felt a demand to simply not do anything which would break protocol in the hospital. The latter feeling was responsive not to any specific rule or regulation, but derived from my month long experience of negotiating my entry. The gravity of the response to my request to do research had created within me a tension about proceeding with my work in the research setting.

At the end of the meeting, I was told that the Acting Head would inform me of the committee's decision in three days. Upon contacting him, I was notified that both the hospital committee and the university committee had granted me permission to carry out my research.

It is important to note that I do not harbour any negative feelings about my month long experience, despite the fact that I found upon entering the research setting that the rules and regulations stipulated by the committees are not always strictly observed in the course of ongoing work that gets done in the hospital. It was the task of the two committees, and in particular the hospital committee, to screen "outsiders" who wish to do work in the hospital, in order to make sure

that official policies and regulations are not abused. It is the task of the staff working within the hospital to treat patients, and these two tasks are not necessarily compatible, as they are structured according to different demands.

Methodology

The methodology of the thesis has already been briefly discussed. I shall again take up this topic, and shall offer a further description and defence of it. I have argued that the ethnographic method which was employed to gather data allowed me to discover that my preconceived constructs, which I brought with me into the research setting, did not make sense in terms of what I observed and experienced in the setting. As the ethnographic approach did not provide for the use of instruments such as interview schedules and attitudes scales, I was not able to gather data which would simply serve to support my constructs. I was unable to gain, to use Turner's metaphor, "snapshots" of activities such as therapists invalidating "paranoid" patients' versions of the world. Instead, I entered the setting and began non-participant observation without the baggage of this type of methodological instrument. I did have my preconceived perspective which I had worked out in detail, but I did not have the means to operationalize it. Thus, I am arguing that the ethnographic method enabled me to make sense of the setting in terms of what I actually observed and experienced, rather than relying upon my preconceived ideas of what was taking place. The constructs, which I later did develop, evolved from my fieldwork experience, rather than my fieldwork experience being determined by my constructs. I therefore did

not engage in a process which David Sudnow describes as ". . . performing transformations on the object."[38] I did not impose my schema on the setting, and provide myself with "snapshots" of what was happening that had little to do with the actual ongoing activities of the setting. I concur with Jeff Coulter's assertion that "the morality of social organization is surely not a topic for arbitrary redefinition by sociologists of all people,"[39] and I am arguing that the ethnographic method allowed me to avoid this practice.

The Data and Their Collection

I conducted my fieldwork over a period of seven months. During this time, I visited the hospital partially on a scheduled basis; every second week I attended the therapy session of a "paranoid" out-patient. The rest of the time that I spent in the hospital was not regularly scheduled. One week I would spend part of every day at the hospital, while the next I might only be there for two days. I did not visit the hospital on a regular daily basis because of my particular research interest. Sometimes there were no patients on the wards who had been diagnosed as "paranoid." Since I was interested primarily in patients with this type of diagnosis, I spent more time in the hospital when such patients were present. I had arranged with one therapist from each ward to notify me when a patient whose admitting diagnosis made reference to a paranoid type of disorder, was admitted.[40] I therefore was able to keep track of the flow of "paranoid" patients into the hospital. My observational work in the hospital was organized in terms of these patients, and thus the frequency of my visits to some degree depended

upon the number of "paranoids" who were in the hospital, or were coming to the out-patient department.

I gathered three types of data while in the research setting. I made tape recordings of therapy sessions in which a therapist and a "paranoid" patient participated.[41] I examined and made notes on the clinical records of these "paranoid" patients that were made by their primary therapists and other members of the hospital staff, and I made fieldnotes of my observations of the therapy sessions and other activities that I experienced and observed while in the hospital. In addition to these data, I developed a fourth type of data which consisted of a journal which I wrote at home, and in which I kept a log of my reflections upon what I had observed each time that I was in the hospital. Together, these four types of data provided me with a number of perspectives on the work that was done with "paranoid" patients; my own, the therapists', and also the objective record of therapy sessions which the transcripts of tape recordings provided. My data were not, however, simply limited to the activities which ensued with "paranoid" patients. In the course of collecting the data on "paranoids," I also gathered data on the other activities which were going on around me in the hospital. Thus, my fieldnotes, journal, transcripts, and notes on the clinical records did not filter out references to activities that I experienced and observed which were not directly related to patients who had been diagnosed as "paranoid." When I attended, for example, rounds because a particular "paranoid" patient whom I was interested in was being discussed, I also observed the discussion of other patients by the therapists, and I kept a record of these observations. Another

example will illustrate this point. One day I was in the nursing station of a ward talking to a fourth year medical student about a "paranoid" patient whom I wished to meet when a psychiatric resident came up to us and invited us to watch a videotape of a therapy session with a woman who had been diagnosed as schizophrenic. I went to a room in another part of the hospital with the medical student and the resident, and spent the next hour watching the videotape with them, the patient, and four other medical students. During the next two hours I sat in the room while the patient discussed how she felt about seeing herself on the videotape, and I also was present while the resident and the students discussed the patient after she had left the room. This was the pattern of how I spent my time in the hospital. I organized my work around gathering data on "paranoid" patients, but often I ended up observing and recording activities that were not related to patients who had this particular diagnosis. Thus, I was able to gather data and develop insights on psychotherapy with not only "paranoid" patients, but also patients with other diagnoses. This allowed me to put the work done with "paranoids" into perspective in terms of how it compared to the work that was done with other patients.

Once I gained permission from the Research Committee of the hospital to do my research there, I was not able to simply proceed, and walk into the hospital and begin my fieldwork. I did not have an identity or a role in the hospital, and I therefore could not walk off the street and into the setting. As I did not have a structured role in the hospital which would provide me with a "cover" for being there (i.e. a job such as an aide or a cleaner), it was necessary for me to make

contact with the hospital staff and establish my identity as a researcher, and explain to them the purpose of my work in the hospital. In my meeting with the Research Committee of the hospital, I had met the Acting Head of the hospital, some of the clinical supervisors of the wards, and a number of other senior staff members. I had previously met the Head of the hospital and a staff psychiatrist who had been appointed by the Head to discuss with me my interest in doing research in the hospital. I did not know, however, anyone else on the hospital staff, and the senior staff that I had met usually were not present when I came on a ward. I therefore had throughout the course of my fieldwork to account for my presence in the hospital, and establish my identity with the staff as a researcher. Although I came to know a number of staff on every ward, I always met new ones, and therefore it was necessary for me to go through this process of explaining who I was, and what I was doing on their ward. I even had, for example, problems establishing my identity with staff whom I had previously met. At the beginning of my fieldwork, I phoned one of the clinical supervisors in order to find out if there were any "paranoid" patients on his ward. He did not at first remember who I was, and gave the phone to his secretary, apparently with the intent of "getting rid of me." The secretary proceeded to tell me that I could not simply come into the hospital and do research. She told me that I had to speak to other people in order to do research there, and that I had to follow a strict procedure in order to gain permission. While I tried to explain to her that I already had been granted permission, she went on and warned me that "there have been problems with people doing studies in the hospital." Realizing that

the clinical supervisor had forgotten who I was, I did not give up, and I repeated my explanation of who I was, and why I wished to speak to him. By this time, he had remembered who I was and again got on the phone, and began to discuss with me the patients on his ward. On another occasion, I went to the Medical Records Office of the hospital in order to look at the clinical records of a patient who I was interested in. The head of the office (a medical librarian) was out, and the woman to whom I spoke said I had to see the librarian before I could look at the patient's chart, although I had explained to the office worker who I was and what I was doing in the hospital. Two hours later the librarian returned, and I introduced myself, and explained what I wished to do. The librarian responded by saying that she didn't know who I was, and that she is always informed first if anyone is doing research in the hospital. Thus, I was faced with a challenge of my identity, and the legitimacy of the work that I wished to do. I happened to have with me a two-page list of regulations concerning my research, which the Research Committee had given me, and I presented it to her as proof of my identity. The librarian looked over this list and lectured me on each of the rules on it, although I informed her that I had already gone through this procedure with the Research Committee. Finally, she said that she remembered getting a memo about me and my work, and thus acknowledged that I was "okay."

I did not always have as difficult a time in establishing my identity, but it was necessary for me to explain who I was, and what I wished to do every time that I made contact with a staff member whom I had not met before. Sometimes I was able to make my task easier by

distributing a copy of the statement of protocol which I had prepared for the Faculty of Medicine Committee on Research Involving Human Subjects. This protocol outlined the nature of my research project, and the steps that I planned to take in order to ensure that the rights of the individuals whom I studied would not be abused. When I was able to, I would send a copy of the protocol to staff members before I met them.[42] I found that this procedure worked well, as it gave the staff members the opportunity to get to know who I was through a more gradual process. After the members of the staff had had a chance to read the protocol, I would arrange to meet them, and I found that these encounters went much more smoothly than when I met staff members who had no prior knowledge of who I was.

In addition to the problems that I had in establishing my identity in the hospital, I was also faced with the task of negotiating my entry onto the wards and into therapy sessions. Simply establishing who I was, and that I had official permission to carry out my research, did not guarantee me the opportunity to carry out my work. In order to observe therapy sessions, make tape recordings, attend rounds, etc., I required both the written permission and the co-operation of the staff who were involved. It therefore was necessary for me, after I had established my identity on a ward, to develop a friendly working relationship with the staff of that ward. To some degree, the volume and kind of data that I gathered were affected by the strength of the relationships that I worked out with staff members. On the wards where I had closer relationships with the staff, for example, I also was kept better informed of the admittance of "paranoid" patients, invited more often

to observe therapy sessions and attend rounds, provided with more information about activities on the ward and in the hospital, and in general allowed more free access to the ward. The relationship that I developed with the clinical supervisor of a ward seemed to affect the quality of the relationships which I worked out with the other staff of the ward. On one ward, for example, the clinical supervisor was interested in my work and gave me encouragement, and it was from this ward that I received the most co-operation from the staff. On another ward, my first meeting with the clinical supervisor did not go well, as the assistant clinical supervisor from the ward, whom I had met before and who attended this meeting, expressed doubts about the value of my work. He stated that my "hypothesis" was unclear, and that I would not be able to find patients with the diagnosis that interested me. The clinical supervisor seemed to be influenced by him, and began to express disinterest in and skeptical remarks about my work. I subsequently found that it was on this ward that I had the hardest time in making contact with the staff and in carrying out my work.

I shall now outline in more detail how I actually went about gathering data. The first phase of my work involved making contact with the staff on the wards which involved, as has been discussed above, making phone calls, sending copies of my statement of protocol, and arranging to make my initial visits to the wards. I kept track of these encounters and all subsequent experiences that I had in the course of my fieldwork in my journal. Every evening I set aside time to record my observations and experiences from the day in the hospital. At first I found this to be a difficult task, as I was not used to consciously

remembering and analysing in a disciplined fashion what had happened to me during the day. I found it a strain every evening, to bring up again in my mind material that I had already dealt with before. After the first few weeks, however, I adjusted to this new pattern in my life, and no longer found it so trying to rethink the events of the day. The journal proved to be a useful source of data, as I was able, in the calmness of my home away from the immediacy of the research setting, to analyse and develop insight into what had happened that day. I was able to make use of my fieldnotes to help me remember what had gone on, and then I was able to reflect and build upon this material. I found that there was a skill involved in this process, and that my ability to carry it out improved over time.

My first visits to the wards were stressful to me. Although I had visited mental hospitals before, I had never done so in the capacity of a researcher. My head was filled with the rules of research conduct that I had agreed with the hospital Research Committee and the Faculty of Medicine Committee on Research to abide by. I was also very aware of the commitments that I had made to the hospital Research Committee with respect to making sure that my presence and work would not interfere with the functioning of the hospital. Thus, I felt on edge, worried that I might inadvertently do or say something wrong. I had already been "coached" by one of the hospital psychiatrists on how to look and behave. He had advised me that I should dress like him; ". . . dress like a doctor," in a sweater, tie and slacks. By adopting his style of dress, I was able to look like one of the staff, as none of them wore uniforms. He had also given me advice on how to talk to

patients, and in particular how to talk to "paranoid" patients. Thus I entered the research setting gingerly, and during one of my early visits I arranged with a therapist (who had been introduced to me by the clinical supervisor of a ward, because the therapist was treating a "paranoid" patient) to observe and tape record a therapy session.

I shall discuss the steps that were involved in the observation and tape recording of this therapy session, and the outline may serve as a guide to how I typically went about gathering this type of data. In my first meeting with the primary therapist, I had (after explaining what I wanted to do) to gain the therapist's informal approval to proceed. I was not always successful in gaining the approval of the therapist. One resident, having been encouraged by her clinical supervisor to work with me as she was treating a "paranoid" patient, declined, saying that she felt that the patient (who was an out-patient) might terminate therapy if I became involved. After I got the therapist's approval, I arranged the date and time at which I would be able to observe a therapy session. This in part depended upon when the observation room on the ward was available. This was a room from which one could see (through a one-way mirror) and hear what took place in the adjacent room. During the therapy session I would sit in this room and observe the session, writing down my observations in my fieldnotes. Beside my I would have my tape recorder which was connected to an audio pick-up located in the other room. Thus, I was able to clearly see and hear what took place in the other room without radically changing, because I was not present, the nature of the interaction between the primary therapist and the patient. Although they were both aware that

I was observing them, one can assume, as it seemed to me after watching a number of sessions, that my presence in the other room did not have a significant effect upon how the therapy session evolved. The particular therapy session which I am addressing myself to, the first one that I observed, did not take place in a room connected to an observation room. This happened because the patient refused to be observed in that setting. The patient did agree, however, to have me sit in on the session, which I did; sitting off to the side of the patient and the therapist, making notes and operating my tape recorder. It was through this experience that I was able to see how my immediate presence could alter a session. When I sat in on the session, the patient made reference to me in his dialogue with the therapist, and at times turned and addressed me. Although my presence altered the nature of the session, I found that sitting in on a session provided me with new insights as I became more directly involved with the patient and the therapist.

The patient's refusal to be observed from behind a one-way mirror occurred when I asked him for his written consent to record and observe the session. Before I taped a session, I was required by the hospital Research Committee to follow a strict procedure with respect to obtaining permission. The rules that I had to adhere to were set down by the committee as follows:

> (a) Each of the patients would sign a valid consent form permitting the recording and observation.
> (b) Each of the primary therapists would also sign a valid consent form on each occasion that a session was recorded and/or observed.
> (c) For each patient, Mr. Maidstone would obtain the approval of the clinical supervisor and of the head nurse before proceeding to record and/or observe the sessions.
> (d) For each taping session, the primary therapist would record

> his clinical opinion that the patient understood the nature of the consent he had given. This statement by the primary therapist together with the primary therapist's own written consent would be entered in the patient's chart at the time of the taping.[43]

I took these rules seriously and, on every occasion that I attended a session, I attempted to follow them exactly. To my surprise, some of the staff that I met did not seem to take the rules seriously and, in fact, at times disregarded and were critical of them. This phenomenon will be discussed later in the thesis.

After I had observed and taped a session, which usually lasted about forty to sixty minutes, I thanked the patient, and sometimes had the opportunity to talk to the patient by myself for a short time. During these conversations, the patients frequently asked me such questions as: what I hoped to find out by observing them, what was my job in the hospital, or what was I studying at university. I usually talked to the therapist after the session, and I found that the therapists were often anxious to hear my opinions on what had evolved during the session, and what I thought about the patient. A closer relationship seemed to develop between the therapists and myself after I had shared the experience of a therapy session with them. I think that they felt that we now had more in common, and in these talks after the sessions I received many data. The therapists would talk not only about the patient they were treating, but also about a range of topics such as their understanding the "paranoid" disorder, their relationships with the other staff, their feelings about their job or role in the hospital, their views on the nature of their ward and the hospital, etc. I found, after taping sessions, that I became more accepted by both the

therapist with whom I had worked, and the other staff on the ward. It seemed that the rest of the staff also felt more in common with me, and my involvement in the therapy sessions served to provide me with more of a role on the wards to which the staff could relate. I now became not only the graduate student doing research, but also the person who observed and had a special interest in the "paranoid" patient or patients on the ward. Thus, the clinical supervisors also would sometimes discuss with me a "paranoid" patient whose sessions I had observed. One day, for example, after I had taped and observed a session, I met the clincial supervisor in the nursing station, and he asked me with interest what I thought of the ideas of the patient whom I had observed, and if I thought that the patient had fixed delusions. After I expressed my opinions, he then gave me his analysis of the patient. My role in the hospital, therefore, at times shifted from that of non-participant observer to participant observer. One therapist in particular made a point of consulting after every session with me, on my views of how her patient was progressing in therapy. I never sought out the opportunity to adopt this role, and participate in these types of discussions, but rather found that the staff brought me into the role of a participant. On another occasion, I was invited by a psychiatric resident to present my views of a "paranoid" patient in rounds, because I had previously observed a number of sessions with this newly admitted patient on another ward. Thus, my involvement in taping and observing therapy sessions provided me not only with data on the sessions, but also helped to create the opportunity for me to gather data in other settings.

My other two methods of data collection were my fieldnotes, and my notes on the clinical records. I kept my fieldnote book with me at all times when I was in the research setting, and in it I kept my immediate observations of what was happening around me. Sometimes this took the form of an account and brief analysis of an activity that I was witnessing, such as a therapy session, while at other times I would include an outline and quotations of a conversation that I was having or had had; or that I was hearing or overhearing. When it was possible, such as when I was in the observation room or when a person gave me their informal permission to make notes, I would write the fieldnotes at the same time as the activity that I was involved in took place. At other times, I had to wait for the first opportunity that I got to get away from an activity in order to write my notes. I made a point of doing this as quickly as possible after something happened that I wanted to get down, so that I was able to preserve my original sense of the conversation or activity. On one ward there was a room provided for social work students to use as a study, and I often went to this room to write up notes. I also used the offices of medical students, and sometimes went to the hospital cafeteria to make notes. At times, if I felt that I needed privacy in order to write something up, I would go and write in my van, which was parked beside the hospital.

The fourth type of data that I gathered was taken from the clinical records of the patients whose therapy sessions I had observed and taped. I collected this type of data, as I was interested in gaining an insight into the perspectives which the therapists had on the "paranoid" patients who they were treating. Until a patient was

discharged from the hospital, his/her records were kept in the nursing station of the ward. I had noted in my research proposal to the Research Committee of the hospital that I would not examine patients' records while they were kept in a nursing station in order to avoid interfering with the work carried on in the station. I had made this point in my proposal on the advice of the staff psychiatrist who had been appointed to discuss my research interests with me. He felt that the Research Committee would look favourably upon a suggestion by me that I would try to avoid interfering with hospital work. As it turned out, on a number of occasions I was invited by therapists to examine patients' records before they had been discharged. At these times I would mention my commitment in the proposal, but if they still extended the invitation, then I would take it up. I would locate, with their help, a place to work such as the back of the nursing station, and begin to peruse the records. I was able to gather two types of data at these times; not only did I gain data from the patients' charts, but also the setting in which I worked was an excellent source of data for my field-notes. Located in the corner of the nursing station with a patient's chart serving as an identifiable explanation for my extended presence there, I was able to gather much useful data on the activities which ensued in the nursing station.

I examined charts of discharged patients in an office that was used for transcription services, and was located across the hall from the Medical Records Office of the hospital. The librarian (whom I mentioned above in my description of the problems I had in establishing my identity) of the office insisted that I had to get her personal

permission every time that I wanted to see a chart. She warned me that she would be checking on the charts of the patients whose therapy sessions I had observed and taped, in order to establish whether all the consent procedures had been properly recorded in the charts.[44] This produced anxiety in me, as my experience had been that not all therapists took these rules seriously, and I worried that some had not followed the procedures correctly. The librarian saw the charts in terms of her task which was to protect the hospital from legal suits and to protect the patients' rights and privacy, while the staff did not seem to share this concern to the same degree.

When I examined the records, I found that they consisted of reports on and analyses of the patient made by his/her primary therapist and other members of the staff who saw the patient. Usually, there would be several entries made by different staff members for each day that the patient stayed in the hospital. The records also contained an admitting diagnosis, history, and problem list, plus any previous psychiatric or relevant medical records, a discharge summary, and a record of medications that were prescribed. From this material I would copy verbatim, entries that I thought revealed the staff's perceptions of the patient, similar information from previous psychiatric admissions, and the official diagnoses that were made upon admittance and discharge. What follows is a typical entry, of the sort that I copied, made by a staff member.

#9 Paranoid #10 Introversion[45]

S. "I walked around-- "No-- I saw no one I knew "No-- I know I'm to get a job and I'll start on it Monday" "I have an idea" "No I won't tell you in front of everyone" "No I won't go to

> my room-- Why should I tell you? It's simply that I won't stay here a day longer than I have to-- won't leach off your system any longer.
>
> O: very angry tone.
>
> A: -- remains paranoid re: exchanging information in front of patients on topics even as general as "Did you shop?" -- remains defensive re: problem sharing with therapists. . . .
>
> Orders:
> Remains suspicious of staff intentions.
> -- Use friendly greetings in hall, day room, etc. to increase his sense of "OK" via staff. . . .

A number of factors which made my fieldwork difficult and hindered my data collection need to be mentioned. Some of them have been pointed out already, and others will be discussed more fully later in the thesis. I am bringing these points up because it is necessary to make it clear that I was not able to gather data easily, simply because I had been given permission to conduct my research in the hospital, and it is relevant to account for this, as my difficulties, I think, reflect the influence upon my fieldwork of features of the setting within which I worked. First of all, I had to conduct my work within the bounds laid down by my university's Faculty of Medicine Committee on Research Involving Human Subjects and the Research Committee of the hospital in which I conducted my fieldwork. These rules complicated my work, and at times denied me the possibility of gaining data, as a patient would refuse to give his/her formal written consent to be taped and observed during a therapy session. The rules also created problems for me, as I found that the staff did not always follow them, and I had to spend time making sure that their omissions were corrected. The seriousness with which the two committees treated the research rules also created

tension for me, as I felt pressure to meet these obligations; a task which, as noted, was not always easy. This tension at times inhibited me in my exploration of the hospital, as I sometimes felt that I had to "watch my step" in order to avoid breaking the protocol. I have already discussed my problems in establishing my identity and in finding a role for myself in the setting. Part of these problems can be traced to what might be termed "hospital security." As the hospital was a psychiatric hospital, the staff seemed to share an awareness of the need to keep close track of the patients, and to fend off interference with the patients from the outside world. There existed a clear distinction of being an "outsider" if one was neither a patient nor a staff member, and "outsiders" were treated with suspicion, and denied information about hospital activities. Even after I had established my identity as a researcher, found that a role had evolved for me, and made friends with some of the staff, I still sensed that this barrier existed. This hampered me, as it denied me the opportunity to simply "hang out" in the setting for longer periods of time. I found as an "outsider" that I always needed a reason to be in the setting such as seeing a therapist and patient, or looking at a chart, etc. I could not, for example, simply sit down in the nursing station for two hours and record what I observed. I found that I needed to be involved in a task in order to account for my presence in the setting. Being an "outsider" I think, also accounted for the lack of interest, co-operation, and at times suspicion that some of the staff displayed toward me and my work. It seemed that some of them felt uncomfortable being observed by an individual who came from the "outside."[46] I would venture to guess that,

undertaking the same research project, I would have received more co-operation and trust from these individuals if I had been a medical student or a resident. Another factor to consider is that some of these individuals were themselves medical students and psychiatric residents, and therefore may have felt somewhat insecure in their work if they were being observed. Finally, it is necessary to note that the patients, given a diagnosis that made reference to a "paranoid" condition, also tended to be patients who exhibited the characteristic of being mistrustful. Their mistrust made it more difficult for me to gain their co-operation and consent in carrying out my work.

Footnotes

[1]Hans H. Strupp, "Psychotherapy Research and Practice: An Overview," in *Handbook of Psychotherapy and Behavior Change: An Empirical Analysis*, eds. Sol L. Garfield and Allen E. Bergin (New York: John Wiley and Sons, 1978), p. 8.

[2]Ibid., p. 11.

[3]A distinction must be made between the belief of the psychotherapist, and the beliefs of the social scientist and the lay person. While the psychotherapist may espouse the same belief as the others, we shall see that his/her belief must be understood in a different context, as the therapist, unlike the social scientist or lay person, is also the person who actually practises therapy.

[4]The argument claims that psychiatric theory (which I define as the range of theories pertaining to mental illness and psychotherapy derived from the work of both psychologists and psychiatrists) provides "rules" or guidelines for the therapist with respect to the diverse matters with which he/she must deal while working with patients; such as the correct way of conceptualizing a patient's remarks, the appropriate manner of speech to use when addressing a particular type of patient, the proper time to be directive with a patient, etc. See, for example, Strupp's remarks with respect to the role of psychiatric theory, noted above.

[5]The researcher defined intuition as a sense derived from one's common sense knowledge, acquired through socialization, and shared with with the other members of one's culture.

[6]What was being rejected here was the traditional sociological approach to psychiatry which theorizes about this enterprise in terms of our common sense notions with respect to it. The data from the researcher's fieldwork will show that he came to realize that he could not proceed in this way, utilizing these common sense notions as a resource to accomplish his work. Rather, he came to see that what was required was a more fundamental understanding of the enterprise, which could only be accomplished by treating our common sense knowledge of it, as a topic. For a further discussion of this approach, see: D. Zimmerman and M. Pollner, "The Everyday World as a Phenomenon," in *Understanding Everyday Life*, ed. J. Douglas (London: Routledge and Kegan Paul, 1971). See also: A. Blum, "The Sociology of Mental Illness," in *Deviance and Respectability*, ed. J. Douglas (New York: Basic Books, 1970).

[7]We use the term "paranoid" in quotation marks throughout the thesis, as the researcher is unable, despite a basic shift in his

understanding of paranoia as a consequence of his fieldwork, to subscribe to the psychiatric diagnostic system of nomenclature. A further discussion of this point is taken up in footnote 26 of this chapter.

[8]The term "gap" is used in quotation marks in order to signify that we are unable to prove whether the "gap" is merely a construct of the researcher, who, due to his inability to make use of psychiatric theory, arrived at a superficial evaluation, based on appearances of what he observed, or whether it is, in fact, an integral feature of the practice of psychotherapy.

[9]The following sources are representative of the ethnomethodological perspective: Harold Garfinkel, *Studies in Ethnomethodology* (Englewood Cliffs, N.J.: Prentice-Hall, 1967); David Sudnow (ed.), *Studies in Social Interaction* (New York: The Free Press, 1972); and Roy Turner (ed.), *Ethnomethodology* (Harmondsworth, England: Penguin, 1974).

[10]I am referring to the following sources: Jeff Coulter, *Approaches to Insanity* (New York: John Wiley and Sons, 1973); David Sudnow, *Passing On* (Englewood Cliffs, N.J.: Prentice-Hall, 1967); and Roy Turner, "Occupational Routines: Some Demand Characteristics of Police Work," paper presented to the CSAA, Toronto, June 1969; "Some Formal Properties of Therapy Talk," in *Studies in Social Interaction*, ed. David Sudnow (New York: The Free Press, 1972); "Utterance Positioning as an Interactional Resource," *Semiotica*, 17:3 (1976), 233-254.

[11]I make reference here to my level of understanding (of their perspective) which I shall discuss shortly.

[12]Roy Turner, "Occupational Routines," pp. 17-18.

[13]Jeff Coulter, *Approaches to Insanity*, p. viii.

[14]He is referring to the collectivity of activities such as communicating with patients, making sense of patients' behaviour, etc.

[15]Jeff Coulter, *Approaches to Insanity*, p. 150.

[16]Roy Turner, "Utterance Positioning," p. 236.

[17]In addition to Freud, some of the authors studied were Wilhelm Reich, Erich Fromm, Philip Rieff, and Erik Erikson.

[18]Representative of this literature are such works as: J. Agel (ed.), *The Radical Therapist* (New York: Ballantine Books, 1971);

R.D. Laing, *The Politics of Experience and the Bird of Paradise* (Middlesex, England: Penguin, 1968); and T.S. Szasz, *Ideology and Insanity: Essays on the Psychiatric Dehumanization of Man* (New York: Doubleday-Anchor, 1970).

[19]Peter Maidstone, Canada Council Doctoral Fellowship Application, Vancouver, B.C., 1971, p. 1.

[20]Ibid., p. 1.

[21]It is important to note that I was particularly interested in psychoanalytic theory but that I felt that this analysis was applicable to other schools of psychiatric theory; i.e., I felt that these other psychiatric theories also respectively determined the nature of psychiatric practice.

[22]Peter Maidstone, Ph.D. Dissertation Proposal, Vancouver, B.C., November 1974, pp. 5-6.

[23]Jeff Coulter, *Approaches to Insanity*, p. 142.

[24]Roy Turner, "Occupational Routines," p. 3.

[25]Ibid., p. 3.

[26]This term is taken from the "Diagnostic and Statistical Manual of Mental Disorders" (Washington, D.C.: American Psychiatric Association, 1968), p. 38. I do not subscribe to the claim that individuals given such a diagnostic label necessarily possess a specific set of characteristics. Paranoia, after all, as Morton Schatzman has pointed out in his book *Soul Murder* (London: Penguin Press, 1973), is an attribution, not an experience. Rather, the terms paranoia and paranoid state will be used in order to denote behaviour seen by therapists to be representative of this type of disorder, or to indicate that an individual has been given this diagnostic label. Thus, my use of these terms and other diagnostic labels such as paranoid personality or paranoid schizophrenic does not imply a commitment on my part to the psychiatric diagnostic system of nomenclature.

[27]D. Swanson, et al., *The Paranoid* (Boston: Little, Brown, 1970), p. 249.

[28]Norman Cameron, *Personality Development and Psychopathology* (Boston: Houghton Mifflin, 1963), p. 508.

[29]"Diagnostic and Statistical Manual of Mental Disorders," pp. 37-38.

[30]Kenneth Munden, "Consideration of the Paranoid Problem in Psychiatric Practice," *The Journal of the Tennessee Medical Association*, 60:9 (1967), 939.

[31]I am speaking here of my original perspective that psychotherapy is a theory-governed activity.

[32]Of the other three patients whose cases I followed in detail, two were diagnosed as paranoid schizophrenics, and the other was seen to be suffering from an acute paranoid reaction.

[33]David Swanson, et al., *The Paranoid*, p. 34. See also the work of A. Lewis, "Paranoia and Paranoid: A Historical Perspective," *Psychological Medicine*, 1 (Nov. 1970), 2-12; and G. Sisler, "The Concept: 'Paranoid'," *Canadian Psychiatric Association Journal*, 12:2 (1967), 183-187, who also argue that there is considerable difficulty in assigning the correct diagnostic labels to behaviour that is seen to be of the "paranoid" type.

[34]"Residency Brochure," Department of Psychiatry, University Hospital, 1973.

[35]"Hospital Information Booklet," University Hospital, 1976, p. 1.

[36]"Patient Information," Department of Psychiatry, University Hospital, 1971, p. 1.

[37]These procedures are noted in the section on data collection. In addition to those outlined there, the following two rules were stipulated by the committee, and are quoted from the minutes of the meeting:

> In response to a specific question from the chairman, Mr. Maidstone undertook that the tapes would be transcribed only by himself or his wife, that they would be erased immediately after transcription and that no one other than he or his wife would have access to the tapes. Neither patient nor primary therapist would be identified by name in the transcript or in any record made from the transcript or, in particular, in Mr. Maidstone's Ph.D. thesis.
>
> Mr. Maidstone would also require access to the charts of the four patients whom he was investigating. It was agreed by the committee that this was reasonable subject to the usual safeguards.

[38]David Sudnow, *Passing On*, p. 9.

[39]Jeff Coulter, *Approaches to Insanity*, p. 63.

[40]I conducted my fieldwork in three wards of the hospital; the out-patient ward and two regular in-patient wards. The Research Committee of the hospital recommended that I not do observational work in the fourth ward of the hospital, as the primary therapists (the patient's main therapist) on this ward were medical students who had had less experience in practising psychotherapy than therapists on other wards. It turned out, however, that I did encounter primary therapists on the other wards who were medical students.

[41]I tape recorded therapy sessions of four different "paranoid" patients.

[42]This, of course, was not always possible, as I often encountered staff members for the first time on the wards.

[43]These rules were set down in the minutes of the meeting of the hospital Research Committee in which my proposal to do research in the hospital was discussed. A copy of the minutes of the meeting was sent to me by the chairman of the committee.

[44]It is important to note that I felt no animosity toward her because of her behaviour. I just saw her strictness in light of the job which she was faced with.

[45]Each daily entry was preceded by one or more diagnostic terms which were numbered, and which were seen by the therapist who made the entry to describe the patient's current condition. The entries were also organized in terms of a particular format. "S" stood for the word subjective and under this term were included quotes that were seen to express the patient's current state. "O" stood for objective, and was the staff member's description of what the patient looked like, and what they were doing when the quoted material was expressed. "A" stood for assessment, and was the staff member's analysis of the patient's current condition. "Orders" indicated the staff member's proposed strategy as to how the patient's therapy should proceed.

[46]In the previous year another researcher from the "outside" had conducted fieldwork in the same hospital, and had by the end of his fieldwork become involved in a feud with one of the staff psychiatrists over the way he had conducted himself in the hospital. Possibly, this controversy was in part the source of the negative feelings that I got from some of the staff.

CHAPTER 2

DEVELOPING CONSTRUCTS: THE RESEARCHER STUDIES THE LITERATURE

The "Map": The Evolution of the Researcher's Perspective

It is my purpose at this point in the thesis to set out, in some detail, the constructs or preconceptions which I held with respect to paranoia prior to entering the research setting. These thoughts formed, in a sense, a map in my mind which would, I assumed, serve as a reference guide while in the research setting. In other words, I made the assumption that my study of the literature on paranoia would provide me with the means to understand my observations and experiences in the psychiatric hospital. Thus, I prepared myself as if I were an anthropologist about to enter the field. Just as they attempt to become, through the literature, familiar with the culture that they intend to enter, so too did I attempt to glean as much as possible from the literature on paranoia which would enable me, I assumed, to make sense of my encounters with paranoia in the setting.

Thus to me, the psychiatric hospital represented to some degree a foreign culture which I planned to enter in order to further my knowledge of one aspect of the "culture"; paranoia. In some ways, it felt like my first opportunity to do anthropological fieldwork, having done my undergraduate degree in anthropology. I, therefore, studied the literature on paranoia as if I were studying ethnographies of a foreign culture which I would later do fieldwork in.

Prior to entering the setting, I formulated from the psychiatric, sociological, psychological, and popular literature some definite ideas as to the characteristics of paranoia and the "paranoid."[1] These ideas or constructs derived from the literature, were the basis of my expectations as to what I would find in the research setting. They provided me with my "map" which would serve, I thought, as a guide to making sense of the "foreign culture" that I was to enter. As has been previously pointed out, my map did not serve its purpose. What I was led to expect, and what I actually found in the research setting were not synonymous. I intend at this point in the thesis to outline chronologically how I put this map together, and to discuss its contents. Later in the thesis, I shall document by means of my research data, what I actually experienced and observed in the setting.

As was pointed out previously in the thesis, I developed an interest in psychiatry and mental illness prior to the emergence of my interest in paranoia. It is relevant to discuss these initial concerns, as it was from this period in my studies and research that I evolved my understanding of psychiatric theory and practice. I then utilized this understanding to explore the literature on paranoia. Thus, to fully grasp, to use the popular parlance, "where I was coming from" when I began my research in the psychiatric hospital, it is necessary to discuss my initial analyses of psychiatry and mental illness.

My interest in this area grew out of a desire to broaden my understanding of human behaviour. In my undergraduate work in sociology, I developed a specific concern with the sociology of knowledge. This interest stemmed from my belief that an understanding of human behaviour,

required one to understand the ideas or theories that shaped human consciousness. Having studied the sociological literature in this area, it seemed reasonable to explore the psychologically oriented material which addressed itself to this question. In particular, I was interested in the literature that attempted to bridge the gap between sociology and psychiatry, as I wished to better understand the link between individual and collective consciousness. Part of my motivation to pursue this work stemmed from numerous discussions that I had with a relative who was a psychiatrist, and with other psychiatrists who were his friends. As was pointed out earlier, I discovered that their perspectives differed considerably from mine, particularly because they seemed to ignore the sociological point of view.

In my first year of graduate work, I had the opportunity to explore the common ground between sociology and psychiatry in terms of a sociology of knowledge perspective. I focused my studies on theorists who had attempted to integrate sociological and psychiatric explanations of human behaviour.[2] In particular, I focused on the writings of what has been termed the Freudian Left;[3] those authors who had attempted to synthesize the work of Marx and Freud. Their endeavours were of importance to me, as they, the Freudian Left, drew upon both sociology and psychiatry and sought to explain human behaviour from what seemed to be an integrated perspective. Thus, from this work, I hoped to find the means to resolve some of the differences that emerged in my discussions with psychiatrists. I thought that I might discover psychiatric theories that also could account for social phenomena, and that would explain the link between the consciousness of the individual and the collective.

Thus, I was looking for psychiatric theories that contained a sociological component, and acknowledged its importance.

As I worked my way through the literature, I came to the realization that the theorists of the Freudian Left had to transform a fundamental tenet of Freud's perspective in order to synthesize his work with Marx's sociologically oriented perspective. They were forced to reject Freud's view that there existed an inevitable conflict between human instinctual needs and the needs of society.[4] To accept Freud's view, meant the acceptance of the necessity of repression, the inevitability of illusions, and the imperfectability of humans. Most importantly from a sociological point of view, it meant that all sociological analysis was in a sense redundant, as the core of human behaviour was to be found in biology, not in the nature of a society or a historical epoch. Thus, I discovered in the work of Wilhelm Reich and Herbert Marcuse an emphasis upon the need for the liberation by society of human instincts rather than their necessary repression, as stated by Freud.[5] Contrary to Freud's view of inevitable repression, Reich argues, for example, with respect to repressive civilization, that ". . . this structure is not native to man but was inculcated by social conditions . . . ," and therefore may be subject to what he terms "restructurization."[6]

Erich Fromm took his analysis even further, dropping completely the reliance on biology, and placing emphasis instead upon the role played by a specific society in shaping the behaviour of its members. Thus, Fromm in a discussion of "the sick individual and the sick society"[7] argues that:

> Freud sees man as primarily formed by his experience in the family group; he appreciates little that the family is only the representative and agent of society, and he looks at various societies mainly in terms of the quantity of repression they demand, rather than the quality of their organization and of the impact of this social quality on the quality of the thinking and feeling of the members of a given society.[8]

My study of the literature of the Freudian Left, confirmed the conclusion that I had reached as a consequence of my discussions with psychiatrists. Psychiatrists, or at least the ones that I had met, did not acknowledge the validity of a sociological perspective. Now, I felt, I knew why. Their orientation was explicable to me. As their point of view was derived from Freudian theory, there was no place in their thought for a societal explanation of human behaviour. I knew, from the literature, that one had to reject or transform major elements of Freud's perspective in order to integrate the societal point of view. Thus, I felt that I was able to explain the psychiatrists' perspectives in terms of the orientation of Freudian theory.

This was an important observation for me, as it marked a significant point in the development of my thinking. Psychiatric thought, I now realized, was shaped by a body of theory that could be seen as essentially ideological.[9] As it rejected the possibility of fundamental social change, Freudian theory, I came to realize, was a conservative doctrine. Thus, those who adopted this doctrine would understand human behaviour ideologically. This had, I felt, important social and political implications. If this was the orientation of psychiatric thinking, what was the orientation of psychiatric practice? If the thought was conservative, would the practice of psychiatry also be oriented this way? These questions began to influence my thinking, and led me to

refocus the direction of my work. I became interested not only in the nature of psychiatric theory, but also in the nature of psychiatric practice, and in particular, in the relationship between this practice and the orientation of the theory.

The shift in the direction of my work developed directly out of my study of the literature of the Freudian Left, as was discussed above. In addition, the authors noted in the second footnote of this chapter also helped to shape my new direction. I had originally read their work searching for the common ground between psychiatry and sociology. I discovered, however, that the prevalent theme in their work was a critique of psychiatry. Rather than exploring the interrelationship between sociological and psychological perspectives, the authors often used a sociological perspective to discuss critically psychiatric theory and practice. I read these works and made this discovery subsequent to the development of my new insights with respect to the ideological nature of psychiatric theory. The conclusions of these authors, therefore, complemented my own analysis that I had derived from my study of the Freudian Left. They provided me with more evidence to support the premise that the conservative, "anti-sociological" orientation of Freudian theory had significant social and political implications, particularly with respect to the practice of psychiatry. I had first encountered a specific reference to the social and political considerations that may be raised with respect to psychotherapy, in the work of Herbert Marcuse, who, quoting from Freud, noted the following in a discussion of Freud's work:

> . . . therapy is a course in resignation: a great deal will be gained if we succeed in "transforming your hysterical misery into everyday unhappiness" (J. Breuer and S. Freud, "Studies in Hysteria," *Nervous and Mental Disease Monograph No. 61*, New York, 1936, p. 232) which is the usual lot of mankind.
>
> . . . the analyst, as a physician, must accept the social framework of facts in which the patient has to live and which he cannot alter (S. Freud, *New Introductory Lectures*, New York, W.W. Norton, 1933, p. 206).
>
> This irreducible core of conformity is further strengthened by Freud's conviction that the repressive basis of civilization cannot be changed anyway--not even on the supraindividual, societal scale.[10]

These new authors frequently made reference to this issue, often linking their analyses of the practice of psychiatry, psychotherapy, back to their analyses of psychiatric theory.[11] Thus, I found support for my new point of view, and no longer wished to simply analyse psychiatric theory, independent of the practical activity of psychiatry, psychotherapy. It was at this point in time that I encountered a new body of literature that had recently emerged; the anti-psychiatry literature.

The literature that may be termed anti-psychiatry differed from earlier critiques of psychiatry, such as those previously cited, as it represented a new direction in the critical literature. Much of it was published in the late sixties and early seventies, and was directly linked to the social and political movements of that time. Unlike earlier critiques such as those of Thomas Szasz and R.D. Laing, the new literature attempted to not only critically analyse psychiatry, but also to relate this analysis to political and socio-economic issues. In some ways, it represented the "New Left's" and the "Counter Culture's" position on the issue of psychotherapy and mental illness.[12] A quotation from the Manifesto of *The Radical Therapist*, a critical journal of the

time, may illustrate the new perspective:

> In the midst of a society tormented by war, racism, and social turmoil, therapy goes on with business as usual. In fact, therapists often look suspiciously at social change and label as "disturbed" those who press toward it. Concerned with maintaining and justifying current practices, therapy avoids moving toward making life more meaningful for all people.[13]

The Manifesto goes on to state that:

> The therapist in this society is safe: he lives near the top of the heap, pursuing moneyed comforts, influence, and prestige, while the rest of society is racked by violence and war. . . . Often he even seems unaware of the bias he perpetuates or of the oppression he enacts in the name of "liberation." Expert as he may be at analyzing intrapersonal forces, he is often ignorant about forces controlling the larger society in which he lives. . . . Therapy today has become a commodity, a means of social control. We reject such an approach to people's distress.[14]

I found no difficulty, at that time, assimilating this perspective into my own analysis. As it built upon earlier works such as Szasz, Laing, Foucault, etc. which I had already integrated into my understanding of psychiatry, and as it did not contradict the perspective which I had evolved from my study of the Freudian Left, it seemed to be the logical application of these more general works to the specific issues of the day. Furthermore, I was myself actively involved in the movements of that period, and found that the new literature provided me with the means to relate my own political views to the more general understanding of psychiatry which I had already established. Thus, I was receptive to the literature, as it further clarified my point of view.

In particular, the new literature raised for the first time in a systematic way, the theme of social control. Psychotherapy, it claimed, should be viewed as a political act whose intent may be to pacify and defuse dissent, and thereby stifle social change. Seymour Halleck, in

his book *The Politics of Therapy*, put it this way:

> A psychiatrist usually focuses on his patient's internal problems, presupposing that the patient's environment is adequate and not contributing to his misery. But the patient is part of a social system. Treatment that doesn't encourage the patient to examine or confront his environment strengthens the status quo. Treatment that emphasizes the oppressiveness of the patient's external environment or shows the patient how to change it may help alter the status quo. The psychiatrist either encourages the patient to accept existing distributions of power or encourages the patient to change them. Every encounter with any psychotherapist, therefore, has political implications.[15]

Although this theme had been implicit in my own analysis, and explicit at times in the work of others that I had studied, it was not until this point, that it became the core of my analysis, around which I subsequently fitted my previous ideas.

Now, I felt that I had a firm grasp of psychiatric theory and practice. The theory guided the practice. Being conservative in orientation, it directed psychiatric practice, psychotherapy, away from liberation and toward social control.[16] Thus, to understand psychiatry one must, I believed, understand psychiatric theory. A firm understanding of the theory would, I thought, allow one to make sense of the practice.

Having evolved a defined perspective, I felt ready to pursue my doctoral studies. I planned to focus on the then current political critique of psychiatry. My intent was to validate the critique. I hoped to show that the exercise of social control that I saw as basic to psychotherapy, had its source in the conservative element that I perceived to be fundamental to psychiatric theory.

The "Map" Becomes More Detailed

Upon beginning my doctoral studies, I did not immediately pursue the objective outlined above. In my first semester, I had the opportunity to participate in graduate seminars which related to my interests in the sociology of knowledge. I also took part in a social psychology course which was directed toward the exploration of interpersonal relations through counselling, both at the experiential and conceptual levels. I had not, however, lost interest in analysing psychiatry. I participated in the graduate seminars because I felt that they would complement my broader theoretical concerns with consciousness, and I took part in the social psychology course because I thought that it would offer me some first hand experience in psychotherapy.

I shall briefly outline my experiences in these courses, as the knowledge that I gained from them also forms part of the "map" discussed earlier. One of the graduate seminars was devoted to an attempt to fuse Marxist theory with ethnomethodology. The aim of the synthesis was to develop the means of putting into practice a radical sociology. By combining the methodology of ethnomethodology with the theory of Marxism, the members of the seminar hoped to evolve an approach through which critical thought could be practically applied to the understanding of the social world. The focus of the attempt was directed toward an analysis of the role of ideas, the production of ideology, and the development of false consciousness. This focus complemented my own research interest, as I saw the possibility of utilizing ethnomethodology, in the ways discussed in the seminar. I thought that it might provide me with the means to unmask the practice of social control that

I assumed ensued in psychotherapy, as a consequence of the orientation of psychiatric theory. Therapy, I believed, adjusted the individual to an unjust world, and the process of adjustment, I came to see, could be understood as the production of false consciousness.

Although the seminar itself did not touch upon the area of mental illness and psychiatry, I was able to draw upon the analysis developed within it to further my own understanding of psychiatry. At the end of the seminar, each student was required to write a short paper on what he/she had gained from the course. I shall quote briefly from my paper, as it may illustrate the impact which the seminar had upon my perspective:

> The seminar has directly influenced my thinking with respect to my research interest. The focus of my research will be an analysis of the relationship between psychiatric theory and the influence upon society of the practice of psychiatry. I have come to realize that I could utilize the ethnomethodological approach to penetrate the ideological cover of psychiatric practice, and get at the practical operations of psychiatrists. An example of this type of research would be an analysis of how psychiatrists who are involved in the penal, welfare, or the military systems "get through the day."[17]

The other graduate seminar that I participated in was devoted to an analysis of the attempt to formulate a Marxist theory of consciousness. The work of Lukacs, Habermas, the Frankfurt School, and the Freudian Left was examined with the aim of formulating a more thorough understanding of class consciousness and false consciousness. Dealing as it did with the Freudian Left, and focusing on the question of consciousness, the seminar proved useful. Although it did not provide me with a firmer grasp of how I might actually do my research (as was raised in the other seminar), it did enable me to develop a better

understanding of critical theory. Again, I found that my research interest seemed viable in light of the course material. The control of consciousness, the central concern of the course, was after all, in my view, the primary task of the psychotherapist. Thus, I was able to relate the analysis in the course, centred as it was on the control of consciousness at the societal level, to what I felt was a similar process occurring at the interpersonal level of psychotherapy. The therapist was, I believed, engaged in shaping consciousness to fit the demands of the social system, and therefore could be seen as simply another agent of social control, engaged in the exercise of another means of social control.

The third course that I took, interpersonal relations, did not, in my view at that time, further my understanding of psychiatry, and as a consequence, I withdrew from it. I had enrolled in the course with the aim of developing a better understanding of the therapeutic process, as I felt that I needed to become more familiar with the actual subject matter of my proposed research. The course was designed to be primarily experiential in orientation, and I assumed that it would take the form of group therapy conducted by a therapist. Thus, I thought that I would gain some initial exposure to what psychotherapy was really like.

The course did not, however, follow the form that I thought it would. Rather than group therapy, each student counselled another student, and I was therefore unable to witness the activities that interested me. I did not have the opportunity of observing a therapist adjusting a student to the social world, as each student simply became both the client and "therapist" of another student. As the students

were not trained therapists, and had no substantive knowledge of psychiatric theory, I felt that the processes which I was looking for would not be found in this setting. Thus, I gave up the course in order to devote more time to the study of the relevant literature.

Paranoia Gets on the "Map": The Researcher Develops a Focus

It was in my second semester of doctoral studies, that I encountered, for the first time, an extensive analysis of paranoia. I was taking a course which was devoted to a sociological exploration of the role played by emotions in human behaviour. The basic text in the course was a two-volume work entitled *Affect—Imagery—Consciousness.*[18] The author of the text argued that emotions, not instincts or drives, were the fundamental determinants of human activity. He presented a critique of traditional explanations of both normal and abnormal behaviour. Focusing in particular on Freud, he argued that one's personality was shaped by one's emotional experiences and regulated by one's affect system rather than by one's sexuality.

Each student in the class was expected to lead a seminar on a chapter of the text, and I selected a chapter which was entitled, "Continuities and Discontinuities in the Impact of Humiliation: Some Specific Examples of the Paranoid Posture." I had chosen the chapter as it dealt with material which seemed to make sense in terms of my existing perspective on insanity and psychiatry. It was the author's contention that individuals who were seen to suffer from paranoia were victims of externally induced negative emotional experiences, in particular, humiliation and terror. This analysis caught my attention, as

it argued that the source of paranoia lay not in intrapsychic sexual problems, as Freud had argued, but rather was derived from the external environment. As proof of his thesis, the author stated that paranoia may be induced on a collective basis amongst persecuted minority groups, through the same processes of terror and humiliation as are responsible for the disorder in the individual. The author, Silvan Tomkins, put his argument this way:

> The paranoid has been humiliated and terrorized at once, by a parent who combined shaming with attempts to dominate and control, and who was quick to threaten punishment for resistance.[19]

Tomkins links this analysis to what he sees as a collective phenomenon:

> . . . there are minority groups who have been subjected by society at large to the same pressures to which the paranoid schizophrenic has been subjected by his parents in the process of socialization.[20]

Tomkins notes that diagnosed paranoids, when compared with normal subjects, using a picture arrangement test, showed a marked denial of physical aggression. He states, in turn, that a study by Karon of normal blacks, using the same picture arrangement test, indicated that the greater the chance that the individual might be exposed to violence, for example, a Southern rural black, then the greater the probability that the individual suffered from a complex of terror and humiliation, feelings of persecution, which was indicated on the test by a marked denial of physical aggression.[21] Tomkins also cites a study which he conducted with paranoid schizophrenics in state mental hospitals. He found that the black paranoid schizophrenics had a tendency to show a more marked denial of physical aggression on picture tests than did the whites, thus indicating the effects of more massive persecution.[22]

Tomkins' analysis and evidence drew my attention to the disorder of paranoia. Prior to that time, I had only encountered passing references to it in the literature. From his work, I came to realize that it was a disorder that lent itself to analysis in terms of my perspective. Tomkins pointed out that the commonly accepted Freudian view of the disorder denied the possibility that the "paranoid" individual's feelings might have any basis in reality, placing their source in a sexually based intrapsychic disturbance. Freud's view that Tomkins discussed was, I realized, an example of Freud's application to a specific disorder of his more general theory of human behaviour that I had already critically analysed. Tomkins' perspective presented an alternative interpretation which fitted with my own view that psychiatric problems could be caused by, and therefore explained in terms of, forces in the external environment of the individual.

Thus, I was able to integrate his views into my analysis, but more importantly he made me aware of a specific disorder which highlighted the contrast between the Freudian based explanation of human behaviour, and alternate orientations, that stressed explanations in terms of social forces. The paranoid disorder centred on feelings of persecution which were said to be delusional in nature. The important issue that emerged for me out of studying Tomkins' work was: are these feelings, in fact, delusional? If their source lay, as he argued, in the external environment of the individual, then psychotherapy which ignored the social basis of the disorder (labelling the feelings as delusional), could be seen as an act of social control. Paranoia, therefore, seemed to be the ideal disorder for me to examine, as the contrast between the

intrapsychic and societal theoretical explanations of paranoia appeared to become explicit in the psychiatric practice that I believed derived from the respective theories. The Freudian perspective would by definition orient the therapist toward rejecting the "paranoid's" version of his world, which might, in fact, be the accurate rather than delusional explanation of what was, or had been, happening to the individual.

Thus, I came to see that paranoia was an ideal disorder for me to examine in order to validate the political critique of psychiatry. The rejection of the "paranoid's" feelings as delusional, epitomized for me the act of adjustment that I saw as basic to psychotherapy. Drawing as it did upon the intrapsychic perspective of Freud, psychotherapy would inevitably deny the validity of the individual's claims of persecution, as it would search instead for defects within the individual which would account for his feelings. By focusing on the paranoid disorder, I felt that I would be able, therefore, to clearly illustrate the theoretically based exercise of social control that was fundamental to psychotherapy.

Having identified a disorder that seemed to lend itself to analysis in terms of my perspective, I set out to familiarize myself with the literature that focused on it. Tomkins' work helped me to fix my direction, and I now began to build upon this initial knowledge of paranoia. Thus, I added more material to my "map." By now, however, I was beginning to narrow the scope of my work, and I was able to be more selective as to the appropriateness of the material that I added to it. By this stage, I was actively engaged in developing from the literature the basic constructs that formed my understanding of paranoia at the time that I entered the research setting.

I turned my attention next to Freud's work on paranoia, this time using primary sources.[23] As his perspective represented the essence of the point of view which I had set out to critically review, I felt that it was necessary for me to deal directly with his work on the paranoid disorder. Having already read Tomkins' critique of Freud's perspective, I was familiar with the basic elements of his argument. Reading his work first-hand simply confirmed for me my more general understanding of Freud's explanation of human behaviour. Once again, I encountered the view that all individuals were faced with an intrapsychic battle between their instinctual needs, and the needs of society, represented in the superego. The paranoid disorder, for Freud, seemed to be another version of this phenomenon that had its own special elements such as latent homosexuality and excessive use of projection, but that was, in essence, simply another example of a disorder that stemmed from the same inherent human condition.

I discovered that the particular dynamic of the disorder in Freud's view was homosexual conflict. He argued that a person who is unable to repress unconscious homosexual impulses develops strong guilt feelings which he/she projects, and therefore experiences as persecution from the external environment. Freud put his argument this way:

> . . . we are in point of fact driven by experience to attribute to the homosexual wish-phantasy an intimate (perhaps an invariable) relation to this particular form of disease. Distrusting my own experience on the subject, I have during the last few years joined with my friends C.G. Jung of Zurich and S. Ferenczi of Budapest in investigating upon this single point a number of cases of paranoid disorder which have come under observation. The patients whose histories provided the material for this inquiry included both men and women, and varied in race, occupation, and social standing. Yet we were astonished to find that in all of these cases a defence against a homosexual wish

> was clearly recognizable at the very centre of the conflict which underlay the disease, and that it was in an attempt to master an unconsciously reinforced current of homosexuality that they had all of them come to grief.[24]

Freud's view of paranoia stood in opposition to that of Tomkins. As the source of the problem, for Freud, lay in the psyche of disturbed individuals, their feelings of persecution were, by definition, delusional. Once again I felt that I faced the crux of the instinctually based explanation of behaviour. As no significant recognition was granted by Freudian theory to the external world of the individual, the possibility that their feelings were valid, and that they were, in fact, the victims of persecution was not an issue. Thus, Freud's conceptualization of the disorder took as given the premise that the social world in which the disturbed individual lived was not a hostile world that victimized the disturbed individual.

Tomkins' analysis and evidence had raised in my mind the possibility that "paranoids" were, in fact, victims of persecution, as he was able to demonstrate that the disorder could be induced by external as opposed to intrapsychic forces. If this was the case, then psychotherapy that derived from an intrapsychic perspective, and labelled the "paranoid's" thought and feelings as delusional, would be responsible for adjusting the individual to a social world that was, in fact, the source of his/her disturbance. The individual would, therefore, be denied the possibility of identifying and alleviating the source of persecution, as the therapist, working in terms of an intrapsychic model of the disorder, would deny its existence. These ideas drew me back to my original perspective on the relationship between psychiatric theory

and practice, and brought forward once more in my mind the issue of social control that had been raised by Seymour Halleck and others.

One could after all, I realized, analyse the relation between homosexuality and paranoia without relying on any intrapsychic arguments. If one considers the persecution that is brought to bear upon a homosexual in our society, then it does not seem illogical for a latent homosexual to have feelings of paranoia. Tomkins, in a critique of Freud's view, put it this way:

> When one fears detection of an immorality . . . it is altogether possible that what he calls guilt would more properly have been labelled terror lest I be hurt, exposed and degraded for sexual behavior.[25]

I concluded that I could account for Freud's explanation in terms of my established perspective. I did not need to alter my point of view in order to come to grips with his understanding of the disorder. Furthermore, my reading of Freud's views on paranoia confirmed for me the value of examining this particular disorder. It seemed that one could illustrate the social control argument clearly from a critical analysis of the intrapsychic explanation of the disorder. I set out, therefore, to review more of the literature that dealt with it.

I chose next to examine the work of an author who had written extensively on paranoia, Norman Cameron.[26] Cameron had both a Freudian and a symbolic interactionist perspective. I became aware of his work, as I was taking a graduate course entitled "Social Control," which was devoted to an analysis of symbolic interactionism, and its origins in the work of John Dewey and George Herbert Mead. In particular, the course focused on their theory of self-control, and made reference to

Cameron's work, as it represented a more recent formulation of their perspectives.

From my first reading of Cameron, I uncovered two points that I felt strengthened the explanation of the paranoid disorder, that I had begun to construct. Cameron noted that paranoia is distinguished from schizophrenia, as "paranoids" are seen to have good organization, and to have contact with reality. He argued, for example, that ". . . both in perception and in action the patient is not nearly as desocialized as are other psychotic persons."[27] Furthermore, he stated that the thinking of normal individuals could at times resemble the delusional thought of "paranoids." He put his argument this way:

> All of this leads up to the question of distinguishing between delusional and nondelusional thinking. The way we all have of acting on the basis of fragmentary information, of interpreting signs and signals, of depending heavily upon hidden meanings and intuitions, of reconstructing what we "recall" and of being always subject to shifting emotional influences, makes a clear distinction exceedingly difficult to formulate.[28]

Cameron goes on to add that:

> It would not be difficult to make a case for the presence of delusions even among normal people. The full acceptance of a belief, and its indefinite persistence, even though it contradicts all the objective evidence, is not uncommon in ordinary life.[29]

The two points that he made, again, in my mind, raised doubt as to the validity of the intrapsychic explanation of the disorder. If those labelled "paranoid" were unlike other psychotics, and resembled "normals" in their thinking, and if "normal" people thought in ways that were identical to those of "paranoids," then one had, I thought, to question the premise that "paranoids'" feelings of persecution were necessarily delusional. This aspect of Cameron's analysis seemed to indicate that

"paranoids" had a sustained relationship with their social world, which raised the possibility, for me, once more, that the source of their thinking had its basis in real life experiences of the individual. If this were the case, then one could argue that not only did "paranoids" and "normals" think alike, as Cameron had stated, but also that "paranoids'" thought was not delusional. It could, I believed, be seen as thought that accurately reflected the experiences of the "paranoid," but that had come to be seen as having no basis in reality. If this were the case, then "paranoids" did not suffer from delusions, but rather from the failure of those around them to acknowledge the validity of their feelings and thought.

The conclusions that I had drawn from Norman Cameron's analysis did not fit, however, with his perspective. Cameron was Freudian in orientation, and to him, therefore, the "paranoid's" thoughts were delusional, not real. Their source lay not in the social world of the individual, but rather within the individual, stemming from what he terms "id eruptions," or "primitive fantasies and conflicts" which the "paranoid" then projects and experiences as persecution from the external world.[30] Although Cameron acknowledged that the "paranoid's" thinking resembled normal thought, and that the "paranoid" was not desocialized, the "paranoid" to Cameron, was a psychotic individual who experienced delusions which were a consequence of being ". . . swamped by cruel, sadistic, homoerotic and murderous fantasies."[31] Cameron integrated a symbolic interactionist perspective into his analysis which will be discussed below, but for him the social components of this disorder were directly tied to an analysis that was fundamentally Freudian in orien-

tation. This may, perhaps, be revealed most clearly in his analysis of the development of paranoid logic:

> The force of this irresistable forward movement comes from id impulses. Delusional reasoning is drive organized. It is propelled forward by libidinal and aggressive pressures. Its directions are determined by previously unconscious motivation which has come to take charge of thinking.[32]

Although he accounted for the source of paranoia in terms of a Freudian analysis, Cameron did adopt an interpersonal orientation, symbolic interactionism, to explain the structure of paranoid thought. He, in fact, labelled as static, interpretations of the disorder that failed to acknowledge an interpersonal component.[33] As I became more familiar with the symbolic interactionist perspective through the course that I was taking, I realized that my rejection of the Freudian part of Cameron's analysis did not rule out the possibility of drawing upon the symbolic interactionist element within his work.

One aspect basic to symbolic interactionism, in particular, made sense to me in terms of the understanding of paranoia that I was developing; the concept of shared social meanings.[34] George Herbert Mead argued that members of a society share in common a set of social meanings which they have internalized, and which form the basis of their consciousness. This set of meanings, which he termed the "generalized other," allowed for self-control and therefore social interaction, as the individual adjusts his/her behaviour in terms of the expectations of others, by means of adopting the standpoint of the "generalized other" prior to actually engaging in a specific behaviour. Individuals are, therefore, able to see themselves the way that others see them, which may serve as a basis of action.

Norman Cameron made use of this analysis to explain the nature of paranoid thinking. He argued that "paranoids" lack basic social skills such that they are unable to adopt the standpoint of the "generalized other," and are therefore unable to see themselves as others see them. This leaves them, he feels, in a vacuum devoid of means to measure the validity of their perceptions of the social world. At the same time, he argues, they experience the "id eruptions" discussed previously. Unable to identify and deal with this negative unconscious material, "paranoids" project it and experience it as emanating from real and imagined persons in their social environment. Cameron argues that "paranoids" see these individuals to be linked together in a conspiracy against them, and has labelled this delusional entity "the paranoid pseudo-community."[35] Thus, not sharing the same set of social meanings, or, as Cameron sees it, social reality as those around them, "paranoids," in Cameron's view, engage in a spurious symbolic reconstruction of reality. Cameron summarizes his argument this way:

> What the paranoid patient does is as follows: Into the organization of social reality, as he perceives it, he unconsciously projects his own previously unconscious motivations, which he has denied but cannot escape. This process now requires a perceptual and conceptual reorganization of object relations in his surroundings into an apparent community, which he represents to himself as organized wholly with respect to him (delusion of self-reference). And since the patient's erupted, denied, and projected elements are overwhelmingly hostile and destructive, the motivation he ascribes to the real persons he has now organized into his conceptual pseudo-community is bound to be extremely hostile and destructive.[36]

My own use of the symbolic interactionist perspective began with the premise that the "paranoid" might not be delusional, but rather the victim of persecution. I formulated an explanation of paranoia that

utilized the concept of shared social meanings, but, drawing upon the evidence from Tomkins, rejected Cameron's view that the "paranoid" resorts to an inaccurate reconstruction of reality (the paranoid pseudo-community) in order to preserve his/her personal equilibrium. As I believed that the environment of an individual was the key to understanding his/her personality, I felt that the paranoid disorder derived from the nature of the relationship between an individual and his/her environment. Thus, the behaviour of the "paranoid" could, I believed, be seen as an expression of his/her own life experiences. His/her behaviour could, therefore, be seen as "rational" within the context of the individual's own set of social meanings derived from his/her life experiences, although other individuals with different life experiences, and, therefore, not identical sets of social meanings, might view it as irrational or indicative of a disease of the psyche; paranoia. Thus, I did not accept the view that persons whose behaviour is not in accordance with the social meanings shared in a society are necessarily delusional. Nor did Cameron, as pointed out earlier, but he qualified his analysis significantly, as he stipulated that the delusions of "normals" are delusions that are shared by others in the same culture and are therefore based upon what he terms "group identification."[37] To him, all other delusions were a sign of insanity, whereas I believed that all so-called paranoid delusions possibly were accurate reflections of life experiences.

From my perspective at that time, I viewed the disorder as a "rational" response of an individual that is consistent with his/her symbolic reconstruction of reality; i.e., a "logical" response based on

his/her set of social meanings which were derived from past or present experiences of persecution. Thus, I believed that the "paranoid" was an individual who was responding to genuine persecution, rather than projected intrapsychic problems. Instead of searching for defects of the individual which would account for feelings of persecution, it seemed to me that one should look for the actual occurrence of persecution. The determination that an individual's views were paranoid could, I believed, be understood as a decision-making process that took the following form: if individual "A," for example, has been subjected to the stress of persecution, it seems conceivable that his set of social meanings would differ from those of individual "B" who has not undergone such an experience. "A" would include persecution as part of his symbolic reconstruction of reality, and, therefore, would behave differently than "B." To "B," the actions of "A" may appear irrational, and therefore lead "B" to believe that "A" is mentally ill--paranoid. Thomas Scheff (whose work I had encountered earlier) pointed out the consequences of this type of process:

> . . . the more the rule-breaker enters the role of the mentally ill, the more he is defined by others as mentally ill; but the more he is defined as mentally ill, the more fully he enters the role, and so on.[38]

I did not rule out from my analysis the possibility that a persecuted individual or social group may not have an awareness of, or may be prevented from responding to, their persecutor. This could lead, I believed, to misdirected anger and feelings of persecution which, when viewed from Norman Cameron's perspective, would seem to confirm his concept of the paranoid pseudo-community. While I recognized that some

paranoid disorders may involve genuinely irrational and even dangerous behaviour, I felt, however, that one could not overlook the fact that these behaviours may be responses of individuals who have lost sight of the source of their persecution, and are, therefore, blindly acting out their justifiable anger.

Thus to me, at that point in time, it seemed that "paranoids" could be seen as individuals who have been put in a double bind. Some element in their environment persecuted them. They responded in a normal fashion by feeling persecuted. In turn, society responded to them with further persecution--they were deemed to be paranoid--mentally ill. I felt that my formulation of the paranoid disorder derived logically from my more general critique of psychiatry. If psychiatrists, utilizing an intrapsychic approach such as Freud's or Cameron's did not take into account the possibility that their "paranoid" patient in fact was a victim of persecution, then their therapy might turn out to be serving the function of social control. Therapy would adjust the disturbed individual to the social world, despite the fact that it was this social world, or some element within it, that was the source of the disturbance.

There was, I believed, an authoritarian and repressive potential implicit within this process. Evidence of a blatant abuse of psychiatry in the Soviet Union had recently been revealed,[39] and I felt that these practices, the labelling of social and political dissent as mental illness, were simply logical extensions of the problem that I had identified. In my view, Cameron expressed the problematic orientation distinctly, when he stated:

> The therapeutic process now involves another reconstruction of reality, one which undoes the restitutional pseudo-community. . . . The patient can begin to entertain doubts and consider alternative interpretations. . . . In this way the conceptual structure of his pseudo-community may be gradually replaced by something approaching the conceptual structure of social reality.[40]

It appeared to me that Cameron advocated the undermining of the "paranoid's" definition of reality, and the imposition of a "correct" definition of reality in its place. I believed that this task was predicated upon the erroneous view that the "paranoid's" definition of reality was necessarily false; a view which stemmed from the adherence by Cameron and other psychotherapists to the intrapsychic perspective which directed them to search, in an attempt to account for the "paranoid's" beliefs, for defects within the individual rather than accepting the "paranoid's" definition of reality as correct, and looking for the source of the individual's beliefs in the social environment of that individual. Cameron's approach represented the essence of what I took to be a fundamental fault inherent within psychotherapy that was based upon an intrapsychic explanation of human behaviour.

Consolidating the Perspective

Having developed an analysis of paranoia which I felt provided an adequate explanation of the disorder in terms of my understanding of mental illness, I set out to locate more evidence to support my perspective. With the help of one of my professors who had an interest in mental illness, I located in the literature further references which viewed paranoia as a disorder that derived from the real life experiences of an individual, rather than from intrapsychic problems. These

sources did not label the "paranoid's" feelings of persecution as delusions, but rather asserted that the "paranoid" was a victim of persecution, and therefore had good reason to believe that he/she was being persecuted. The discovery of other sources that supported my perspective helped to confirm my beliefs that the political critique of psychiatry was valid, and that I had selected an appropriate disorder to use as a means of illustrating the validity of the critique. Thus, these sources made further contributions to the development of my constructs, and I shall, therefore, discuss the knowledge that I gained from them.

The first of these additional authors that I dealt with, Edwin Lemert, had produced one of the better-known sociological studies of paranoia.[41] As the extent of sociological literature on the disorder was limited, I felt fortunate that one of the major studies also turned out to be critical of the intrapsychic explanation, and, therefore, was not incompatible with my perspective on the disorder.[42] In essence, it was Lemert's contention that the "paranoid" individual was, in fact, a victim of a conspiracy which, in Lemert's view, forced one to discard explanations of the disorder that focused on intrapsychic problems, and forced one to look, rather, at the social setting of the disturbed individual.[43]

According to Lemert, paranoia had to be conceived in terms of "a relationship and a process," rather than seeing it "as a disease, a state, a condition, or a syndrome of symptoms."[44] To me, this was further confirmation of the analysis that I had originally begun to develop out of the work of Tomkins. Lemert offered not only his own research findings as evidence, but also cited other studies that pointed

to a social basis to the disorder, concluding that ". . . paranoia suggests, more than any other forms of mental disorder, the possibility of fruitful sociological analysis."[45] Reading Lemert, I felt that I was on the right track, as it appeared that others also recognized the alternative societal explanation of the disorder. It seemed to me, therefore, that I had chosen an appropriate disorder to use as a means of validating the political critique of psychiatry.[46]

In his article, Lemert presented a critique of Norman Cameron's perspective on paranoia, which was of particular interest to me, as Cameron's work seemed to stand out in the literature as a significant example of an intrapsychic explanation of the disorder.[47] Furthermore, I had already, as discussed above, developed my own analysis of Cameron's perspective, and thus I was most interested to study Lemert's, in light of it. As has already been pointed out, Lemert's perspective did not contradict my own. Based upon his research of eight cases of persons seen to suffer from some form of paranoia, he concluded, for example, that:

> . . . members of communities and organizations do unite in common effort against the paranoid person prior to or apart from any vindictive behavior on his part. The paranoid community is real rather than pseudo in that it is composed of reciprocal relationships and processes whose net results are informal and formal exclusion and attenuated communication.[48]

Thus, contrary to Cameron's perspective, in Lemert's view:

> . . . the "pseudo-community" associated with random aggression (in Cameron's sense) is a sequel rather than an integral part of paranoid patterns. They are likely products of deterioration and fragmentation of personality appearing, when and if they do, in the paranoid person after long or intense periods of stress and complete social isolation.[49]

Lemert's analysis was of significance to me, as he too rejected Cameron's concept of a paranoid pseudo-community. I felt that our views were compatible, as our common rejection also acknowledged the possibility that such a delusional entity could at times exist in the mind of the disturbed individual (see, for example, my earlier reference to misdirected anger and feelings of persecution), but that it was not the primary component of the disorder, as, after all, this community was in most cases a real, not a pseudo, entity. This confirmation of my analysis was, I felt, important, as it was based upon actual research with "paranoids," as opposed to my own logical speculation derived from my study of the literature.[50] Thus, my own views of the disorder were, in my eyes, developing credibility, as I now could add Lemert's research to that of Tomkins and Karon with together, I thought, constituted considerable evidence in support of my perspective.

According to Lemert, one did not have to rely at all upon intrapsychic explanations in order to account for feelings of persecution. He notes, for example, that:

> . . . a number of studies have ended with the conclusions that external circumstances--changes in norms and values, displacement, strange environments, isolation, and linguistic separation --may create a paranoid disposition in the absence of any special character structure. The recognition of paranoid reactions in elderly persons, alcoholics, and the deaf adds to the data generally consistent with our thesis. The finding that displaced persons who withstood a high degree of stress during war and captivity subsequently developed paranoid reactions when they were isolated in a foreign environment commands special attention among data requiring explanation in other than organic or psychodynamic terms.[51]

The evidence that Lemert presented helped to confirm my own beliefs. After all, to postulate that persecution could be a causative factor, as I did, seemed, in light of the evidence which implicates other

external factors, to be a sound explanation of the source of the disorder. Thus, views that argued that a "paranoid's" feelings of persecution were necessarily delusional did not, from my perspective, take into account what I saw to be the very real possibility that the "paranoid" was a victim of persecution. Lemert also argued this position, which he stated this way:

> The general idea that the paranoid person symbolically fabricates the conspiracy against him is in our estimation incorrect or incomplete. Nor can we agree that he lacks insight, as is so frequently claimed. To the contrary, many paranoid persons properly realize that they are being isolated and excluded by concerted interaction, or that they are being manipulated.[52]

To me, Lemert's statement was of some significance, as it was based upon his actual study of cases of paranoia; a study which he characterized as follows:

> The investigation of the cases were as exhaustive as it was possible to make them, reaching relatives, work associates, employers, attorneys, police, physicians, public officials and any others who played significant roles in the lives of the persons involved.[53]

Thus, I felt that my own conclusions as to the nature of the disorder were validated by his thorough study of it. Lemert's evidence made clear what I took to be of crucial importance. He revealed the presence of persecution directed toward the "paranoid" individual. Lemert states, for example, that:

> . . . while the paranoid person reacts differentially to his social environment, it is also true that "others" react differentially to him and this reaction commonly if not typically involves covertly organized action and conspiratorial behavior in a very real sense.[54]

Lemert's analysis raised once more for me the theme of social control. His research indicated that individuals who were taken to be

paranoid, were, in fact, responding to actual persecution. The consequences for their lives were significant. Lemert points out that nearly all of the individuals that he studied had been admitted or committed to mental hospitals,[55] and all of them were seen to have "prominent paranoid characteristics."[56] As their feelings of persecution were taken to be signs of insanity, I felt sure that psychotherapy with these individuals would utilize an intrapsychic approach, and would attempt, therefore, to adjust them to their social world, thereby serving the function of social control.

The next author that I dealt with was introduced to me by the same professor who had alerted me to the work of Lemert. He had recently received the galley proofs of a new book by Morton Schatzman, that was to be published shortly, and made them available to me, as the book was devoted to a critical analysis of paranoia. Upon reading the galley proofs, I was pleased to find that Schatzman, like Lemert, also viewed paranoia as a disorder that stemmed from the relationship between an individual and his social world. He, too, rejected an intrapsychic formulation of the disorder. As Schatzman's views did not contradict my own, I again had the experience of feeling that I had developed a perspective on the disorder that really did make sense of it.

Once more, I felt that my views were validated, as another researcher had arrived at the same conclusions as I had. Schatzman noted, for example:

> I think many people whom psychiatrists call paranoid are or have been persecuted and know it, but they do not recognize their real persecutors or how they have been persecuted. To call them paranoid which presupposes they are not really persecuted, but imagine it, is false and misleading.[57]

He went on to add that "what is clinically called paranoia is often the partial realization--as through a glass darkly--that one has been or is persecuted."[58] As he viewed the "paranoid's" feelings of persecution to be justified, I placed Schatzman's analysis together with that of Tomkins and Lemert, and saw them collectively as sources of further information and support for my perspective. I greeted all evidence that did not contradict my viewpoint enthusiastically, as most psychiatrists (whom I saw to be the "experts" with respect to mental illness[59]), and most of the literature on the disorder did contradict my understanding of it. Schatzman made this point, when he noted with respect to his perspective that "I part company here with prevalent views about paranoia."[60] Schatzman's analysis of paranoia, therefore, may be seen as another source which served to determine my expectations as to the nature of the disorder. It too was a contributor to my "map."

Schatzman summarizes the structure of his book this way:

> . . . I link the strange experiences of Daniel Paul Schreber, for which he was thought mad, to his father's child-rearing practices. I bring forth and match two sets of facts--the son's bizarre experiences as an adult and his father's techniques of educating children--and I conjecture about how they may be connected.[61]

The Daniel Paul Schreber whom he refers to, was the subject upon whose memoirs Freud based his theory of paranoia[62] (thus, the significance of Schatzman's book). In response to Freud's study of Schreber's autobiography, Schatzman, in turn, had examined the writings of Schreber's father; a well-known German educator and physician. He (Schatzman) made a significant disclosure. Schreber's father advocated in his writings (and we may assume practised in his family) what amounted to a program of persecution against the child by his parents. Schatzman concludes

from his findings that Daniel Paul Schreber's "paranoid" disorder cannot be understood without viewing it in terms of the practices of his father.

Freud's study of the Schreber case was not only the basis of his theory of paranoia, but also, as discussed previously, became the cornerstone of the entire intrapsychic explanation of the disorder, as expressed in the work of Norman Cameron and many others. Schatzman's study seriously questions the validity of Freud's analysis. Schatzman describes his critique of Freud this way:

> I have placed Freud's theory of paranoia within what I think is its relevant ideological setting, shown that the theory by-passes the issue of parents' persecution of children.[63]

Thus, his work casts doubt upon the validity of the intrapsychic explanation in general. To me, Schatzman's analysis was, therefore, significant, as it provided me with a specific response to Freud's conceptualization of paranoia.[64] As Edwin Lemert gave me a critique of Norman Cameron that fitted with my perspective, so too did Morton Schatzman give me a critique of Freud. Thus, I felt that I was building an explanation of paranoia that was logically derived from my more general understanding of mental illness, and that could critically account for the intrapsychic views that I rejected. This alternative explanation would, in turn, allow me, I felt, to illustrate the validity of the political critique of psychiatry.

Schatzman not only raised the possibility that the feelings of persecution experienced by a "paranoid" are not necessarily delusions, he also explored the implications of denying the truth of a "paranoid's" claims. I, therefore, was able to relate my own views on psychotherapy and social control to his analysis. Schatzman, too, recognized the

problem that I had identified with respect to psychotherapy with "paranoids," that was based upon an intrapsychic perspective on the disorder. He pointed out the consequences of an intrapsychic approach, which typically regards the onset of paranoia, as discussed previously, to be linked to the inability to repress impulses from the id. A therapist, he notes, relying upon this configuration of the disorder, would aim in therapy to restore repression; a tactic which Schatzman views this way:

> If I am right in my theory, to restore repression could mean to move people from the category of being persecuted and knowing it to being persecuted and not knowing it.[65]

Schatzman's perspective, to me, was further confirmation of my belief that psychiatric practice which was based upon intrapsychic theory would inevitably lead to the exercise of social control.

I also drew support from another aspect of Schatzman's analysis. I discovered that he, too, conceptualized the decision-making process, which led up to the labelling of an individual as paranoid, in terms of reality definitions.[66] He pointed out, in ways similar to my own, that the failure to acknowledge the validity of the "paranoid's" definition of reality stems directly from the influence of the intrapsychic perspective upon the practice of psychotherapy. As this perspective rejects the "paranoid's" view as a delusion, searching instead for defects within the individual, and asserting that he/she is, in fact, projecting intrapsychic problems, the therapist who holds an intrapsychic perspective cannot help but see the "paranoid's" definition of reality to be invalid, and, therefore, would inevitably attempt to impose a "correct" definition of reality upon him/her. Schatzman describes this process in these terms: "They say he is less conscious

than they of 'reality'; that is his 'illness' they say."[67]

Schatzman's analysis strengthened my convictions. His perspective helped to convince me that not only was the social control-political critique of psychiatry correct, but also that it could be most readily applied in cases of "paranoia." Here, more so than in any other form of disorder, there appeared to be an imposition of one definition of reality (society's, as represented by and through the psychiatrist), at the expense of another (the "paranoid" individual's); a classic example, in my view, of social control.

Schatzman helped, I felt, through his analysis of therapy with "paranoid" patients, to deepen my understanding of this process. One idea, in particular, influenced my thinking. Schatzman expressed it this way:

> Many people feel persecuted but no one ever feels paranoid. Paranoia is not an experience; it is an attribution one person makes about another. It is a judgment that someone else's feelings of persecution do not refer to anything real.[68]

His point raised my awareness of the authoritarian and repressive potential inherent in any instance of a psychiatric diagnosis of paranoia, and prompted me to proceed with my study of the disorder confident that I had identified a key example of the social control "phenomenon" that I believed was basic to psychotherapy that relied upon an intrapsychic explanation of behaviour. Schatzman also offered what I took to be a viable alternative to therapies, such as Norman Cameron's, that sought to adjust "paranoids" to their social environment. His approach seemed to me to offer a therapist the means to liberate individuals disturbed by feelings of persecution. Rather than imposing a "correct" definition

of reality upon the "paranoid" patient, substituting the psychiatrist's version of the social world for the patient's, Schatzman offered the following:

> Presume in cases of "paranoia," in which no intoxication or organic disease is present, that the person who feels persecuted is responding to behaviour, past or present, of other people who are or have been near him. Starting from this point, invite everyone in his social world to join in a search for the origin of his feelings of persecution.[69]

Footnotes

[1]I developed an outline of features such as: what paranoia is; what forms it takes; the nature of the "paranoid" personality; how paranoia is handled; how it should be handled; etc.

[2]In addition to the authors noted in footnote number 17, chapter one, I also studied the work of Paul Robinson, Ashley Montagu, Frantz Fanon, B.F. Skinner, H. Schoeck and J.W. Wiggins, Michel Foucault, Ernest Becker, and others.

[3]Paul Robinson, *The Freudian Left* (New York: Harper and Row, 1969). Robinson includes in this group, amongst others, Erich Fromm, Herbert Marcuse, and Wilhelm Reich.

[4]Freud's most thorough statement of his perspective is set out in *Civilization and Its Discontents* (London: Hogarth Press, 1939).

[5]See, for example, Marcuse's discussion of "surplus-repression" and "performance principle" in Herbert Marcuse, *Eros and Civilization* (New York: Vintage Books, 1955); and Reich's theory of "sex-economic sociology" in Wilhelm Reich, *The Mass Psychology of Fascism* (New York: Farrar, Straus and Giroux, 1971).

[6]Wilhelm Reich, *The Mass Psychology of Fascism,* p. xxvii.

[7]Erich Fromm, *Beyond the Chains of Illusion: My Encounter with Marx and Freud* (New York: Simon and Schuster, 1962), chapter vi.

[8]Ibid., p. 61.

[9]My use of this term, at that time, stemmed from my understanding of Marx's formulation in *The German Ideology* (New York: International Publishers, 1947), and Karl Mannheim's formulation in *Ideology and Utopia* (New York: Harcourt, Brace and World, 1936).

[10]Marcuse, *Eros and Civilization,* p. 225.

[11]See, for example, the perspectives expressed in: H. Schoeck and J.W. Wiggins, eds., *Psychiatry and Responsibility* (Princeton: Van Nostrand, 1962).

[12]For a history and analysis of these movements, see: Jack Newfield, *A Prophetic Minority* (New York: New American Library, 1967), and T. Roszak, *The Making of a Counter Culture* (Garden City, N.Y.: Doubleday, 1969).

[13]J. Agel, ed., *The Radical Therapist* (New York: Ballantine Books, 1971, p. xv.

[14]Ibid., p. xvi.

[15]Seymour Halleck, "Therapy Is the Handmaiden of the Status Quo," *Psychology Today*, April 1971, p. 32 (excerpted from a chapter in *The Politics of Therapy* (New York: Science House, 1971).

[16]I used the terms "liberation" and "social control" in the same sense as they were used in the anti-psychiatry literature. Thus, I employed political, rather than the more widely held sociological or moral, definitions of these terms. See, for example, the contrast between the definition of social control found in any introductory sociology text, and my pejorative use of this term.

[17]Peter Maidstone, unpublished manuscript, Santa Barbara, California, December 1972, p. 4. The term "get through the day," was used in the course to denote the practical activities which comprise one's working day.

[18]Silvan Tomkins, *Affect--Imagery--Consciousness* (New York: Springer Publishing, 1963).

[19]Ibid., p. 552.

[20]Ibid., p. 481.

[21]Ibid., p. 572 and pp. 565-566.

[22]Ibid., pp. 567-568.

[23]Sigmund Freud, "Psycho-Analytic Notes upon an Autobiographical Account of a Case of Paranoia (Dementia Paranoides)(1911)," *Collected Papers*, Volume III (London: Hogarth Press, 1950); "Some Neurotic Mechanisms in Jealousy, Paranoia and Homosexuality," *Standard Edition* (London: Hogarth Press, 1955).

[24]Sigmund Freud, "On the Mechanism of Paranoia," *Collected Papers*, Volume III (London: Hogarth Press, 1950), pp. 444-445.

[25]Silvan Tomkins, *Affect--Imagery--Consciousness*, p. 576.

[26]See, for example, Norman Cameron, "The Paranoid Pseudo-Community," *The American Journal of Sociology*, XLIX (July 1943-May 1944):32-38; *The Psychology of Behavior Disorders* (New York: Houghton Mifflin, 1947); "The Paranoid Pseudo-Community Revisited," *The American Journal of Sociology*, LXV (July 1959):52-58; and *Personality Development and Psychopathology* (Boston: Houghton Mifflin, 1963).

[27]Norman Cameron, *Personality Development and Psychopathology* (Boston: Houghton Mifflin, 1963), p. 508.

[28]Ibid., p. 472.

[29]Ibid., p. 473.

[30]Norman Cameron, "The Paranoid Pseudo-Community Revisited," *The American Journal of Sociology*, LXV (July 1959):54-57.

[31]Norman Cameron, *Personality Development and Psychopathology*, p. 504.

[32]Ibid., p. 485.

[33]Norman Cameron, "The Paranoid Pseudo-Community," pp. 35-36.

[34]The origins of this concept lie in the work of George Herbert Mead. See, for example: G.H. Mead, *Mind, Self and Society*, C.W. Morris, ed. (Chicago: University of Chicago Press, 1934); and G.H. Mead, *George Herbert Mead on Social Psychology*, Anselm Strauss, ed. (Chicago: University of Chicago Press, 1964).

[35]See: Norman Cameron, "The Paranoid Pseudo-Community"; and "The Paranoid Pseudo-Community Revisited."

[36]Norman Cameron, "The Paranoid Pseudo-Community Revisited," p. 56.

[37]Norman Cameron, *Personality Development and Psychopathology*, p. 473.

[38]Thomas Scheff, *Being Mentally Ill* (Chicago: Aldine Publishing Co., 1966), pp. 97-98.

[39]N.B. Hirt, "Medical Ethics and the Misuse of Psychiatric Hospitals in the USSR," unpublished brief, Vancouver, B.C., 1970; P. Reddaway, ed., *Uncensored Russia* (New York: American Heritage Press, 1972).

[40]Norman Cameron, "The Paranoid Pseudo-Community Revisited," p. 58.

[41]Edwin Lemert, "Paranoia and the Dynamics of Exclusion," *Sociometry*, 25 (1962):2-20.

[42]It is perhaps important to explain why I had not yet encountered Lemert's work. The explanation lies in the fact that I was, at that point in time, just beginning to accumulate further knowledge of the literature on paranoia. Aside from my study of Tomkins, Freud, and Cameron, I had until then focused my attention only on psychiatry and mental illness in general.

[43]Edwin Lemert, "Paranoia and the Dynamics of Exclusion," *Mental Illness and Social Processes*, in *Mental Illness and Social Processes*, ed. Thomas Scheff (New York: Harper and Row, 1967), p. 273.

[44]Ibid., p. 273.

[45]Ibid., p. 274.

[46]It is important to note that I did not believe that the critique was inapplicable to other types of disorders such as schizophrenia. Rather, it was my belief, having read Lemert and others, that it was possible to illustrate the validity of the critique more clearly by focusing on paranoia, as this disorder, more so than others, had an obvious social basis.

[47]As I became more familiar with the literature, it became apparent to me that other authors who dealt with the disorder typically made reference to his work.

[48]Edwin Lemert, "Paranoia and the Dynamics of Exclusion," pp. 291-292.

[49]Ibid., p. 293.

[50]I include this point, as it may help to clarify the state of my thinking at that time. Although I felt that my understanding of paranoia was basically sound, as it derived logically from what I felt was a valid understanding of psychiatry and mental illness, I was, nevertheless, somewhat unsure of my views, as I had not done any research beyond my ongoing study of the literature, nor had I even met an individual who was diagnosed to be "paranoid." Thus, Lemert's research represented to me an important contribution to my knowledge, as it helped to instill in me more confidence in my own views.

[51]Edwin Lemert, "Paranoia and the Dynamics of Exclusion," pp. 273-274. Lemert cites the following studies in support of his claim: S. Pederson, "Psychological Reactions to Extreme Social Displacement (Refugee Neuroses)," *Psychoanalytic Review*, 36 (1946):344-354; F.F. Kine, "Aliens' Paranoid Reaction," *Journal of Mental Science*, 98 (1951):589-594; and I. Listivan, "Paranoid States: Social and Cultural Aspects,"

Medical Journal of Australia, 1956, pp. 776-778.

[52]Edwin Lemert, "Paranoia and the Dynamics of Exclusion," p. 287.

[53]Ibid., p. 276.

[54]Ibid., p. 273.

[55]Ibid., p. 275.

[56]Ibid., p. 275.

[57]Morton Schatzman, *Soul Murder* (London: Penguin Press, 1973), pp. 130-131.

[58]Ibid., p. 131.

[59]I held this belief about psychiatrists despite my critical analysis of the theories that I believed they relied upon, and the practice that I felt emanated from the theories. Although I felt that they ignored the social component in their theories, and, therefore, in their work, I did not take their practice to be fraudulent. Rather, I saw it to be misdirected. Thus, I felt that psychiatrists had far more expertise than I with respect to paranoia and mental illness, particularly as I had not, at that point, as previously mentioned, even done any actual research in a psychiatric setting, or met a person diagnosed to be "paranoid." To uncover evidence which supported my counterview was, therefore, significant to me, not in the sense that it showed intrapsychically based psychiatric practice to be a fraud, but rather in the sense that it gave credibility to my alternate conception of the disorder. Such a conception would direct a therapist, I believed, toward liberating, rather than adjusting, their "paranoid" patients.

[60]Morton Schatzman, *Soul Murder*, p. 136.

[61]Ibid., p. x.

[62]Sigmund Freud, "Psycho-Analytic Notes upon an Autobiographical Account of a Case of Paranoia (Dementia Paranoides)(1911)."

[63]Morton Schatzman, *Soul Murder*, p. 115.

[64]By this, I mean that Schatzman offered a critique of Freud that not only argued that persecution could, in fact, induce paranoia, as Tomkins did (it is interesting to note, for example, that Schatzman,

like Tomkins, also reasons that the link, identified by Freud, between homosexuality and paranoia need not be seen in intrapsychic terms. He argues that: "Given the way active and suspected homosexuals have been and are persecuted, it is no surprise that 'latent' homosexuals fear persecution" [Morton Schatzman, *Soul Murder*, p. 124]), but also was able to show that Freud's study had actually ignored this possibility, that persecution causes paranoia, when it presented itself in the case upon which he formulated his theory.

[65]Morton Schatzman, *Soul Murder*, p. 132.

[66]I refer here to my earlier discussion of social meanings and the symbolic reconstruction of reality.

[67]Morton Schatzman, *Soul Murder*, p. 138.

[68]Ibid., p. 130.

[69]Ibid., p. 157.

CHAPTER 3

FIELDWORK BEGINS: THE RESEARCHER ENTERS THE RESEARCH SETTING

The Format of the "Story": Use of the Narrative Style

Having discussed my constructs or preconceptions which I formulated from the literature prior to entering the research setting, it is now time to set out what I actually experienced while in the setting. This material constitutes the fieldwork data of the thesis, and is presented in order to document what I found, or any other culturally competent member (with the exception of therapists) who had also studied the literature on paranoia would have found; i.e., that there existed a significant "gap" between a "map" derived from the literature, and what one actually observed while in the research setting. Thus, my data will show that my constructs that constituted my "map" did not fit with my fieldwork experiences and observations. Prior to setting out these data, it would, I believe, be useful to offer an explanation and justification of the format which I have adopted in order to present my data. Thus, I shall briefly outline this format.

I have chosen to discuss the format of this part of the thesis, as I feel that it is helpful for the reader to have an insight into not only how my ideas with respect to paranoia were developed and ultimately were transformed as a consequence of my fieldwork experience, but also into the process through which I developed a suitable structure for demonstrating this transformation of my thinking. Thus, I feel that, as

this is an ethnographically based thesis, it is incumbent upon me to describe for the reader how I decided to handle my data. When I began to think about how to present my data, I felt unsure of how to proceed, and I decided, therefore, to review the formats of other ethnographies in order to ascertain what would constitute a suitable structure for presenting my data.

I discovered that many authors handled their data in what might be termed a traditional format. Typically, this involves structuring the ethnography in terms of chapters that represent sequential elements of the central argument of the work, and data that support or document the theme of each chapter is then taken from the ethnographer's "pool" of data and inserted in the appropriate parts of the respective chapters. I considered adopting this approach, and attempted to formulate appropriate chapter themes that might lend themselves to illustrating my argument. I contemplated selecting, from my analysis earlier in the thesis, my major constructs, in order to use them as the cores of specific chapters. I considered, for example, adopting a construct such as the invalidation of a "paranoid's" definition of reality as the basis of a theme for a chapter. My intent was to juxtapose such a construct with data derived from my fieldwork in order to illustrate the "gap" discussed earlier. I did not, however, adopt this approach.

Instead, I adopted what may be termed a more "organic" approach. By this, I mean that I rejected what may be characterized as an artificial order for presenting my data. Rather than constructing chapters dictated by the need to convey to the reader the validity of my argument, and then inserting data to uphold this structure, I opted to simply tell,

in a chronological form, the story of my fieldwork experiences. Thus, the structure of this part of the thesis resembles the previous section, as it too is organized in terms of a chronology of my research into paranoia. In this case, however, I will be outlining my observations derived from experiences in the research setting, rather than presenting my insights into paranoia deduced from the literature.

I shall, therefore, trace from my data what I encountered in the research setting, in the time sequence in which I actually encountered it.[1] I want to emphasize that the "story" of my experiences is, in fact, also the argument of the thesis, as the "story" details my experiences over the duration of my fieldwork, and, therefore, has inherent within it a record of the subsequent changes in my understanding of paranoia, that emerged as I became aware of a "gap" between my "map" and what I was actually encountering in the setting. Thus, I believe that the record of my experiences that I shall present not only validates the argument that I am making, but also is in a sense the argument itself, as the reader of the "story" is, I believe, confronted by the argument of the thesis, simply as a consequence of reading the "story."

Thus, I am asserting that it is neither necessary nor helpful for me to organize the presentation of my data according to a more traditional structure. My approach allows for a more accurate portrayal of one's fieldwork experiences, as the data that document these experiences do not have to be sliced up and taken out of context in order to satisfy the demands of a traditionally-structured presentation. I shall, instead, simply set out my experiences and observations chronologically, highlighting those parts of my "story" that best illustrate the argument

implicit within it.[2]

First Impressions

The "story" of my experiences in the research setting begins early in the new year of 1975. Having received tentative approval to proceed from the Head of the psychiatric hospital in which I was to conduct my fieldwork, I contacted the psychiatrist who had been appointed to facilitate my entry into the hospital. We arranged that I should drop off an outline of my research plans for him at the hospital, which gave me my first opportunity to enter the facility.[3] I was excited in the way that anthropologists must be excited at the prospect of beginning their fieldwork in a foreign culture. Like the anthropologist, I too was thoroughly prepared for my entry, having extensively studied the literature on "my foreign culture," as discussed in the previous section of the thesis. However, in addition to my "map," derived from the literature, I was also armed with other preconceptions with respect to the hospital, as it was an institution that existed within my own community. Thus, unlike the anthropologist, I had already been exposed to various stories, remarks, and references with respect to this "culture" (facility), simply as a consequence of living within the same domain. The opportunity to enter the hospital was a type of experience that Peter Berger has aptly described this way:

> A person who lives in such a city will time and again experience surprise or even shock as he discovers the strange pursuits that some men engage in quite unobtrusively in houses that, from the outside, look like all the others on a certain street. Having had this experience once or twice, one will repeatedly find oneself walking down a street, perhaps late in the evening, and wondering what may be going on under the bright lights showing through a line of drawn curtains. An ordinary

> family engaged in pleasant talk with guests? A scene of desperation amid illness or death? Or a scene of debauched pleasures? Perhaps a strange cult or a dangerous conspiracy? The facades of the houses cannot tell us, proclaiming nothing but an architectural conformity to the tastes of some group or class that may not even inhabit the street any longer. The social mysteries lie behind the facades. The wish to penetrate to these mysteries is an analogon to sociological curiosity. In some cities that are suddenly struck by calamity this wish may be abruptly realized. Those who have experienced wartime bombings know of the sudden encounters with unsuspected (and sometimes unimaginable) fellow tenants in the air-raid shelter of one's apartment building. Or they can recollect the startling morning sight of a house hit by a bomb during the night, neatly sliced in half, the facade torn away and the previously hidden interior mercilessly revealed in the daylight. But in most cities that one may normally live in, the facades must be penetrated by one's own inquisitive intrusions. Similarly, there are historical situations in which the facades of society are violently torn apart and all but the most incurious are forced to see that there was a reality behind the facades all along. Usually this does not happen and the facades continue to confront us with seemingly rock-like permanence.[4]

To me, the hospital had, for many years, been such a facade. Now, for the first time, I would be able to actually witness what went on within it.

This facility, as mentioned earlier, had been dubbed the "Psychiatric Hilton"; a title which seemed appropriate to me upon entering the building. My first reaction to the hospital was a feeling of being in a hotel rather than a medical setting. As noted earlier, the floors were well carpeted, the furniture was fashionable, the walls were panelled in wood, the lighting was subdued, and background music was playing. I crossed the lobby of the building and addressed a woman seated at a reception desk. Again, I had no sense of being in a medical facility. The woman was not wearing a medical uniform, and the station that she manned could have been mistaken for the front desk of a stylish hotel. I inquired as to the location of the ward where I was to drop off my

outline, and was directed to what the woman termed the "nursing station" of the ward to which the psychiatrist was attached. As I made my way to the ward, down what could have been taken as the hallway of a modern hotel, I thought of the overt contrast between my surroundings and those of two other psychiatric facilities that I had had an occasion to visit. I was curious to discover if the lobby and front desk were only exterior trappings, and if the wards, which I took to be the work settings of the hospital, would be more utilitarian and medical in appearance. I was surrounded by background music as I made my way to a hotel-like reception area that I recognized, knowing that I was in a hospital, to be a nursing station. None of the staff in the station wore uniforms, and I had no way of knowing which of them were medical personnel. The woman that I addressed might have been a secretary, or could have been a nurse.[5] I explained who I was, and gave her my outline. In response, she stated that she knew me well from previous phone calls; a remark which I was not sure how to interpret, as I was sensitive to making a favourable initial impression in the setting. I wondered to what extent I had already established my presence in the setting, prior to even entering it.[6] My task completed, I left the hospital, reflecting on whether the hospital would continue to feel like a non-medical facility once I became more immersed in it.

Two days after my first visit, I returned to the hospital to consult with the psychiatrist who had been appointed to assist me. We met in his office, and after brief introductions, we began to discuss my plans for doing research in the hospital. He stated that after reading my outline, he still was not sure what I wanted to do, and how I would

do it. His lack of understanding was, I felt, a function of the nature of my research design; a problem that I encountered a number of times while doing my fieldwork. I discovered that the limited knowledge that most medical personnel had of social research methods was restricted mainly to an epidemiological-survey research orientation. They had little understanding of, and sympathy for, what they saw to be my "unscientific" methodology. To them, all research required a tightly structured research design, based upon instruments such as rating and attitude scales, questionnaires, interview schedules, etc., which would, in their view, allow the researcher the possibility of gathering "hard data," in order to prove the validity of his hypothesis. As I was to discover on a number of occasions, my ethnographic approach simply did not fit with their quantitative orientation toward research. To them, my research plans were unstructured and unformulated, and therefore did not fall within the domain of the scientific method. This psychiatrist, and others that I met, had the impression, I believe, that my proposed ethnographic approach was little more than a cover for my failure to adequately define a "scientific" research design for myself.

As soon as I became aware of the psychiatrist's attitude toward my research plans, I shifted the conversation into a discussion of the specific details of the proposals that I had to submit to the Research Committee of the hospital and the Ethics Committee of the Faculty of Medicine of my university. Here, he seemed to feel more at ease, and his critical comments gave way to a helpful, and, to me, most interesting discussion on how I should proceed. Our discussion was of interest to me not only because the psychiatrist conveyed to me information that

might help to expedite the official approval for my research, but also because our meeting was already, I realized, the start of my fieldwork. By this, I mean that this encounter was not only useful in order to facilitate my future research, but also was, in fact, in addition to my first visit to the hospital, an actual fieldwork experience, that constituted part of my data.[7]

I came to this realization shortly after we began our analysis of how to write up the Ethics Committee proposal. The psychiatrist stated that we were involved in a bureaucratic game; the rules of which demanded the production of a document which promised that my research procedures would be ethical, and would uphold patients' rights. He noted that it was an important ethical consideration that I respect patients' privacy, that I obtain their voluntary agreement to observe them, etc., but it was his view that these procedures were, as he put it, somewhat unrealistic. I sensed him to be skeptical about the demand that I work out elaborate statements of my commitment to ethical research procedures. He pointed out that there was a gap between the ethical considerations to which I had to pledge myself, and some of the practices that were pursued in the hospital.

His commentary was of significance to me. I felt that his comments represented vital information about the "real" workings of the hospital. The anti-psychiatry literature came to mind, and I could not help but link the social control theme of the literature to what I had just found out.

I was, in the course of my fieldwork, to encounter, at times, a gap between official policies with respect to ethical procedures, and

the actual practices that I observed. The psychiatrist's comments proved to be correct. As I outline my "story," I will describe these events, as they were part of my fieldwork experiences. It is not my intent, however, to develop an analysis of this "gap," not only because this thesis is not meant, as previously pointed out, to stand as a critique of the practices pursued in the hospital, but also, more importantly, because it is my intent to present the reader with an account of another "gap" that I, as has been previously discussed, came to recognize.

After some further discussion re the content of my proposals, the psychiatrist and I worked out a final draft of the material that he felt should be included. He suggested that I should insert an outline of the steps that I would take to ensure that my research would not only avoid infringing on the rights of patients, but also would not interfere with the normal functioning of the hospital; a point that the Research Committee of the hospital subsequently made an effort to impress upon me. I began to wonder if the many rules to which I pledged myself would adversely affect my freedom to pursue my research, but these doubts did not, at that time, dominate my thoughts. It was not until after I had met with the hospital Research Committee that I came to feel pressured by these commitments.

Having drafted an outline of the proposals, our discussion then turned to how I should approach and deal with the "paranoid" patients that I planned to interview. I had my own ideas, derived from the literature, but had not as yet discussed, with the psychiatrist, how I should utilize them, in my encounteres with "paranoids." His advice,

to my surprise, seemed very pragmatic and commonsensical. He stated that I should also treat this activity as a "game." I expected him to give me a theoretically-based account of how to interact, which would link up to the constructs of my "map." Instead, he offered a straightforward explanation, that seemed to me to be one that a lay person might also offer in response to the question: how should one interact with persons who have incapacitating or irrational fears? His explanation did not, in other words, sound particularly psychiatric, and, therefore, did not resemble the accounts that I had read in the literature. The essence of the "game," he stated, was to be honest with the "paranoid," yet, at the same time, not to be completely open with them. One must play this "game" correctly, he advised, in order to avoid becoming a conspirator in the eyes of the "paranoid." He noted, for example, that I should never contradict a "paranoid's" assertion, yet at the same time I should also avoid agreeing with him.

He stressed that I must be subtle in my approach, and in order to illustrate his advice, he acted out a dialogue between a "paranoid" and a person attempting to obtain his permission to study him. During the course of his dramatization, I began to laugh, as I envisioned myself carrying on such a dialogue with a "paranoid" patient. I found the contrived quality of the dialogue to be humorous. He agreed, but stressed that it was necessary for me to follow such a format, if I hoped to obtain a "paranoid's" consent.

Upon reflection, I continued to be puzzled by the common sense quality of his advice. The "game" that he outlined, I thought, did not differ from one an individual might opt to play in order to assist a

friend who froze while climbing on a rocky or icy face. This analogy came to mind, as I had, in the past, talked people out of an immobilized state, and had persuaded them to descend or ascend from their perch. The "talk" that I had used was not derived from the study of psychiatric theory, yet was, I realized, not different in quality from the "talk" that the psychiatrist advocated one use in encounters with "paranoids." Why, I wondered, did his advice not fit with my "map?" Why did it, unlike the material from the literature, have a mundane, common sense quality?

I did not spend a great deal of time mulling over these questions, as I arrived shortly with an answer to my puzzle. I decided that the psychiatrist had purposely transformed psychiatric theory into common sense lay concepts in order to facilitate my grasp of the correct way to interact. This transformation was, I believed, necessary, because I had no psychiatric training. I felt sure that if I had been a psychiatrist, our discussion with respect to how to approach and handle "paranoids" would have sounded much like the theoretical material in the literature, as no transformation, for lay purposes, would have been necessary. At that point in my fieldwork, I was unaware that similar puzzles would continue to recur, and would become a recognizable "gap" that would ultimately constitute the focus of my thesis.

Becoming Oriented to the Setting

My second visit to the hospital ended with a tour of the psychiatrist's ward. Before we left his office to take the tour, we discussed how I should dress while in the hospital. I had raised the question

because I was anxious to blend into the environment, as I felt that a "low profile" would facilitate the carrying out of my research.[8] The psychiatrist, who was wearing a tie, dress shirt, sweater, and slacks, responded to my question this way: "Dress like a doctor; like me. That way, you will seem less like an outsider." I subsequently made a conscious effort to "look like a doctor" whenever I was in the research setting. In addition to dressing like the psychiatrist, I also cut my hair shorter, and carried a briefcase instead of a shoulder pack.

Our tour of his ward again left an impression that the hospital aimed to create a modern, pleasant atmosphere. I once more had the feeling of being in a non-medical setting. While background music played, I was introduced to nurses who were called "team leaders," and was given an explanation of the structure of the wards, which were called "therapeutic communities." Despite the absence of uniforms and other obvious signs of a medical setting, I was able to identify some of the patients. They stood out from the staff, as they, in many cases, appeared dazed (a consequence of medications), and tended to dress differently than the staff, who seemed,to me, to have the appearance of social workers.

By now, I was aware that the hospital attempted, by design, to create an amicable atmosphere on its wards. Although I could not identify the reasons, I noticed, by contrast, that the psychiatrist had become tense when we arrived on the ward, and the nurses to whom I had been introduced, were not particularly friendly towards me. I subsequently discovered that there existed a controversy within the institution with respect to its "progressive" orientation, which may have

accounted for the strained atmosphere that I sensed then, and at other times, on the wards.

I did not enter the research setting again for a month, as I was involved in officially negotiating permission to conduct my research. I have already discussed the nature of these proceedings. I am dealing with them once more, in order to bring out a different aspect from my data. My earlier discussion focused on the procedures involved in obtaining consent to conduct my research. I wish, at this point, to set out the advice that was given to me in the course of the proceedings, and to describe the influence of these events upon me.

The experiences of negotiating approval to proceed with my research had a negative emotional impact. Despite my new-found awareness of my involvement in a bureaucratic game, and the coaching that I had received, I was unprepared for the events that took place. I felt insecure to begin with, as I wished to obtain approval to enter an institution that, by its nature, did not welcome intrusions of "outsiders." Furthermore, I had to deal with psychiatrists whom, I assumed, by virtue of their training, would be more prone to subject me to a probing study of my plans, motives, etc.

The events that transpired confirmed my fears, and had a lasting impact upon my outlook throughout the course of my fieldwork. Contrary to my expectations, however, I was not subjected to a scrutiny by the clinical supervisors of the hospital. It was, rather, the administrators of the institution who challenged my initial request to conduct my research, and who subsequently demanded extensive regulation of my activities.[9]

I had begun my research excited at the prospect of doing fieldwork, and finding out what the paranoid disorder and psychotherapy were really all about. I felt that I had an excellent opportunity to use my intellectual skills to further the understanding of a topic of long-standing interest to me. I had not, however, anticipated the stress involved in the fieldwork experience.

The following is an example of the type of interaction that dampened my excitement, and created tension within me. At a crucial stage of the negotiations to obtain my entry to the hospital, the psychiatrist who had been assigned to assist me suddenly refused to write a letter of support to one of the committees to whom I had to present my proposals. Citing the absence of the head of the hospital as grounds for his stand, he stated:

> This is out of my hands. It's not my responsibility. I helped you to prepare the proposals, but that's the limit of my involvement. I can't do more.

This left me in a precarious position, as this individual was, at that point, my primary contact in the hospital. I was forced to turn to one of the hospital administrators for support. He rejected my request, however, and furthermore admonished me for what he saw to be my attempt to circumvent official hospital procedures. I was perturbed as I had been proceeding in good faith according to my best judgement. Suddenly, I had been denied assistance, and my methods has been characterized as improper.[10]

The regulations that had been imposed upon my work, together with the type of experience discussed above, inhibited me. Throughout the course of my fieldwork, I felt compelled to rigidly observe the official

protocol which, at times, prevented me from pursuing my research objectives, and denied me the enjoyment inherent in doing fieldwork. The following incident may illustrate my point.

The first time that I went to the Medical Records Office of the hospital to look at the clinical records of a "paranoid" patient that I was observing in therapy, the medical librarian gave me a long lecture on the necessity of adhering to the regulations laid down by the Research Committee of the hospital. The lecture was then followed by a stern warning that was put to me this way:

> I will be checking to see that the consent forms are all in order. Don't underestimate the importance of this! I know that some of the residents are sloppy when it comes to the charts, especially Dr. .... [doctor's name]. That will be no excuse. I expect them all to be complete.

The librarian's remarks were threatening to me, in part because they came across as an accusation, but also because the resident that she referred to happened to be the therapist of the patient whose chart I had requested. Despite my efforts, this resident had not followed the proper consent procedures for taping, claiming that the patients all signed a general consent form when they entered the hospital. The librarian placed the responsibility for the charts upon me, yet I had been unable to convince the resident and other therapists to follow the procedures correctly.

This raised anxiety in me, as I anticipated the librarian discovering the incomplete charts, and reporting me to the Research Committee. I had visions of being cast in the role of a liar; being seen as one who makes commitments that he chooses not to keep. My ultimate fear was that I might be denied the right to continue my research. I hastily

phoned the resident at his home, and requested that he complete the chart as soon as possible. He responded this way:

> Don't worry! She is nothing to worry about. Her bark is bigger than her bite.

This experience, and others like it, left me feeling insecure, which tended to make me less aggressive in my pursuit of research material, as I was overly conscious of the regulations to which I had pledged myself. It brought back the feelings that I had experienced when I was seen, by the administrator, to be attempting to circumvent institutional procedures. Again, I had been proceeding in all honesty according to the best of my ability, yet circumstances left me in the position of being portrayed as underhanded.

I shall now deal with the final step in my month-long negotiations for entry to the hospital; my meeting with the Research Committee, and I shall focus on the remarks of the clinical supervisors at the meeting. I will mainly discuss their participation, as they involved themselves with the substantive elements of my proposal in contrast to the concerns of the administrators, which have already been outlined.

At the beginning of the meeting, I was asked "to take the hot seat"; a most appropriate term, which I was familiar with from Gestalt therapy. In my case, however, I was dealing with my intellectual rather than my emotional concerns, and with a group made up of a number, rather than one, therapist. I was tense, as I realized that I would have to explain and justify my theoretically based approach to paranoia to a body of practitioners, well-versed not only in the theories of the disorder. At that point, I felt less confident of my views. Who am I, I wondered, to assert a critique of psychiatry to a group of psychiatrists,

relying upon nothing more than my theoretical understanding?

I was asked how I arrived at my topic, and then asked by two of the clinical supervisors about my theoretical perspective on paranoia. I responded with my social control analysis of the disorder, citing the work of Lemert, Schatzman, and others, which prompted the following question from the clinical supervisors: "What do you think goes on in a therapy session with a paranoid patient?" Again, I raised the theme of social control, noting, as an example, Cameron's work on the reconstruction of reality. They, in turn, responded this way:

> No, you have misconstrued what goes on. You seem to feel that therapists try to talk paranoids out of their ideas. You will find out this isn't done. It would threaten the paranoids' balance--their inner dynamic.

Their answer made me question my understanding of what transpired in therapy. I did not, however, reject my own perspective, as I was, upon reflection, able to account for their response. Sensitive to the anti-psychiatry perspective, they were attempting to defend psychiatry from the social control critique by focusing their remarks on the task at hand in any one therapy session. One might not attempt to invalidate a "paranoid's: views in the course of any particular session, but over the course of the therapy, this would be the goal; a goal which they had not acknowledged. My views remained unchanged. I assumed that my perspective would be confirmed by my observation of therapy sessions.

One of the administrators then asked if I would be prepared to accept a member of the Department of Psychiatry on my Graduate Committee. Before I answered, another administrator added that he felt this member should have a vote. I responded that it was all right, as long as they

recognized that the sociological perspective of the other members of my committee might differ from their psychiatric perspective. I was asked for an example of what I meant, and I, in turn, cited the differences between a labelling theory and an intra-psychic explanation of mental illness. This prompted a strong response from one of the administrators:

> You are mistaken! No one in this room is a Freudian. You are unaware of our orientation.

I explained that I had not meant to imply a strictly Freudian perspective, but rather the variety of intra-psychic views that derived from it, which I had encountered in my study of the literature.

At that point, the topic was dropped, but I again felt the need to make sense of their remarks. Their source also lay, I decided, in a need to defend psychotherapy from what they perceived to be an unjust critique. The therapists were not Freudians, nor did they invalidate their patients' definitions of reality. This was their view of their enterprise. I still questioned this interpretation, as the literature pointed toward other conclusions. This exchange heightened my desire to finally observe what really did ensue in psychotherapy with "paranoids," as the practitioners denied what the literature asserted.

A discussion then ensued with respect to the procedures that I would follow to obtain informed consent. In contrast to the administrators, the clinical supervisors were interested in the interpersonal aspects of these procedures. One of them, in a joking tone, stated: "The therapists will be more paranoid than the patients." Another added, also in a joking manner:

> Getting a patient's approval each time? Then the fun will really start! Bloody noses!

I was unsure how to interpret these remarks, but I made the assumption that they were related to the advice that the psychiatrist (who was my primary contact) had given me. I assumed that they implied the following: I needed to gain consent from individuals who by definition (or in the case of the therapists by virtue of their role) would be suspicious of my requests. In order for me to be successful, I would have to treat this problematic interaction as a "game," and act accordingly.

None of the remarks had been stated in theoretical terms, nor did they reflect a direct relationship to the literature on paranoia. This was another puzzle that could be solved by viewing the remarks as material that had been transformed from the theoretical to the mundane in order to facilitate communication with a lay person. These common sense remarks were, I deduced, *really* theoretically informed.

I left the meeting with the impression that the committee had decided to grant its approval prior to my participation. Its purpose had been to introduce me to the senior staff, and to impress upon me the need to abide by the protocol. I was confident that I had broken through what I saw as a "smokescreen" that was put up to keep "outsiders" from meddling with the institution. Having penetrated this cover, I was ready to continue my fieldwork, burdened, however, with the regulations to which I was committed.

I spent a month, following the official approval of my research proposals by the two committees, establishing my presence within the hospital. During the course of the hospital Research Committee meeting, one of the administrators had stated:

> Once you gain approval for your work, you will have to make contact with therapists on your own. This is part of the research process.

Although I did not find it as trying as the previous month, this period was not easy for me, and certainly constituted an integral, and one of the more demanding parts of my fieldwork.

It proved to be a difficult task, as I had to establish a network of social ties to the wards without being able to move freely within them. I could not simply walk onto a ward, and start chatting with the staff. The wards were a "closed" territory in which all individuals were accountable for their presence. As I did not have a role such as an aide or cleaner, etc. that would allow me to legitimately enter this social space, and as no one on the wards knew me except the clinical supervisors (who often were not there), my task was formidable. During this early period of my fieldwork, I had, therefore, to negotiate each entry in advance by phone, often in the face of a defensive staff who exercised the same protective function over their wards as the Research Committee did over the hospital.

My aim was to introduce myself to the therapists on the wards where I was to do my research, and to familiarize them with my research plans. As their participation was voluntary, I then sought agreement to take part, from those who showed interest in my research, and I requested a commitment from them to locate from their wards, patients that had been diagnosed to be "paranoid." The latter step was necessary, as I did not have free access to the clinical records on the wards, and therefore could not keep track of the "paranoid" admissions. I shall now recount my experiences during this period.

The first meeting that I arranged was with the psychiatrist who was my primary contact, and the clinical supervisor of his ward, who had not been present at the hospital Research Committee meeting. I had set up the meeting, as I felt that it was important for all of the clinical supervisors to meet me, since therapists on their wards might wish to discuss my research plans with them. If the clinical supervisors were familiar with my work, then my chances of gaining the therapists' co-operation would, I believed, be improved.

I had sent a copy of my research proposal to the clinical supervisor ahead of the meeting, and was, therefore, surprised at his first question: "What is it that you want to do? Please explain your plans." This left me wondering if: he had not gotten the proposal; not read it; or perhaps wanted me to verbalize it in order for him to have the opportunity to evaluate me.[11] As I outlined its contents, I came to the realization that he viewed social scientific research in quantitative terms, and did not fully understand my qualitative approach:

> Clinical Supervisor: What exactly is your hypothesis? What are your variables?
>
> Other Psychiatrist: I wonder too. We are always trying to press him on his hypothesis.

I continued to outline my theoretical and methodological orientation, while feeling concerned that once more my primary contact had not supported me in the face of criticism from a senior staff member.

Our discussion turned to the problem of finding patients whose diagnosis fell within the category DSM-11-297 (*The Diagnostic and Statistical Manual of Mental Disorders* classification).

Other Psychiatrist: He hasn't taken note of the fact that there are very few patients with this diagnosis.

Clinical Supervisor: Yes, well there have been no patients in the last eighteen months on the ward who didn't also exhibit symptoms beyond those of paranoia. None without other disorders. E-1 [outpatient ward] would be a more likely place to find such people.

I was not deterred by their statements, nor did I feel ill-at-ease using diagnostic nomenclature, and discussing the characteristics of the disorder. From my study of the literature I was familiar with the terminology, and was aware of the rare incidence of "true paranoia" (DSM-11-297.0). I felt confident, as their remarks made sense in terms of my "map." I knew that "true paranoids," with the exception of their delusions, did not suffer from disturbances of thinking and personality, and often could function within the community. I was not surprised, therefore, that the clinical supervisor had suggested the outpatient ward. Furthermore, I had anticipated the problem of locating sufficient numbers of "true paranoids," and had already decided that observing therapy with patients suffering from variants of the paranoid disorder such as paranoid schizophrenia (DSM-11-295.3), or paranoid personality (DSM-11-301.0), would still allow me the opportunity of witnessing the theoretically determined processes of invalidating the patient's version of reality that I believed ensued in therapy. No puzzles presented themselves. Unlike earlier remarks re the "game" I was advised to play with "paranoids," their statements sounded psychiatric, and their reasoning could be linked back to the literature.

In a further attempt to explain my understanding of reality definitions, and how one might go about studying them, I cited Joan Emerson's

research on gynecological examinations, as her work stood as an example of a non-positivist approach to the study of reality definitions and the relationship between patient and practitioner.[12] I had no sense, however, whether my explanation of her work clarified my own intentions. Our meeting ended with a promise from the clinical supervisor to notify me of the admission of suitable patients.

I contacted the outpatient ward next, placing a phone call to the clinical supervisor. When I spoke to him, I identified myself, and stated that I wished to establish whether there presently were any "paranoid" outpatients, and asked how I might go about observing them in therapy. He answered that he didn't know who I was, and gave the phone to his secretary.

Secretary: I am sorry. You cannot just come into the hospital and do research! There are strict rules about this. Go and see Dr. ..., or Dr. ... .

Researcher: I have already been granted permission to do research in the hospital. Dr. ... just doesn't remember me. I would like to speak to him again.

Secretary: Listen; there have been problems with people doing studies in the hospital.

Researcher: Please let me talk to Dr. ... . I can assure you that I have permission.

At that point, the clinical supervisor returned to the phone, and apologized.[13] He had remembered me from the hospital Research Committee meeting, and in a friendly tone he quickly proceeded to list patients who he thought might prove to be suitable candidates for my research purposes.

He mentioned an Israeli male who had lived in the city for twenty years, and had owned a scrap metal business which he had abandoned, or

lost by default, as a consequence of his "paranoia." This episode had followed his return from a trip to Israel, at which time, he had publicly expressed criticism of Israeli government policy. His business and residence had subsequently been broken into, which he saw to be a response to his statements. He believed that some Jews and Zionists were "out to get him." This belief was, the clinical supervisor stated, the core of his delusions. He described the patient this way:

> I think that you would find him an excellent subject for your study. His previous diagnosis was psychotic depressive reaction; paranoid personality. In fact, he is a real paranoid.

The clinical supervisor's comments did not perplex me. I was able to account for them, as would others, in terms of knowledge derived from the literature. I knew what he meant when he said that the patient was a "real paranoid," and I could relate his remarks back to the advice of the other clinical supervisor. The outpatient ward would, it appeared, yield, as predicted, ideal subjects; "true paranoids" (patients who did not suffer from other disorders in addition to those of the "paranoid" variety).

Things seemed to be falling into place despite my anxiety. I had located a potential subject, and my theoretical knowledge (derived from my research of the literature) had given me the means to communicate with psychiatrists. Furthermore, the characteristics of this patient (as described to me by the clinical supervisor) seemed to lend themselves to analysis in terms of my perspective on paranoia. Perhaps his "delusion" was, in fact, a "logical" response to his present or past life situation. I knew from the literature that members of persecuted minority groups, and immigrants, both had a higher incidence of "paranoid"

disorders. Their feelings of persecution were said to be delusional in nature, but some had argued that the source of these feelings lay in the external environment of the individual rather than in some psychic defect.[14] The patient in question was both a member of a persecuted minority and an immigrant. In addition, his nationality and his political views had been described as prominent elements of his situation. I wondered, therefore, what would transpire in therapy. Would the therapist, relying upon an intra-psychic perspective, ignore the possible social basis of his disorder? Would the therapist reject his possibly accurate (rather than delusional) explanation of his situation? As his characteristics seemed to make him, according to my perspective, a likely recipient of the exercise of social control, I looked forward to observing him in therapy.

The clinical supervisor noted a second male patient who he thought would also prove to be a suitable subject. He, too, he stated, was a "real paranoid." The patient was described as a former member of the German nobility. The description raised two points in my mind. Again, the subject was an immigrant. I wondered in this case, however, if he was seen to have delusions of grandeur rather than persecution. Once more, a psychiatric account prompted recall of material discussed in the psychiatric literature. I assumed that being familiar with the literature had allowed me, as it would have others, to make psychiatric sense of the clinical supervisor's remarks. We were able to communicate effectively, I decided, because we held in common a knowledge of the literature. At that point, I was unaware that I would shortly encounter numerous situations in which my knowledge would not fit with my exper-

iences and observations. I would again confront mundane material that could not be explained in terms of my understanding of psychotherapy or paranoia.

The clinical supervisor concluded by stating that he would check the case load, as he thought that there would be other suitable patients. He then invited me to meet, and have lunch with, the therapists of the ward.

Further Puzzles Emerge: The Problems of Making Sense

Two days later, I visited the outpatient ward. My visit began in "rounds"; a daily meeting of the clinical supervisor and the therapists of the ward, at which each therapist presented a report on the status of their patients, and the therapy sessions that they had conducted that day. I was surprised at the informal atmosphere of the meeting. It did not resemble what I perceived to be a "normal" or typical meeting of therapists. It did not have a medical-psychiatric quality; which seemed to have little to do with the absence of uniforms or the modern decor. It was the way that people communicated with each other, that caught my attention. Their interaction lacked the clinical quality that I expected. They made little use of psychiatric concepts, reasoning, or terminology in their conversations. Consider, for example, the following:

Clinical Supervisor: How long has it been since ... [patient's name] worked?

Therapist: Over one year.

Clinical Supervisor: That's bad, very bad. We had better get him back into circulation before it's too late. Get him going!

Therapist: Yes, I think so too.

Clinical Supervisor: Otherwise, he will spend the rest of his life on welfare. How about our friend ... [patient's name]? Is he working?

Therapist: Yes, I arranged a part-time cleaning job through Manpower. It's not much, but it's a start.

Clinical Supervisor: Well, it's a good sign.

In reaction to this type of dialogue, I jotted down in my field-notes: *No Mystique*. I was puzzled. Why didn't they talk like therapists? There was no psychiatric quality to their conversations. There was no psycho-dynamic element in their analysis of the patients. They seemed to discuss them in the same way that concerned relatives would discuss the problematic life situation of a family member. They employed common sense reasoning. I could not understand, for example, why so much emphasis was placed on the employment problems of patients. I could appreciate that having a job might put some stability into an individual's life, but resolving one's employment problems did not seem to be the domain of therapists. Therapists were supposed to resolve intra-psychic problems, not find people jobs. Their reasoning with respect to the value of working puzzled me. It seemed to stem from a mundane concept not unlike "idle hands make waste." Where was, I wondered, the theoretically informed analysis that the literature had led me, or might lead anyone, to expect? What did psychotherapy amount to, helping people find jobs?

That evening, I mulled over my observations, attempting to find some answers to my puzzles. I arrived at the following conclusions. The clinical supervisor held the power on the ward, and therefore was

able to determine the style of "rounds." As he liked to maintain an informal atmosphere, the therapists all adopted his "unprofessional" approach for purposes of the meeting. Despite its mundane quality, their conversations really were theoretically informed. The pragmatic, common sense characteristics that I had identified were deceptive. Underneath this facade, a psycho-dynamic perspective was guiding their remarks. The psychiatrists had been able to transform material from the theoretical to the mundane in order to facilitate communication with me. Similarly, the therapists were able to transform their remarks into a style that was compatible with that set by the clinical supervisor.[15]

I had one other explanation, which I developed at this point, but also utilized later in my fieldwork to explain similar puzzles. Some therapists were not as well trained as others. On this ward, for example, some of them were registered nurses. Lacking theoretical knowledge, these therapists, I concluded, were unable to communicate in theoretical terms, and practised poor or superficial therapy. As practitioners, they engaged in something more akin to counselling than to psychotherapy as practised by highly trained therapists. Part of the mundane quality of the meeting, then, could be attributed to their lack of psychiatric training. Putting aside the question of the clinical supervisor's personal style, I felt sure that I would have observed what my constructs had led me to expect, if more of those present at the meeting had been highly trained therapists such as psychiatrists.

I was introduced by the clinical supervisor after the therapists' reports. He asked the therapists who were treating "paranoids" how they felt about my research plans. An older resident stated: "If he were to

get involved, I feel that my patient might terminate therapy." The clinical supervisor responded this way: "Many paranoids would welcome his presence. It would provide them with another interested listener."[16] A nurse and another resident who were treating "paranoids" picked up on his cue, stating that they were ready to participate. The younger of the two, the nurse, appeared to be particularly interested, stating: "Sure, I'd like to give it a try." I noted that the responses of the three therapists to my plans varied according to their age and their professional status. The older the therapist (which in this case was linked to their level of training), the less enthusiastic they were to participate, and the more formal was the style of their reply.

I attributed the variance in responses to the two factors discussed above. The older, more highly trained therapists were, I concluded, less inclined to adopt the informal unprofessional style set by the clinical supervisor, as to do so would minimize the difference in status between them and the other therapists. Secondly, they were less enthusiastic about participating, as they had, by virtue of their advanced training, a more highly developed sense of the importance of maintaining the integrity of the therapist-client relationship. They had a propensity for defining their patients as their own domain. The clinical supervisor's remark with respect to the attitude of "paranoids" was, I believed, an attempt on my behalf to use his power to undermine the senior therapists' perspective. The common sense quality of his statement could be explained, I decided, in terms of this pragmatic purpose.

After it had been established which therapists were interested in participating in my study, the clinical supervisor asked me to explain in more detail my research objectives. I saw his request to be educationally oriented. It was a means of eliciting further discussion of the disorder. After I had completed my presentation, he stated:

> Paranoid is a nasty term to put on someone. People can have real reasons for being paranoid.

His remarks struck me as unusual, as I did not expect him to assert a perspective which acknowledged the possible legitimacy of individuals' feelings of persecution. Although his view sounded much like my own, I decided that it was unlikely that we shared a common perspective. I knew from the literature, that very few psychiatrists accepted the critical ideas which I held. I decided that his statement was didactic in origin. He wished to point out (to the therapists) the need to exercise care when making a diagnosis. I assumed that he was not compromising, what I took to be, his theoretical stance.

Despite the opportunity, at first none of the therapists asked me questions, which was a function, I presumed, of the clinical supervisor's power. As he had accepted the legitimacy of my work, they did not venture to question it. Finally, a question was asked.

Therapist:	Do you want to get involved with the patients?
Researcher:	No; not at all. That's not my intent.
Clinical Supervisor:	[Joking tone] Seems like he's afraid. Too timid?

I had responded negatively, as I wished to make clear that I would not threaten the therapeutic relationship. I did so for two reasons. I

did not want to alienate the therapists whose consent I wished to gain, nor did I wish to contravene my commitment to avoid interfering with the functioning of the hospital. The clinical supervisor did not share my concerns. He thought that I should get involved with the patients that I would observe. He expressed his feelings to me after the meeting.

Clinical Supervisor: The hospital is a silly place. They make too many restrictions. It makes it hard for people to do research.

Researcher: The protocol makes me feel like I must walk on tiptoes.

Clinical Supervisor: You should go ahead and get some data. Get your feet wet! Find out what paranoia is about.

The clinical supervisor's attitude confirmed my earlier observation. Unlike the hospital administrators, the clinical supervisors were not overly concerned about protocol. I was unsure, however, why the clinical supervisor encouraged me to "get involved" with paranoid patients. I knew that it would be useful for my research, but I had a fear (derived from my study of the literature) of becoming part of the patient's paranoid "pseudo-community." I did not want to put myself in a position where this might become a possibility, as I was not sure that I could deal with such a situation. The references in the literature to the potential threat posed by "paranoids" had tempered my desire to get directly involved in their lives.[17] I attributed his attitude, once more, to a pragmatic stance. As he felt that my research might prove to be worthwhile, he decided to overlook the problems which (I knew from the literature) would be generated by my involvement, and pushed instead for me to "get my feet wet." As the hospital was meant to be a research

facility, he was prepared to ignore what he knew to be potential problems. In order to facilitate my research, he was willing to persuade his therapists to ignore them also.

I was unsure how I should proceed. Apparently, the protocol was not as important as I had been made to believe, nor were my constructs as applicable as I had expected. I was left feeling insecure, and was tempted to withdraw rather than follow up the contacts that I had established that day. Before leaving the hospital, however, I "made the plunge," and arranged to meet with the nurse (therapist) to discuss her "paranoid" patient, who turned out to be the Israeli male that the clinical supervisor had described on the phone.

We met the next day in one of the therapy rooms of the outpatient ward. The therapist arrived late, as she had been delayed at a community mental health clinic. She apologized, and then began to present a case history of the Israeli "paranoid." I was familiar with case histories from the literature, but aside from the clinical supervisor's brief remarks on the phone, I had never been party to a psychiatric account of a "paranoid" patient. I was excited, as I was taking another step toward actually observing "paranoids" in therapy.[18] I was given the following factual information about the patient. He was forty-eight years old, single, and he lived alone. He was unemployed, and he spent his days at the main library where he read newspapers. His main meal was lunch, which he ate at a department store, and he spent his evenings watching television at home, retiring at 8 p.m. He had no social life, as he had no friends. His family had been active in Israeli politics, and he had been in the British Air Force.

Having given me an overview of his life, the therapist began to present her analysis of his situation. I had already formed an initial analysis of his problems from the clinical supervisor's account. I expected that the therapist would present an intra-psychically based counter interpretation which would ignore the social variables, such as his immigrant and minority status, that I had identified. To my surprise, she did not discuss the patient in either social or intra-psychic terms. Consider the following:

> I started him in occupational therapy. I wanted to put him in contact with other things, but he felt demeaned by it; which I understand. He wants to get a truck and go back into the junk business. That worries me. Another failure would really upset him. Dr. ... [clinical supervisor's name] said that this was still a better choice than continuing his present existence.

I was not sure what to make of this talk. I had expected an intra-psychically based analysis focusing on his delusions. The content, focus, and style of the therapist's analysis, instead, reminded me more of a lay person's discussion of the personal problems of a family member or a friend. For example:

> He seems to have a thing against women. It comes out in remarks about the way I dress. When I wear pants, which I usually do, he comments on my improper attire, but he also makes remarks and is uncomfortable when I wear skirts.

Or, consider the following:

> I see him less often now, only once every two weeks. One of his problems is that he has become too dependent on the hospital. Its like a womb for him here. I hope to get him to stand on his own feet; to get out into the world.

Although the therapist's remarks had a discernible psychological content, they lacked the psychiatric quality that I had expected. I attributed their mundane properties to the following reasons which I had

already relied upon to make sense of previous observations. The therapist, I decided, had purposely chosen to discuss the patient in common sense rather than psycho-dynamic terms, in order to communicate more effectively with me. Her analysis was still theoretically informed, but it lacked the characteristics that I had expected, because it had been transformed into common sense terms. If she had been conferring with a colleague, I would have heard the kind of talk that my constructs had led me to anticipate. Another previously used explanation also occurred to me. As she had limited training in psychotherapy, it was possible that she was more inclined to give a common sense account, as she lacked the extensive theoretical knowledge of a psychiatrist. I was unsure which of the two explanations offered a more accurate answer to my puzzle, but felt that together they provided a reasonable solution.

In the latter part of our meeting, we got into a discussion of the characteristics of "paranoids." I was again surprised, as the therapist made a "switch" in her talk from the mundane to the psychiatric, which I could not account for, particularly because I had assumed that she was deficient in theoretical knowledge. Her discussion of paranoia did not sound like her discussion of her patient. It lacked common sense references to job failure, uncomfortableness, "getting on one's feet," etc. It exhibited, instead, psycho-dynamic knowledge derived from psychiatric theory. Consider the following:

> 'As you may know, there are a number of classic paranoid traits such as delusions. Some of the patients' delusions may be readily apparent to you, others may not. They are all engaging in projection. They are unable to manage their inner conflicts. They project their anger onto those around them.

The therapist stated, in response to a question I had about the way

delusions were handled:

> We don't always work directly on the patient's delusional material. If the patient has some sanity, then we can confront his paranoid delusions, but if he becomes too angry, then we can only encapsulate them.

I was familiar, from the literature, with these perspectives. They made sense in terms of my knowledge of the theory, but I was unable to arrive at a satisfactory explanation of the "switch." Her talk was divided between a theoretical discussion of the disorder and a mundane discussion of her patient. She did not, and I was unable to, integrate the two. I wondered why, for example, I could not discern, from her comments about her patient, the classic symptoms that she described as defining the disorder. I decided that the disparity stemmed from my own lack of knowledge, and would be resolved when I had the opportunity to actually observe psychotherapy with "paranoids." I felt that at that time I would become aware of a link between the mundane and the theoretical, which would allow me to both explain her "switch," and make sense of the mundane material, in terms of my knowledge of psychiatric theory.

At the conclusion of our meeting, the therapist introduced me to a woman in the nursing station who I took to be a secretary.[19] Upon hearing that I planned to observe "paranoids," she made a joke (that had a distinct non-psychiatric quality) about the impossibility of my task, given their fears. I did not interpret the joke to be theoretically informed,[20] as I felt sure that she was not a therapist. My judgement was confirmed when I was told that she handled the appointments and the clinical records of the outpatient ward. I found out from her that all of the Israeli "paranoid's" clinical records were in the nursing station,

and, being conscious of my commitment to avoid disturbing the functioning of the ward, established that 2:30-4:00 p.m. was the best time to examine them, as rounds were held daily at that time. I also gained a promise from her to notify me of any patient assessments that included a diagnosis of some form of paranoid disorder. I noted with interest, given that she was a secretary, that she seemed to know which diagnoses I was making reference to.

My interest stemmed from my desire, throughout the course of my fieldwork, to establish the roles played by individuals in the hospital. As the staff did not wear name-plates or uniforms, I was unable to easily differentiate between clinical supervisors, other psychiatrists, residents, interns, nurse/therapists, aides, secretaries, and even patients. I needed to do so, however, as establishing their roles allowed me to make sense of their behaviours. The common sense jokes of the clinical supervisor and the secretary are a good example. Although both jokes had the same quality, I interpreted them differently, as I was aware of the tellers' dissimilar roles. By establishing roles, I was able to place my observations into a meaningful context. The process was not, however, unambiguous, as often the material that I used to differentiate a role such as dress, manner of speaking, demeanour, etc. was the same as that which, upon having confirmed an individual's role, I subsequently placed into a relevant context. I was able, for example, to make adequate sense of the secretary's remarks. They were a clue to her role, yet at the same time, it was only upon establishing her role that I was able to make meaningful sense of them.[21]

The following day, I returned to the hospital to examine the Israeli "paranoid's" clinical records. Before going to the outpatient ward, I met with a resident from another ward who had read my research proposal, and was prepared to notify me of any "paranoids" admitted to his ward. I now had established a link with a staff member on each of the wards which the hospital Research Committee had recommended as suitable for my research (two inpatient and the outpatient ward).

The resident introduced himself as Doctor ... (his name), and stated that after having read my proposal he had two questions, which he put to me this way:

> There aren't many patients with a diagnosis of paranoia who come on the ward. Almost always, they are also diagnosed to be manic or schizophrenic. What type of patient are you looking for?
>
> Have you considered the emergency ward and the assessment unit of ....(initials of the largest hospital in the city)? I am sure that you would find more clear-cut cases of paranoia there.

I was struck by the similarity between his questions and the remarks of the clinical supervisor, and my primary contact from the other inpatient ward. He, too, pointed out the scarcity of inpatients who were "true paranoids," and also suggested an alternate source that drew upon "true paranoids" from the community. Once more, I was confronted with and able to make sense of these ideas, in terms of my knowledge of the literature, which gave me confidence. The resident's questions helped to confirm my belief that the literature would provide me with a "map" of the research setting. Although I had encountered a number of puzzles, I had been able, after all, to account for them within my theoretical framework.

I responded to the resident as I had previously replied to the other psychiatrists. I noted that I was aware of the rare incidence of cases of "true paranoia," and that "true paranoids" were more likely to be found in an outpatient setting, as they often were able to function in the community. I pointed out that I was prepared to study patients suffering from variants of the paranoid disorder. The resident stated that this would improve my chances of finding patients on his ward, and promised to inform me of any suitable admissions.

The Puzzles Are Compounded

I was pleased that I had now secured an informant on each ward. I proceeded to the outpatient ward, curious to explore the contents of a patient's clinical records. My curiosity was heightened by my prior knowledge of the Israeli "paranoid," attained from his therapist and the clinical supervisor. I wondered in what ways his clinical records would add to the picture I already had of him. I wondered if they would help me to make further sense of the "switch" and other ambiguities that I had encountered in my discussion with his therapist.

I arrived at the nursing station, and was met by the clinical supervisor, who was standing in the entranceway. Inside, the secretary and a number of therapists that I recognized from the rounds which I had attended, were working at desks. Conscious of my promise to avoid interfering with the work done on a ward, I mustered up my courage, and announced that I had come to examine the Israeli "paranoid's" clinical records, on the advice of his therapist. The clinical supervisor seemed pleased that I was taking an interest in the patient, and motioned me

toward the secretary who handed me his file. I was then taken by the secretary to a room, close to the nursing station, used as a study area by students in professional programs who were working in the hospital. I sat down at one of the desks in the unoccupied room, and began my examination of the patient's records.

The records were organized chronologically, and were dated from the present back to his first admission to the hospital. In addition to entries made at the hospital, the format of which has been outlined earlier,[22] the records also contained material from the clinical records of other hospitals to which he had been admitted. The patient had a voluminous file, as the records contained a history, an admitting diagnosis, and a problem list for each time he was admitted to the hospital, and a discharge summary for each time he was discharged. As he had been admitted a number of times, these sections of the records added many pages to the extensive daily records that were kept.

After reading approximately one-third of the eighty-odd pages, I arrived at a general impression of their character. Much of the patient's file was made up of documents such as consent forms which were included for legal purposes; non-psychiatric medical histories which contained, for example, lengthy descriptions of surgery and non-psychiatric diagnostic tests that had been performed on the patient; and extensive lists of medications which had been prescribed for the patient in the hospital. The second feature that I noted, was the repetitive nature of the clinical notes that were made daily by the various staff that worked with the patient. The notes varied little in their content, appearing to follow a pattern set in the initial entries made after the

patient was admitted. Finally, I observed that parts of the records gave me a more composite view of the Israeli "paranoid" than I had gained from his therapist, as they discussed the extent and character of his delusions.

The following day, I finished reading the patient's records, and began to mull over their contents, in an attempt to make sense of them in terms of the literature. As I thought more about them, I realized that I was confronted with material that both did and did not fit with the literature on psychotherapy and paranoia. I was able to make sense of the patient's admitting diagnosis, history, and problem list; his discharge summary; and the "Assessment" section of the daily entries, as the style in which they were written, and the material with which they dealt, were similar to that found in the literature. The "Subjective," "Objective," and "Orders" sections of the daily entries were, however, a puzzle. The first two sections were meant to stand as a record of the state of the patient's disorder, while the latter section was meant to be an outline of the therapist's psychotherapeutic strategy for dealing with the disorder. To my surprise, the contents of the three sections did not make sense in terms of the analyses of paranoia, or the descriptions of psychotherapeutic approaches to the disorder, that I had encountered in the literature.[23] They had, instead, a distinct common sense quality. I shall now set out some material from the patient's clinical records that I found I could make sense of, and some that I found puzzling. I shall, furthermore, show how I fitted together my initial impressions of the records with my subsequent thoughts on them, that were developed in the days that followed my first reading of them.

The material from the patient's records that I was able to understand in terms of the literature on paranoia included both a section of the daily entires (the "Assessment"), and the summaries of the patient's condition (the admitting diagnosis, history, problem list, and the discharge summary) which were noted respectively at the time of admitting, and upon discharge of the patient. These entries did not pose problems of interpretation, as they were made up of theoretically based analyses of the patient. In both their form and content, they resembled material that I had read in the literature. Consider, for example, the following, taken from "Case History" and "Discharge" entries made at another hospital to which the Israeli "paranoid" had been previously admitted:

> Case History: .... [name of the hospital]
> Therapist: Dr. .... [name of the psychiatrist]
>
> This patient was referred by Dr. ... after he had presented himself at Emergency on several occasions. He again came to Emergency on the morning of his admission to hospital and appeared confused, disturbed and related three different names--none of which could be verified. It was felt by Dr. ... [pscyhiatrist's name] that he was a schizophrenic and he was accordingly admitted. When seen, his conversation was rambling and disjointed and he talked about threats having been made but would not specify what they were. When out of the room he was heard to be talking loudly to himself and shouting periodically. He claims that he owns a junk yard in ... [name of neighbouring city] and has been here for 2 or 3 days. He says that he has been under considerable emotional strain and was to get rid of the business. He related that he thinks he has been projected into saying things, has been talking to himself all night, and has been under compulsion to talk.
>
> He relates that he has been in ... [name of hospital in the USA] for two years--'58-'60 but does not relate any other hospitalization for mental disorder.
>
> He was not able to give much information about his family, in that, he says his parents are living in Israel....
>
> Diagnostic Impression:
> Paranoid Schizophrenia.

"Discharge Note" ... [name of the hospital]
Ther. Dr. ... [name of the psychiatrist]

This patient responded quite rapidly to treatment in the hospital and was discharged on Trilafon 8 mgms. b.i.d. He was to take the bus and return to his business running a junkyard in ... [name of neighbouring city] and he was discharged at his own request. He said he had business dealings that he had to get back to at once. He said that he would contact his family doctor when he was told that he should have some follow up care. There were no delusions or hallucinations elicited at the time of his discharge. It was felt that this was a relapse of a chronic schizophrenic illness.

Diagnostic Impression:
Acute Schizophrenic Reaction

These entries did not contradict my expectations of what therapists would have to say about "paranoid" patients, or how they would express their views of them. The material had a psychiatric rather than mundane quality, another illustration of which is found in the following, taken from an entry made at the time of a previous discharge from the hospital (where I conducted my fieldwork):

Discharge Summary, Therapists: Dr. ... [name of a clinical supervisor] and ... [name of a fourth-year medical student].

Condition on admission and relevant history:

His psychiatric history has spanned 20 years, but during the last 2 years he has been admitted on 4 occasions. This last clutch of admissions was precipitated by politically oriented letters he had mailed to the press concerning Jewish reaction to Russian domination. He has gross guilt feelings regarding these letters.

Mr. ... [patient's name] was pleasant, vocal with no loosening of association. However he did have mild fixed delusions concerning the letters described above.

Patients Problems:

i Depression: This was treated with a combination of supportive psychotherapy and Amitriptyline 50 mg. b.i.d. and 100 mg. h.s.

As part of the depression ... [patient's name] was aggressive when approached and shunned company of any type. This state gradually decreased with time.

ii Introversion: To start with ... [patient's name] was very stingy in all respects. He sat by himself and rarely talked except to castigate someone. He said he was a loner--and he was. It was made easy for him to socialize and he was greatly helped by other patients.
iii Paranoid: Right until discharge ... [patient's name] refused to be taped and disliked being in a room with a 2 way mirror even though it was not activated. This paranoid state was reduced by giving Trifluoperazine 5 mg at noon and 10 m.g. h.s.

Discharge Instructions:

Medications: Amitriptyline and Trifluoperazine in dose indicated above. He has been asked to join in O.T. daily .... He retreated rapidly from any suggestion of "Team" follow up.

Final Diagnosis
Psychotic Depressive Reaction.
Paranoid Personality.

Both sets of entries "sounded right," as they described and analysed the patient's thought and behaviour in the same theoretical and conceptual terms that I had anticipated I would encounter. I was (and I assumed that others familiar with the literature would also be) able to identify in the references to his delusions and "paranoid" thought the theoretical perspectives that had guided the therapists' formulations of their accounts, which enabled me to see the theoretical significance of the material in them. I could, for example, link phrases such as "no loosenings of association," or terms such as "mild fixed" used to describe his delusions, back to the body of theoretical knowledge on paranoia which I had studied, and which guided (I assumed) the therapists' understanding of the disorder. Although I did not have much evidence to support my premise, as there was minimal description in the entries of how the patient's disorder was treated, beyond a listing of medications, I concluded that the therapeutic work done with the patient must also have been theoretically guided. I did not view

references such as "this was treated with a combination of supportive psychotherapy," and "there were no delusions or hallucinations elicited" as indicative of a common sense approach to handling the disorder. There was no question in my mind that these entries reflected a theoretically based approach. I was able, therefore, to make sense of them in terms of the literature.

The "Assessment" section of the clinical records was written up each time a therapist met with the patient. This part of the records was also a theoretically based account of the patient's condition, and did not, by itself, present me with problems of interpretation. I had no difficulty in identifying the theoretical significance of the material within it. It also had the style and content of the psychiatric literature, which is evident in the following examples taken from the patient's clinical records:

> ... [patient's name] is partially suppressing, denying and unconsciously physically expressive of anger. He has set himself up for frustration via rejection.

> Mr. ...'s [patient's name] paranoid thought is becoming more evident. He will feel threatened by so many people around him (i.e.) the no. on the ward; and by many of the close relationships being set up among staff and patients. Because of his paranoia he would naturally be resistive to many of the suggestions and become hostile or angry not even being able to release this anger.

Throughout the Israeli "paranoid's" records, I was able to locate examples of "Assessments," such as those cited above, which analysed his character in psycho-dynamic terms. It was obvious to me that the therapists had relied upon psychiatric theory to arrive at their conclusions in this section. I was puzzled, however, by the material that the therapists cited as the source of their "Assessments."

The puzzling material was found in the "Subjective" and "Objective" sections of the daily entries. It was written up at the same time as the "Assessments," as it was meant to stand as evidence for the views expressed in the "Assessment" section. I could not, however, make sense of it. To me, the material was mundane. I did not view it as evidence of a paranoid disorder, yet the therapists were able to read into this material the psycho-dynamic content that they then discussed in the "Assessment" section. I was able to see the theoretical significance of the material in *that* section, but failed to see how it could be understood in terms of the contents of the other two sections. Consider, for example, the following, which is representative of the "puzzle" that confronted me:

> #9 Paranoid, #10 Introversion,
> Therapist: ... [therapist's name]
>
> Subjective: "I walked around"--"No--I saw no one I knew" "No--I know I'm to get a job and I'll start on it Monday" "I have an idea" "No I won't tell you in front of everyone" "No I won't go to my room--why should I tell you?--It's simply that I won't stay here a day longer than I have to--won't leach off your system any longer"
>
> Objective: very angry tone
>
> Assessment: --remains paranoid re: exchanging information in front of pts. on topics even as general as "Did you shop?"
> --remains defensive re: problem sharing with therapists.
> --although the topography is not a thought disorder but presenting partly as a cultural behavior type, ...'s [patient's name] inaccessibility to therapy the past weeks could be due to a deeply submerged bizarre thought pattern.

I was able to interpret the content of the "Subjective" section, as the talk of a person who was upset, angry, and unwilling to share his feelings. I felt that any other culturally competent member might also

have viewed his conversation this way, and would have agreed that the statement of the "Objective" section was compatible with the material of the "Subjective" section. I failed to understand, however, how the therapist viewed this talk as theoretically relevant. Although emotional, none of it struck me as characteristic of a person who was necessarily paranoid, defensive, or disturbed by "a deeply submerged bizarre thought pattern." I could entertain the perspective that the conversation stood as evidence of a disturbed individual, but could not go beyond that level of analysis, and pick out material of theoretical significance. I failed to see how the therapist viewed such mundane talk to be theoretically meaningful.

I was left feeling confused, as I had believed that my knowledge of the theoretical literature would enable me to see things the way that therapists saw them. I could not grasp why I was unable to do so. I had thought that a knowledge of the literature on paranoia would allow one to make psychiatric sense of cases of the disorder. I had failed, however, in my first attempt to apply my knowledge. I could not locate, in the patient's talk, the traits that the therapist had identified as characteristic of the patient's disorder. This "problem" presented itself each time I compared a therapist's "Assessment" with the "Subjective" section of the respective entry. I decided that the answer lay in my own inexperience. Once I had the opportunity of observing a number of "paranoids" in therapy, I would be able to make sense of their conversations in terms of my theoretical knowledge. Their talk only seemed mundane because I had not yet heard "paranoids" converse in the context of a therapy session.[24]

I was confused not only by the "Objective," and particularly by the "Subjective" sections, however, but also by the "Orders" section which was the final part of a therapist's daily entry. It was here that a therapist outlined a plan for dealing with the disorder that they had noted and discussed in the previous sections of the entry. I was perplexed, because this section, which I assumed would reflect a theoretically directed psychotherapeutic strategy, instead was also made up of common sense material. The therapists' "Orders" did not sound like the orders of therapists, just as the "paranoids'" talk had not sounded like the talk of "paranoids." They sounded like the mundane advice of a helpful lay person attempting to deal with the problems of someone they knew. They resembled the puzzling statements that I had heard in rounds, and from the patient's current therapist. The "Orders" did not "come across" as directives issued by one versed in psychiatric theory. Consider, for example, the "Orders" that concluded the entry discussed above:

> Orders: Remains suspicious of staff intentions.
> --use friendly greetings in hall, day room, etc. to increase his sense of "OK" via staff.
> --consider phenalthiazine therapy to render pt. more accessible to therapy.

I was unable to grasp how the use of "friendly greetings" constituted a psychotherapeutic response to what the same therapist had already described as a "paranoid" disorder, possibly characterized by a "deeply submerged bizarre thought pattern." The common sense quality of the directive astounded me. The reference to a medication (which will be discussed fully below) sounded medical, but I was unable to

understand how the first order could be seen as a psychotherapeutic directive. I was not faced, however, with an isolated example. In addition to instructions re medications, the "Orders" sections typically contained mundane directives, as the following examples will illustrate:

> Orders: Help him set up short term goals that he can achieve while here, i.e. getting a job, finding places he can join for after-work entertainment.
>
> Orders: Increase Amitriptythine up to limit.
> --If this fails to change his mood use a combination of Amitriptythine + Maoi.
> --... [a therapist's name] will contact Drs. ... and ... re helpful areas in the Jewish community.
> --explore ways of developing community support in men's clubs (Lions etc.).
>
> Orders: Recognize his difficulties in relationships and talk to him about his ideas of how to overcome this in his way.
> --Support him re no real feelings of belonging to any one country or society, e.g. "It's pretty unpleasant not to have any real 'roots' anywhere."

I found the mundane quality of the therapists' "Orders" even more puzzling than the common sense conversations of the patient that were noted in the "Subjective" sections of the patient's records. I could at least find an answer for my failure to see the theoretical significance of the patient's talk, but I could not explain the mundane character of the therapists' directives. As they had engaged in theoretically based analyses in the "Assessment" sections, I had expected the therapists to issue instructions that in their style and content also resembled the material found in the psychiatric literature. Instead, the "therapy"[25] they ordered, as illustrated by the examples, dealt with finding the patient jobs and interest groups, giving him common sense advice re realistic goals, and understanding his ideas and feelings. Could this

be psychotherapy, I wondered? I had previously been able to explain my primary contact's mundane advice on how to approach and deal with "paranoids." In that instance, I had accounted for the common sense quality of a therapist's remarks in terms of his conscious transformation of the material for the purpose of facilitating communication. In this case, however, that explanation would not work. The "Orders," after all, were written for other therapists, and therefore had no need to be transformed.

Thus, I was left with another puzzle. How did joining a Lions club, for example, constitute psychotherapy? I could not grasp the psychiatric meaning of the directives. Only one part of the "Orders" seemed therapeutic in the sense that the literature had led me to expect. The instructions re the patient's medications were not common sense material. They were unquestionably medical in character. Therapists often linked these prescriptions to the course of the patient's "therapy," using terms such as: "render patient more accessible," "change his mood," "control depression with medication," etc. These references did not, however, solve the "problem" of the mundane character of the other parts of the "Orders," as they were, after all, examples of chemotherapy. I had been unable to locate in the "Orders" what I took to be examples of psychotherapy.

I spent a number of days trying to make sense of the Israeli "paranoid's" clinical records. They were, at that point, the most comprehensive and readily available body of data on paranoia that I had access to. As I am, by personality, inclined to strive to create order, I attempted to organize my various observations of the clinical records

into a framework that made sense in terms of the theoretical perspectives on the disorder found in the literature. I discovered, however, that I was unable to integrate all of my insights.

I set out at first to clarify my initial impressions of the records, in terms of my subsequent thoughts on them. My analysis led me toward the major problem that emerged in my study of them. The records inexplicably seemed to be both a relevant, theoretically based account of the patient's disorder and its treatment, and yet at the same time, an unimportant common sense document kept only for bureaucratic reasons. I unaccountably was able to interpret the records both ways, depending on which sections I focused upon.

Two of my initial observations pointed toward the latter characterization. I came to see that my earlier observations of the legal/bureaucratic character of the records, and the repetitiveness of the entries, derived from what I had subsequently discovered was the mundane character of the "Subjective," "Objective," and "Orders" sections. I was not aware at the time of my first reading of the records, however, that the source of my impressions lay in the common sense material of these three sections. It was only upon subsequent analysis, that I connected my impressions with my interpretation of the three sections, and arrived at one view of the records. Adopting this approach led me to conclude that the records bore no relation to psychiatric theory either of the traditional variety, or of the critical perspective which I held. My concerns with respect to the social control potential that I saw to be inherent within an intra-psychic explanation of the disorder were of no relevance to the clinical records. They were not meant to

stand as a psychiatric account of either the state of the patient, or the course of his treatment. They were, instead, a legal/bureaucratic document kept by the institution for legal/bureaucratic reasons, such as the possibility of law suits. According to this interpretation of the records, my "problem" of making psychiatric sense of the patient's mundane talk, and the therapists' mundane orders, was resolved, as the records were not to be understood as psychiatric accounts.

My larger problem was not resolved, however, by this interpretation, as not all parts of the records were mundane. I was still left with my other impression that the records had given me a fuller picture of the patient's delusions, and my view, which I decided was the source of this impression, that the "Assessment" section and the intake and discharge summaries were theoretical accounts that did provide a psychiatric record of the patient's disorder and his therapeutic progress. Together, these interpretations formed a counter explanation of the clinical records. From this perspective, the records were to be seen as theoretically based documents vital to a psychiatric understanding of the patient, and amenable, therefore, to analysis in terms of my social control perspective. Using this approach, I was left, however, with a reverse problem. This time, I had to make sense of the mundane material, particularly that found in the therapists' orders.

I was faced with another instance of a "switch," as I had been in my earlier discussion with the patient's therapist. The clinical records had not, as I had hoped, clarified the ambiguities that had emerged from that discussion, but rather had compounded them. I now faced another confusing shift (within the context of a segment of my observations)

from the mundane to the theoretical. I found the shift (or as I saw it: the disparity in my data) inexplicable, and sought refuge in my earlier answer. I decided that I would eventually locate a satisfactory explanation that would allow me to resolve the puzzles, and fit the parts together. My failure to do so stemmed, I thought once more, from my lack of real life encounters with "paranoids." Observing them in therapy would, I decided, provide me with an explanation for the problems of interpretation that continued to confront me.

Footnotes

[1]I am not alone in adopting a narrative format. There are other precedents in the sociological and psychiatric literature, in addition to that set by Freud, for utilizing the narrative style. See, for example: Elaine Cumming and John Cumming, *Closed Ranks* (Cambridge: Harvard University Press, 1957); and Alexander H. Leighton, *My Name Is Legion* (New York: Basic Books, 1959).

[2]I use the term "highlighting" in the sense that I will dwell more extensively on certain parts of the "story" (experiences that I took to be of significance while doing my fieldwork) than on others. It is my contention that these significant experiences are also those that best illustrate the validity of my argument.

[3]I had walked and driven many times past the hospital, but had never had an occasion to enter it. Psychiatric hospitals, like prisons, are public buildings that deny one the opportunity of unscheduled visits. One must, in other words, have some reason, deemed legitimate, for entering this type of social space.

[4]Peter Berger, *Invitation to Sociology: A Humanistic Perspective* (Garden City, N.Y.: Anchor Books, 1963), pp. 31-32.

[5]I assumed that she was not a doctor or an intern, as she appeared to be "servicing" the front counter of the nursing station.

[6]Like all ethnographers, I worked hard to establish a positive relationship with the members of the "culture" that I was studying. My task, as was and will be discussed elsewhere, was not made easier, as this was a psychiatric and, therefore, "closed" facility.

[7]I had, in fact, begun to keep fieldnotes and a journal from the time of my first visit, but it was not until this point that I came to recognize that I was really playing the role of an ethnographer.

[8]In retrospect, I believe that my desire to maintain a "low profile" stemmed as much from my need to "fit in" and thereby reduce stress and insecurity, as it did from my need to effectively pursue my research. One could argue, of course, that the reduction of stress did, in itself, help to facilitate my endeavour.

[9]I was surprised that the clinical supervisors did not concern themselves with the regulation of my activities. I assumed that they, as the psychiatrists in charge of the wards where I would be conducting my research, would be the ones who would be prone to imposing controls over my fieldwork. That it was the administrators who adopted this

stance, can, I believe, be explained in terms of the "gap" between official policies and actual practices on the wards. It is the task of administrators in any institution to generate and maintain a framework of official policies for their institution, and to control the interaction between their institution and the "outside" world. It is the task of personnel working within an institution, however, to get their work done. I discovered that the two tasks were not necessarily compatible. As an "outsider" active within the institution, I was frequently faced with the contradictory demands of these different tasks, which created stress for me. It is important to point out once more that I recognize the source of the administrators' demands, and hold no negative feelings toward them, nor do I seek to develop a critique of the institution based upon my discovery of this "gap." The following is taken from the research proposals that I submitted to the hospital and to the Ethics Committee of my university, and from the minutes of the meeting of the hospital Research Committee at which my proposal was reviewed. It may serve to inform the reader of the extensive regulations to which I was formally committed.

(1) The researcher will not use the records in the nursing station, but rather will peruse them in the Medical Records Office upon discharge of the patient. Thus, there will be no interference with the work normally carried on in the nursing station.

The patients will be chosen in consultation with the Clinical Supervisors of the three wards and the primary therapists of the patients who are selected. Written consent to participate in the study will be obtained from both the therapists and the patients in accordance with the regulations of the Faculty of Medicine Committee on Research Involving Human Subjects.

The research will be conducted under the strict supervision of the patient's primary therapist, the Clinical Supervisor of the ward, and the other psychiatric staff of the ward. The researcher will be checking regularly with the Head Nurse and Clinical Supervisor to make sure that the research is not disrupting the routine of the ward. The researcher will make every effort to ensure that his presence and work does not interfere with the functioning of the psychiatric hospital.

(2) The primary therapists will be contacted by the investigator through their clinical supervisors. The investigator will inform them of the nature of the study, as outlined above, and will gain their written consent to observe and tape their interaction with the patients in therapy sessions. In addition, the investigator will gain their written consent to examine the clinical records that they keep.

The paranoid subjects will be contacted through their primary therapists. They will be informed by the investigator that he is a university student who is carrying out a study of the interaction between patients and their therapists. In the presence of the subject's therapist, the investigator will inform the subject that his/her therapist has agreed to participate in the study, and the investigator will put forward the idea that the subject might also participate. The subject will be told that the investigator is interested in finding out

the way that the subject and his/her therapist communicate and what difficulties exist in their communication. The investigator will note that he is interested in how the subject and his/her therapist "sort out" these difficulties. The subject will be informed that the investigator would like to find out these things by observing and taping the subject's therapy sessions, and by examining the subject's clinical records. Should the subject request a fuller description of the study, then this will be given. If the subject agrees to participate, then the investigator will gain his/her written consent.

(3) Mr. Maidstone was also submitting the proposal for consideration by the Screening Committee for Investigations Involving Human Subjects of the Faculty of Medicine.

The following points were either contained in the original proposal or emerged in the course of discussion:

(a) Each of the patients would sign a valid consent form permitting the recording and observation.
(b) Each of the primary therapists would also sign a valid consent form on each occasion that a session was recorded and/or observed.
(c) For each patient, Mr. Maidstone would obtain the approval of the clinical supervisor and of the head nurse before proceeding to record and/or observe the sessions.
(d) In response to a specific question from the chairman, Mr. Maidstone undertook that the tapes would be transcribed only by himself or his wife, that they would be erased immediately after transcription and that no one other than he or his wife would have access to the tapes. Neither patient nor primary therapist would be identified by name in the transcript or in any record made from the transcript or, in particular, in Mr. Maidstone's Ph.D. thesis.
(e) For each taping session, the primary therapist would record his clinical opinion that the patient understood the nature of the consent he had given. This statement by the primary therapist together with the primary therapist's own written consent would be entered in the patient's chart at the time of the taping.
(f) Mr. Maidstone would also require access to the charts of the four patients whom he was investigating. It was agreed by the Committee that this was reasonable subject to the usual safeguards.

[10]I subsequently found out that my primary contact had failed to inform the administrator of my research plans, and when questioned about them, had not given his support.

[11]My interaction with psychiatrists was, at that point, subject to some suspicion on my part, with respect to the psychiatrists' motives. Like other lay persons, I often felt that I was being professionally evaluated by them. The source of my feeling lay in my belief that a

therapist would invariably assess others in terms of his/her psychiatric theoretical knowledge. Being steeped in a body of knowledge, he/she could not help but use it to evaluate others.

[12]Joan Emerson, "Behaviour in Private Places: Sustaining Definitions of Reality in Gynecological Examinations," in *Recent Sociology* No. 2, ed. Hans Dreitzel (New York: Macmillan, 1972).

[13]This experience confirmed my view that the hospital saw itself as a "closed" entity, and felt the need to protect itself from intrusions by "outsiders."

[14]See, for example: Silvan Tomkins, *Affect--Imagery--Consciousness* (New York: Springer Publishing, 1963); and Libuse Tyhurst, "Displacement and Migration," *American Journal of Psychiatry*, 107 (1951).

[15]In arriving at this explanation, I took into account the fact that all the therapists were women, and the clinical supervisor was a male. I believed that the sex difference gave him further power to dictate the style of the proceedings.

[16]His response surprised me, as he described "paranoids" as compulsive story-tellers who forever sought an audience. The literature had led me to expect that they would distrust all intruders, placing them into what Cameron termed the paranoid "pseudo-community."

[17]My fear was, in part, a third factor in my negative response to the therapist's question re my involvement with patients.

[18]Having spent much time reading and thinking about "paranoids," I was eager to finally observe one. Although it may sound callous, and despite my lack of commitment to the diagnostic nomenclature, I had a feeling akin to that of a zoologist who, having extensively studied the characteristics of a species, was on the verge of finally seeing one of its members.

[19]My decision was based upon her casual, unprofessional style of dressing, and manner of speech, which stood in contrast to that of the therapists.

[20]By contrast, see my earlier discussion of the clinical supervisor's joke made during the meeting of the hospital Research Committee.

[21]I am drawing a distinction between adequate and meaningful according to the distinction between any culturally competent member's interpretative schema and my own schema, which was also made up of my

theoretical perspective. Thus, I use the term "meaningful" or "relevant" in the sense that I was able to place the material in question within my own theoretical perspective.

[22]For a more detailed outline of the structure of the clinical records, see chapter one.

[23]It is important to note that I am not referring solely to my own theoretical perspective on the disorder; but rather to any or all theoretical perspectives to be found in the literature.

[24]I felt that my theoretical knowledge of the disorder was adequate, but my lack of practical experience hampered me in my effort to make psychiatric sense of "paranoid's" talk. I did not anticipate eventually being able to construct, as therapists did, a theoretical account of "paranoids'" conversations, but did assume that I would be able to identify such talk as talk characteristic of "paranoids," rather than viewing it as the common sense talk of upset, disturbed, and frightened individuals.

[25]I put the term "therapy" in quotation marks in order to express the extent of my disbelief. The material in the "Orders" did not even approximate what I had expected.

CHAPTER 4

THE PUZZLES ARE NOT RESOLVED: THE RESEARCHER OBSERVES PSYCHOTHERAPY

The "Paranoid's" Uncharacteristic Talk: The Patient's Talk Does Not Make Sense as Expected

I finished my study of the Israeli "paranoid's" clinical records two days before I was to observe him in therapy. The records had brought me one step closer to my first encounter with a "paranoid." Despite the puzzles that I had discovered in them, and had experienced earlier, I remained confident that my "map" would ultimately prove to be an accurate guide to my observations. I believed that my "problems" of interpretation would be resolved, once I had the opportunity to observe therapy sessions.

I assumed that I would witness theoretically directed psychotherapy, which would take a particular form. My assumption was based upon my understanding of the relationship between psychiatric theory and practice.[1] The therapy would be based on an intrapsychic perspective which would lead the therapist to ignore the real persecution experienced by the patient, and search instead for inner defects, which would culminate in an invalidation of the patient's definition of reality. The theory would give rise, therefore, to the exercise of social control. The psychotherapy practised by the therapist would be a response (albeit, in my view, a misguided response) to a patient whom I, and others familiar with psychiatric theory, would be able to identify as exhibiting

behaviour cited in the literature as characteristic of the disorder.[2]

I continued to hold this view in spite of my "problems" of making sense of therapists as therapists, and making sense of the Israeli "paranoid" as a "paranoid." Although these problems put into question *both* the traditional and my own critical perspectives on the disorder, as they raised doubts about the taken-for-granted relationship between psychiatric theory and practice, my commitment to my views did not waver. It stemmed from my belief that my inexperience with the "practical" side of psychiatry obscured my understanding of it. Furthermore, I had been able to find other satisfactory explanations for some of the puzzles, such as the transformation of material for the purposes of communication. Finally, I had, after all, encountered material that did fit with my expectations. Therapists that I had met were well versed in the literature, and had given me psychiatric accounts of patients, and analyses of the disorder that were theoretically based, and intrapsychically oriented, as I had anticipated. In the clinical records, I had read therapists' entries that did make psychiatric sense (even if I had been unable to) of the patient's conversations. Thus, at that point, I had no reason to doubt the validity of my perspective on the disorder, or to fundamentally re-evalue my understanding of the relationship between psychiatric theory and practice.

I continued to be confronted with puzzles through the course of my fieldwork, but I did not reject my views outright until some time after I finished it, as I persisted in seeking and locating suitable explanations for the "problems" of interpretation that I faced. It was not until I had time to retrospectively reflect upon my fieldwork experience

that I came to see that the doubts which I had explained away while in the research setting, collectively undermined the perspective which I had been relying upon.[3]

Two days after finishing my study of his clinical records, I was introduced to the Israeli patient, and had my first opportunity to observe psychotherapy with a "paranoid." The patient, whom I met in one of the therapy rooms of the out-patient ward, was a middle-aged male who, to my surprise, in appearance, looked perfectly normal, and could perhaps have been described as somewhat distinguished.[4] I had hoped that the therapy session would be conducted in one of the observation rooms, which would have allowed me to observe without being seen, but the patient had not agreed to this procedure. Obtaining his consent to even tape the session, and to observe him in the same room, had been problematic. As had been predicted by the clinical supervisor and the secretary in their jokes, the patient was most reticent to allow me to become involved with his therapy session.[5]

The therapist had to introduce the patient to my proposed study on a step by step basis, in order to overcome his negative responses. After having been presented with a summary of what I intended to do, he declared that it would be an "invasion of his privacy." Upon prodding from the therapist, he agreed to be observed and taped, but not in an observation room. It was, he said, "definitely out of the question there." He would only agree at all, he stated, in order to "keep his good relationship with the hospital." The therapist then told him that he had to sign a consent form, which appeared to upset him further, as he saw the form not as a document for his own protection, but, as he put

it: "something that could be used against me." The therapist offered him assurances, and after much hesitation, he signed. One more issue was then raised. The therapist asked permission, on my behalf, for me to observe a number of his sessions. The patient again responded negatively, agreeing to only two, but the therapist told me after the session that she thought she could persuade him to agree to more (I eventually observed four sessions with this particular patient).

I was unsure how to interpret the patient's responses to my requests. It was difficult to decide how to characterize them, as they could be seen to be based upon both realistic and unrealistic concerns. On the one hand, anyone might reject a request to be taped and observed, given the confidential nature of the psychotherapy session. Looking at his actions from this perspective, they could be interpreted to be of no psychological significance. On the other hand, his behaviour could have been viewed as that characteristic of a "paranoid," who, by definition, was afflicted by unjustified fears. This was the view that I assumed the clinical supervisor had been alluding to (in a transformed common sense form) in his joke made during my meeting with the hospital research committee.

Neither of these interpretations fit with my observations, however. I sensed that the patient was frightened to an unrealistic extent, yet I did not have to rely upon my knowledge of the literature on paranoia to realize this. I knew intuitively, by the sound of his voice, and the look in his eyes, that I was observing an individual who was dwelling on more than merely the protection of his privacy, yet at the same time, he did not behave in ways that I could identify to be characteristic of a

"paranoid." I was puzzled by this, as I had expected that I would be able to distinguish between normal and abnormal behaviour, solely by making reference to the descriptions of the disorder outlined in the literature. I was unable to view his fear as reasonable by drawing upon my perspective on the disorder, and seeing him as a possible victim of past or present persecution, nor did I draw, however, upon other theoretical perspectives in making my judgement about his mental status. It was strange for me because it was as if all the literature on the disorder was irrelevant to what I was observing, while, at the same time, I had the expectation that what I observed would make sense by virtue of my knowledge of the literature.

I put these thoughts aside once the formalities of obtaining consent were completed, and focused my attention on the dialogue that had begun between the patient and the therapist. I was seated to the side of the patient and the therapist, who faced each other across a coffee table, which allowed me to avoid making eye contact with either of them. I concentrated on their conversation, searching for material of theoretical significance, while at the same time making fieldnotes and keeping track of my tape recorder. By half-way into the hour-long session, I had developed an overall impression of what I was observing. Foremost in my mind was the sense of normality that prevailed; a middle-aged Israeli man and a young woman were sitting in a modernly furnished room, discussing a range of topics, including his personal problems. The following is typical of their dialogue:

> Patient: Jews do not allow anybody to talk categorically against them. I have yet to see in the paper anybody that has written against all this commotion about

Jewish, Russian Jewish people to Israel. It is just a part of the propaganda, the long scare that has to do with the cold war.

Therapist: Um hum.

Patient: And all the rest of it. And that was basically it. I came up to speak at the time that the Soviet Premier was in Vancouver. I don't know if you remember.

Therapist: Yes, I do.

Patient: They tried to attack him, and in fact they did attack him in Toronto, and it was this time that I really, I was consciously felt who the hell do you think you are for heaven's sake? How are you going to attack a person who comes as a visitor in your country? Where is your hospitality? Well all that's what really burned me up. (( )).

Therapist: So that really, it, it ah, was pretty upsetting to you was it ... [patient's name]?

Patient: Very much so.

Therapist: Were you upset, were they Jewish, the people who were after him? The Premier?

Patient: I beg your pardon?

Therapist: Well, the attackers, were they Jewish?

Patient: No.

Therapist: They weren't.

Patient: They were Hungarian.

Therapist: So it was kind of against anyone who would attack.

Patient: Yeh, but at the same time there were written reports about some Jews who were attacking and shooting at the Soviet Embassy in New York.

Therapist: Yes.

Patient: And they injured a few children. All those things together.

Therapist: Um hum.

Patient: Were a group called who themselves the Jewish Defence League led by a rabbi who wrote a book, and ...

Therapist: Yes, I've heard.

Patient: And he went to Israel and propagated to kick the Arabs out of Israel. He is a rabbi. He is a born New Yorker who goes to Israel and he tells them to get rid of the Arabs of Israel!

Therapist: That's as bad as an Israeli telling the Russians what to do, huh? Right?

Patient: Yeh. That's right. I am pretty upset about it. I'm an Israeli.

Neither the segment quoted above, nor the rest of their dialogue, provided me with the means, as I had hoped, to resolve my earlier puzzles. I was left, instead, with the impression that there still was an inexplicable gap between the literature on paranoia, and my observations. The patient did not, for example, come across in the session as the type of person identified in the literature as a "paranoid." His conversation was mostly mundane, exhibiting few of the characteristics that I had expected to find. There was nothing "paranoid" per se in his strong views on Zionism, Russian Jewish emigration, or Jewish nationalism. Being an Israeli who dissented from the commonly held views of Zionists, he naturally felt emotional about these topics and others that he raised in the session, which included, amongst others, an analysis of the relationship between being Jewish, and being a Zionist. These were themes that dominated the existence of many Israelis and Jews, and I could not, therefore, characterize his discussion of these topics as "paranoid." I had, after all, heard others, who had not been labelled "paranoid," presenting views identical to his.

I was unable to apply an intrapsychic analysis to his behaviour. I could not make sense of it in terms of excessive projection, and other intrapsychic defects, as the therapists had done in the "theoretically based" sections of the clinical records. Nor could I apply my own counter perspective to his behaviour.

If the patient had seemed sane, then I could have made use of my own theoretical perspective to analyse his disorder. This approach would have "worked," as his claims of being persecuted by Zionists, if taken at face value, would have placed him directly within the theoretical framework that I had evolved prior to entering the research setting. I might also have searched in his past for incidents of anti-semitism that could have unconsciously motivated his feelings of persecution. I could have seen him as a victim of persecution. There was a problem, however. I intuitively knew him to be insane.[6] I had arrived at this conclusion, without relying upon either a traditional intrapsychic explanation, or my own theoretical configuration. Neither perspective helped me to make sense of his behaviour, as my insight into his mental status was derived, I realized, from my own "feelings" that his behaviour was abnormal, rather than from some theoretical perspective that I had acquired from the literature.

I knew the patient to be insane, because I realized that he was attaching personal significance to larger socio-political issues in ways that were unrealistic.[7] Segments of the above noted conversation were clues to his insanity. Take for example, the following statement:

> And all the rest of it. And that was basically it. I came up to speak at the time. . . .

I intuitively linked this passage to others in the therapy session, in which the patient discussed his "downfall" (the loss of his business). He attributed his loss to the actions of Zionists who were seeking, he believed, to silence him because he had sent critical letters to a number of Jewish and non-Jewish newspapers and organizations. The phrase "basically it" that he used, was, I realized, a reference to his delusion that he had come under surveillance, and his property had been entered and damaged, as a consequence of his letter writing. Some of these ideas are expressed in the following passages taken from the session:

A. Therapist: There was another issue there too. Right?

Patient: That's right.

Therapist: You were pretty concerned after you said that. That people, some of the people in the Jewish organizations etc. were being, ah, somehow out to get you.

Patient: Yup. I've talked to a friend of mine involved in the Better Business Bureau. He told me one of the things. A Jewish person approached him, and asked him about me.

Therapist: And that led you to believe that perhaps people were against you?

Patient: It was the very same period of time that I have sent, ah, some of the letters to Jewish organizations. I made a copy of the letters, and I spread it across the country.

B. Patient: That's what happened to me. I worked for years. I did my business. I worked so hard to make ends meet. For years I did without things. Finally, I was manoeuvred, and forced to give it up. I sacrificed my (( )). I had to sell my truck. Every night I go through treachery. Constantly it bothers me that I gave up my business and so on. (( )).

Therapist: You were feeling that the, ah, the business was, ah, (( ))?

Patient: Sure, I was broken into my place.

Therapist: Um hum.

Patient: And I was broken into my place of business. And I've been bugged, home and places like that ...

Therapist: How did you know that ... [patient's name]?

Patient: Because I have contacted my. I have approached the Attorney-General, and I am willing to talk to him, Mr. ... [Attorney-General's name], but he refused to let me talk to him.

Therapist: Because you wanted to talk to him about ...

Patient: I asked him for protection, because I said I have written letters ...

Therapist: Um hum.

Patient: That are quite serious, and I'm afraid for my life, and asked him, from him for protection. They laughed at me.

Therapist: You wrote letters to Jewish newspapers, right?

Patient: Jewish organizations, right.

Therapist: Here in Canada.

Patient: Here in Canada, right.

Therapist: What, what made you think that your telephone was tapped ... [patient's name]?

Patient: I believe that my phone was being tapped. (( )). I may be wrong, but ...

Therapist: Is it now?

Patient: No, it is not now. I may be wrong, but I still believe that it has been.

Therapist: Would you, would you tell me what made you believe that? What things made you believe that?

Patient: As I said before, I may be wrong ...

Therapist: Okay, I see ...

Patient: I'm, it's quite possible that my phone has been tapped and the reason that my place has been broken and my place of business has been broken in, in an attempt to scare me out, and they succeeded. I've given the business away.

I realized that I did not have to refer to the literature, or be trained as a therapist, to identify the patient as insane, but when I did try to match my observations of him with the literature, they did not fit. I could not make sense of the material that I had identified as pointing to his insanity, in terms of the literature on paranoia. I knew him to be insane, but my knowing did not derive from my knowledge of the literature. I was left in a quandary, as I was unsure of how to interpret my observations and impressions. In the nursing station after the session, I discussed my experiences with the clinical supervisor:

Clinical Supervisor: So, were you convinced by ... [patient's name] ideas?

Researcher: Well, taken away from him, they are not delusional. Its just the way that he relates them back to his own life that the delusion comes in.

Clinical Supervisor: Yes, that's it.

Our conversation did not help me to sort out the problems of interpretation that I faced. I knew that I had intuitively identified the patient to be insane, but had been unable to make sense of his "paranoia" in terms of my own or other theoretical perspectives. As the clinical supervisor was a psychiatrist, I also "knew" that he *must have* identified the patient to be insane by relying upon his knowledge of psychiatric theory. He also was able to utilize his theoretical knowledge to give a psychiatric account of the nature of the patient's

disorder. If he could use the theories of the literature, and I could not, how, I wondered, did we manage to agree about the patient's delusion? Since I had been unable to make sense using my knowledge of psychiatric theory, I took it that we were using different lines of reasoning, yet we both arrived at the same conclusion; the patient was insane. My inability to make sense of his disorder, or to identify his talk as talk characteristic of a "paranoid," had not hampered the accuracy of my judgement of his mental status. I had been able to pick out of his conversation the clues which pointed to his insanity, yet I had done so without making reference to psychiatric theory. To my surprise, the psychiatrist had agreed with my assessment. If we were using different lines of reasoning (common sense and psychiatric), why, I wondered, had we both identified the same element in his behaviour to be of significance? In summary, I did not perceive the patient to be a "paranoid," despite my knowledge of the theories of paranoia. I recognized his unjustified fears, but could not place them within *any* theoretical framework, as they seemed to be inexplicable elements that surfaced within an otherwise mundane conversation of an otherwise "normal" person. Like the clinical supervisor, I could pick the unjustified fears out, but I could do this without making use of the theories. Unlike the clinical supervisor, I could not make psychiatric sense of them.

The Therapist's Uncharacteristic Talk: The Therapist's Talk Does Not Make Sense as Expected

The sense of normality that I had identified half-way through the session, stayed with me. I realized, to my surprise, that it stemmed,

not only from my impressions of the patient, but also from my impressions of the therapist. I was struck by her unpsychiatric "talk,"[8] as I had been in our earlier meeting, when she discussed the patient. Again, I was confronted with a therapist whose professional talk did not sound psychiatric in style or content. I was even more surprised this time, however, as the "talk" of the therapist was directed toward her patient rather than myself, and therefore was defined as psychotherapy.

Her talk was characterized by its mundane quality. I unaccountably could not read into it any theoretical significance. Consider the passage cited above. It is a typical example of the puzzling talk that I encountered. I was unable to view it as therapeutic, since it did not meet my expectations of therapists' talk. I had in my mind a model of psychotherapy that was based on the premise that a therapist's conversation with a patient was guided by his/her theoretical knowledge of the patient's disorder. I expected that the literature on this particular disorder, paranoia, would be the therapist's guide to interacting with the patient, and that I would be able, therefore, to pick out from her conversation the theoretical underpinnings upon which it was formulated. I was startled to find that I was unable to do so.

Contrary to my expectations, the therapist sounded like a helpful friend who was willing to listen to another individual discuss his/her ideas and problems. As we see in the above passage, and throughout the dialogue, the therapist's talk is made up of many "um hums," "yeses," and other phrases of agreement, interspersed with short questions that seek to clarify the patient's remarks, such as: "Well, the attackers,

were they Jewish?" and, "That's as bad as an Israeli telling the Russians what to do, huh? Right?"

I was puzzled that nothing more took place, as I had in my mind an image of the therapist engaged in an attempt to redefine the patient's "inaccurate" definition of reality. This task would be expressed, I thought, in an identifiable form in the therapist's remarks to the patient. One can appreciate the extent of my surprise, when we consider that my image did not eminate from some idealized fantasy of what psychotherapy was all about, but rather from the same body of literature on the disorder that the therapist was, I assumed, familiar with. I was led to question, by my observations, the existence of a tie between her talk and *any* theory of paranoia.[9] If there was no tie, how, I wondered, could her interaction with the patient be seen as psychotherapy?

The therapist was directive with the patient, but not in ways that I had anticipated. When she was not communicating her agreement, or asking questions, she merely was giving helpful advice that also had a mundane quality. I had expected to be able to identify a theoretically based strategy inherent within the therapist's remarks, that in some identifiable way was directed toward dealing with the particular problems that the theories associated with this particular type of disorder. I found none. Consider the following advice which was given to the patient in the latter part of the therapy session:[10]

> Therapist: Okay, I, ah, seriously though, would like to, ah, do you think there is something we could do at this present time to help you with a job? Because if you will allow us to help you, we will put a fair amount of effort into trying to help you ... [patient's name] you know, ah ...

Patient: I could drive a truck. If somebody would put a good word in for me here in the university grounds, on the application.

Therapist: Well, I guess you'd have to take me out for a spin in a truck. I don't know, know what kind of truck driver you are.

Patient: I don't know of any trade. I want to be humble about it, but I could try.

Therapist: Well, I think the best way to kind of say that to any prospective employer would be to take a driver's license, driver's test, eh? And, ah, that would be pretty conclusive kind of evidence. Would you like to talk with one of the social workers again? Or how about if we think about, you know, it's up, it's up to you ... [patient's name]. We can, you know, galvanize the, our resources, and see what we can do.

Patient: Okay.

Therapist: Okay?

Patient: Be a truck driver.

Therapist: As a truck driver, that's what you want to look into? Okay, let's look into that.

Patient: Okay.

This passage, and others like it, contributed to my feeling that what the therapist said and did with the patient was not really psychotherapy, as I could not account for it in terms of the literature. The therapist's remarks were helpful, and, to a degree, directive, but I was unable to discern a theoretical perspective in terms of which they were organized. They were mundane rather than psychiatric in character. I was even more confused than I had been in attempting to interpret the "Orders" section of the clinical records. Although I had not found an answer to the common sense quality of those instructions, I could at least assume that the "problem" they presented me could be accounted for

in terms of the legal/bureaucratic function of the records. I had no answer for the therapist's talk, however. It was defined as psychotherapy, yet it was as mundane and as "unpsychiatric" as the "Orders" had been. I was unable to find an inherent theoretical structure in either of them. Using the pragmatic definition of their function, I could accept that there might not be a theoretically based strategy underpinning the "Orders," but I felt that the therapist's talk *must have* some theoretical basis, in order to justify its definition as psychotherapy. I could, however, find none.

Consider the passage quoted above. In it, we see typical examples of the interpretative "problems" that I encountered. The therapist begins by stating to the patient that she (and the other staff) are prepared to put "effort into trying to help you." Given the definition of the situation[11] as psychotherapy, one might assume that this statement refers to a willingness on the part of the staff to help the patient overcome his psychological disorder. When placed in the context of the rest of the conversation, however, we realize that this is not the case. The therapist is making reference to what I believed was a non-psychiatric activity; finding the patient a job. Later in the conversation, we see another example of what I took to be incongruous remarks. The therapist states: "We can, you know, galvanize the, our resources and see what we can do." Again, my inclination was to interpret the statement in terms of the "definition of the situation," and see it as a therapeutic remark which was meant to stand as a promise to aid the patient in dealing with his primary problem, his feelings of persecution. Placed in the context of the conversation, however, it is

obvious, once more, that the therapist is referring to the mundane activity of finding the patient a job.

It seemed to me that it is not the task of therapists to find people jobs, nor had the literature on paranoia discussed finding employment as a therapeutic technique for treating "paranoids." I wondered if the therapist was practising psychotherapy. I had serious doubts, as I could not locate a theoretical strategy that guided her interaction. The therapist did not reveal, however, any signs that she questioned the nature of her activity. At one point, for example, during the employment discussion, she suggested that the patient should consider talking to a social worker. I saw this to be an ironic remark, as I viewed her talk to be like that of a social worker, but the statement reveals that she saw her talk as therapy, and drew a distinction between it and that of a social worker. I also had difficulty making psychiatric sense of the therapist's final remark: "Okay, let's look into that." Once more, I was able to read psychological significance into her remarks, but knew by their context that my interpretation was incorrect. I was inclined to view the statement as the opening line of a psychodynamic analysis of the patient's desire to be a truck driver, but realized that the therapist meant merely: "Let's look into getting you a truck driving job."

I was confused, as I was observing an activity which took place in a psychiatric setting, and was defined as psychotherapy. The participants were defined as patient and therapist, and the patient had been given a diagnostic label. I could not, however, make psychiatric sense of their talk. Although I sensed his insanity, the patient did not talk

like a "paranoid," and although, when taken out of context, I could read psychiatric sense into her remarks, the therapist's conversation did not sound like the talk of a therapist.

I could identify only one aspect of the therapist's talk, her discussion of the patient's medications, to be characteristically therapeutic, rather than mundane. It was clear to me, as it had been when I studied the "Orders" section of the clinical records, that this was not common sense material. Consider the following:

A. Therapist: Tell me, ah, how did the medications go this time?

Patient: Everything is okay except the tortuous sensation that I miss my work. That I have given it up just like that.

Therapist: Um hum.

Patient: It kills me.

Therapist: The medications, though, don't, don't ah, ah, don't have ah, don't take that away. Are you sleeping all right ... [patient's name]?

B. Therapist: You were taking the yellow pills, weren't you?

Patient: Right. Yeh.

Therapist: Yeh, and you were taking four of them. Four of them?

Patient: No, two.

Therapist: (( )) are you cutting down again?

Patient: No, I was taking two of those.

Therapist: Two at night and?

Patient: And one in the morning and one in the afternoon. Four pills.

Therapist: Okay, that's working out all right. Okay.

The therapist's remarks, in both segments, are distinctly medical in character, but this attribute did not allow me to redefine the other parts of the therapist's conversation this way, nor did their medical orientation qualify them as examples of psychotherapeutic talk. I could not distinguish the remarks to be psychotherapeutic, as they were based upon a chemotherapeutic approach to the patient's problems.

I found the therapist's conversational shift in segment "A" away from the patient's complaint about his state of mind ("it kills me"), to a question about his sleep patterns, to be of particular interest, as I had expected the therapist to explore the psychological meaning of his remarks. Instead, she asked him another standard medical question about his appetite. Her conduct confirmed my belief that she was not practising psychotherapy. She seemed, throughout the session, to ignore the possibilities of delving into the patient's disorder, engaging him, instead, in mundane talk that I found inexplicable in terms of the literature on paranoia.

The Researcher's Talk

At the end of the session, I was left alone with the patient while the therapist went to the nursing station to arrange for the patient's medications. Despite his "normal" demeanor, and lack of distinguishable "paranoid" characteristics, I was nervous. I sensed that he was insane, and I assumed that he *must* be a "paranoid,"[12] even if I couldn't make psychiatric sense of his talk. My mind was filled with material from the literature that referred to "paranoids" as potentially dangerous patients who have a tendency to integrate persons in their surroundings

into what Norman Cameron termed their "pseudo-communities." I did not want to become part of his "pseudo-community," and tried to recall what the psychiatrist, who had been my primary contact, had said about talking to "paranoids." I remembered that he had advocated what sounded like a common sense approach to dealing with them. I was to treat the interaction as a game, being honest, but not completely open with the patient. I did not feel very confident of my ability to handle the encounter, as I still was unsure how to make sense of his advice. Having no choice, I did my best to participate in a fashion that I thought would approximate his counsel. Consider the following:

Researcher: You used to drive a truck for your business, I guess, did you?

Patient: I did my business with a truck.

Researcher: Yeh. What did you do? Was it scrap metal? Your business? Cars and ...

Patient: I made my place not so much scrap metal as I concentrated on pipes and iron and metal.

Researcher: Oh yeh. Fittings and things like that.

Patient: Um hum.

Researcher: Right. So people would come and buy from you?

Patient: Yeh.

Researcher: Well, people go through changes. (Pause) You would buy them from some people and then sell them to others?

Patient: I beg your pardon?

Researcher: You would buy them at one place, and ...

Patient: Yeh. I had connections with people in the industry and so forth.

Researcher: Hem.

Patient: I didn't used to get much you know.

Researcher: No.

Patient: But I was content in it.

Researcher. Right.

Patient: I wish I knew better than to starting sending, and writing or anything.

Researcher: Well, you know. Things change. People go and start doing something else. You know, start up some new thing. Get involved in something else. People do that all the time. (Pause) Maybe you will get a job that will lead to something else again.

Patient: I hope you are right.

Researcher: Yeh, well I have seen it. I mean I know of people who I know have done things. Lost a business, whatever, something. Dropped out of school, whatever, you know. And they went through a period of, of working all that out ...

Patient: It sounds pretty good if you are twenty-five, you know.

Researcher: No, I mean I, no ...

Patient: Have that self-confidence that goes with youth.

Researcher: Right, I know. Right, but I know of older people who have done it. It's a big job. I think that's really common now.

Patient: Oh yeh. I think it is.

Contrary to my expectations, I found that I could manage to bring off our encounter without difficulty. I felt that I was in control of our conversation, and lost my fear of being alone with the patient. I did not know what to make of my experience, however. In my discussion with the clinical supervisor after the session, I mentioned that my interaction with the patient had been unproblematic, which pleased him.

He noted that his earlier comments about my unfounded fears had proved to be correct. I agreed, but was puzzled. I now was confronted with making sense of my own talk.

That night, listening to the tape of my conversation with the patient, I attempted to interpret my remarks. I was unable to decide if I had played the "game" (advocated by the psychiatrist) correctly, but I did arrive at another conclusion. The style and content of my talk did not differ significantly from that of the patient's therapist. At the same time, however, it did not sound like what I, having read the literature, had anticipated therapeutic talk should sound like. It had no reason to sound therapeutic, as I was not a therapist, nor was I attempting to utilize my theoretical knowledge to guide my remarks, nor should it have sounded like the therapist's talk, as her remarks supposedly were structured in terms of theoretical knowledge. Why, then, I wondered, did our talk sound similar? We both discussed the patient's business, and offered advice about dealing with his problems, but our intent was different. She supposedly was practising psychotherapy, while I was studying paranoia. Her remarks were not supposed to be mundane in character. I was left confused, as the therapist did not talk like a therapist.

Attempting to Account for the Puzzles

I met with the therapist at the nursing station after the session. I was interested to discover her view of the proceedings, and hoped that her perspective might clarify the "problems" that I had encountered. I wondered if she would provide me with insights that would allow me to

account for the uncharacteristic talk of the patient, or even her own "unpsychiatric" conversation with him. I decided, however, to avoid directly raising my problems of interpretation with her, as I still felt that their source lay in my own inexperience, and possibly in her skill as a therapist. Since I had not yet sorted out my thoughts on the session, I did not want to broach the potentially embarrassing subject of her professional competence.[13]

As I had some tentative answers for my puzzles, I was surprised by the therapist's response to a question about her view of the session. She explained her talk and that of the patient in theoretical terms. Material that I had observed to be mundane, was unaccountably given theoretical significance. I was reminded of the puzzling "switches" that I had previously encountered.[14] The therapist had this to say about the patient:

> His paranoia is not checked. His delusions are still fixed. He is still blaming society for his problems. He is projecting much of his anger. His inner conflicts are feeding it. On the other hand, he was more lucid this time than ever before. He has never admitted his loneliness in such clear terms. He described himself as a ghost in his own house. He may be beginning to turn his anger inward, which means we will see the onset of depression. That's tied in with a dependency that he's building toward me.

Making sense of the therapist's answer was as problematic for me as interpreting the relation between the "Assessment" and the "Subjective" sections of the clinical records. Once more, the patient's talk, which I had found to be theoretically insignificant, was explained in terms of theoretical knowledge. Despite my familiarity with the literature on the disorder, I had not located in the patient's talk the signs of unchecked paranoia, projection, fixed delusions, and the other

"phenomena" that she referred to. I wondered why I was unable to identify them, as it seemed to me that my problem did not stem from a failure to fully understand the literature. How, I wondered, might *anyone* who read the literature be able to place the patient's talk within a theoretical framework?

I decided to become more direct, and asked the therapist, specifically, how she viewed her own role in the session. She replied this way:

> I tried to get him to deal more openly with his suspiciousness, by focusing on his history. That elicits his delusions. I didn't confront them directly. I am trying to encapsulate them, so that he can continue to function socially. I am trying to check the paranoia by curbing his projection. I am getting him to redirect his anger. That's bringing out his depression. At the same time, I'm making him deal with reality. That's to counter his dependency.

I had equal difficulty making sense of this answer, as it too did not fit with my observations. I had been unsuccessful in identifying a theoretical strategy which guided the therapist's talk during the session, yet her answer dwelt upon the various strategies that she claimed she had employed in it. I had no difficulty in understanding the strategies, as they were common to the literature on the disorder, but I could not forge a link between them and her talk in the session. Her remarks had consisted of short questions and affirmative statements in the first part of the session, and helpful, mildly directive advice in the latter part. I had searched within them, but had been unable to locate the "phenomena" such as the eliciting of delusions, and the redirection of anger, that she now described. In my view, her talk in the session had lacked a theoretical basis. It had a common sense quality that made it distinctly "unpsychiatric" in character. It had

not differed significantly from my own mundane talk, made with the patient at the end of the session.

In the days that followed my first observation of a therapy session, I attempted to rethink my experience, in order to work out solutions for the problems of interpretation that confronted me. I groped for new answers that might allow me to reformulate my conclusions, but found none. I had placed my hopes on my observation of therapy sessions, thinking that experiencing "the real thing" would provide me with the means to account for my earlier puzzles. Having observed a session, left me, however, with more unanswered questions about the relationship between psychiatric theory and practice. Despite this contradiction, it still seemed to me that there must be an explicit tie between the theories of the literature, and what actually transpired in a therapy session. The therapist had, after all, identified the theoretical significance of the patient's talk, and her own talk. I put my failure down, as I had done before, to my own inexperience, and to the limited skills of the therapist. I decided that observing further sessions, particularly ones conducted by more highly trained therapists, would resolve my problems. I remained optimistic that things would fall into place.

Footnotes

[1]For a more extensive outline as to the nature of my expectations with respect to what I would observe, see the discussion later in this chapter, and in the section of chapter one entitled "The Choice of a Diagnostic Category."

[2]It might be useful to again point out that, from my perspective, which I shared with Schatzman and others, "paranoids" might even be delusional and exhibit other classic symptoms of the disorder, yet still have been actual victims of persecution. My argument with the traditional perspectives was not directed toward their definitions of the disorder's characteristics (although, as has been previously pointed out, I did not share a commitment to the psychiatric diagnostic system of nomenclature), but rather toward their explanations of the source of these characteristics.

[3]One may legitimately question my naivety with respect to the constructs that I developed prior to my fieldwork, and which I subsequently attempted to use to understand my observations while in the research setting. Why did I not take into account, for example, the work of Erving Goffman, or the perspectives of the Ethnomethodologists? Their work, with which I was familiar, seriously questioned the premises upon which I had built my perspective. Why, then, did it not have an impact upon my analysis until after I had completed my research? The answer may be found in my particular interpretation of these perspectives. I saw them to be part of, or applicable to, the anti-psychiatry approach which I had adopted, and therefore did not distinguish between them and the work of labelling theorists such as Thomas Scheff, Edwin Lemert, or D.L. Rosenhan. I viewed all of these perspectives as collectively providing a social psychological critique of traditional psychiatric and sociological theories. I failed, at that time, to understand that the work of Goffman and the Ethnomethodologists could not, as I had presumed, be viewed as merely a critique of the traditional theories (see my earlier reference to my flawed attempt, during my first year of doctoral studies, to integrate an ethnomethodological analysis into my perspective on psychiatry). I did not see that they were as much a critique of the radical anti-psychiatry perspective which I had adopted, as they were of the traditional viewpoint, as *neither* perspective accurately took into account the relationship between psychiatric theory and the practice of psychiatry. My failure to grasp the depth of their critique accounts for the character of my analysis prior to and during my fieldwork. It was not until after I had finished my fieldwork, that I was able to accurately make use of the ethnomethodological perspective.

[4]Having already heard and read so much material with respect to the characteristics and nature of his personality, I expected to meet someone who in appearance was readily identifiable as insane. My

preconception was not based on any insight gleaned from the literature, but rather from the impact of the extensive information on him, to which I had been exposed. The clinical supervisor may have sensed my surprise, as he commented in the nursing station after I returned from observing the therapy session: "He looks more normal than most people. Quite respectable, in fact!" I knew from the literature that "paranoids," being less disoriented than those suffering from other disorders, would be more likely to appear normal. I had been unable, however, to avoid constructing an image of the patient, that was built around a typification of the appearance of an insane person, which stemmed, I believe, from the picture painted of him in the therapists' accounts.

[5]At that point, I was unsure of the significance of the accuracy of their humorous predictions, as I had interpreted their respective jokes differently. See my earlier discussion of this point.

[6]I am defining intuition as a sense derived from one's common sense knowledge, acquired through socialization, and shared with the other members of one's culture.

[7]My "realization" that his "ways were unrealistic" did not stem from a theoretically based insight, but rather from my ability, which I shared with other culturally competent members, to make insanity ascriptions. At the time, I was not aware, however, that all competent members of a culture had this capacity, as I believed that it derived from a knowledge of psychiatric theory. Thus, my confusion, as I knew that I sensed his insanity *without* making reference to any theoretical body of knowledge. For a further discussion of this point, see Jeff Coulter's treatment in his book *Approaches to Insanity* (New York: John Wiley and Sons, 1973).

[8]I use the term "unpsychiatric talk" to refer to talk that has a mundane, and, therefore, what I saw to be, unpsychiatric quality.

[9]Even when I discounted my own social control theory of therapy with "paranoids," and sought to understand the interaction in terms of traditional perspectives, I still was unable to make any theoretical sense of the therapist's talk. I failed to identify any examples of processes such as the "undoing of the restitutional pseudo-community" that Norman Cameron spoke of, or the encapsulation of a patient's delusion that the therapist, herself, had spoken of.

[10]I noticed that in this, and in subsequent sessions that I observed, therapists spent the first part of a session listening to a patient's "story," and the latter part in giving advice to the patient. This format struck me to be comparable to that found in a conversation between friends, in which one individual is sharing his/her concerns with the other. The comparison raised further doubts for me about the nature of the interaction that I was observing.

[11]I am borrowing the concept of "definition of the situation" from Joan Emerson's article "Behaviour in Private Places: Sustaining Definitions of Reality in Gynecological Examinations," in *Recent Sociology* No. 2, ed. Hans Dreitzel (New York: Macmillan, 1972).

[12]My assumption was based upon the "obvious." Those who had not only studied the literature, but also were defined as therapists, had diagnosed and "treated" the patient as a "paranoid."

[13]It occurred to me, as it had done in the Rounds that I had observed, that the level of training in psychotherapy that an individual had received would determine their skill as a therapist. Those who had received more extensive training, such as residents, would, I believed, be able to practice real psychotherapy (as it appeared in the literature), while others, such as nurses, might only be able to engage in counselling. This raised in my mind the possibility that the therapist in question, who was a nurse, might have thought that she was practising psychotherapy, when, in fact, she was only counselling the patient. This, then, would have accounted for the puzzling, mundane, unpsychiatric character of her talk, to which she mistakenly gave theoretical significance.

[14]I refer here to the shift from the mundane to the theoretical in the earlier conversation of the therapist, and between different sections of the clinical records.

CHAPTER 5

THE "GAP" BECOMES MORE EVIDENT: THE RESEARCHER IS UNABLE TO MAKE SENSE OF HIS OBSERVATIONS

Contrary to my expectations, things did not fall into place. Observing therapy sessions of other "paranoid" patients did not resolve the problems of interpretation that I had encountered. Nothing was clarified. Instead, I was faced with the same puzzles that I had come across earlier.[1] The "paranoid" patients still did not talk like "paranoids," yet I was once more able to identify, without relying upon my knowledge of psychiatric theory, elements of their talk that pointed to their insanity. Despite their more advanced training,[2] the therapists still did not talk like therapists, yet like the therapist of the Israeli paranoid, they too were able to give theoretically based accounts of their own and the patients' talk, which I again could make sense of by drawing upon my knowledge of psychiatric theory. I discovered that my previous observations were not anomalies. Upon observing other cases of paranoia, I concluded, as I had done before, that there was a seemingly inexplicable "gap" between the literature on paranoia and the actual instances and treatment of the disorder that I observed, which I once more attempted to account for in terms of my own inexperience, and the limited skills of the therapists.[3] I shall now set out some of the material from which I drew my conclusions.

Before observing the other "paranoid" patients in therapy sessions, I studied their clinical records, and spoke to their respective therapists (as I had done in the case of the Israeli "paranoid"), in an

effort to get a better understanding of their problems, in order that I might clarify some of the puzzles that I had already encountered. Neither strategy provided me, however, with the means to integrate my previous observations with my theoretical knowledge of the disorder. Instead, they both highlighted the existence of the "gap."

When I questioned them as to their understanding of the disorder, the therapists typically provided me with theoretically based accounts that I was able to make sense of in terms of my knowledge of the literature. When I asked them to discuss the specifics of their patients, however, I was often given common sense accounts which were distinctly unpsychiatric in character. I was confronted again with a "switch" from mundane to psychiatric talk for which I was unable to account. As it was obvious that they were capable of giving theoretical accounts, I wondered why they did not place their descriptions of their patients within a theoretical framework. Consider, for example, the following analysis of the disorder given to me by one of the residents whose "paranoid" patient I was to observe:

> It's a difficult diagnosis to make. So much judgment is involved. It's vague because it overlaps with other disorders, especially schizophrenia. Age at the time of onset, level of affect, degree of coherence, presence of hallucinations, all have to be considered.

His account was unmistakably theoretical in character, and I had no difficulty in placing it within the literature. When our discussion turned to his patient, however, I encountered the puzzling "switch." There appeared to be no theoretical basis to his description of the patient. Except for the use of the diagnostic terms "florid delusions," "fixed delusions," and "paranoid state," which he used to describe his patient's particular condition, his remarks were devoid of theoretically

significant material. Like the therapist of the Israeli "paranoid," his talk resembled that of a lay person discussing the problems of a friend or family member. Consider the following:

> She doesn't talk much in groups, and doesn't like to go out of her house. She lived away from her home in a half-way house for three years. She returned the same day that her husband died. She has three children. Two are living at home. She has been having problems with them. I am trying to get her to think about getting out a bit. She is too isolated. She should get a job, be a volunteer, or something.

Although I could discern some psychological content in this segment and in others like it that made up his account, it lacked the theoretical quality basic to his earlier discussion of the nature of the disorder. I wondered why he made no attempt to bring his theoretical knowledge to bear on his description of his patient. The mundane character of his description was puzzling, but I suspected, by now, that it had something to do with what would transpire in the therapy session. My suspicions subsequently proved to be correct. In this instance (the second case that I was to observe), and in the other cases of the disorder that I observed, a pattern, consistent with my earlier findings, emerged. Therapists were able to give theoretical accounts of the disorder, and could (and did, at times) give theoretical accounts of their patients (in addition to those which they gave in the assessment section of the Clinical Records), but typically their accounts of their patients resembled the mundane description cited above. Upon observing further therapy sessions, I discovered that these accounts were similar in content, focus, and style to the therapists' talk in therapy sessions. Thus, I had established that the mundane quality of their descriptions of their patients fit with the mundane quality of their talk in therapy, but was unable to reconcile either with my understanding of the rela-

tionship between psychiatric theory and practice.

Examining the Clinical Records of the three other "paranoid" patients did not enable me to make any further sense of the puzzles that I faced.[4] I discovered that I had the same problems interpreting them as I had in making sense of those of the Israeli "paranoid." I had expected their format to be the same, but had hoped that the inexplicable elements of the Israeli "paranoid's" records were something peculiar to his situation.

My hopes proved to be unfounded. I still could not make theoretical sense of the mundane talk, in the "Subjective" sections, that was offered by the therapists as evidence for the theoretical accounts that they gave in the "Assessment" sections. The patients' talk that was cited in the "Subjective" sections sounded like the talk of upset or disturbed individuals, but did not resemble the talk of "paranoids" as described in the literature. Furthermore, I could not account for a "switch" from the theoretical to the mundane, that I again discovered when I compared the "Assessment" sections with the respective "Orders" sections. Consider, for example, the following entry taken from the clinical records of the third patient that I observed:

> SUBJECTIVE: "How long am I going to be here? I must go home to attend to my business. I just don't want to have all my money gone when I get out of here--I want to phone the bank to make sure no one else can take the money out. I can't stay in here another three weeks. I have to settle my business. I'll be losing money."
>
> ASSESSMENT: Paranoid ideation: expressed desires to leave are still persisting, but are NOT v. fixed i.e. she can be talked into staying, although she comes up with somatic complaints. . . . Continues to be delusional when anxious but seems that delusional system is weakening (i.e. beginning to question whether she is sick).

ORDERS: Will stay on same medication.
— When states suspiciousness (i.e. "Dr. is going to kill me") reassure that you don't believe this is going to happen.
— State this once and then be firm that you don't want to talk about that any more.
— Superficiality on staff's part ↑ her suspiciousness. So don't interact with her on that level!
— Keep staff involved to a significant few.

I had no difficulty in making sense of the theoretical account in the "Assessment" section cited above, or those in other "Assessment" sections that I read. Nor did I have a problem in interpreting this patient's, or other patients' "Admitting Diagnoses," "Histories," "Problem Lists," or "Discharge Summaries." I could account for them in terms of my knowledge of the literature. I did not know, however, what to make of the mundane material in the "Subjective" and "Orders" sections, as cited, for example, above. It supposedly reflected the theoretical account of the "Assessment" section, but I was unable to grasp its theoretical significance.

Unlike the therapist, I could not make psychiatric sense of this "Subjective" section, nor was I able to discern the theoretical import of the material in the "Subjective" sections of other patients' clinical records. I was forced again to explain away this problem by attributing it to my limited experience in observing "paranoids" in therapy. More experience would, I thought, allow me to view the material of the "Subjective" sections as talk characteristic of "paranoids." I relied on a previously used explanation to make sense of the "Orders" section. I decided that the "Orders," and others like it that I encountered in other patients' records, were not meant to reflect a theoretically directed psychotherapeutic strategy. I accounted for their mundane quality by seeing them, once more, as part of a document kept merely for

legal/bureaucratic reasons. By placing the "Orders" in this context I did not need to search for their theoretical significance, as they were not meant, I decided, to be interpreted as psychotherapeutic directives.

I was left unsettled, however, by my "legal/bureaucratic" explanation, as it did not take into account the material from other sections of the records, such as the "Assessments," that I *did* interpret as having theoretical significance. This raised a contradiction that I could not account for, which led me to fall back on my "further experience" explanation. I put aside my doubts by making the assumption that the added experience gained each time that I observed a "paranoid" patient in therapy, would ultimately allow me to resolve the problems of interpretation that I faced. As my research progressed, however, more doubts emerged, as further experience did not provide me with the answers that I sought.

Observing more patients in therapy did not furnish me with explanations for the puzzles, nor did it confirm my own perspective on the disorder. I was as confused at the end of therapy sessions with new patients, as I had been after observing sessions with the Israeli "paranoid." I was struck, as I had been earlier, by the sense of normality that prevailed in the sessions with the three other patients that I had observed.

All three[5] looked normal, and, to my surprise, displayed, for the most part, common sense talk that sounded normal. Although I could identify segments of their conversations that were indicative of their insanity, the bulk of their remarks were mundane in character. Consider the following, taken from the transcript of one of the second patient's

therapy sessions:

Therapist: Who's concerned about you now? Is anyone concerned about you?

Patient: I think my kids are.

Therapist: Yeh.

Patient: Um hum.

Therapist: You mean in spite of the fact that they do things?

Patient: Well, I don't know what arguments these thugs use to get them to do it.

Therapist: But they are concerned. But it upsets you that they don't listen to you. They don't seem to respect you?

Patient: That's right. They look upon me as an inferior being, I suppose.

Therapist: Does anybody look upon you the same way? (( ))

Patient: Well I think the nurses and the staff do out here to a certain extent.

Therapist: I don't mind if you think so. I don't look down on you at all, but you know. I don't mind you telling me if you feel like it.

Patient: No, I don't. [Silence]

Therapist: You were telling me that you were trying to get some kind of job. You have a B.A. degree, don't you?

Patient: Bachelor of Commerce.

Therapist: Commerce. And you worked when you were at ... (name of a half-way house)? And you worked (( )) when you were young? And you're (( )).

Patient: To get a job.

Therapist: Um hum.

Patient: Something that's not too challenging.

Therapist: Challenging. In what way?

Patient: Well, just something simple. That I can do in my spare time.

Therapist: An office job?

Patient: Well, not necessarily. I thought maybe clerking in a store. I'd like to do something like that. I'd be meeting more people. And I think I'd be more outgoing.

Therapist: That's right. You've sort of been isolated. For three years in ... (name of a provincial psychiatric institution) and then one year at ... (name of a half-way house), and you was away from your friends, you know. That's not much of a social life. (( )) You had a lot of friends at that time, people that you knew, did you?

Patient: Yeah, especially when I was president of the co-op. You know, every time I was into Safeway, I'd meet somebody and we'd have a chat. And that really took up a lot of time, and I was on the phone a lot. And are you familiar with the co-op?

Therapist: No, I'm not.

Patient: Well, the mothers participated by helping the teachers and then there's a president and a secretary.

Therapist: Oh, yeh, I know. We have that.

Patient: And you pay so much a month.

Therapist: So you were president of that too. And do you have people over to visit you at your place and things like that?

Patient: Not very often, no.

Therapist: So it was mostly during those meetings that you were involved with other people.

Patient: Yeh.

Therapist: You didn't have any friends? You and your husband didn't have another couple?

Patient: We used to play bridge with a couple, but it sort of folded.

I was able to make sense, *but not psychiatric sense*, of the patient's talk in the above segment, and other segments displayed by this patient, and others that I observed. As in the case of the Israeli "paranoid," I

realized that I was utilizing my common sense, rather than theoretical knowledge, to interpret her conversation. I was unable to apply either my own social control perspective, or the traditional theoretical perspectives to explain her talk. I could not identify the characteristics of the disorder such as unconscious motivation, denial, excessive projection, etc., that were described in the literature. Only one aspect stood out in her otherwise mundane talk; the reference to thugs, which I knew from talking to her therapist, reading her clinical records, and hearing the rest of her conversation, referred to her insane idea that the Mafia had a contract on her life, and were enlisting the help of those around her, such as her children, to murder her. I knew her idea was insane, just as I had known, by making reference to common sense knowledge, that the Israeli "paranoid's" idea that Zionists were threatening him was insane. Again it was intuition, not knowledge of the literature on the disorder, that told me her ideas were insane. Upon reflection, I once more concluded that any other culturally competent member could also have made the same insanity ascription. I realized that one did not have to be versed in psychiatric theory in order to identify her as insane. This conclusion challenged my understanding of psychiatric theory. Furthermore, having a knowledge of the theories of the disorder did not enable me to view the patient as a "paranoid," as I could not identify in her talk the characteristics of the disorder that were cited in the literature.

I had the same experience each time that I listened to "paranoids" talk. I knew them to be insane by virtue of their irrational fears, but was unable, despite my determined efforts, to find the "phenomena"

characteristic of paranoia, that therapists were able to locate in their talk. With the exception of their references to their insane ideas, their remarks seemed mostly mundane in character. I could see the patients as insane, but not as "paranoids" in the sense that they were described in the literature. As far as I could discern, they were neither victims of persecution (the view that I held of all "paranoids"), nor were they individuals dominated by id impulses (the intrapsychic view of "paranoids").

After observing all four patients, I was able to distinguish only one pattern common to every case; a pattern that I took to be of significance because it linked together all the cases, yet I had not come across it in the literature, nor had I utilized my knowledge of the literature in discerning it. It was, I decided, a pattern that any other culturally competent member might also have identified, had they observed a number of "paranoids" in therapy. I had discovered that the patients' irrational fears were built around some significant aspect or aspects of their current or past life situations. The Israeli, for example, focused on his Jewish identity, and his business. The housewife dwelt on her husband and her children. The Scottish hairdresser concentrated on her health and her income, while the university student focused on his family and his studies. Consider, for example, the following remarks taken from a transcript of one of his therapy sessions:

> Therapist: What about when you were in over Christmas? Did you feel then that things weren't right? That maybe someone was out to get you then or to follow you?
>
> Patient: Oh yes, at that time I thought all the students were out to get me, at the university, when in fact it turned out it wasn't true really.

Therapist: In what way did you think they were out to get you? You know, what happened?

Patient: Well, I figured that they all knew that I'd done these terrible things, like ripping people apart and things like that, and I believed that that was the case, so I believed the students were out to get me for what I'd done to all these other people. That's what got me into the hospital this last time at Christmas.

Therapist: And you thought that they knew you had done these things?

Patient: Yes, I thought they knew I had done these things and they were going to get me for doing it.

Therapist: And how were they going to get you? In what way did they show, you know, did they give you little hints along the way that they knew?

Patient: Oh yes, they were giving little hints along the way for a period of about a month, a month and a half.

Therapist: Sure. And what were these hints?

Patient: Pardon?

Therapist: What were these hints? Could you tell me a little?

Patient: Oh, they used to hint about hanging someone in January, and disfiguring someone with acid in the face. That's what one person was saying, we should try to disfigure him by throwing acid in his face. And things like that.

Therapist: Um hum. And were they telling this to your face, or were you sort of overhearing?

Patient: I was overhearing what they were saying.

Therapist: Where would you be when you overheard?

Patient: Oh right in the classroom, you know.

Therapist: During the lecture or what?

Patient: Oh no, it usually happened right after we had the lecture. They'd start talking about things like that, and about doing group research projects, so that I wouldn't be able to do them by myself. And then I'd fail the courses. And that's what one of them suggested that they do group researches, and then they didn't say

my name, and then they said if everyone would do a group research, then they would be able to get rid of the student that we don't like, get rid of him right there because he wouldn't be able to do a group research by himself. So then like one of them was saying, its very simple to get rid of someone you don't want around. Just have everyone do group research and then not let him do a group research. He can't do one on his own so that's it, game over for him.

Therapist: Um hum.

Patient: And some of them were suggesting that it should be done in every class. Get rid of the students that you don't like.

Therapist: Were they doing anything to trip you up? You know you were saying you felt they were making plans in order for you not to do well. Were they doing anything else so you wouldn't do well at school or giving you problems?

Patient: No, not that I know of. [Silence]

In this segment, the student makes references to his irrational fears at the time of a previous admission, while later in the session he discusses his current fears regarding his family and one of his professors. I intuitively could see the relationship of his fears to the context of his life, and could intuitively identify their irrational basis.[6] I did not, however, make use of my theoretical knowledge to draw these inferences, nor was I able to make theoretical sense of them by viewing them in terms of my theoretical knowledge of paranoia. The "phenomena" of paranoia cited in the literature and outlined by therapists in their theoretical accounts of patients, bore no relation to my observations of "paranoids." All that the patients held in common, as far as I could discern, were unjustified fears that were linked to some significant aspects of their lives. Having observed therapy sessions of

four "paranoid" patients, I knew little more about paranoia. I could not see things the way that therapists saw them, nor could I grasp why I was unable to do so. I had inexplicably failed in my attempt to make psychiatric sense of cases of the disorder.

Although I could not make psychiatric sense of the other three patients' talk, I had hoped, at least, to be able to grasp the theoretical significance of their therapists' talk in therapy sessions. I had accounted for my inability to find a theoretical basis for the talk of the first therapist that I had observed, in terms of her limited training as a psychotherapist. As the remaining three therapists that I observed had undergone more advanced training, I anticipated that I would be able to make psychiatric sense of their remarks in therapy sessions. I encountered, however, the same problems that I had faced in interpreting the first therapist's conversations with her patient. Although helpful, and somewhat directive, their remarks were distinctly mundane, rather than psychiatric in character. I was, to my surprise, unable to discern any theoretical core around which they were organized. The therapists' remarks to their patients lacked an identifiable psychiatric quality that I had expected to find, which again gave me the feeling that what I was observing was not really psychotherapy. I quote from an entry that I made in my research journal shortly after having observed the third patient in therapy:

> After the session, he [the therapist] asked me what I knew about how to treat paranoids. He seemed to want feedback on how he had done with her. He said when her "*therapy* was finished" he would give me a call--I found this strange as I view what was done with her as counselling, but not therapy in the sense of a cure; i.e. . . . [patient's name] working out her delusions and problems.

(1) what went on in the session certainly did not seem like therapy as I have read about it--yet he was her primary therapist, and will work with her during her stay in the hospital.

(2) it seems that medications are the mainstay of therapy in the hospital.

As in the case of the Israeli "paranoid," the therapist discussed above, and others that I observed, defined their work with their patients as psychotherapy, but I was unable to view it that way. To me, their talk was mundane, and bore no relation, as far as I could see, to the theoretical strategies outlined in the literature. Consider, for example, the remarks of the therapist in the following segment taken from the transcript of one of the second patient's therapy sessions:

Patient: If I could get a new hairdo and something nice to wear, I'd love to go out.

Therapist: You know you told me you were going to get your hair done the first day you came here, and you haven't done it yet?

Patient: No.

Therapist: Well, maybe that's something you should start doing. It's a good way to improve the image of yourself. It's like saying I'm not going out because my hair is not made, so in order for me to go out, I have to make my hair. But I never do my hair, so I never go out.

Patient: Well, I brush it periodically, and I tie this thing around it.

Therapist: There's a hairdresser that comes here.

Patient: I don't think he has come this week.

Therapist: Yeh, but if you don't let the nurse know you want your hair to be done, you know.

Patient: Well, I'll look into that then.

Therapist: In fact, there is a hairdresser here, in the Village, and you could go and have your hair, make an appointment, make an appointment, and you could go.

Patient: Um hum.

Therapist: And make your hair there. Maybe you could do that on Saturday, so when you go home on Sunday you'd have your hair done.

Patient: I'll have to get some money first.

Therapist: Um hum. You don't have any money left now?

Patient: Not enough for that.

Therapist: But you have your account somewhere. I mean you...

Patient: It's about 20,000 dollars in my account.

Therapist: You have 20,000 dollars in your account?

Patient: Yes, I'm planning to invest it now. Cause I want to, there'll be more after the probate goes through and I want to buy a farm.

Therapist: Um hum. That's a good idea.

Patient: And in November, when the Canada Savings Bonds come out I'm going to get 2,000 dollars for each child.

Therapist: Um hum.

Patient: And put it in their name.

Therapist: But you don't have any money left from you get the pension? From your husband, 300 dollars a month or so? Plus...

Patient: Yeh.

Therapist: And you don't have any money from that left?

Patient: Well, I got a check for 18,000 dollars from the ... that was a year's pay.

Therapist: I'm talking about making your hair, which is not going to cost you more than seven, eight, nine dollars. I don't know how much it cost, but that's how much my wife pays, so you know. We're not talking about thousands.

Patient: No.

Therapist: I'm sure you could get, you know, ten or twenty bucks and fix your hair. What about your, do you have any clothes at home?

Patient: Uh, not really. I usually wear slacks around the house.

Therapist: So you haven't bought any clothes.

Patient: I did buy a few when I was out this time.

Therapist: Um hum. Well, then, maybe you should buy a few more clothes, if you want to. Because, you know, if that's going to make you feel better about meeting some people and talking to them, then you have to do it.

Patient: I thought I might get my hair dyed. It's getting quite white.

Therapist: Um hum. Dyed completely or just put a bit of grey (( )).

Patient: No, completely dyed.

Therapist: Um hum. Have you dyed your hair before?

Patient: No. Never have.

Therapist: That would make you look younger.

Patient: Um hum. I could use some help. [Laughs]

I was able to locate within the therapist's remarks, material that was psychological in orientation, such as the emphasis that he placed on the patient's "double-bind" in failing to get her hair done, and the stress that he put upon the importance of the patient's looks to her self image. In my view, however, these remarks were not what I deemed to be psychotherapeutic, as they might as easily have emanated from a lay person seeking to give a friend helpful advice. They did not reflect a theoretical perspective oriented toward treating the patient's disorder, which was the criterion that I used as a basis for distinguishing between psychotherapy and helpful advice. How, I wondered, could one

view advice re fixing one's hair, looking after one's money, finding a job, or making new friends (advice that was offered in the segments noted above, and at other points in the session) as psychotherapy for "paranoids," or even any other mentally ill person? Yet in addition to asking short questions, and issuing phrases of agreement, this was all that this therapist's remarks in this session and the remarks of the other therapists in other sessions, amounted to.

Where, I wondered, were the theoretically based therapeutic strategies that I had read about in the literature, and expected to find in the therapy sessions? Consider the remarks directed by a therapist to his patient, the fourth "paranoid" that I observed:

Therapist: You're going home for the weekend?

Patient: Yeah.

Therapist: Right after this? Uh, are there any problems you think you're going to run into?

Patient: No, I think everything will go O.K. I'll probably be discharged Monday, right?

Therapist: Monday or Tuesday. We'll see how things go on the weekend and we'll have a talk on Sunday.

Patient: I'll probably be discharged Monday then, won't I?

Therapist: I can't promise you.

Patient: No?

Therapist: Can't promise you. Don't (( )) me into it.

Patient: You know, I'd like to get away from the hospital.

Therapist: Um. I know.

Patient: Each day is like getting an extra million dollars in your wallet. Each day you're away from the hospital.

Therapist: O.K. So is there anything you would like to ask me? Concerns about going home?

Patient: No. Not at the moment, except that I should phone the Medical Plan and find out if I'm still on it. I'll have to do that.

Therapist: O.K. You'll have to do that. O.K.!

Patient: So I can go home now?

Therapist: Sure. You can get a few things together if you want. Go home, go home.

Patient: My belongings will be safe in the hospital, won't they?

Therapist: I think so. You have a cupboard, haven't you? A locked cupboard?

Patient: No, I don't have a locked cupboard. No, I have a cupboard.

Therapist: Look on the top if you have a locked cupboard too. You'll just have to use it. You'll have some medications too.

Patient: Oh.

I wondered if this was all that "psychotherapy" amounted to, discussing cupboards and medical plans. Do therapists "treat" "paranoids," I pondered, by merely listening to them talk, and giving them common sense advice? If so, then what was the relation of this mundane activity to the extensive body of theoretical knowledge on the treatment of "paranoids"? I was unable to identify a link between the two entities. Nowhere in the therapists' talk could I locate, as my social control perspective had led me to expect, an attempt to invalidate a patient's definition of reality. Nor could I discover, adopting an alternate viewpoint, any of the processes such as the "encapsulation of the patient's delusion," the "curtailment of his projection," or the "undoing of the restitutional pseudo-community," that were described as therapeutic strategies basic to the traditional perspectives on the disorder.

At the most, therapists occasionally expressed mild disagreement with a patient's delusional statements, in a way that resembled one's denial of the validity of a friend's perceptions with respect to what was happening to him. Neither their form, their content, nor their timing, allowed me to make sense of these "disagreements," in terms of the therapeutic processes cited in the literature. Consider the following example taken from one of the therapy sessions of the third patient:

Patient: Did you speak to Dr. V.? (A general practitioner whom the patient had been seeing.)

Therapist: I haven't spoken to him personally.

Patient: What, what, what were his notes like?

Therapist: They were, uh, very complete. In what way do you want to know what they were like?

Patient: I would just like to know what he said about me.

Therapist: Well it just is, he just managed to describe your visits. And then describe what you're complaining about, and then the tests he did.

Patient: He's a very clever man, Dr. V. And have you got in touch with Dr. B.? (Another general practitioner whom the patient had been seeing.)

Therapist: No, but we have his notes. In what way do you think Dr. V. is a clever man?

Patient: He's subtle, very subtle.

Therapist: Would you explain further to me?

Patient: He knows exactly what he's doing and why he's doing it.

Therapist: Um hum.

Patient: Could it be some line of defence for him? Or to help me physically? Cause he actually asked me, at least his nurse did on the telephone, I heard him saying it to her, had I phoned the British Medical [pause] not the British, the Medical Council.

Therapist: Um hum.

Patient: And I said I hadn't. And anyone knows that if I was going to sue him it'd have to be done in black and white, with my signature, which I have not done! [pause] But I don't intend to die for him.

Therapist: Um hum.

Patient: For his stupid notes or anything. Or Dr. B's stupid notes. I don't intend to die for them at all, because I'm not frightened of them. [pause] And that's all I can say about them, ... [therapist's name]. They disgust me.

Therapist: ... [patient's name], I can just sort of say once again that, um, from what I know of Dr. B. and Dr. V., I really don't think they were trying to harm you.

Patient: O.K. [pause] You can say that. I don't mind what you say, ... [therapist's name].

Therapist: Well it's, you know. You have your opinion and I have mine.

Later in the same session, the therapist again "disagreed" with the patient:

Therapist: [pause] We hope during your stay in hospital here, we can put an end to all that. ... [patient's name], I can't stress strongly enough that, um, I think you're ill, so there's no doubt in my mind. And your sister thinks you're ill.

Patient: Physically ... [therapist's name] or mentally?

Therapist: That you have an emotional problem. That you're mixed up in your mind at the moment.

Patient: No, I'm not mixed up. I'm telling you the exact truth, in fact!

Therapist: See, ... [patient's name], you sort of have your opinion, and I have mine. But I recognize your opinion.

Patient: Well, I'm telling you facts, and there could be dates to prove it, ... [therapist's name]. [pause] And bills and receipts.

Therapist: I know you're telling me facts, but, um, but sort of, I'm just trying to stress again that I think you're ill, and I think you're getting better while you're here in hospital. And that everyone here is trying to help you.

Patient: I say I'm not ill, ... [therapist's name]. Not that mentally ill.

Therapist: Um hum. I understand that you don't think you are.

Patient: No. Don't understand. I'm stating a fact. I'm not that mentally ill.

Therapist: I tried to. But that we think that's part of your illness, or I know it is.

Patient: I'm sorry I can't agree with you.

Therapist: Well, as I said before, ...[patient's name], you have your opinion, and you're entitled to it. [silence] But we do think while you're here in hospital you are getting better, and you are a lot better now.

In neither instance cited, nor in others that I came across in therapy sessions with other patients, was I able to identify a theoretical basis to the therapist's "disagreement." He appeared to be tactfully responding to pressure from the patient to confirm her view of the world, rather than utilizing an appropriate moment to exercise a psychotherapeutic strategy derived from his knowledge of the theories of the disorder. Observing more sessions had not resolved my puzzles, nor had it confirmed my social control perspective on the disorder. I was even more confused about the nature of therapists' talk in therapy sessions, than I had been before, as the more cases that I observed, the more convinced I became that their talk was mundane, as opposed to psychiatric, in character.

I realized, as I had done in the case of the therapist of the Israeli "paranoid," that only one element of the therapists' talk, their

references to medications, lacked the common sense quality that I had identified as basic to their remarks. These portions, as noted above in the entry from my journal, were the sole parts of the therapists' conversations that seemed to approximate what I took to be talk more characteristic of therapists. Consider, for example, the following remarks of a therapist during a therapy session with the second patient:

> Therapist: And now you're taking that medication? You're taking that promazine? We started with Stelazine then. The same that you used to take when Dr. ... [psychiatrist's name] was prescribing. O.K. And then we changed that to promazine. And now you're taking those injections you started yesterday, plus you take that antidepressant.
>
> Patient: Um hum.
>
> Therapist: Do you understand the reasons that we changed the medication?
>
> Patient: No, I don't.
>
> Therapist: I told you, you know, because you don't like taking medications. Nobody likes, but I think the chances are that if you continue taking your medications the chances are you're not going to come back to the hospital. And I think it's good for you to....

Despite the medical/therapeutic character of the above example (and others like it in the conversations of other therapists, and in the "Orders" section of the clinical records), it did not help me to resolve my puzzles with respect to the nature of therapists' talk, or their written "Orders." As it related to a chemotherapeutic rather than psychotherapeutic approach to the patient's problems, I concluded as I had done earlier that I could not classify this portion nor others like it, as examples of psychotherapeutic talk, nor could I utilize them to help me reconceptualize other segments of therapists' talk as examples

of psychotherapeutic utterances. These portions were, without question, non-mundane in character, but this attribute did not enable me to make psychiatric sense of them; or by means of them.

Having observed three more "paranoid" patients in therapy, I was left with the same unanswered questions. I still could not explain the common sense character of either the patients' or the therapists' talk. The patients did not talk like "paranoids,' nor did the therapists, while conducting therapy sessions, talk like therapists. I was faced with an inexplicable "gap" between the psychiatric literature on the disorder, and the instances and treatment of it that I had observed. By now, I felt that I could no longer explain away the "gap" by making reference to my own inexperience, or the therapists' level of training. I was confronted with a series of puzzles pertaining to the relationship between psychiatric theory and practice, for which I had no answers. I still felt, however, that my theoretical perspective on the disorder, which I had evolved prior to entering the research setting, might yet prove to be a viable means of understanding the nature of the disorder and its treatment.

My "feeling" stemmed from a number of sources. Foremost among these was my sense that the extensive body of theoretical knowledge on the disorder could not simply be irrelevant to the practical psychiatric work that pertained to paranoia. If it were, I wondered, why would it exist? Furthermore, I had observed that therapists, themselves, *did* make reference to the theoretical knowledge. In the course of their work, they gave verbal and written theoretically based accounts, some of which have already been cited, of their own work, and of the state of

their patients. Consider, for example, the following theoretically based summary that a therapist gave me of his approach to treating the second patient:

> She is not easy to treat. Her delusions are fixed. She doesn't question them. Did you notice how she confronted me about accepting her ideas? I'm trying to probe her delusions, to get her to question them. I'm still not sure of her diagnosis though. She doesn't report any hallucinations, so I'm viewing her as a paranoid, but you may have noticed. Her story gets hazy. She can't explain all of it. That points toward schizophrenia.

Thus, there was no question in my mind that therapists did refer to the theories, although I still could not grasp why their talk in therapy sessions and the talk of their patients, seemed to be devoid of theoretical significance. I decided, therefore, that despite my observations, the theories of the disorder still must be relevant to an understanding of its character, and must serve as a guide to its treatment. If this were the case, I reasoned,[7] then my social control perspective, which I had worked out prior to my fieldwork, might still provide a valid, alternate means of understanding paranoia, and therefore might also serve as a useful approach to treating it.

Footnotes

[1]It is important to note that I did not employ a "case study" approach in my research. My extensive analysis of the Israeli "paranoid" and his therapist is not meant to stand as an example of this type of research strategy. I studied four different "paranoid" patients in detail. I read their clinical records, observed them in therapy, talked to their therapists, etc. I have written at length about one, the Israeli "paranoid," however, as the insights that I gleaned, and the conclusions that I derived from my study of him, do not differ from those that emerged from my study of the other three patients. He represents a typical example of any "paranoid" patient, and is just one of any possible number that I could have discussed extensively. I chose, furthermore, to write at length about him, as he was the first "paranoid" patient that I encountered. My analysis of him provides a chronological link, therefore, with the earlier parts of the thesis, which allows one to trace the evolution of my thought.

[2]I am making reference to the point raised in the previous chapter. As the other therapists that I observed were more highly trained (one, for example, was in his final year of a residency in psychiatry) than the therapist of the Israeli "paranoid," I assumed that they would practise "real" psychotherapy, which would, I thought, be reflected in the character of their talk in therapy sessions.

[3]In an effort to make sense of my observations, I relied upon the same explanations that I had previously used. I decided that I still was inexperienced in understanding, and the therapists that I observed were inexperienced in treating paranoia. I hung onto my "superficial therapy" interpretation of the therapists' work, as it was the only answer that I had for their mundane talk. This time, however, I was forced to escalate my criterion of adequate training. I made the assumption that only therapists who were experienced psychiatrists (none of whom did I observe conducting therapy with "paranoids") would exhibit in therapy sessions, the talk that I thought to be characteristic of psychotherapists. By drawing upon these explanations, I endeavoured to account for the puzzling "gap" that I faced.

[4]The aim of my research by this time was to seek not only evidence that supported my perspective on paranoia, but also to uncover answers to the questions that my research in the field had already raised. The latter task was as important as the former, since the puzzles that confronted me put into question not only my perspective on the disorder, but also my more fundamental understanding of the relationship between psychiatric theory and practice.

[5]After the Israeli "paranoid," I observed, in chronological order, the following patients in therapy: (a) a fifty-two year old widowed

housewife diagnosed to be paranoid schizophrenic, with a differential diagnosis of paranoia or involutional paranoid state; (b) a thirty-three year old single Scottish woman, who worked as a hairdresser, who was diagnosed as a paranoid schizophrenic; and (c) a twenty-two year old single male university student diagnosed to be a passive-dependent personality suffering from an acute schizophrenic episode characterized by delusional thinking with paranoid ideation.

[6]See my definition of "intuition" in the previous chapter.

[7]My reasoning took the following form: if all theory with respect to the disorder was not irrelevant, then my own theory, which I took to be the most promising, must also still be relevant.

CHAPTER 6

CONCLUSION

The intent of this chapter is to provide the reader with an outline of the findings of the thesis, and to place these findings within a theoretical context. The style of the chapter differs from earlier chapters in that the quasi-autobiographical mode is not employed. Instead, the more traditional scientific style is used, as its use may enable the reader to better grasp the scientific import of the thesis. Although the chapter does represents the final segment of the researcher's intellectual journey, it is most important to note once more that the thesis stands not as a mere autobiographical account, but rather as a sociologically relevant document that makes a further contribution to our knowledge. Thus, it is the aim of this chapter to make theoretical sense of materials that might otherwise be taken by the reader to be of no social scientific significance, which will, in turn, demonstrate the validity of the researcher's claim as to the status of the document. Convincing the reader that one's research represents more than a personal intellectual discovery, is a task not uncommon to the ethnographer,[1] and accounts, in the case of this thesis, for the absence of the brevity customarily found in the concluding chapter of a thesis.

Before identifying and analyzing the research findings, it may be useful to outline the stages that led up to their discovery. The outline will be brief, as the body of the thesis documents the process of

discovery. The researcher began with what was referred to as a "map," which comprised a set of constructs derived from a study of psychiatric and social scientific literature. Contrary to the researcher's expectations, the "map" did not provide him with the means to make sense of his observations in the research setting.

The researcher's "map" had been formulated in terms of the taken-for-granted notion that psychiatric theory guided psychiatric practice. Having studied the theory, the researcher assumed that he would be able to discern the theoretical significance of the activities that he observed in the field.[2] As this was not the case, the researcher concluded that there was a "gap" between his constructs and his observations which raised the question of a "gap" between the theoretical accounts of paranoia and its treatment set out in the literature, and the practical work of therapists that ensued with "paranoid" patients. The chapter will address itself to this question, as it is held, for reasons which will be made clear, that the discovery of a "gap," and the discovery of the inadequacies of the explanations for it, are the major research findings of the thesis.

Two explanations initially emerge when one attempts to account for the "gap." From one perspective, the "gap" is merely a construct of the researcher who, owing to his inability to make use of psychiatric theory, arrived at a superficial evaluation, based on appearances of what he observed. The other perspective holds that the "gap" is not a creation of the researcher, but in fact is an integral feature of the practice of psychotherapy. The explanations are derived from opposite premises.

The first explanation is predicated on the premise that psychotherapy is, as the taken-for-granted notion would have it, a theory guided enterprise, while the second is founded on the assertion that psychotherapy is not theory-guided, but rather is an enterprise conducted in terms of the common sense cultural knowledge of the psychotherapist.

Despite the contradictory character of the respective explanations, the researcher was faced, as was pointed out in the preceding chapters, with evidence that lent support, although not conclusive support, to both of them. Thus, while in the field, the researcher was confronted with "puzzles," which seemed, at first, best resolved by means of one explanation; then by the other. It is our task, free from the immediacy of the research experience, to critically examine the adequacy of the respective explanations, in order to explicate a satisfactory answer for the research findings. We will first consider the perspective that psychotherapy is a theory-guided enterprise.

The First Explanation

The thesis began with a quotation from Hans Strupp[3] which outlines the "theory-guided" perspective. From this point of view, psychiatric theory provides the psychotherapist with a scientific body of knowledge that governs his/her practical work with patients. Strupp is not alone in asserting this position. Psychotherapists, social scientists, and lay persons alike share his perspective. Freud, in his *Introductory Lectures on Psychoanalysis*,[4] took great pains to make it clear that psychoanalysis was a science which could be scientifically applied. In his "First Lecture" for example, he notes that ". . . psychoanalysis has

forfeited at the outset the sympathy of the sober and scientifically minded, and incurred the suspicion of being a fantastic cult occupied with dark and unfathomable mysteries."[5] He claims that his critics' views rest on prejudiced invalid arguments which disregard the legitimate scientific status of psychoanalysis. Freud asserts that:

> . . . in their best moments psychiatrists themselves are doubtful whether their purely descriptive formulations deserve to be called science.[6]

He argues, however, that it is precisely this problem which psychoanalysis is able to overcome.

Contemporary psychiatric literature, and the data of the thesis, confirm that psychotherapists still see themselves to be practising a science. Their work, as they see it, is guided by the canons of psychiatric theory. This raises the question: how was it that the researcher perceived a "gap" between their work and the theories to which they subscribed? If we accept the "theory-guided" explanation, then we may conclude that the therapists and the researcher did not see the same, despite the fact that they viewed the same, things. This apparent paradox may be explained by drawing upon the work of Melvin Pollner.

In his paper "Mundane Reasoning,"[7] Pollner analyzes the character of our intersubjective world, in an attempt to arrive at an understanding of what he terms its "inferential operations." These operations, he argues, derive from the assumption of an intersubjective world, and together with this assumption make up what he terms ". . . an idiom of mundane reason."[8] Pollner addresses the following question; a question, he argues, that confronts the mundane reasoner:

> . . . how can persons who are simultaneously looking at the same world experience and/or describe that world in disparate and contradictory ways?[9]

Using transcripts from the proceedings of municipal traffic courts, Pollner points out that such questions or disjunctures are frequently confronted and solved by the mundane reasoner. The solutions are of interest to us, as the question that he raises is of the same order as the question that confronts us in coming to terms with the "gap." The solutions, he points out, are based upon the notion that in the case of any disjuncture:

> . . . a community of compatible experience would have been forthcoming had it not been for the exceptional character of the methods, motives or circumstances of one or another of the parties to the disjuncture.[10]

Herein lies support for the "theory-guided" explanation of the "gap." If we assume that psychotherapists rely upon "exceptional"; i.e. different means of making sense of behaviour than do lay persons, then following Pollner's outline, a disjuncture such as the "gap" would inevitably present itself to the researcher, as he is not a psychotherapist. By applying Pollner's analysis, we may provide an answer to the researcher's puzzle. It can be argued that when dealing with the social world, psychotherapists make use of ". . . exceptional methods of observation and perception";[11] i.e. psychiatric theory, while the researcher (the lay person) when viewing that same world, relies as a mundane reasoner, upon common sense cultural knowledge.[12] Hence, there is a disjuncture or "gap."

Before assessing the adequacy of the "theory-guided" view, we shall summarize its explanation of the "gap." The perspective asserts

that psychotherapists are persons who not only subscribe to a body of theoretical scientific knowledge, but also are able to utilize this knowledge to make sense of the social world, and to guide their work as therapists within that world. Psychotherapists are free from a dependency upon common sense cultural knowledge. They do not need, nor do they rely upon, this knowledge to accomplish their practical work as therapists.

Lay persons, by definition, are not therapists, and the primary characteristic that in fact distinguishes them from therapists, is that they are unable, even when they have studied the theoretical knowledge, to utilize it in the ways that therapists do. Lay persons are unable to fully identify the theoretical significance of mentally ill behaviour, and therefore lack the means to provide appropriate therapeutic responses to such behaviour.

Thus, the researcher was mistaken in his notion that there existed a "gap." What appeared to him to be mundane talk (on the part of the patients and therapists) was strictly an appearance. Not being a therapist, the researcher was unable to identify what in reality was theoretically significant material. The "gap" was, therefore, a gap only for the researcher. It was a construct that he invented, as a means of explaining his observations. By making use of Pollner's analysis, we seem to be able to account adequately for the researcher's mistaken notion that psychotherapy is not a theory-guided activity.

We have now set out in some detail one of the possible explanations for the research findings. Before examining the other, we need, in light of our analysis, to comment on the notion of "inexperience"

raised by the researcher while in the field. In an attempt to make sense of the "gap" without rejecting the theory governed premise, the researcher proposed that it was his own and/or the therapists' inexperience that accounted for his observations. We shall take up the question of his own inexperience, first.

If we accept the "theory-guided" explanation as discussed above, we may set aside the notion that the researcher's inexperience denied him the opportunity to "see" things the way that therapists "saw" them, as the "theory guided" explanation rejects the view that a lay person may ever become familiar enough with psychiatric theory to make sense of behaviour in the ways that therapists do so. In other words, familiarity with the psychiatric theoretical literature does not make one a therapist, any more than familiarity with anthropological or sociological theory makes one an anthropologist, or sociologist, etc.

The distinction between a lay person and a professional appears to lie in the ability, as Pollner put it, to make use of ". . . exceptional methods of observation and perception" which, we may conclude, means the ability to "see" (i.e. interpret) the social world in terms of the special forms of consciousness that are implicit within the theoretical knowledge of one's particular discipline. The source of this ability lies, we may deduce, in the training that a professional, such as a psychotherpist, receives.

Identifying the source of the distinction between lay and professional in the special forms of consciousness that derive from one's training, brings us back to the other possibility that the researcher raised while in the field, to account for the "gap." As none of the

therapists that he observed were experienced psychiatrists, the researcher attempted to account for what he took to be their mundane talk in terms of their limited training as therapists. We can discount this view if we draw once more on the "theory-guided" explanation, and keep in mind that all of the therapists that were observed had received training in psychotherapy, while some, such as Residents, had received extensive training in psychotherapy. Thus, none of them could be defined as lay persons. Rather than concluding that their work was not theory guided, we may dismiss this notion as another instance of the researcher's failure to recognize that the "gap" was *his* construct, formulated out of the appearance rather than the reality of the interaction that he observed. Again, we may attribute his perception of a "gap" to his status as a lay person, who by definition lacked the special forms of consciousness of the therapists, and, therefore, was unable to "see" what therapists were able to "see."

The Second Explanation

We shall now consider the second explanation of the "gap." This viewpoint offers us an opposite interpretation to that of the first. We shall begin with a brief summary of its argument. From this point of view, the "gap" was not a creation of the researcher, but rather an accurate reflection of the nature of the relationship between psychiatric theory and practice. Psychotherapy is not a theory-governed enterprise. Instead, psychotherapists rely upon common sense cultural knowledge to accomplish their practical work, which then accounts for the researcher's observation of a "gap." Thus, those such as Strupp,

Freud, and others who would argue that psychotherapy is theory guided, are, rather than the researcher, seen to be the ones who depend upon an inaccurate construct. Their view, that the talk of therapists and patients is theoretically significant, is merely a version that they, as subscribers to psychiatric theory, *read into* the interaction. In fact, the interaction is, and can only be, mundane in character. Therapists do not "see" the social world in exceptional ways. They too are mundane reasoners, who *retrospectively* make theoretical sense of their own and their patients' talk, which in turn creates the appearance of a disjuncture between their experiences of the social world and those of lay persons. In reality, there is a disjuncture between accounts, not experiences, of the social world.

If one accepts the above interpretation of the research findings, an interpretation which was in part raised by the researcher while in the research setting, then one must discount the validity of the researcher's original theoretical perspective on paranoia; i.e. his "map," as it rests upon what may be seen to be the faulty taken-for-granted notion that psychiatric theory guides psychiatric practice. The researcher had hoped to gather data that would prove that the exercise of social control was basic to the practice of psychotherapy, especially with "paranoids," as the practice derived its direction from a body of theory that was essentially conservative in orientation. The researcher had not understood that his perspective rested upon what may be seen to be an incorrect formulation of the relationship between psychiatric theory and practice, which neither the perspectives that he had set out to criticize, nor the perspectives that he had mainly drawn

upon to develop his viewpoint, had taken into account. We are left with the conclusion that psychiatric theory does not guide psychiatric practice. The researcher's social control theory, and other theories of the disorder are, therefore, irrelevant to making sense of, or serving as a guide to, the treatment of patients diagnosed as "paranoids." In other words, psychiatric theories may serve to ratify, but do not guide therapists' understanding of or response to "paranoids."

Furthermore, acceptance of the second explanation leads one to again reject, this time for different reasons from those of the first explanation, the notion that the researcher's and/or the therapists' inexperience is the source of the "gap." In this case, the rejection is not formulated in terms of a distinction between therapist and non therapist, but rather in terms of the premise that knowledge of psychiatric theory, no matter what one's status or level of training, has no direct bearing upon one's ability to practise psychotherapy. Psychotherapists rely, after all, it is held, upon their competency as cultural members, to accomplish their practical work.

We shall now examine the second explanation in more detail, keeping in mind that any claims which may be established as to its adequacy in turn tend to invalidate the counter claims of the first explanation. If one reviews the data of the thesis, a number of points consistently stand out.[13] The therapists engage in talk with their patients that appears to be mundane in character; devoid of theoretical significance. In addition, the patients do not talk like "paranoids." Although there are clues within their remarks that point to their insanity, their talk is not the talk of "paranoids" as described in

the literature. It is distinctly mundane in character. It is by drawing upon one's common sense cultural knowledge, that one is able to make sense of both the patients' and the therapists' talk.

One cannot, however, dismiss the role of psychiatric theory. Reviewing the data, it seems evident that it is an integral component of the processes that were observed. The therapists' verbal and written accounts of their own work, and of the character of their patients, are unmistakably theoretically based. One cannot understand their accounts without a knowledge of psychiatric theory.

Thus, we are confronted with data that can be characterized as both mundane and theoretically significant. Therapists make theoretical sense of material that appears, to one reviewing the data, to be mundane in character. One must utilize one's knowledge of psychiatric theory to understand the therapists' accounts, yet that same knowledge proves to be of no value in making sense of the transcripts of therapy sessions; i.e. the interaction upon which the accounts are based. We face again the identical problem; i.e. how is it that individuals are able to make very different sense of the same material?[14] This time, however, we shall not explain the disjuncture in terms of a lay/professional dichotomy re perception. We shall work from the premise that both lay persons and therapists "see" and respond to the social world in terms of common sense cultural knowledge. Therapists, however, reconceptualize what they "see" and do as therapists in theoretical terms. Hence, there is a disjuncture of accounts.

The premise may be restated another way. Psychotherapists use common sense cultural knowledge as their resource for accomplishing

their practical work, psychotherapy. This is not only a common, but also a *necessary* feature of their work.[15] Psychiatric theory does not play the decisive role that the researcher and others had attributed to it. Jeff Coulter asserts this view in a discussion critical of attempts to arrive at a "culture-free" psychiatry:

> Any practical psychiatric work is intelligible only against the background of the cultural conventions within which it operates, and cultural conventions do indeed differ. Extrapolating common denominators from transcultural materials and reifying one's own standards as ontological absolutes will not remedy this situation, if it stands in need of remedial attention in the first place. This entire exercise appears to stem from misconceiving *psychiatry*, as distinct from psychopathology, as a theoretical, scientific enterprise with respect to which questions about objectivity could legitimately be raised. Actually, psychiatric practices are unavoidably and essentially bound up with the pragmatics of everyday living, and the objectivity of psychiatric judgements is more a matter of reasonableness and necessary precautions in specific cases than of operating according to universal, culture-neutral principles and procedures. Every diagnostic procedure shorn of reference to cultural conventions and standards of conduct is irrelevant to the central, practical concerns of psychiatry.[16]

Adopting such an interpretation allows one to resolve the puzzles that confronted the researcher while in the field, and that may face the reader who reviews the data of the thesis.[17] According to this perspective, the absence of a theoretical core to the therapists' conversations with their patients does not stem from the inexperience of the researcher or the reader, nor does it stem from the therapists' inadequacy as therapists. Their remarks to their patients had sounded mundane, and do appear mundane to the reader, as they are, in fact, of necessity organized in terms of the therapists' common sense cultural, rather than psychiatric theoretical, knowledge.[18]

Coulter is not the only author who holds a point of view that may be used to lend support to the second explanation. Roy Turner and Melvin Pollner present us with viewpoints that also may be seen to sustain the explanation. Turner, in an analysis of the methods available for interpreting transcripts of psychotherapy sessions,[19] argues that the basis of all interpretative schema, including those that seek to interpret remarks of therapists in therapy sessions, must be common sense cultural knowledge, as this is the resource, rather than psychiatric theory, which the therapist himself/herself employs as a guide to formulating his/her remarks. Referring to the task of interpreting the exchanges of therapy sessions, Turner states, for example, that "such an enterprise is permitted--*required*--to make reference to the cultural knowledge which the talk draws upon as a resource."[20]

It is of interest to us that Turner identifies common sense cultural knowledge as both the patient's *and* the therapist's resource for producing their remarks in therapy sessions. We may, without attributing our interpretation to him, conclude the following: if it is cultural knowledge, then it cannot be psychiatric theory which guides therapists' remarks. It is evident that Turner regards cultural knowledge as playing a primary role. Consider, for example, his contention that:

> . . . in the course of conducting the psychiatric interview the therapist exercises those conversational skills he possesses as a member of the culture, competent to talk to other members and be understood. It does not matter, of course, that the therapist may have principled grounds for breaching conversational rules: the recognition and production of breaches are dependent upon the very same competence which provides for the recognition and production of talk which observes those rules in the first place.[21]

We need to establish, for purposes of validating the second explanation, that cultural knowledge plays the only role in guiding the therapist. Turner's analysis does not provide us with such evidence. Building upon Turner's analysis, however, we may be able to respond to a premise that is basic to the argument of the first explanation. We refer to the view that the researcher's status as a lay person gave him the mistaken notion that the remarks of therapists are mundane in character when, in fact, they are formulated in terms of psychiatric theory; in other words, the view that the researcher's incorrect interpretation, or an incorrect interpretation on the part of another lay person who might review the data, may be attributed to their lay status, which limits their ability to correctly interpret the character of the therapists' remarks.

We are able to come to terms with this perspective by formulating a response that utilizes Turner's analysis. If therapists' remarks were structured in terms of psychiatric theory, therapists would be unable to communicate with their patients, as most patients have a limited knowledge of psychiatric theory. Therapists would only be able to communicate with other therapists. We must assume, therefore, that therapists' remarks are formulated in terms of common sense cultural knowledge. As members of a larger culture who must interact with other members of that culture, what else, in fact, could therapists do?

We are able to draw a similar conclusion from the work of Melvin Pollner. By again making use of his paper "Mundane Reasoning," we are able to help substantiate one of the explanations. This time, however, a different segment of analysis, a segment which provides support for

the second explanation, will be used. We previously argued that Pollner's analysis lent support to the view that therapists have special methods of "seeing" and consequently dealing with the social world, which distinguishes them from the mundane reasoner. If this were the case, following the argument derived from Turner, then psychotherapists would exist in a social vacuum. They would be unable to communicate with others (lay persons), as those others, being mundane reasoners, lack the psychotherapists' special methods; methods which derive from the therapists' ability to apply their knowledge of psychiatric theory. Although one may conclude from his analysis that therapists do possess special methods, it would appear that Pollner would reject the notion that such persons may, by virtue of their status as therapists, interact in ways that are guided by a strictly scientific schema, devoid of mundane reason. Pollner notes, for example, that:

> . . . the mundane schema seems to be implicated in the very notion of person. One who never grasped the sense of that which was other than and independent of himself--*the* world--could not grasp himself as a self and would thus be condemned to live his life in an autistic, egocentric fashion (whose character as such would be available only to others). And indeed it is perhaps just those persons who are said to move in such realms--schizophrenics and children--persons who have abandoned or have yet to achieve use of the mundane assumptions.[22]

By drawing upon the work of Turner and Pollner, we have attempted to establish the premise that common sense cultural knowledge, rather than psychiatric theory, provides therapists with a guide for formulating their remarks in therapy sessions. By adopting this viewpoint, we are able to clarify the researcher's and, as the case may be, the reader's puzzle as to the character of the therapists' remarks. Keeping in mind the tentative nature of the explanations which we are presenting,

we shall now attempt to account for the researcher's inability, despite his knowledge of psychiatric theory, to make theoretical sense of the remarks of patients. We have already dismissed the notion that the source of this puzzle lay in the inexperience of the researcher. We can also make the same argument with respect to the reader for whom the patients' remarks, as set out in the transcripts, constitute a puzzle.

One way to explain the researcher's and possibly the reader's "problem" is to view their inability to make theoretical sense of patients' remarks as neither a "problem" nor as a characteristic unique to them. If we discard the notion that therapists are able to make theoretical sense of patients' remarks, as an erroneous assumption of the first explanation, then we are not faced with a "problem." Instead, it can be argued that all persons, whether they be therapists, the researcher, or the reader of the thesis, have no recourse but to make sense of patients' remarks and behaviour in terms of common sense cultural knowledge. In other words, we return again to the premise that despite their training and extensive knowledge of psychiatric theory, therapists are no more able to scientifically understand, although their verbal and written accounts might give this impression, the nature of the social world, than is the lay person. Coulter, in a discussion of insanity ascription, states the argument this way:

> . . . the point about insanity-ascribing procedures which I have tried to establish is that they are generally wholly sensitive to seeing the relevant conduct and belief in terms of some notions of adequate performance in the contexts and culture within which they were found, since those contexts and cultural milieux furnish the very resources that are employed in conceptualizing the beliefs and conduct in the first place as inappropriate and groundless. The Haitian voodoo believer who reports holding conversations with the dead, and the Yoruba who 'carry

> their heads around,' could both be envisaged doing the same thing in this country; it is obvious that their beliefs and conduct would be assessed in the light of the normative order of their own cultures and not in the light of ours so that no one would sanctionably consider them insane (unless they considered the original cultures 'insane'). In other words, whilst it is true that insanity ascriptions are culture sensitive, no insanity ascriber could take as an excusing condition for some mad belief held by an Englishman in England the 'explanation' that he happens to believe the same things believed by some Haitians or Yoruba. The beliefs are mad because the Englishman has no possible source of social corroboration of his beliefs *where he avows them*. Beliefs and conduct are never appraised by any competent person in pure abstraction; what is appraised is belief and conduct in context. The only relevant context for the appraisal of beliefs is the knowledge people have of the culture and circumstances in which they are avowed and seen as problematic.[23]

We have developed, by drawing upon the work of other researchers, a counter argument to that of the first explanation. We have put forth the view that therapists subscribe to a body of scientific theoretical knowledge, but that they are unable to employ this knowledge in order to accomplish their practical work. Before we discuss the status of psychiatric theoretical knowledge in light of our analysis, it would be useful to examine the views of an author who has analyzed the distinctions between scientific and common sense knowledge, with respect to the implications for an understanding of human behaviour.

Harold Garfinkel, in "The Rational Properties of Scientific and Common Sense Activities,"[24] provides us with an interpretation of the differences between actions that are governed by scientific "attitudes" and those governed by common sense "attitudes." It is Garfinkel's contention that many actions which are taken to be governed by scientific "attitudes," are, in fact, governed by common sense "attitudes," a circumstance which creates unnecessary problems in interpreting the

character of these actions. Garfinkel puts his argument this way:

> It is the scientific rationalities to which writers on social organization and decision making commonly refer as features of "rational choice." It is proposed here, however, that the scientific rationalities are neither properties of nor sanctionable ideals of choices exercised within the affairs governed by the presuppositions of everyday life. If the scientific rationalities are neither stable properties nor sanctionable ideals of choices exercised within the affairs governed in their sense by the presuppositions of everyday life, then the troubles encountered by researchers and theorists with respect to the concepts of organizational purposes, the role of knowledge and ignorance in interaction, the difficulties in handling meaningful messages in mathematical theories of communication, the anomalies found in studies of betting behavior, the difficulties in rationalizing the concept of abnormality in light of cross-cultural materials may be troubles of their own devising. The troubles would be due not to the complexities of the subject matter, but to the insistence on conceiving actions in accordance with scientific conceits instead of looking to the actual rationalities that persons' behaviors in fact exhibit in the course of managing their practical affairs.[25]

We do not wish to imply that Garfinkel would necessarily accept the ensuing analysis, but it would appear that we are able to make use of his perspective to further the argument of the second explanation. If we conceive of psychotherapy as an activity that falls within the category of activities that are "governed by the presuppositions of everyday life," then, following Garfinkel's analysis, we have an explanation for the "gap," or as he might term it, our "trouble." The source of the "gap" lies, not as the first explanation would have it, in our inability to make use of psychiatric theory the way that therapists do, but rather in our original attempt to understand an activity which we, accepting the taken-for-granted notion, took to be guided by scientific theory, when in fact it was guided by common sense rationality. He summarizes the perspective which we wish to draw upon this way:

> . . . the scientific rationalities can be employed only as ineffective ideals in the actions governed by the presuppositions of everyday life. The scientific rationalities are neither stable features nor sanctionable ideals of daily routines, and any attempt to stabilize these properties or to enforce conformity to them in the conduct of everyday affairs will magnify the senseless character of a person's behavioral environment and multiply the disorganized features of the system of interaction.[26]

If we assume that psychotherapy is an activity "governed by the presuppositions of everyday life," then we have in Garfinkel's analysis a perspective that provides us with a cogent explanation of the "gap." Having examined the data of the thesis, and having reviewed the respective explanations of it, it is up to the reader to assess whether we are justified in arguing that psychotherapy is such a type of activity; i.e. one "governed by the presuppositions of everyday life." Garfinkel's analysis of the distinctions between scientific and common sense attitudes, as they relate to what he terms ". . . the conditions of their occurrence,"[27] are set out by him in a table form. His table may assist the reader in making the assessment.

We shall conclude our discussion of the second explanation with an analysis of how one might account for the role of psychiatric theory, given the nature of the arguments already presented. Although the second explanation discounts the view that psychiatric theory plays a primary role in guiding the work of psychotherapists, we cannot disregard psychiatric theory, as it is evident that therapists do explain the character of their patients and their work with them in terms of it.

The therapists' explanations take the form of verbal and written accounts. We are faced with the necessity of arriving at a formulation of the status of these theoretically based accounts. We are, in other

words, confronted with the question: given their theoretical content, what is their significance? If one adopts the first explanation, this question is not difficult to come to terms with. The accounts are, predicatably, theoretically based, as therapists make sense of and respond to their patients in terms of psychiatric theory. Adopting the second explanation does not, however, provide one with such an answer. If, as the explanation has it, therapists rely upon common sense cultural knowledge in order to accomplish their practical work, we must be able to explain why their accounts of this work are formulated in terms of psychiatric theory.

If we address the question: "Given the arguments of the second explanation, what makes a therapist a therapist?"; we may be able to provide an adequate account of the role of psychiatric theory. The second explanation is built upon the premise that therapists and lay persons alike experience the social world as mundane reasoners. Therapists do not, by virtue of their status as therapists, have exceptional methods of understanding the social world which would allow them to "see" things that others do not "see." Thus, this perspective might lead one to conclude that those who adopt the second explanation inevitably view psychotherapists as imposters who engage in the provision of fraudulent accounts, in an attempt to disguise the common sense cultural basis of their practical work. By inference, one might also be inclined to conclude that subscribers to the explanation come to believe that anyone could practise psychotherapy, "since all that is required, after all, is that one be a culturally competent member." One can, however, adopt the second explanation without subscribing to such views.

If we return to the concept of a disjuncture of accounts, we may be able to provide an adequate explanation of the questions that we have raised. We previously put forth the view, in the context of the second explanation, that therapists' theoretical accounts of their practical work gave the appearance of a disjuncture between their experience of the social world and that of a lay person. It was argued that, in reality, the experiences were, of necessity, the same, but that the accounts were different. It is this difference which may provide us with an understanding of the role of psychiatric theory and the distinction between a therapist and a lay person.

Drawing upon the arguments of the second explanation, one may assert that what makes a therapist a therapist is his/her ability to provide a psychiatric theoretical account of his/her common sense based experience and interpretation of the social world. The researcher's and other lay persons' inability to provide such accounts is what distinguishes them as non-therapists. Psychiatric theory serves the purpose of furnishing therapists with a body of knowledge which they can draw upon to retrospectively make theoretical sense of their own and their patients' mundane talk. The "retrospective making sense" is expressed in the form of verbal and written theoretically based accounts such as those cited in the thesis.[28] Psychotherapists, in other words, utilize psychiatric theory to retrospectively read theoretical significance into their mundane experience of the social world. Hence one who is party only to their accounts (i.e. not party to the interaction, or some record of it such as transcripts, out of which the accounts are formulated), may gain the mistaken notion that therapists "see" the social world in different

(i.e. scientific) ways than do lay persons.

Without attributing our interpretations to them, we may again draw upon the work of others to further establish the argument that has been made. Roy Turner, in his paper cited above, notes that ". . . a component of psychiatric competence is the ability to 'discover' retrospectively in routine utterances the therapeutic motivations taken to govern their production."[29] One may argue that "the ability to 'discover' retrospectively" is, in fact, the distinguishing characteristic of a psychotherapist, and that psychiatric theory provides the therapist with the means to engage in this enterprise. Furthermore, one may assert that training in psychotherapy allows one to acquire this ability, but it does not allow one, as the first explanation would have it, to acquire exceptional methods of experiencing the social world. Therapists, like lay persons, experience the social world as mundane reasoners. They, however, have the ability, acquired from their training, to reformulate their experiences in theoretical terms.

Another researcher, in a study of psychotherapy with children, arrives at a conclusion, with respect to the status of psychiatric theory, that one may also interpret to be of importance to the "retrospective discovery" argument. He holds the view that psychiatric theory provides the therapist with a method ". . . for the *post hoc* discovering of rationality," and serves as a means ". . . for seeing the adequacy, appropriateness, logicalness, properness, etc. of events."[30] Keeping in mind that we do not wish to attribute our interpretation to him, we may conclude that his view helps to further establish the argument that psychiatric theory provides a resource for the reconceptualization of

mundane practical work (based as it is, by necessity, upon common sense cultural knowledge), as scientific work. Finally, to reiterate, it is important to note that subscribing to the above analysis does not force one to view psychotherapists and their work in a negative light. The researcher and other, untrained members of his culture need not be seen as implicitly competent practitioners of psychotherapy. Unlike trained therapists, the researcher was, he discovered, unable to make psychiatric sense of the dialogues between patients and therapists that he observed. So too, it can be argued that the untrained (lay) reader would be unable to make psychiatric sense of the data of the thesis. Furthermore, the researcher and his fellow lay members would not be able to make psychiatric sense of their own reasoning and actions, if they were given the opportunity to attempt to treat a "paranoid" patient.[31] Thus, it is the ability to make theoretical (albeit, retrospective) sense of (and thereby provide theoretically based accounts of) one's own and one's patients' behaviours, that constitutes, one may argue, the defining characteristic of a psychotherapist.

An Evaluation of the Explanations

We have set out two possible explanations of the "gap." The second was developed more extensively than the first, as it was necessary to explain, in more depth, a perspective which contravenes our taken-for-granted notion of the relationship between psychiatric theory and practice. The second explanation, as discussed above, offers one a detailed account of the source of the "gap," and thus is able to provide answers for the puzzles that confronted the researcher, or that may

confront the reader who reviews the data. One might be inclined to conclude that the second explanation not only disproves key premises of the first, but also is, unlike the first, free of problematic elements. This, however, is not the case. If one carefully reviews the explanation, two features stand out. First of all, the important premises of the argument do not adequately come to terms with the questions that confront us. Secondly, the material, taken from the work of other researchers, that was used to support the argument, does not accurately reflect the integral views of these researchers, as it has been removed from the context of their respective works. We shall discuss the latter characteristic first.

It is important to point out, as we did when we set out the arguments, that our utilization of other researchers' work was not meant to imply that these researchers themselves would necessarily interpret their perspectives in the same way that we did. In other words, one may read into their work support for the second explanation, which they themselves might not be ready to grant. If one reviews the work of the authors who were cited, one must conclude that only Coulter would accept the second explanation. The inescapable conclusion that one gains from his book, *Approaches to Insanity*, is that psychotherapy is, of necessity, a pragmatic enterprise, which derives its direction from the common sense cultural knowledge of the psychotherapist. Although we are able to find segments in the work of the others (Turner, et al.) that acknowledge or point out the mundane component of psychotherapy, the other researchers, unlike Coulter, do not argue that psychiatric practice is strictly a mundane enterprise devoid of scien-

tific theoretical influence. While we may draw support for the second explanation by citing segments of the others' works, we are not free to conclude that they would argue that psychiatric theory plays no part in governing the work of psychotherapists. Thus, their views with respect to the role of common sense cultural knowledge may negate the arguments of the first explanation, but they do not allow one to assert that these researchers, with the exception of Coulter, would accept the perspective of the second explanation.[32]

Our inability to attribute a commitment, on the part of the other researchers, to the premise that the schema utilized by psychotherapists to accomplish their practical work is devoid of psychiatric theory, raises a problem for one who subscribes to the second explanation; a problem that is also raised if one carefully reviews the arguments of that explanation. The problem that confronts the second explanation is fundamental, and therefore, if we are unable to satisfactorily resolve it, the validity of the entire explanation must be questioned. The problem may be summarized as follows: how are we to account for the distinction between what the researcher "saw," and what therapists, who were party to the same interaction, "saw"? Does the second explanation offer us an adequate account of this "gap"?

It would appear that it does not. To put it simply, one cannot be sure that the therapists and the researcher experienced the interaction to which they were party, in the same way. Even if the therapists did rely upon their common sense cultural knowledge to make sense of, and to serve as a guide to, formulating their responses to their patients, one has no way of knowing that their mundane understanding

was not in some way penetrated or influenced by their knowledge of psychiatric theory. In fact, looking at the evidence, i.e. their verbal and written accounts of their experiences, it seems quite plausible that psychiatric theory does play a role in determining their understanding of the social world. If they were, after all, strictly dependent upon common sense cultural knowledge, why would they claim, as they do in their accounts, to be "seeing" things that the researcher or other lay persons do not see? The notion that these accounts are in some way a retrospective theoretical reformulation of their experiences of the social world, and the argument that the disjuncture between what the therapists "saw" and what the researcher "saw" can be explained in terms of these accounts, does not seem to do justice to the practice of psychotherapy as described by the data. If, as the second explanation would have it, the "gap" can be explained in terms of a disjuncture of accounts rather than of experiences, then one is led, contrary to what subscribers to the second explanation might argue, to the conclusion that psychotherapists are "imposters," and that any culturally competent member is able to practise psychotherapy. The premise that the ability to provide theoretically based accounts is the distinguishing characteristic of a therapist does not, in other words, seem to come to terms with these sorts of problems.

The crux of the objections to the second explanation may be stated as follows: do lay persons and therapists actually experience, or "see" the social world the same way? If they do, what makes a therapist a therapist? Isn't it possible that the researcher failed to identify the theoretical significance of the therapists' and the

patients' talk because he was not a therapist? These sorts of questions undermine the second explanation, as they point toward an issue that the explanation is unable to adequately deal with. The second explanation does not come to terms with the problem of conclusively identifying which schemata govern the consciousness of the researcher, and which ones govern the consciousness of the therapist. The second explanation cannot rule out the possibility that therapists make use of both mundane reasoning and psychiatric theory in order to make sense of the social world. Their ability to do so would differentiate their consciousness from that of lay persons such as the researcher, and would account for what can be seen to be the researcher's mistaken notion of a "gap" between psychiatric theory and practice. The "gap" may exist strictly in the mind of the researcher, who, as a lay person "seeing" the social world from the perspective of the mundane reasoner, is unable to identify the theoretical significance of the interaction that he observed. His inability may stem from his limited consciousness. One cannot rule out the possibility that the practical work of the therapists that he observed, was theory guided. The guiding role of psychiatric theory might not, after all, have to be identified by the researcher or other lay persons, in order to confirm that it plays a part in governing the practical work of therapists. Given the limited consciousness of lay persons, one could argue that such a determination on their part might not be possible.[33] Nor could, for example, lay persons determine the ways in which anthropologists or sociologists "see" the social world, as they again would lack the special forms of consciousness, in this case peculiar to sociologists and anthropologists, that would enable them to

make such judgements.

Although it is not our intent to explore it in detail, another, separate objection to the second explanation may be raised. The objection is rooted in the premise that one can demonstrate historical changes in psychiatric practice. Michel Foucault's book, *Madness and Civilization*,[34] for example, traces, amongst other things, changes in psychiatric treatments from 1500 to 1800. If psychiatric practice is not influenced by psychiatric theory, as the second explanation would have it, one is hard pressed to account for historical changes in psychiatric practice. One could argue that such changes come about as a consequence of changes in the body of common sense cultural knowledge that practitioners must rely upon, but such explanations must overlook historical changes in medical and psychiatric theory, with respect to insanity, that are concurrent with changes in practice. Seen from a historical perspective, psychiatric practice seems to have changed as a consequence of the impact of new theoretical conceptualizations of the character and the treatment of insanity.[35] If this is the case, then the second explanation is presented with another question for which it appears to have no adequate answer.

We have set out some questions for which the second explanation does not appear to have adequate answers. We do not wish, however, to imply from our analysis that the first explanation does have adequate answers. The first explanation also is unable to conclusively identify the schemata which govern the consciousness of the researcher and the therapist. We are left in a quandary, as neither perspective is able to provide an unproblematic explanation of the research findings. The

first explanation is built upon the premise that the therapists' practical work was theory guided, while the second asserts that psychiatric theory played no part, aside from the provision of accounts, in enabling therapists to accomplish their practical work. Neither explanation, by itself, appears adequate. Both of them leave us with unanswered questions with respect to the meaning of the data. We are still unsure whether the interaction that the researcher observed, as set out by means of the transcripts, is merely mundane talk, or whether it is material that was formulated in terms of, or may be interpreted in terms of, psychiatric theory. Nor are we certain if the researcher's observations, entered in the thesis, are a valid interpretation of the interaction that he observed.

We face, in a sense, another disjuncture. Earlier in the thesis, the notion of a disjuncture between the therapist and the "paranoid" patient was raised. Subsequently, a disjuncture between the researcher's and the therapists' interpretations of the interaction to which they were party was identified. Now we are confronted with a disjuncture between competing explanations of the research findings. Although we may be able to establish, using Pollner's analysis discussed above, that these disjunctures are of the same order in that they share certain characteristics in common, we are, it appears, unable to resolve them. We are not, in other words, in a position to arrive at a conclusive scientific judgement as to the validity of the competing claims. We have raised the issues, have presented interpretations of them, and in turn have identified objections to the respective interpretations. We have no grounds, however, to provide the reader with *the* answer to the

questions that emerged. One is inclined, in producing a document such as a thesis, to attempt, in the final chapters, to "wrap it all up." An attempt on our part to do so would, however, produce conclusions that would be inadequate, as the problems that we have addressed do not lend themselves to a straightforward resolution.

Conclusions

One may conclude that the thesis does not realize the aims stated in the introduction to this chapter. One might argue that it makes no further contribution to our knowledge, as it fails to provide a definitive explanation of the research findings and their relevance. Furthermore, one might assert that its nontraditional methodology, in addition to its inability to explain the questions that it raises, deny it the status of a scientific document. It is understandable that the reader might raise such criticisms. One could view the thesis as a mere autobiography that does not represent anything beyond an account of the personal intellectual discovery of the author, that making sense of the relationship between psychiatric theory and practice, is problematic. We wish to assert, however, that discoveries of wider, social scientific significance have been made, and that the difficulty in interpreting them is simply a consequence of the nature of the discoveries. We shall attempt, in this segment of the chapter, to clarify our claims for the reader.

As we noted in the introduction to the chapter, sociological ethnographers commonly must justify the status of their documents. One ethnographer, addressing himself to this task, notes that his work:

> . . . is clearly locatable within an emerging body of sociological research in which the researcher himself is treated as the informant and his own experience of making sense is treated as a topic worthy of study. What these studies have done is (a) discover and explicate a feature of the social world . . . and then, (b) treat that discovery and explication as a practical accomplishment.[36]

We wish to make the same claim with respect to the status of our study. We view it as a work that transcends an autobiographical account of a personal intellectual discovery, and that it stands, therefore, as a sociologically relevant document.

Our claim rests upon the premise that the "gap" which the researcher discovered is not a construct peculiar to his personal study of psychotherapy with "paranoids." We are asserting that *anyone* (with the exception, we may assume, of psychotherapists) who studied the psychiatric and social scientific literature on paranoia, and then observed psychotherapy with "paranoids" as the researcher has done, would become aware of a "gap" between what they read, and what they observed in the research setting. We are arguing, in other words, that the "gap" may be a construct, as the first explanation would have it, but that it is not a construct that only the researcher would invent. Any culturally competent member familiar with the literature would, we claim, have also discovered a "gap," had they pursued the same study as the researcher. The "gap" is not, therefore, the researcher's personal invention, but rather is a discovery of wider significance as its existence, even if it is only a construct, is something that any other culturally competent member would have been able to discern. Thus, the explication of the "gap" represents more than an account of a personal discovery. It is, we claim, a sociological discovery; one that is problematic to interpret,

but nevertheless of social scientific importance.

Furthermore, the "gap" appears to be something that confronts others besides the researcher and persons that would undertake a study similar to his. By this we mean that the "gap" that we have discovered may exist for others who seek some understanding of the relationship between a body of theoretical knowledge and what purports to be the practical application of that knowledge. Consider, for example, the potential criticism, by a reader of this thesis, that we have already cited. A reader might argue that the approach utilized by the researcher in pursuing his research bears little resemblance to sociological research as described in the sociological literature. Gaining insight into a disorder from a book recommended by one's professor, rereading the major works of a paradigm, and thereby "seeing" it in a new way, gleaning an alternate understanding of a patient from a discussion with an informant, are activities of the sort which have been described by the researcher in the thesis, and are to be viewed, from his perspective, as integral components of the research process. To the reader, however, these activities may appear to be ad hoc random practices which are not the sorts of pursuits that could collectively be classified as scientific research procedures. The reader might, therefore, arrive at the conclusion that a "gap" exists between the practice of sociological research as set out in the sociological literature, and the pursuits of the researcher set out in the thesis.

We do not dispute that such a "gap" may exist for the reader. Rather, we are claiming that the discovery of such a "gap" on the part of a reader familiar with the sociological literature, may be of the

same order as the researcher's discovery of a "gap" between the psychiatric literature and the practical work of psychotherapists. In other words, the activities of the researcher may appear as mundane, untheoretical, and unscientific to the reader as the pursuits of the therapists did to the researcher. Yet both the therapists and the researcher claim to be engaged in scientific enterprises, and both are able to point, from their perspectives, to the scientific bases of their activities. Thus, a reflexive examination of the production of the thesis yields another instance of a "gap" between theory and practice.

Using a reflexive analysis, we are also confronted anew with the need to make sense of a disjuncture between conflicting claims as to the character of the "gap." Once more a practitioner makes claims with respect to the status of his work which contradict those made by an observer of that same work. As before, explanations of the "gap" may be broken down into two types; one that would argue that the observer is correct in asserting that the activities observed are not theory guided, and the other that would assert that the observer is incorrect in claiming that a "gap" exists. The latter explanation, to review, asserts that the "gap" exists only in the mind of the observer, who invents it as a construct in order to account for his/her inability, not being a participant in the actual practice,[37] to grasp its scientific basis that is claimed by the practitioner.

To sum up, we are asserting that this study has made "discoveries" that justify viewing the thesis as a scientific document. The "gap" that has been uncovered is, we assert, a significant finding; a "discovery"; as it exists, we argue, not only for the researcher, but also

for any others who would pursue the same study as he did. In addition, we believe that the "gap" may be of even more widespread significance. It would appear, based upon our reflexive analysis, that a "gap" may exist for any persons who would study a body of theoretical knowledge, and then observe what purports to be the practical application of that knowledge. This raises a question as to the character of any "scientific," "theory-guided" enterprise. The "gap," it would appear, is common to not only psychiatry and sociology, but also all other "theory-guided" disciplines. One could argue, therefore, that we have explicated a "phenomenon" characteristic of scientific work. We believe that this may be the case, but we are not, as we have pointed out, in a position to give a definitive explanation of its "existence." That we are unable to do so is not, however, a failing of the thesis. We claim, rather, that our demonstration of the inadequacies of the two explanations of the "gap" is, in itself, an important finding, or "discovery." We have, we believe, shown that neither the taken-for-granted explanation of the relationship between psychiatric theory and practice, nor its counter view, provide one with an adequate account of the interplay between a body of scientific theoretical knowledge, and the practical work of those who subscribe to that knowledge.[38]

Although we are not able to give *the answer* for the "gap" we shall speculate further, as to its source. A third way to attempt to make sense of the "gap" is to draw upon both of the explanations that have already been discussed. Contrary to those perspectives, one might argue that practitioners, such as psychotherapists, make use of both common sense cultural and scientific, theoretical knowledge to accomplish their

practical work. What they "see" in the social world, and how they deal with that world, might be guided, in other words, by both types of knowledge. This approach might allow one to come to terms with the conflicting evidence presented in the thesis, and the contradictory views of the researchers that have been discussed. One may develop the argument by reconsidering the aforementioned disjuncture between practitioners and observers.

If we assume that one's standpoint in relation to a process (i.e. practitioner or observer) inevitably denies one a complete understanding of the character of the process, then we might have some basis for arguing, although we cannot demonstrate our view, that both types of knowledge come into play. We might speculate that neither the observer's nor the practitioners' accounts of processes to which they were party, are fabricated or incorrect. Rather, their accounts might be seen, with reason, to be incomplete. A lay observer of psychotherapy may never be able to "see" the theoretical basis of this process as he/she is not a trained therapist. His/her conclusion; i.e. that the activity is mundane in character, need not be seen, however, to be an incorrect interpretation. Rather, it might be a partially correct interpretation. So too, a practitioner's claim that his/her work is theory governed might also be seen to be in part correct. If we assume, in other words, that psychotherapy might be governed by both types of knowledge, but that one is unable, due to the determinant effect of one's standpoint, to see that this is the case, then we might have a basis for explaining the conflicting accounts, explanations, interpretations, etc. as to the character of the relationship between psychiatric theory and practice.

We would not have to rule out either explanation; nor the research of others, nor the evidence from the thesis that supports these respective explanations. This third explanation might also provide us with an insight into the character of the "gap" that others encounter, either as readers of the thesis, or as observers of other "theory-guided" enterprises. Furthermore, from its perspective, one need not find it problematic that observers of a process such as psychotherapy, in the face of counter claims by practitioners, cannot identify the theoretical significance of the activity. One would not be forced to conclude that psychotherapy, or other "theory-guided" enterprises, are devoid of theoretical content, that therapists are "imposters," that anyone could practise psychotherapy, or that the researcher has been engaged in a mere personal intellectual discovery.[39] Nor would one be forced to conclude that the opposite perspective; that psychotherapy and other disciplines are in some way strictly guided by scientific knowledge (i.e. "untainted" by common sense cultural knowledge).

We shall seek, as we did in the case of the other explanations, support for the explanation in the work of others. Identifying work that has a perspective similar to that of the third explanation, may enable us to better judge the explanation's adequacy as another possible answer for the questions that have emerged. Melvin Pollner's analysis of disjunctures, cited earlier, appears to be of use in providing some support for the perspective. As the reader may recall, Pollner's work was used to account for both the first and second explanations. Pollner argues that some persons have exceptional methods of viewing the social world; a view which was interpreted as lending support to the theory-

guided explanation. At the same time, however, he argues that no persons beyond children and the insane may be free from mundane reason, which would rule out the view that psychotherapists are able to see the social world in ways that are devoid of mundane reason. We have, then, in Pollner's work, elements of both explanations, which one could interpret as a contradiction. If one adopts the third explanation, however, one is not led to this conclusion. Rather, Pollner's analysis might be seen to account for the view that the consciousness of some persons, such as psychotherapists, may be grounded in both mundane reason and an alternate schema such as psychiatric theoretical knowledge. Although the standpoint of such persons (i.e. that of psychotherapists), might lead them to argue that they view the social world strictly from the perspective of their scientific schema, we may have, in the work of Pollner, a basis for arguing that one's perception of the social world might be guided simultaneously by both mundane reason and an alternate schema such as a body of scientific knowledge.[40]

Another researcher, Henry C. Elliot, in his paper, "Similarities and Differences between Science and Common Sense,"[41] addresses the issue that concerns us more directly than does Pollner. Elliot studied the work of scientists in a laboratory, with the aim of gaining an understanding of ". . . how common sense may be critically involved in the actual doing of science."[42] Elliot concludes that ". . . common-sense modes of perception and operation are an *integral* and *essential feature of* recognized scientific practice."[43] His conclusion is of some interest to us, as it verifies the findings of other researchers that were cited in making the argument of the second explanation. Of even more

interest to us, however, is another of his conclusions. In the last paragraph of his paper, Elliot notes the following: "I have, of course, no intention of claiming that science *merely* comprises doing common-sense activities in laboratories, etc."[44]

His latter conclusion appears to rule out the second explanation, while his former conclusion appears to rule out the first. Thus, we may conclude that Elliot believes that scientists accomplish their practical work by drawing upon both mundane reason and their scientific knowledge. Both schemata come into play in the carrying out of scientific work. Elliot, it appears, is making such an argument (i.e. one that would lend support to the third explanation). He notes, for example, that a scientist *must* rely upon his/her common sense cultural knowledge in order to make sense of, and respond to, the subject matter of his work; yet at the same time he argues that what the scientist ". . . 'makes of' what he sees is usually far from common sense."[45] He goes on to add, referring to a scientist's observation of colour changes in gas chromotography, that:

> . . . the scientist observes coloured patches, and his colours are everybody's colours, only he makes something special out of the manner of their appearance.[46]

One could argue that it is the ability to "make something special" out of what to others (i.e. lay persons) appears to be mundane material, that characterizes a scientist, such as the one described by Elliot, a psychotherapist, such as those described in the thesis, or, for that matter, a sociologist, such as the author of this document. According to the argument of the third explanation, a scientist is one who has this ability, and yet at the same time, is one who is incapable of

transcending a reliance upon common sense cultural knowledge. We may have in Elliot's study further support for such a perspective. We do not have, however, an explanation of the dynamics of how persons such as physical scientists, psychotherapists, etc. manage as mundane reasoners to actually "see" the things that they "see." In other words, we are still confronted with the question of "appearances versus reality," that we discussed earlier. We are still unable to explicate the means by which psychotherapists and other scientists are able, according to their accounts, to "see" things that others, despite their knowledge of psychiatric theory, or other bodies of relevant theoretical knowledge, are unable to "see." We have not, in other words, come to terms with the "gap."

Susan Sontag, in an essay entitled "Against Interpretation,"[47] discusses the interpretation of art by critics. In her view, critics in the search for what she terms the "content" of art, "violate art,"[48] as they read into it meanings that they themselves impose upon it. Sontag argues that the appearances of art are its essence, and that attempts to discover its content (reality) are faulted. She asserts that the critic's:

> . . . task is not to find the maximum amount of content in a work of art, much less to squeeze more content out of the work than is already there. Our task is to cut back content so that we can see the thing at all.[49]

Although her comments deal mainly with art, and though it *is* a primary task of the scientist to interpret his/her subject matter, her analysis may be of some value in helping us to analyze the "gap."[50] If we assume that the "gap" represents as intangible an "entity" or "phenomenon," as

does art, then we might, drawing upon her analysis, be able to make further sense of it.

Whether we "see" a "gap" or not is dependent, we have argued, upon one's standpoint; i.e. as observer or practitioner. To the observer, the "gap" is the reality (content) of the interaction that he/she observes, yet to the practitioner the "gap" is merely an appearance. He/she is able, using his/her scientific knowledge, to "make something special" out of the appearances of the interaction. The scientist-practitioner, in other words, may be able to find meaning in his/her subject matter, in the same way that critics are able to find meaning in a work of art. Sontag herself makes the comparison, noting that Marx and Freud claimed to find the "true meaning" of human behaviour. She points out, for example, a claim of Freud's that we have already cited; his assertion that there is a "latent content" behind slips of the tongue.[51]

We wish to be able to show how scientists are able to "see" such things. It would appear, however, that our task is not feasible. Explaining the "gap," or, in other words, explaining how scientists find theoretical meanings in what appears to be mundane material, may be as problematic as attempting to explain or find the meaning of a work of art, as the "content" of psychiatric practice or the practical work of other disciplines may be as much of an intangible as the "content" of art. One could proceed by simply adopting one of the three explanations that were discussed above, which would, in effect, exclude the validity of the others. Such an approach would, however, put one in a position comparable to that of a critic who "squeezes out content" and thereby

"violates art." One is inclined to take this route, as interpretation is the task of the scientist, and one is not at ease with an inability to arrive at a definitive answer for one's findings. To do so, however, would violate or reify the complex nature of the process that we seek to explain. Such oversimplified interpretations are not, we have shown, adequate. Thus, we are faced with the task of explicating the "true meaning" of how scientists go about finding the "true meaning" of their subject matter. Viewed reflexively, the author of the thesis occupies two different standpoints in relation to the process of finding "true meaning"; that of observer and that of participant. Drawing upon both a reflexive perspective and the third explanation, one could argue hypothetically that one is able to explain why the author is unable to "see" the scientific basis of the therapists' work, yet able, he claims, to produce scientific work himself. However, we do not, in fact, have the ability to account for this apparent contradiction as we are unable to explain the character itself, of the process of finding "true meaning."

Thus, we are faced with an unanswered question. Coming to terms with the nature of the relationship between psychiatric theory and practice, or any body of theoretical knowledge and related practice, is a problem which we have not been able to resolve. Although we might assert that the practical work of psychotherapists or other scientists is guided both by their knowledge of the scientific theories to which they subscribe and their common sense cultural knowledge, we are unable to specify how this process actually takes place. We are unable to demonstrate how these respective bodies of knowledge may enable the

practitioner, whether he/she be a psychotherapist, a sociologist, anthropologist, etc., to accomplish his/her practical work. We may argue that both types of knowledge play a part in the process of finding "true meaning," but the parts which may be played by each remain indeterminate.

The third explanation is, we argue, inadequate. Its attempt to combine insights from the first two explanations does not come to terms with the "discovery" which we seek to explain. It offers further speculative insights, but the "gap" remains unresolved. One may question why we are unable to account for the "gap." If it is as basic to "theory-guided" disciplines as we claim, why is it not possible to arrive at a definitive explanation of its "existence"? We may respond to such a viewpoint by returning to the questions with respect to the character of theory-guided activity, that we raised early in the chapter. At that point, we noted that the reader might claim that we had failed to define what a theory-governed enterprise was. We had a vague, but not a delineated standard to work with, which may have led one to question why such a standard had not been developed.

We wish to argue that a well defined standard was not developed because we did not then, nor do we now, have the means to develop one. If we did have such a standard, then we could specify examples of theory-guided activity. Lacking a standard, we are unable to explain why the researcher could not see the guiding role of theory (i.e. the "gap"), as we have no definitive criteria of theory-guided activity against which we may evaluate his observations. In other words, in order to explain the "gap" one must first of all be able to explain

what theory guided means. Hence, the failure of the three explanations to account for the "gap," in that we have no clear notion of what it means for a practice to be governed by theory.

We could argue, therefore, that the research had a misguided beginning as the researcher employed an unexplicated concept. That is not to say, however, that we might now be in a position to explain what theory guided means, or that others do have such explanations. Despite its claims that it is a theory-guided discipline, psychiatry, for example, offers no evidence of how psychotherapy is actually theory guided. We have no indication of how the guiding process, in fact, works. Nor are such explanations or accounts to be found in the philosophy of science, the social sciences, or other scientific disciplines.

We are left with unanswered questions, as we are unable to specify what theory governed means. That does not imply, however, that we have no sense of its meaning. We did, as discussed above, utilize a vague standard in the course of our fieldwork, and we are able to set out examples that illustrate the general meaning of the concept. Consider, for example, a patient in psychotherapy who begins to frequently miss appointments with his/her therapist. Such behaviour may be viewed by the therapist's office receptionist, as inconsiderate, or a nuisance. To the therapist, however, such behaviour may suggest the onset of a new phase in the patient's illness, which may raise in his/her mind the need to adopt a different approach to the patient's problems. The therapist's ability to interpret the psychological implications of the patient's behaviour, and to adopt a therapeutic strategy in relation to it, is derived, one could argue, from the therapist's knowledge of

psychiatric theory. Such practices might be termed theory-guided. Consider another example; this time from internal medicine. A patient who presents himself/herself to the office receptionist of an internist may appear to the receptionist to be ill. The patient's appearance may mean much more than a sign of illness, however, to the internist who examines the patient. To the internist, the patient's appearance may suggest the presence of a chronic ailment which the internist knows he/she is unable to treat. One could argue that the internist's ability to recognize a disease and to make a decision with respect to treating it, derives from his/her knowledge of the theories of physical medicine. We could argue that this represents another example of theory-guided practice. Thus, we are not unable to outline in a general way what theory guided might mean. We cannot, however, become more specific.

One may insist that the lack of clearly defined criteria forces one to question the existence of any theory-governed disciplines. One could argue, for example, that psychiatric practice, and the practices of other disciplines are conducted only in terms of the practitioners' common sense cultural and/or their empirical knowledge. Although we cannot prove that scientific disciplines are theory governed, as we have no clearly defined standard to work with, we may respond to a query re the existence of any theory-guided disciplines, by pointing out the following.

Neither psychiatry, nor other disciplines provide us with an account of what theory guided means. Psychiatry and other scientific disciplines do, however, make claims in their literature that they are theory governed. Furthermore, psychotherapists and other scientists are

able to provide theoretically based accounts of their practical work. To deny the validity of these claims and accounts, and to adopt the stance that there are no theory-governed disciplines forces one, it would appear, to conclude that "scientific" practices are a fraud, as they do not differ fundamentally from lay practices, and that "scientists" are either imposters, or are badly misguided about the character of their practical work.

Other sorts of questions also remain in need of clarification. One may query, for example, the boundaries of scientific theory-guided activity, or ask if some disciplines are more theory governed that others. Lacking a defined standard, we, again, cannot specify such things, but we are able to offer the following comments. With respect to the boundaries, one might argue that any "accredited science"[52] that claims to be theory governed, should be recognized as such. Unless we choose to deny that sciences can be theory governed, we appear to have no other choice than to accept their claims, as we have no standard which we could use to differentiate between them.

The same problem would exist, if we attempted to classify scientific disciplines according to how theory governed they are. We have no means by which we could engage in such a pursuit. Lacking a standard, we are unable to decide if nuclear physics or biochemistry is more theory guided than psychotherapy. Such disciplines may seem to be more theory guided, as it may appear to the lay observer of experimental work in a laborabory, that one could not possibly conduct an experiment in a physics or chemistry laboratory without a knowledge of the theories of the respective disciplines. It may appear, in other words, that

theoretical knowledge is required in order to know what procedures such as the connection of hoses to flasks, etc., must be carried out.

The lay observer of psychotherapy, on the other hand, might not arrive at such a conclusion. Hearing nothing but "mundane talk," the observer might conclude that the psychotherapist's work is not theory guided as the psychotherapist simply seems to converse with the patients in ways that the observer might conclude he/she could duplicate. The observer might, in other words, conclude that he/she could produce talk that others would take to be the talk of a therapist, as the production of therapeutic talk, unlike the carrying out of experiments in physics or chemistry, is not, or is less (he/she may claim) theory guided.

We assert that one is not in a position to draw such conclusions. The absence of a standard denies one the possibility of making such judgements. Psychotherapy may appear to be less theory guided, or not theory guided, but this impression might be attributed to the medium which the therapist works with, language, which he/she shares, as a member of a culture, in common with the patient and the observer. What the observer may fail to "see," is that the therapist uses language in special sorts of ways which are derived from a knowledge of psychiatric theory. Thus, the therapist's talk may appear mundane, but this does not rule out, what Turner (cited above) terms, "principled grounds" for its production.

We do not claim to have answers for the questions which we have raised. It would appear that what is required is a theory which explains the "intangible": how theory-guided work, such as psychotherapy, actually gets done. Such a theory would need to clearly specify how

scientific theories influence the practitioner's understanding of and response to his/her subject matter. It might, as we have shown, contradict both the observers' and the practitioners' views as to the nature of the practitioners' work. Furthermore, seen reflexively, it might be able to explain the process of its own development. We do not propose to develop such a theory. Our study has explicated the nature of the problem; i.e. the "gap." Although we have offered some insights, we do not pretend to have, nor do others have a solution to these concerns. This is, rather, an area for further reflection.

Footnotes

[1]See, for example, another sociological ethnographer's discussion of these concerns: Gary Parkinson, "The Adult Ideology as Practical Reasoning: A Study of Child Psychotherapy," Ph.D. dissertation, University of British Columbia, 1975.

[2]The assumption was based on the premise that the knowledge of a body of theory would allow one to view behaviour in the same way as a practitioner who subscribes to that same body of theory, and thus, would allow one to also identify instances of the application of the theory. In addition, the assumption rests on the principle that the researcher did not engage in a peculiar reading of the literature which might then deny the possibility of these aims. A reader might, at this point, raise a number of objections. One may argue, for example, that we have not defined what a theory-governed enterprise is. We have not shown what theory guided means. We have not specified, in other words, what form instances of the application of theory would take. We agree that we have not set out detailed analyses that come to terms with these concerns. These are not, however, concerns that have been disregarded in the thesis. The researcher did have a conceptual standard of what constituted a theory-guided enterprise, which he employed through the course of his research. Numerous references are made throughout the thesis to his expectations with regard to the form that theory-guided psychotherapy with "paranoids" would take, and to his attempts to match his observations with his expectations. Thus, this question has not been ignored. See, for example, the researcher's outline stated in chapter one, of the sorts of working guidelines which he believed were provided to psychotherapists by psychiatric theory, or see in chapter five, the researcher's attempt to measure his observations of therapists' remarks against his notion of the form, content, and timing of theory-guided remarks. The researcher did have a standard with which he worked. One may assert, however, that one is still faced with unanswered questions with respect to the nature of theory-guided activity. Why, for example, did the researcher not develop a more clearly defined standard? We shall deal with these concerns in the latter part of the chapter.

[3]Hans H. Strupp, "Psychotherapy Research and Practice: An Overview," in *Handbook of Psychotherapy and Behavior Change: An Empirical Analysis*, eds. Sol L. Garfield and Allen E. Bergin (New York: John Wiley and Sons, 1978).

[4]Sigmund Freud, *A General Introduction to Psychoanalysis* (New York: Washington Square Press, 1966).

[5]Ibid., p. 26.

[6]Ibid., p. 25.

[7]Melvin Pollner, "Mundane Reasoning," *Philosophy of the Social Sciences*, 4 (1974), 35-54.

[8]Ibid., p. 35.

[9]Ibid., p. 36.

[10]Ibid., p. 54.

[11]Ibid., p. 48.

[12]Pollner's analysis of disjunctures provides us with a means to make sense of the "theory-guided" explanation of the "gap." It is not our intent, however, to attribute such a perspective to him. As we shall see when we consider other explanations for the "gap," neither the researcher nor Pollner would choose to argue that psychotherapists' ways of seeing the social world are devoid of common sense cultural knowledge.

[13]A therapist, of course, might not agree. That certain points "stand out" to me, as a researcher, might simply be a function, from the therapist's point of view, of my status as a lay person. Be that as it may, we shall still attempt to distinguish, for purposes of evaluating the second explanation, those points that appear to comprise the most important elements of the data.

[14]While in the field, the researcher was confronted with the same problem, which took the following form. He could not come to terms with therapists' accounts, as they did not match his observations. The therapists made theoretical sense of material that the researcher saw to be unquestionably mundane in character.

[15]If, as the second explanation would have it, psychotherapists necessarily rely upon common sense cultural knowledge to accomplish their practical work, then one might argue that we are dealing with an a priori truth rather than a finding of the research. If the practice was, ultimately, knowable or, in fact, known previous to the research, one might question why the researcher chose to treat it as worthy of analysis. One may respond to such an argument this way. Despite the fact that the practice may have been knowable, psychotherapists, social scientists, and lay persons alike do not appear, as we have shown, to be aware of it (i.e. they commonly hold the view that psychotherapy is a theory-governed activity). Furthermore, even if the practice is an a priori truth that was, ultimately, knowable to all, this does not negate the worth of our study of it. One that would deny the value of explicating such a practice fails, it would appear, to take into account what ethnomethodologists argue should be the central concern of sociology. See, for

example, the work of Zimmerman and Pollner who argue that it should be the task of sociology to study the everyday world. They note that: "In contrast to the perennial argument that sociology belabors the obvious, we propose that sociology has yet to treat the obvious as a phenomenon. We argue that the world of everyday life, while furnishing sociology with its favored topics of inquiry, is seldom a topic in its own right. Instead, the familiar, common-sense world, shared by the sociologist and his subjects alike, is employed as an unexplicated resource for contemporary sociological investigations." Don H. Zimmerman and Melvin Pollner, "The Everyday World as a Phenomenon," in *Understanding Everyday Life*, ed. Jack D. Douglas (London: Routledge and Kegan Paul, 1971), p. 80.

[16]Jeff Coulter, *Approaches to Insanity*, pp. 149-150.

[17]It is important to point out that the reader has only the data (such as transcripts and the researcher's observations) that have been included in the thesis, upon which to draw his/her conclusions as to the character of the therapists' and the patients' remarks. The researcher obviously was party to much more material. We wish to assert, however, that the methodology of the thesis, as discussed in earlier chapters, allows for an objective although admittedly limited view of the interaction that the researcher himself observed. Thus we are arguing that it is possible for the reader to be confronted by the same puzzles that confronted the researcher in the field, and any conclusions that the reader may draw, upon reviewing the data, are not in themselves suspect by virtue of the reader not having been an observer of the interaction from which the data were generated.

[18]It may be helpful to clarify the term theoretical knowledge that we have been utilizing, as it may facilitate a better understanding of our analysis of the relationship between psychiatric theoretical knowledge and psychotherapy. One might, for example, contend that the distinction between non-theoretical (common sense cultural) and theoretical knowledge that we draw may, in fact, be a distinction between common sense cultural and empirical (clinical) knowledge. We argue, however, that this is not the case. We have used the term to mean the same thing that we assert is meant by its use within clinical psychology and psychiatry. One may gain this meaning from these disciplines' self-descriptions. Psychotherapists, for example, appear to view themselves to be working with theoretical as opposed to practical, empirical, strictly clinical, or in other words, non-theoretical knowledge. An examination of the disciplines' theoretical law-like claims also leads one to conclude that the disciplines view themselves to be based upon theoretical, rather than empirical, knowledge. Thus, we have employed the meaning derived from what appears to be their views of themselves. In addition to those found in the fieldwork data of the thesis, other examples of the disciplines' self-descriptions may be found in the work of Strupp cited in chapter one, and in the work of Freud discussed

briefly above. For further evidence, see Freud's discussion of the distinction between psychoanalytic theory and non-theoretical knowledge in his analysis of parapraxes; Sigmund Freud, *Introductory Lectures on Psychoanalysis* (Harmondsworth: Pelican Books, 1979).

[19]Roy Turner, "Utterance Positioning as an Interactional Resource."

[20]Ibid., p. 236.

[21]Ibid., p. 236.

[22]Melvin Pollner, "Mundane Reasoning," p. 40.

[23]Jeff Coulter, *Approaches to Insanity*, p. 147.

[24]Harold Garfinkel, "The Rational Properties of Scientific and Common Sense Activities," in *Studies in Ethnomethodology* (Englewood Cliffs, N.J.: Prentice-Hall, 1967).

[25]Ibid., p. 277.

[26]Ibid., p. 283.

[27]Ibid., p. 271.

[28]The term "retrospective" is employed within the second explanation in order to stress that psychotherapists do not make practical use of psychiatric theory prior to or simultaneous to their encounters with the social world. Therapists do not, for example, utilize psychiatric theory in order to plan a conversational strategy for a therapy session, or to make immediate sense of, or respond to a patient's remarks during a therapy session. They draw upon psychiatric theory after-the-fact whether it be immediately after or at some later time, so that they may make psychiatric sense of their experiences for their own purposes, or for purposes of rendering an intra-professional account. Thus, one who accepts the second explanation would assert that psychiatric theory does not play the determinant guiding role attributed to it in the first explanation.

[29]Roy Turner, "Utterance Positioning as an Interactional Resource," p. 236.

[30]Gary Parkinson, "The Adult Ideology as Practical Reasoning," p. 189.

[31]See, for example, in chapter four, the researcher's analysis of his interaction with the Israeli "paranoid," while left alone with this patient.

[32]We do not wish to imply that these authors were misquoted, or that the segments which were cited were taken out of context. Rather, it is our contention that, while these authors assert that common sense cultural knowledge is an element basic to psychotherapy, their views do not, unlike the second explanation, rule out the possible influence of psychiatric theory upon psychiatric practice.

[33]One could argue, furthermore, that one has no clearly defined standard by which one could identify the guiding role of theory, in the first place. This brings us back to a point that was raised early in the chapter. It will be discussed below.

[34]Michael Foucault, *Madness and Civilization* (New York: The New American Library, 1967).

[35]One may refer again to the work of Foucault for specific historical examples.

[36]Gary Parkinson, "The Adult Ideology as Practical Reasoning," p. 193. Parkinson cites the following studies as other examples of research of this type: D. Lawrence Wieder, "The Convict Code: A Study of a Moral Order as a Persuasive Activity," Ph.D. dissertation, University of California, Los Angeles, 1969; Ken Stoddart, "Encountering Fieldwork: Perspectives on the Sociological Ethnography," Ph.D. dissertation, University of California, Santa Barbara, 1975; and Bruce Katz, "The Production of an Ethnography," Ph.D. dissertation, University of British Columbia, 1975.

[37]In the case of readers who are social scientists, and have therefore engaged in research themselves, one might speculate that the source of the "gap" may lie in the readers' inability to ever identify the scientific bases of practical activities to which they are not party. They may never be able to "see" such activities in the same way as did the practitioner, whose account of them they read. Such disjunctures may, in other words, be inevitable, but in many cases the reader may not become aware of them. Most research documents, being formulated in terms of traditional research methodologies, typically do not report all the practical activities that comprise the research process. The reader does not, therefore, encounter puzzling or unfamiliar descriptions which might lead him/her to conclude that there is a "gap." Ethnographies, however, report far more of the activities that transpire in the course of carrying out research. Unlike other methodologies, which tend to produce data that appear "more scientifically based," but which in fact give the reader an edited, circumscribed view

of the social world and the researcher's study of it, ethnographies give the reader a full, and hence puzzling account of what took place. Thus, one may argue that the reader, not being party to the research process, would, given the opportunity, inevitably locate a "gap" in the account of any study that he/she reviewed. In most cases, however, the methodologies of studies do not give the reader the opportunity to arrive at such judgements. For a further discussion of the methodology of ethnographies, see the analysis earlier in the thesis.

[38]One might still be inclined to ask, in the face of our claims, what is the "payoff"? What difference does it make? We assert that the discovery and explication of the "gap" constitutes a significant sociological finding in the tradition of sociological research cited by Parkinson above. We have, to reiterate, made a further contribution to the understanding of the relationship between theory and practice. Some readers may not agree. The source of their disagreement may lie in their failure to treat the everyday world as a topic worthy of sociological research. See our earlier discussion of this point, and our reference to the work of Zimmerman and Pollner.

[39]We refer here to the reader's inability to "see" the scientific basis of the researcher's work. Just as the third explanation may allow us to avoid viewing therapists as mere mundane reasoners, so too it may enable us, by means of a reflexive analysis, to view the researcher's work in a different light.

[40]The issue, then, would not be: which of the two explanations is correct? Rather, the issue would be (given the considerable evidence that supports each of the respective explanations): is it possible that persons such as psychotherapists, anthropologists, sociologists, or other scientists view their subject matter in terms of both mundane reason, and, at the same time, the scientific body of knowledge to which they subscribe?

[41]Henry C. Elliot, "Similarities and Differences between Science and Common Sense," in *Ethnomethodology*, ed. Roy Turner (Harmondsworth: Penguin Books, 1974).

[42]Ibid., p. 21.

[43]Ibid., p. 25.

[44]Ibid., p. 26.

[45]Ibid., p. 24.

[46]Ibid., p. 24.

[47]Susan Sontag, "Against Interpretation," in *Against Interpretation* (New York: Dell Publishing Co., 1964).

[48]Ibid., p. 10.

[49]Ibid., p. 14.

[50]It is important to note that we do not wish to engage in a discussion of the interpretation of art, or an analysis of the relationship between art and science. We are drawing upon Sontag strictly in an attempt to gain further insight into the process of interpretation.

[51]Susan Sontag, "Against Interpretation," p. 7.

[52]I am using this term the same way as it is used by Elliot. He defines it (drawing upon Kuhn) to mean ". . . science as accepted by the scientific community at any given time" (Henry C. Elliot, "Similarities and Differences between Science and Common Sense," p. 23).

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