THE ADULT IDEOLOGY AS PRACTICAL REASONING:  
A STUDY OF CHILD PSYCHOTHERAPY

by
GARY CHARLES PARKINSON
B.A., University of Saskatchewan, 1961
M.A., University of Saskatchewan, 1970

A THESIS SUBMITTED IN PARTIAL FULFILMENT OF 
THE REQUIREMENTS FOR THE DEGREE OF 
DOCTOR OF PHILOSOPHY 

In the Department 
of 
Anthropology and Sociology 

We accept this thesis as conforming to the 
required standard 

THE UNIVERSITY OF BRITISH COLUMBIA 
May, 1975
In presenting this thesis in partial fulfilment of the requirements for an advanced degree at the University of British Columbia, I agree that the Library shall make it freely available for reference and study. I further agree that permission for extensive copying of this thesis for scholarly purposes may be granted by the Head of my Department or by his representatives. It is understood that copying or publication of this thesis for financial gain shall not be allowed without my written permission.

Department of **ANTHROPOLOGY & SOCIOLOGY**

The University of British Columbia
Vancouver 8, Canada

Date **May 23/75**
ABSTRACT

The 'topic' for this thesis was formulated after many months of doing field work—in a clinic offering play therapy to disturbed children. I was struck by the fact that the organization of activities, the therapy talk, and the therapist's explanations appeared from the beginning to be common-sensical, transparent, reasonable. I take this reasonableness as the 'topic' and ask how it was possible for me, on the basis of talk heard in the setting, to discover and describe the rationality of the setting—see events, etc., as instances-of-a-pattern-of-behavior, and concomitantly how therapists were able to make their work appear rational. The data consists of my experience in the setting and more specifically of the talk located in that setting. This formulation clearly locates this thesis in an emerging body of literature which treats the researchers achievement of making sense as the subject of inquiry.

It is a study of practical reasoning, by which I mean to emphasize that psychotherapy accounts were tied to the everyday practises of therapists in ways that are not captured by idealizations of theoretical accounts, etc. An overlooked feature of those accounts are background expectancies, i.e., those taken-for-granted views of the world that enable us to see the adequacy of accounts, reasonableness of explanations, etc. It is proposed that it is our taken-for-granted views of 'children' as social actors which accomplishes this in the field setting. This is referred to as an adult ideology of childhood and this notion is explicated in relation to the therapy activity. Considerable detail is given on the use of one feature of the ideology, the relevance of families in relation to children.
The adult ideology is offered as an interpretive schema which allows adult actors to continuously make sense of, manage, organize for, talk to children. It is claimed that this is an omni-present schema in the setting, that, in fact, it supports what is referred to as the psychiatric interpretive schema. It is demonstrated that it is not simply used to explain patient behavior but it is a device for managing relationships (showing competence), handling conversations (saying what has to be said), explaining relapses and therapy decisions, and so on.

It is then proposed that the adult ideology be seen as a solution to my practical task—it enabled me to make sense of the actions, accounts, explanations of the therapists. Presumably the psychiatric interpretive schema allows therapists to make sense of patients. The two schemas are not substitutes for one another then but are responsive to different tasks in the setting. We are looking at occasioned accounts--treating children, and understanding therapists. The claim for the explanatory power of the adult ideology in the setting is then withdrawn. It is still claimed however that the adult ideology is a feature of our social world and the explication offered here should be seen as a substantive 'discovery'. 
5  REASONABLENESS AND THE ADULT IDEOLOGY .......................... 141
   My Discovery of the Ideology ........................................ 154
   Features of the Ideology ........................................... 156
   The Ideology as a Source of Explanations of Patient Behavior ........................................ 163
   Consequentiality of the Ideology .................................. 166
   Footnotes ...................................................................... 172

6  THE STATUS OF THE IDEOLOGY ........................................... 176
   Footnotes ...................................................................... 192

7  CONCLUSION ................................................................. 193
   Footnotes ...................................................................... 199

BIBLIOGRAPHY .................................................................... 200
ACKNOWLEDGEMENT

I would like to thank Matthew Speier who initiated my interest in 'children' as a topic of inquiry and influenced the direction of my intellectual development. A special thanks to Roy Turner for keeping me going and leading me to an understanding of analysis without which this document would not have been possible.

I would also like to acknowledge the financial assistance of the Canada Council which made my graduate studies and therefore this research possible.
These remarks are to be taken as "instructions" on how to read the following document. This thesis has the structure of a developing argument and consequently positions are taken at points only to be abandoned later. This development coincides in a direct way with my development as an observer of the scenes depicted in the early chapters. At one level then, the document is an autobiographical description of changes in the observer over the course of many months in which I attempted to make something of therapy activity for the practical purpose of producing this dissertation.

While the substantive interest pursued is the play therapy events which occur in a community work setting it is to be seen as an examination of practical reasoning. The focus is on member's accounting procedures which accomplish the essential task of making activities, events, conversations, etc., appear reasonable, logical, appropriate, etc. It is then a study of accounts and their location in the field-work setting. While consideration is initially given to the accounts of therapists, the report is reflexive in that its preparation and reading are also seen as worthy of examination.
CHAPTER 1

INTRODUCTION: THE SEARCH FOR A PROBLEM

Child Therapy as a Puzzle

Early in my graduate student career I became interested in children's talk, particularly in the way in which adults talk to children. My interest in this subject prompted me to contact the director of an outpatient service for disturbed children and their families. Prior to resuming my graduate studies, I had worked as a researcher in the mental health field and had had some involvement with child psychotherapists. However, my choice of a field setting was determined primarily by the need for a place where I would be able to observe frequent encounters between adults and children.

Initially, I had hoped to be able to discover and describe some of the procedures that adults use when talking to children. The fact that this talk was to take place during "therapeutic" encounter was not considered important. That is to say, I felt that the procedures that I was looking for would occur regardless of the function of the contact.

I also suspected that a setting which included professional psychiatrists, social workers and psychologists working with disturbed children would present obvious problems for a 'layman'. I was naturally apprehensive about how I would explain my sociological interest in therapy and, more importantly, how I would be able to make sense of the procedures and 'professional talk' which I expected to encounter. It seemed appropriate to expect a specialized setting to include knowledge, vocabulary and
skills which the 'layman' would be unfamiliar with. Therefore, and in order to prepare myself for my first meeting with the director, I attempted to learn something about psychotherapy with children. I returned to an investigation of this literature over the following weeks and months as I became acquainted with the clinic and its activities.

These first explorations of the how-to-do psychotherapy manuals did little to relieve my anxiety as I repeatedly found the warning that psychotherapy with children is an especially difficult and frustrating undertaking, something which even a fully trained professional should approach with care. For example:

Even a highly trained clinician with many years of experience in adult therapy is professionally unqualified to engage in child therapy unless he has had supervised preparation for work with children.2

And:

Psychotherapy with children is, in many respects even more difficult than therapy with adults, and requires extensive study and considerable supervision to master.3

Or:

Students often find that work with children raises issues and technical problems which never occurred in their contacts with adults.4

And interestingly:

You may have to have been a child within your own conscious memory to be able to talk comfortably with a child.5

Thus, while I believed that there were certain things to be discovered in therapeutic encounters—as in any other adult-child contact—it was with some unease that I embarked on my first visit to the children's clinic. For one thing, I feared that I might well have to be a 'therapist' in order to make proper sense of the events which I wanted to study.

Before talking about my induction to the therapy setting, I would
like to relate some of the advice that I discovered in the literature, and discuss some of the difficulties that I had in locating that literature.

Since I knew little about the setting, I felt that I should undertake an examination of the literature in order to improve my forthcoming presentation. This examination proved interesting. I began with the common-sense notion that I would find the material I wanted indexed under "psychotherapy - children". My search did not prove fruitful until I discovered that most of the information that I wanted was to be found under "children - psychotherapy". If one looks under psychotherapy, he will find that it is essentially an index of materials relevant to adults. Similarly, if one looks at textbooks of psychiatry, he will typically find only passing references to the special problems associated with child psychiatry. The literature reflects a set which is made up of psychotherapy and child psychotherapy, psychiatry and child psychiatry. Contrast this with a set of psychotherapy-adult, child; or adult psychotherapy and child psychotherapy. In retrospect this 'discovery' appeared to reflect the way other aspects of our world are organized, i.e., there is the world and there are children.

My first examination of the literature also revealed a number of distinct perspectives—psychoanalytic descriptions of psychotherapy, behavioristic descriptions of problems, theory and advice for doing play therapy, general advice on how to talk to and interview children, etc. After my first visit, I received some instructions on how to process these different perspectives. I learned that the clinic participated in a special form of therapy called "play therapy". In subsequent weeks I learned that this was also referred to as "relationship" or "non-directive" therapy, and that some of the respected authors in this field included
V. Axline, E. Erikson, R. Moustakas, and H. Ginott. These instructions were not given strictly as "instructions", but references to these authors and others occurred in the construction of explanations, descriptions, etc. I felt safe in assuming that there was some relation between reference to these authors, "theories", and the organization of the literature.

It is a common occurrence that an author writing about psychotherapy with children sets up the process as problematic because of the fact that the patient is a 'child', (i.e., is not an adult), and goes on to list some of the special problems which he sees and, by implication or specification, to offer solutions for them.

The psychotherapist may suggest that:

A primary difference between adults and children must be recognized. This is that a child requires much wooing and giving. The examiner must use many words expressing reassurance, interest, and praise. For example, he might say, "What a tall building you have made"; "You got that right on the target".

It seems reasonable to praise, humor and encourage the child, and to try to make his activities appear to be successful. I was to see this frequently in the form of praising the child's appearance and his play activities, assisting him with activities to insure success, or, perhaps, not keeping score in dart games, etc.

In a similar manner, another author suggests that:

Interviewing young children usually requires a good deal of verbal activity on the part of the therapist. Adults, after a brief introduction to an initial interview, will commonly talk for long periods, twenty to thirty minutes not being unusual; children may say only a sentence or two spontaneously.

I observed this in different strategies designed to get the child to talk; common among these was something like, "can we make up a story about the general", or "what's going to happen next?"
In terms of therapy techniques we are informed that:

... play activity is the child's native tongue—his natural way of showing how he feels about himself and the significant persons in his life. The therapist must be able not only to comprehend play language but also to communicate his understanding clearly to the child.\(^{13}\)

I am certain that the reader is not surprised to find that play is a form of therapy or that it is used and recognized as a specific therapeutic technique. As parents and adults we know that a special relation exists between the child and his play. While the literature suggests that some parents are upset because they feel that their children are coming to the clinic "just to play",\(^{14}\) they can reportedly be satisfied with an account which shows how the child either uses play to work out problems from his past by repetition, or by constructing a microcosm of his world anticipates his worries. While I did not witness a parent making this particular 'complaint', therapists told me that it did in fact happen. One therapist was even instructing a parent in how to make psychiatric sense of his child's play—while the parent observed his child from behind a one-way mirror.

In a similar fashion, sociologists since the work of G. H. Mead have taken into account the function of play in the emergence of the child's 'self'.\(^{15}\) This is still a strong tradition in the social sciences as witnessed by the recent writings of people like N. Denzin\(^{16}\) and B. Sutton-Smith.\(^{17}\) The play of children is seen as such a strong and constitutive feature of childhood that it is a resource which can be examined by practitioners of therapy, social scientists, etc.

In terms of understanding the patient we are cautioned,

The child may not always seem rational in his communication from an adult point of view and yet, from the child's frame of reference, he is communicating something of real down-to-earth feelings. A
therapist who is too literal-minded and who cannot tolerate a child's flight into fantasy without ordering it into adult meaningfulness might well be lost at times.\textsuperscript{18}

and:

The world which the child constructs between the ages of four and eight is dynamic, menacing, animistic and governed by irrational causality. Inanimate things are not only alive and full of consciousness, but they are also motivated and able to punish. It is a world in which moral laws are exacting and severe.\textsuperscript{19}

Or:

Well-established mature adults who have put childish things once and for all behind them find the child's soliloquizing uncomfortable from other points of view. Not only is the content often bizarre, but the thoughts are frequently jumbled together and juxtaposed, and non-sequitur is a normal part of speech. This quality of syncretism can be extremely disturbing and lead to a great deal of confused understanding on the part of the adult.\textsuperscript{20}

These pieces of advice appeared reasonable to me, as I am sure they do to the reader, and it became apparent that this reasonableness had something to do with our subscription to a model describing the 'normal child'. Although the instructions above tell us how to deal with disturbed patients, a large part of those instructions are framed in terms of children we all know—the normal child. These accounts sound reasonable to us because, as members of the culture, we all share some knowledge of what children are like.

I shall conclude this review of what how-to-do-psychotherapy manuals said about making sense of the child-as-patient with a couple of points which demonstrate that this advice also included information on how to talk to children. It is not just a matter of knowing how to interpret or understand children for, in addition to this, a large part of the advice tells the reader how to handle and manage them. For example:

Most children should be given several minutes notice that the end of the session is coming.\textsuperscript{21}
And:

Some children like their words sounded back to them without change, like an echo.  

Or:

When the therapist meets the child for the first time, he greets him with a brief hello, dispensing with formal introductions and social amenities. He does not comment about the weather or about how nice it is to get acquainted. He does not describe to a tearful child the wonderful toy room, nor does he ask him if he would like to come to the play-room. The therapist assumes responsibility for leading the child to the room by saying to the mother, "Johnny and I are now going to the playroom". He extends his hand to the child and off they go. ... Some of the gambits used in play therapy are undesirable because they convey hidden accusation and threats to children. The question, "do you know why you are here?" may imply to the child, "You would not be here if there were not something wrong with you". ... The statement, "I wish you would tell me what bothers you" does not make sense to the child. ... The statement, "Don't you have some questions you want to ask me about why you are here?" will most probably bring a brief "no" and an end to the conversation. When children do not know the therapist they have no reason to trust him, either with questions or with answers.

Now that I have given the reader a brief introduction to the 'problems' of child psychotherapy (as formulated by members of the profession), and a sample of some of the advice on how to handle the problems which someone who works with children in a therapeutic environment might have, I would like to give an account of my induction to the setting.

My Induction to the Setting

The clinic is a sprawling array of governmental buildings surrounded by spacious lawns and large wooded areas. From the parking lot a small play area is visible and, upon approaching this, one can make out a sign reading "Children's Clinic". As I was to discover later, the children's clinic is only a small part of the programs conducted at this complex.

Upon entering the clinic one approaches a receptionist who is located so as to control access to the office and the program area of the building. Next to the receptionist's desk is a waiting area which is
equipped with light reading material including, as might be expected, a selection of child-rearing pamphlets. A waiting room obviously equipped for the use of children is situated behind the receptionist's desk, and ahead of this is an institutional corridor with many doors. Over some of these doors were electric signs saying "do not enter" (which, as it turned out, were never used). Other doors were marked "observation room", "kit (refill) supplies", and "toy storage room". It would be a common experience for a visitor to see adults carrying toys from one room to another, pulling a wagon full of toys, pushing a sand tray across the floor, or escorting a child in or out of one of these rooms. One would often see children playing in the corridors with guns and holsters buckled on, riding a tricycle, pushing a doll carriage, crying, running, talking to the receptionist, or patting a dog. I was to become very familiar with this area over the next year. This was the main play therapy area. I will have more to say about it later.

Upon arrival I presented myself to the receptionist who checked to see that my name was in the director's appointment book and then announced me to his secretary. I was directed to a waiting room on the second floor. As I proceeded to the second floor waiting room I gained the impression that the clinic was very quiet. There were many empty offices and my only company in the waiting room consisted of a few toys, back issues of T.V. guide and some children's magazines. At this point I had not seen even one child.

Upon our meeting the director suggested that we tour the facilities. During our tour he talked about the clinic and I talked about my interest in the clinic. It happened that the provincial minister of health was also scheduled to make his first tour of the facilities that day (this
may have accounted for the absence of children) and this became both a point of discussion and a vehicle for talking about the future of the clinic, about governmental attitudes towards it, and so on.

I learned that this service complex was known as the British Columbia Youth Development Center and was a community service for children and adolescents (i.e., those under the age of 17) with psychological, social and learning problems. The core of the program can be traced back to a Child Guidance Clinic which was started in Vancouver in 1932. While retaining some of the structure, the present clinic appeared to be involved in an identity crisis.

The Center offers three large program areas. Each of these enjoys a great deal of autonomy and each has its own director. The programs consist of (a) a residential unit which provides intensive psychological treatment for up to 45 adolescents; (b) a psychological education clinic for children and adolescents who are doing poorly in school because of emotional, behavioral or perceptual problems and need a specialized school setting and/or extensive psychological examination; and (c) a family and children's clinic which operates basically as an out-patient service for children and families. It was the director of the Children's Clinic that I was talking to and it was this service that I was to be involved with over the next year. Henceforth I will use the term "clinic" to refer to only the Family and Children's Clinic.

The clinic provides a wide range of services. Its services include speech therapy, diagnostic and consultation services, a preschool centre, a team which travels to areas of the province without youth services, a community team of social workers operating out of a community health centre, a training setting for treatment staff, an orientation service for
community service personnel, a family therapy program, a treatment program for children, and even a summer camp. It was the apparent decreasing priority given to direct treatment services that stimulated the identity crisis felt by some staff members, and throughout the course of my field work, there was much talk about the possibility that the clinic might be turned into a staff training centre.  

I explained to the director that I was interested in learning about how adults talk to children. Tentatively, I proposed that children could be and are seen as "special conversationalists" and that this may represent an interactional problem for adults/therapists—a problem for which I might discover some solutions if I could examine their talk. This proposal was met with understanding and enthusiasm for the director interpreted my interest as a concern with the features of communication. He saw immediate practical benefit from this inquiry for he hoped that if one could discover the properties of "therapeutic communication", these properties could be taught to parents and to teachers and this might decrease the chances that these adults would undo the benefits which the children derive from therapy. Like the psychotherapy manuals, he appeared to suggest that there are 'good' ways and 'bad' ways to talk to children, and that psychotherapists have, out of necessity, developed a 'good' way of talking to them. He appeared interested in, saw as problematic, and saw me pursuing these features and this prompted me to return to the psychotherapy manuals to determine what therapists see as problems in talking to children and what advice they have to offer. I also intended to find out what the therapists in the clinic saw as their problems, and to look at how they actually talked of their patients. If I could discover the features of their talk that were specifically designed for children, I felt
that I would have something.

The director gave me complete access to the clinic. I was able to become involved with the staff in the direct service program, and I decided to concentrate on those therapy settings that included children who were old enough to be reasonable speakers (and could thus be heard and recorded). I wanted to participate in the therapy in a way that would cause as little disruption as possible. One of the play rooms was equipped with a one-way mirror and with audio-recording equipment and I was given access to this area. It turned out that the amplifier and tape recorder were not functioning properly and the director undertook to have the equipment improved. Little regular use had been made of the old equipment, but others used the observation room more frequently after I arrived.

During my first visit the director helped me to get started on my field work. He introduced me to another staff member who was actively involved in play therapy with children. She was excited about her work and showed great enthusiasm at the prospect of having someone observing her at work, and was anxious to talk about the skills involved in therapy, about children, about problems, etc. She soon became my greatest source of information. The director also invited me to observe a diagnostic session that he had scheduled with a new patient for the following week.

This child was involved in another clinic program and the director had been asked to see him in order to provide advice for other staff members. It happened that the play room which was attached to the observation room was not available the following week so the therapist suggested that I simply sit in the play room itself. He instructed me to sit in a corner, far enough away to be removed from the centre of
activity but not so far that it might appear that I was hiding. This was my first experience with a therapist talking to a patient. I have reproduced some of the first minutes of that session so the reader can share my experience.

1.1

1. T: ( ) a man who works with me sometimes.

2. R: Hi.

3. C: Hi.

4. T: That's Gary, this is Franz. (pause) Would you like to keep your jacket on or would you like to take it off?

5. C: ( on )

6. T: You will leave it on, sure. What I thought we would do if we could spend a little time together and we would play together and then when we spend some time I could take you back to your classroom.

7. C: Okay.

8. T: Do you go back home at lunchtime? (pause) Do you have lunch here?

9. C: No.

10. T: Where do you go for lunch?

11. C: I don't know.

12. T: Do you, where do you usually go for lunch? (pause) Do you go home?

13. C: No.

14. T: No. (pause) Well we can ask Mrs. ( ). I'm interested to know what you have done to your head. (pause) What happened?

15. C: Don't know.

16. T: ( ) would you like to have a look through this to see what we've got and you can tell me what you're interested in. (long pause) A monkey and some cars. (said in enumerative voice)

17. C: I'm going to play with this.
18. T: Okay. That's a truck. ((pause)) I think I'll get a little chair and sit down. ((pause)) Maybe I can help you with some of the toys. ((long pause)) What else can we see. ((child is starting to take toys out of the box.))

19. C: I don't know. ((pause)) I can see this.

20. T: That's a red car.

((long pause while child plays with car))

21. T: It's stuck in the, stuck in the sand. ((pause)) Is it?

...

34. C: ( ) I'm going to get this.

35. T: I wonder what it is.

36. C: I don't know.

37. T: What does it do?

38. C: When you, when those guys are dead it takes (you) at the hospital.

39. T: When a guy is dead it takes them to the hospital. ((long pause)) What's it going to do here?

...

50. T: Now I wonder what this is.

51. C: Don't know. ((pause)) What is this?

52. T: It's the same sort of thing as this. ((points to ambulance)) but it's one that's used by the army, by the soldiers.

53. C: ( )

54. T: These men can bend.

55. C: ( ) What's this?

56. T: What do you think it might be?

57. C: Don't know.

58. T: We can guess can't we.

59. C: A ship.

60. T: A ship. ((pause)) mmmmm (+)
75. T: What is this, do you know?
76. C: Police car.
77. T: Yea, but what is this on top?
78. C: Don't know.
79. T: What would you call it?
80. C: Don't know. ((pause)) He's getting some sand. ((pause)) I don't know what this is.
81. T: You don't know?
82. C: A house.
83. T: A house. ((said softly))

143. T: Have you got a car?
144. C: Yea.
145. T: Can you tell me about your car?
146. C: No.
147. T: Can I ask about it?
148. C: Yea.
149. T: Is it a big car?
150. C: Yea.
151. T: What color is it?
152. C: I've got a whole bunch.
153. T: A whole bunch of,
154. C: Cars.
155. T: Cars. I see. ((face shows he realized child was talking about his toys))

Before showing how the therapist was able to use this talk to construct a diagnosis, or at least to formulate a problem, I want to make
one observation that I think the reader will appreciate. That is, the conversation above does not sound strange or esoteric, rather it sounds very much like an adult talking to a child. Although we may be strangers, we can follow the session and make some sense of it—it sounds reasonable. Perhaps I should also point out that it is possible to see a number of the points which were referred to in the literature operating in this short transcript.

A short time after observing this play session I joined the therapist as he tried to make some observations about the child that would be suitable for a report. I used this opportunity to discover what sense he had been able to make of the child's play and talk. The following then are some observations the therapist reported to me.26

1.2

R: I see, he was going through the box the whole time, sort of that same old thing of taking out toys and,

T: That's right. There's no sort of, there's no exploration of the room. He settled down to this particular task for the whole time without much reference to anything else going on around him. Now whether your presence was limiting or not I don't know. Uh, maybe to some extent. But compared with the sort of behavior which most seven year olds show when, if they came into this room, for example, is certainly a wider range of styles in the playroom. But, there'd be much more looking around and exploring, and asking questions. 'Gee look at this', or some surprise or excitement.

R: Even on the initial visit to the room?

T: Yea, right. Oh yea. . . . And I'd really rate this kid as being quite far along the inhibited scale, uh, what an inhibition means isn't too clear. Uh, I'm making a guess from what I know about the kid when I say he may be depressed—at this time—this kid. And there are one or two clues here; the theme of getting stuck, the stuck feeling, with the need for some rescue, and the odd little thing like the ambulance, the reference to the dead, where the guy then takes him to hospital. There was something else I think. Maybe it's just these few clues. Ah, the sort of thing that this play wasn't going anywhere. There was no, there was very little life to it. It was partly, well we'll come to that, it's partly the recitation, it was the naming process. Perhaps this may be another problem altogether.
but let's just call it inhibition for the moment but with the possibility that the inhibition may be part of the depression.

This gives an indication of my first involvement with a therapy session. I felt that some important discoveries might be made if only I could get behind the surface level of this talk so I returned to the manuals in an attempt to learn what sorts of things therapists attend to when talking to child-patients.

Having been granted access to the clinic, I approached some of the members of the staff who were using the play rooms on a scheduled basis. I observed and taped therapy sessions on a regular basis and often talked with the therapists about their work. I also learned a great deal on occasions such as coffee breaks, in post session conferences during which the therapist would report on what happened that day, in conversations prior to a session in which I would be instructed by the staff on what to look for, and on those occasions on which I overheard a member of the staff giving descriptions or accounts of problems, patients, or procedures to another member. In addition to these, there were scheduled contacts during which I asked questions about play therapy, children, specific patients, therapist's actions, etc.

I attended the clinic on a fairly regular basis for a period of 18 months and, during that time, I observed over 50 therapy sessions. These were usually conducted by social workers but often included a psychiatrist and/or student therapists. Typically, I would visit the clinic once a week in order to follow a particular patient through a therapy program. However, I would also try to observe other sessions, visit with therapists, read case files, etc., during my visit.

I encountered two major methodological problems. Although both of
these are common problems in 'observational' studies they should perhaps be noted here. The first of these was the limitations that were placed on my activities as a result of the way in which my role in the setting had been defined. Initially I had described my project in terms of the 'talk' that occurred in the therapy room, and the staff had interpreted this as an interest in communication. Much later in the study, I decided that I would like to observe a wider range of activities and expressed some curiosity about how the intake committee did its work. I wondered how referrals were made to the centre, how the intake committee judged applicants as to suitability, etc., and how applicants were slotted into an appropriate program.

The director agreed that I should be allowed to attend a meeting of the intake committee (of which he was a member). Although I was only slightly acquainted with some of the members on this committee, they all had some idea of who I was and what I was doing in the clinic. They expressed some bewilderment about my interest in their activities for they could not see how their doings here were related to 'communication'. I sat through one meeting but my presence caused so much tension that I decided not to attend any more meetings. I felt that to have continued would have required a redefinition of my research interests.

On another occasion, my role became restricted because of therapeutic necessity. During the first few observation sessions, the therapist made it a point to inform the patient a week in advance that he or she was going to be observed. He then followed this up by introducing me to the patient on the day on which the first observation was to take place. This procedure allowed the child to feel secure that I was not a policeman or parent. The child was also shown the play room from my
vantage point behind the one-way mirror so that he would know exactly what I was able to see. The first patient that I observed continued to perform for me for a few weeks, to ask about me, and to try and look through the mirror. As a result of this, the therapist suggested I avoid the child in the halls whenever possible. This meant arriving early and leaving the observation room after I was sure that the patient had departed for home. Eventually I was forced to discontinue observing this child because of the potential for interference with his therapy. While this did not appear to be a problem with future patients, I continued to avoid them outside of the therapy room. Both the therapist and researcher assumed that if the patient did not see me he would not be reminded that someone was behind the mirror. It was also assumed that the child would not have a category structure available to him that could provide a safe identity for me. Without characterizing the patient as 'paranoid' it was taken that the child could only conceive of the person behind the mirror as someone there to check up on him.

Since I never knew when a child who I was observing might be in the halls, I found that I was unable to observe the children in areas outside of the therapy room. To have done so may have jeopardized my welcome. While these may be construed as limitations, they are also pertinent examples of the problem of managing one's role in the construction of an ethnography.

Much later, I expressed a desire to talk with some of the patients or with an ex-patient in order to discover something about the children's own conceptions of therapy. I was discouraged from doing the former because it might interfere with the therapeutic process. I was also told not to attempt the latter because of the danger of "reactivating" the
child's problem at a time when he would have no one to help him through it. This was not strictly speaking fear of a 'relapse', but rather a concern that the child might "relive" the therapy experience and then re-experience his anxieties, worries, fears, etc. were he to be engaged in such a conversation.

Although I continued to see my problem as that of the 'talk' that goes on between the therapist and patient, I continued to accumulate a great deal of information about the operation of the setting itself and participated in many conversations with the therapists. Without really knowing why, I continued to try to make as much sense as possible out of the larger setting. This non-therapy-room material was to prove instrumental in the redefinition of my problem at a time when most of my field work was over.

Typical Sights and Sounds

In this section I would like to introduce the reader to some of those things that 'anyone' might hear, see, understand, if they spent even a short time in the clinic. Drawing on my experience, I will report what I take to be typical sights and sounds of the therapy setting.

While I was waiting to see the director one afternoon, his secretary/receptionist began to tell me about the patient who was being seen. His visit was 'reportable' because of the way he had come to have an appointment on this particular afternoon. The child had telephoned the centre and asked to see the doctor. This was apparently a regular practice for this patient. The teller and the researcher saw this as a 'reportable' event because it stood in marked contrast to the regular procedure by which patients appeared at the clinic. The unusual nature of this event gave it a quality of being 'cute'. This drew my attention
to the procedures by which patients typically came to the clinic.

Children do not make themselves patients. Their parents or guardians, usually on the advice of teachers, courts, or doctors act as intermediaries. Parents arrange for referrals, visit the clinic to explain the problem-with-their-child, make appointments, and see that the child appears, and sometimes they become patients themselves. Unlike most adult patients, the child is not a voluntary patient. Interestingly, in contrast to a caseload of adults, the children did not appear to miss appointments. Those children who claimed that they did not want to enter the play room were simply led or on occasion carried into it.

Referral is made to the centre through a doctor or a community agency which requests a particular service. A joint intake committee which consists of the Family and Children's Clinic and the Psychological Education Clinic reviews the case and, if it is accepted, it is assigned to a program division and, typically, to a specific therapist. Because of the decline of direct treatment, few children appeared to be accepted solely for play therapy. Instead, most candidates for therapy came from some other program within the centre, e.g., the preschool centre.

For many patients, therapy was simply a part of the time that they spent at the centre and they appeared to see it as a routine part of their school experience. These children are usually met by the therapist after class and led or carried to the play room. Other patients typically arrive with a parent on their first few visits but, for the remainder of their program, they often come to the centre by taxi or with a volunteer driver. On one occasion the therapist herself picked the child up at her home and returned her after the hour. I seldom saw parents waiting in the waiting area, although at least one parent appeared to wait for his
child in his car.

Those children coming to the clinic specifically for play therapy usually entered the building alone and were greeted by the receptionist. She would recognize them and frequently engaged them in conversation until the therapist arrived. It was uncommon for the child to sit in the waiting area. Sometimes the patient would enter the therapy room which was adjacent to the waiting area and play with the toys until he heard the therapist coming.

It was not uncommon to find children roaming about the halls and adults would approach them to discover their reason for being there. They might, for example, be over-extending their visit away from the school complex. The presence of unattended children appeared to provide the rationale for locking doors; three doors were consistently locked, namely, the observation room, the toy storage room, and the kit refill room.

The Play Room: Play therapy requires a certain amount of preparation by the therapist. These preparations can be thought of as (a) administrative or technical, and (b) therapeutic. First, let us consider the former. Unlike most verbal therapies, play therapy is carried out in a special setting, i.e. the 'play room', and, since there are a limited number of these special settings, it is necessary that the staff work out a schedule for their occupancy. The therapist usually reserved a room through the receptionist. Patients were seen once or twice a week, usually at the same time of day and in the same room. It appeared that each therapist had a preference for a particular setting and scheduling was seldom problematic.

The clinic has a number of rooms available for therapy activities; two of these are used for group activities, two are small play rooms with
observational facilities, (these were only used once or twice to my knowledge and then only because the other rooms were occupied), two large rooms without observation rooms which were used almost exclusively as play rooms, and two large rooms fully equipped as play rooms. One of the two latter-mentioned rooms is set up to provide for occasional family groups and contains a sofa and arm chair as well as play equipment. The other room was the most fully equipped and appeared to be the most heavily used. Unlike the others it had a child's washroom, a blackboard, a sink, as well as a bench which extended around all of the available walls. This was the room that most observations were made in.

While scheduling of the rooms did not appear to be a problem, it frequently happened that the patient thought "his room" had been violated. Children were typically told that the play room was "theirs" for the hour and that they could do whatever they liked with it (within reasonable limits of course). On one occasion the therapist and patient had gone upstairs for a few minutes and, upon returning, found two children from the waiting area in the room. This appeared to be a significant event and the therapist told the child that he had a right to be annoyed at this intrusion. Later, both of them agreed that they should lock the room whenever they had to leave it in the future.

Another potential problem arises when a child from one room wants to enter another child's room. A child who proposed this kind of violation was told:

1.3

T: No, playrooms are very special places Tanya. Your playroom is a very special place, and no other people, no other children come in it when you're in it, and no other child should go into any other child's play room.
It was also not uncommon for the child to expect to find the room the way he had left it three days, or even a week previously. For instance, consider the following conversation.

1.4

C: Now look what they did.

T: What did they do?

C: They messed it up.

T: Well I'll tell you what Nick, it's your turn now and you can do with it what you want, (deal).

This may have been one reason why therapists would attempt to remove obvious traces of the former 'owner' when preparing for a next session.

For example, one child was allowed to paint on the walls during her hour. This necessitated the immediate bringing together of other interested parties at the end of the session who would then view the picture so it could be washed off in readiness for the next patient. On one occasion, a photographer was called in so that the production could be preserved for the record. Similarly, the sand tray scenes would be dismantled and toys would be replaced in the box. A major consideration in removing the traces of former occupants was that the new patient would be influenced by the work of the previous child and thus fail to provide a 'free' sampling of his own play.

Some features of the play room were physically reconstructed for each play session. Each therapist has a large toy box which contains a vast assortment of small toys, e.g., animals, human figures, trees, guns, cars, trucks, fences, caps, balloons, etc. This is stored in the therapist's office or in the play room. This collection of toys is placed in the play room prior to each session and the toys may or may not be taken
out of their box before the session begins. There are also several large items which can be moved from one room to the other. These include two sand trays, a painting easel, a miniature house, and a child-sized table and chair set. In addition there is a storage room with a large assortment of toys, including guns, rifles, wagons, tricycles, games, balls, swords, stuffed animals, baby carriage, dolls, models, paints, paper, crayons, trains, puppets, and tools. The therapist, in preparation for a therapy session, will arrive early and arrange the room in response to the particular patient that will be seen. This selection and arrangement of objects has been referred to as therapeutic preparation.

If the child is being seen for the first time the arrangement may be geared to what we may call the 'normal child' with the intention of 'sampling' his play. This means that the therapist must provide a wide range of objects and note what the child does with them. One therapist who was preparing for a newcomer placed his toy box in the room but did not open it. He then arranged some paper and crayons, and placed both of the chairs at a safe distance facing one another. Later, the therapist told me that the child was in an age group in which he could be a 'talker' or a 'player', that is, the child was old enough to be able to talk to the therapist without the medium of the toys. However, because of the nature of the situation, he might well want to 'regress' to the safety of playing with toys. With the toy box closed, the choice would be up to the patient rather than the therapist.

When one child who was described as "psychotic" and was reportedly hyperactive was scheduled to use the play room, the therapist would remove as many things as possible from the room. A symptom of her psychosis was "perseveration" which was displayed in her inability to stop taking things
from the toy box until it was completely empty, or to pour sand out until it was all gone, etc. In order to manage this child, the therapist would reduce the stimuli to a minimum. Normally, however, there were a large number of toys in the room.

The arrangement was kept consistent for each particular child from one week to the next and he was provided with those resources needed to work out (i.e., play out) his problems. Although this is not the place to go into detail, it became evident from the therapist's talk that there was some supposed relationship between 'toys' and 'problems'. Some examples of the therapeutic selection of toys follows. A child who was seen as having "dependency needs", that is, a child who did not receive enough love and attention and was still striving to satisfy those needs, should have access to resources that allow him to "regress". For example, his play room would include a baby bottle filled with water, dolls, mud, etc. A child who was assumed to harbour a great deal of pent up anger would be given cap guns, swords, punching clowns, wild animals (e.g., a stuffed bear), puppets of fierce looking animals, darts, etc. A child with a specific anxiety will be given toys related to that anxiety. For example, a child who was concerned about a hospital visit would be given the opportunity to play with medical toys, a child with a fear of flying would be encouraged to play with balloons, toy airplanes, feathers, etc., a child with an apparent sexual misidentification may be permitted to play with lipstick, eyeshadow, bubble bath, etc., one with repressed feelings about his parents or sibling would be given a doll family, and so on. While the selection of appropriate toys was not always as obvious as the examples given above, there were similar justifications available which governed the selection of most items.
Because play therapy is essentially a non-directive activity, these toys were not given to the patient but were placed in the room so that they could be used (or avoided) as he wished. An exception to this was an occasion on which a therapist had acquired a new toy (padded clubs) and urged the patient to use them for two sessions.

Before concluding this brief description of the sights and sounds of the therapy setting I will give the reader some sense of what takes place during the therapy hour itself. As explained earlier, the therapist typically arranges the room prior to the patient's arrival and, at the appointed time, either collects the child from his classroom or waits to be notified of his arrival. There is often a display of pleasure, by the therapist, on seeing the child again. To the observer some of these greetings were of a form that one would normally expect either from parties who had met accidentally or from people who had met after a long absence from each other. For example, the therapist would often greet the patient by calling out his first and last names in a loud, exaggerated voice. After a greeting the pair would usually go to the play room, however, sometimes there were other activities that had to be taken care of first. For example, the therapist might have to attend to some business that was not related to the patient whom he was seeing. He might have to make a telephone call or drop something off at the office. In the latter case, the child would often go with the therapist to the office and then return with him to the play room.

The therapist's office was given a special accent by both the therapist and patient although it was not used for play therapy. On one occasion a child brought a flower for the therapist and they went to his office to place it in a vase. The office was also used as a place to
display some of the productions that children had created during therapy, and each office contained at least one of the children's paintings on the wall. The office was also used as a space to store some of the toys that a patient wants to treat as his own, special property. Since all of the patients use the same toys and the rules do not allow a child to take anything home, the therapist would often agree to put certain toys away in a cupboard until the next session.

Even though the details of the play room have been arranged in advance, some therapists would allow patients to select their own toys from the toy storage room. This was a device for gathering information about the patient. That is, the child's selection of toys was an index of his feelings, problems, needs, etc. For example, one patient enjoyed putting a particular model together during the session. It was significant that he repeatedly selected a dinosaur, thereby demonstrating the need of an inhibited, good child to be violent, angry, monstrous, etc. Conversely, it was also useful to see what toys the patient avoided. This selecting time was not seen as part of the therapy hour, but was regarded as a pre-session activity. One therapist became concerned with the increasing amount of time that a particular patient took to make his selection. Each week he took longer and longer. The therapist referred to it as "shopping" and explained that the lengthening of the "shopping time" was a device for avoiding the play session itself.

Upon entering the play room, the therapist closes the door and sits down. The therapist spends the majority of his time in the play room sitting in a child's chair or on a low bench. Varying amounts of time may be spent in activities like mixing paints, reaching things from a high cupboard, playing an action game, or in managing an active child. Some
therapists may spend most of the hour sitting in the same location, while others will move about in order to stay relatively close to the patient. The therapist may remain inactive during the hour or he may participate directly in some of the play activity, e.g., he might engage in a sword or a cap gun fight, take command of a regiment of soldiers, or move some of the toys about. Sometimes his participation will be of a more indirect nature. He might assist the child in his play by mixing paints, getting water, reading instructions for him, winding up trains, fixing guns, etc. Whatever the form of participation, the therapist tries to direct his attention to the patient at all times.

The child is free to do whatever he wishes and typically elects to play. On some occasions, however, he will "avoid" the toys and talk with the therapist instead. The play activity may be the expected ones of playing games, playing with dolls, building in the sand tray, drawing, painting, etc., or may include undressing and climbing into the sink, handcuffing the therapist and locking him in the bathroom, using a water pistol to attack the therapist who is trying to get into a raincoat, exploding two or three rolls of caps at a time, throwing a punching clown against the walls, painting on the walls, throwing darts at a drawing of his teacher, etc. Although the play sessions were usually confined to the play room, it was not uncommon for the therapist and patient to go outside for a swim, to play in the gymnasium, to play on the trampoline, or to go to the park.

The play sequence may consist of a single activity such as building a model, it may consist of many play activities, such as drawing, playing darts, building in the sand, or it may consist of one or more play activities broken by periods of conversation. In more or less verbal
sessions, the talk may be connected to the play or it may focus upon other concerns.

The therapy sessions were scheduled to last for one hour but could be shortened if the patient was anxious to go and could not be encouraged to engage in any further play or talk. A session could also run over the hour if the child was too 'worked up' or refused to stop playing. Almost without exception the therapist attended to the time and, towards the end of a session he would frequently tell the patient how many minutes were left in the hour. This helped to prepare the child for the termination of the hour and encouraged him to finish his play. Further, the therapist would sometimes terminate an activity which he did not feel was worthwhile in order to move on to something else.

Since the term "play therapy" invokes the idea of playing and, as we have seen, play is indeed a central focus here, one might well assume that these sessions produced a minimum of conversation activity and often included long periods of silence or periods where the child simply "talked to himself" in and over the course of his play. However, this was not the case. Instead, the hour almost invariably had the appearance of a 'conversation' with the participants taking regular and orderly turns at talking. Much of this talk was oriented to the play activity. The following transcripts were taken from a session with a patient who was approaching the end of a treatment program which had lasted for several months. The participants had just returned to the play room after searching for a key for a toy train.

1.5

1. C: It is, ( ) I'll just put my ( ) in there and I might forget it, if I forget it you can always remind me.

2. T: Mmihhmmm, okay. ((2.0)) Oh Dana; I'll // tell you what.
3. C: ( ) get it right away and then I'll save it, for after. ((starts out the door))

4. T: Well, I'll tell you, we'll, we'll get it later okay.

5. C: Unn. ((annoyed))

6. T: Dana.

7. C: ( ) right away.

8. T: Yea.

9. C: Anyways I don't know how much money I've got in here.

10. T: Yea. We've got, only, ((closes door)) about eight minutes left, so you can go after the session and get it, okay.

11. C: Five, oh, oh. ((12.0)) Huh.

12. T: Yea, here's one that's all intact. ((referring to the new train that has been brought back to the playroom))

13. C: No I don't have 16 either. I don't even have 16 cents.

14. T: What do you have?

15. C: 15.


   .......... 

41. C: Hey, something came off, of the extra train. Oh it came off the back thing, the blue thing. The wheels are still on it, still on the blue thing.

42. T: You have another car here too.

43. C: I know. ((4.0)) Oh drat, the red thing and the blue thing don't have one on it. ( ) missing.

44. T: I'll tell you something about that Dana, you have to be quite gentle with it or the hooks come off.

45. C: They do?

46. T: Quite easily, yea. ((2.0)) That's one thing that you have to try and be quite patient with or it doesn't work.

47. C: ( ) but it came off.

48. T: Right.
49. C: 
50. T: Do you know why it came off?
51. C: Nope.
52. T: Have any idea why it came off? ((2.0)) Well, I think it was because you had to really be in such a hurry to get it out of the box.
53. C: Ahhh. ((scoff))
54. T: Hmmm?
55. C: That's not why it came off.
56. T: You don't think so?
57. C: Nope.
58. T: I think so.
59. C: I don't.
60. T: Mmmnhmm ((+))
61. C: Hey //
62. T: Well first of all it's not made very well but, secondly when things aren't made very well I guess you have to be more careful. ((7.0)) I think sometimes we kind of wreck things for ourselves at times.
63. C: ( ) now I got the thing back on.
64. T: Did you get it?
65. C: Yep.
66. T: Good for you. Good for you.
67. C: I fixed it.

...  
81. C: Oh, oh, now this things thing come off. The red things. And I didn't even fool around rough with it.
82. T: No, okay. ((1.5)) So sometimes things break just because they're not made very sturdy, not very strong, and other times I think things get broken because we handle them roughly because we're in such a hurry to get them going.

((As the session ends the patient starts "throwing" the train back into the box))
91. T: Really feeling kind of mad at those things huh.
92. C: Yea especially for breaking.
93. T: Okay, maybe kind of mad at me too, for, saying it had something to do with what you were doing.
94. C: I'm not mad at you.
95. T: No.
96. C: If I am mad at you I'm mostly mad at the trains.
97. T: mmhhmm (+)
98. C: ( ) can of pop.
99. T: Yep, you can go and get the pop now.

On another occasion, the therapist tried to turn the play activity into data by encouraging the patient to elaborate on her activity. In the following case the child had just finished painting and the talk is built around that object. The therapist regarded this patient as a special case because of the seriousness of her problem. At one point he had said that there was the strong possibility that the patient might be psychotic.

1.6

1. T: I wanted to sit down. ((pulled up a chair)) Who is that?
2. C: I don't know.
3. T: mmm /
4. C: I don't know.
5. T: You don't know who / Is it a man or a lady?
7. T: That's a monster.
8. C: He's falling down.
10. C: He has no wings.
11. T: No wings. Was he trying, what's he doing up there in the sky? Is that, is that the sky up there?
12. C: He fell down and it's raining.
13. T: And it's raining.
15. T: Poor monster. So bad things are happening to the monster.
16. C: Yes.
17. T: He's fallen down and it's raining on the monster.
18. C: Yes.
19. T: What kinds of things did the monster do?
20. C: He said (like that).
21. T: He said go away rain.
22. C: Yes, and, and, and he, and he, rained all day all night.
23. T: mmhmm, so the monster said go away rain but the rain just kept on coming down, huh.
24. C: Yes. ((pause)) And, and, there a moon.
25. T: A moon.
27. T: And it's dark outside.
28. C: Yes.
29. T: And there is no sunshine.
30. C: NO.
31. T: So it's dark night and it's raining.
32. C: Yes.
33. T: And the monster is falling down.
34. C: And, and there is a thunder storm.
35. T: Thunder.
36. C: Yes.
37. T: Wowww.
38. C: On his, on his foot.
40. C: Yaa, and he says ouch, ouch, ouch, like that.
41. T: Ouch, ouch, ouch.
42. C: Yes. ( )

In other cases, we can hear that the therapist is trying to get the child to talk about his feelings. The following patient had been in play therapy for a long time and was about to be discharged when he appeared to have a relapse. Here, the child has a pair of boxing gloves on and has been 'mock hitting' the therapist.

1. T: Yep. Ah, would you like to pop me one in the nose with those. (Hitting yourself?) ((pause)) You must be feeling pretty awful hmm? ((pause)) Feeling kind of angry at yourself for //
2. C: Watch this.
3. T: For disappointing Mum.
4. C: ouch, uunhnn (-) I don't do that.
5. T: Don't you?
6. C: Unnhnn (-)
7. T: Angry at yourself for, cause you think you're stupid?
8. C: Nope.
9. T: Or that you're retarded?
10. C: Nope.
11. T: Or mental?
12. C: Nope.
13. T: mmm?
15. T: I think so. ((pause)) Well Tim,
16. C: Guess what?
17. T: What?
18. C: ( )
19. T: I think, I think you're just a really fine fellow.

   Talk is frequently built around the topic of "what kind of room the play room is", with numerous comparisons to the home or classroom. Consider the following three examples.

1.8

1. T: You know // what?
2. C: ( . . . terrible )
3. T: John.
4. C: mmm ((tone of recognition))
5. T: I want to talk to you for a sec.
6. C: (What?)
7. T: Sometimes we can have these kinds of explosions here in the play room, hey?
9. T: When there is flames come out of the caps and stuff,
11. T: But, the play room is a different from home isn't it?
13. T: And we don't want all . . . .

1.9

1. T: Hmmm. ((pause)) Sometimes I bet you even swear.
2. C: No I don't swear.
3. T: Hmm? You know, one place where it is really good to swear is right here in the play room.

4. C: I know.

5. T: That's right. ((pause)) Why you can even say fuck and all those things, right here.

6. C: ( you want to the darts )

7. T: Hmm? ((pause)) At home though I think it sometimes bugs Mom if you swear.

8. C: (Watch this) ((throwing a ball around))


10. C: Watch this.

11. T: I missed it.

12. C: ( )

13. T: Yep right here in the old play room, that's a good place to, let it all out. You can swear ((loud noise)) yell, and all those things. ((pause)) Wowee.


15. T: But really though, Mum sometimes get up tight when kids swear at home. But if you swore in the play room you know I wouldn't even be shocked. You know that?


18. C: ((slight laugh))

19. T: I think you'd like to take that ball and heave it as far and as hard as you could. ((pause)) Good one.

20. C: Ahhh

21. T: Ohhhh. For a minute I thought you were going to wear the garbage can. ((pause)) Go man go. Wow.
This transcript involved the same participants as transcript 1.5 and is from the "next" therapy session, occurring at what the researcher heard as the earliest opportunity for the therapist to get it in.

1. T: You know Dana, ((an interesting tone of voice))
2. C: What?
3. T: I was really thinking about the last time you were here, and I think I must have been sounding like a, a naggy old, Mom or Dad.
4. C: Unnhnn (-)
5. T: Huh?
6. C: Unnhnn (-)
7. T: I think so.
8. C: You weren't.
9. T: I was thinking that
10. C: (noise)
11. T: that I wasn't really being quite fair to you.
12. C: ( two men . . . tanks . . . )
13. T: mmmhmm (+)
14. C: ( ) //
15. T: For a long time Dana I have been telling you that you should be able to do things you want to do in the play room,
16. C: I know.
17. T: and I've been telling you that it's okay to get angry, and stuff like that.
18. C: I know.
19. T: Well and then last week when you came and you wanted to do some things, that you really wanted to do and I said you couldn't do them. Do you remember? ((2.0)) Like you wanted to get some pop, kind of early in the day.
20. C: mnhmm (+)

These particular samples of therapy talk have not been selected to
demonstrate any particular points, but are offered as examples of typical therapy hours. This chapter has presented some of the observations that 'anyone' who placed himself within the setting for a reasonable length of time could have made. The materials in this chapter were selected because of their typicality and are intended as descriptions of the work that is done in a particular section of the centre.

Although I had embarked upon my research at the clinic with some uncertainty, I was surprised to find that I could easily see the reasonableness of the activities that went on there. That is, they made sense to me. Later, this was followed by a lengthy period during which I doubted the reasonableness of my observations. The former impression was that the happenings that went on in this setting would have made sense to anyone (i.e., whether they were or were not members of the setting). As lay members, we may assume that some of the activities reported would (or could) have been done in other ways, but I would suggest that any competent cultural member would have no problem in seeing the reasonableness of these activities. By saying the setting would make sense to anyone, I am pointing to the common-sensical organization of the setting, e.g., to the use of play, to the greeting structures, to the family intermediaries, etc. I would like to point as well to the apparent visibility of the patient's motives, to the awareness of the child as a developing being, to the common sense procedure of getting children to tell stories, to the overall reasonableness of the therapist-patient talk, etc. While we may wonder how therapists are able to account for this talk as therapeutic, we do not doubt that it is an adequate and appropriate way to talk to children.

While we may know little about psychotherapy, we are able to provide adequate motivational accounts for why the setting appears the way it does,
of what the therapist is trying to do in the play activity, of the selection of toys, and so on and so forth. We can also provide adequate (and "adequate" always means adequate-for-all-practical-purposes) motivational accounts for what the participants are doing. That is not to say that we would all agree on these matters, however, because we are competent members of the society, we can produce reasonable accounts. As members, we constantly provide accounts for all kinds of actors and actions in the spontaneous and routine pursuit of our daily affairs.

If we attend to the cautionary remarks given at the beginning of the chapter, i.e., those concerning the "difficult issues and technical problems" which are to be expected in working with children, we could now argue that these are not actual problems and suggest instead that our ordinary and uninformed understanding of what is going on here is sufficient for all intents and purposes. I found myself assailed by questions of this nature.

While these observations appear to be reasonable, we must remember that these occasioned impressions represent something that is supposed to be and is referred to as "therapy" or "treatment". For the adults of this setting, the occasions cited above are not simply an opportunity to meet and talk to children, rather, they are supposed to add up to making disturbed children better. Our observations should be given an organizational relevance—that is, they should be justifiable in terms of the organizational goal of therapy. While we could provide many adequate accounts, we must wonder whether or not they would be psychiatrically relevant. While we can make sense of the observations, what sense do the members of the setting give to them? What do they see going on? How do they attribute motivations? In short, what is the rationale which makes
these sights and sounds psychiatrically relevant? Further, how can we get beyond the immediate sense of reasonableness to occasioned reasonableness?

I doubted that there would, or should, be a correspondence between my accounts and those of the therapist. Essentially, I felt that any sense that I could make out of the situation was not the same sense that the therapist was making but was instead rooted in my own inadequacies.

The themes of 'reasonableness' and 'doubt' were recurring ones for me during the actual field work and during the numerous times when I sat down and tried to make sense out of the data that I had collected. They continue to be essential for the remainder of this paper.

These two themes provided me with my initial problem. While I had entered the setting to search for the properties of adult-child conversation, I found I was spending a great deal of time thinking about the activities (including talk) that went on in the setting itself. Even when thinking about and discussing the conversations, I found myself engaged in constructing the actors' motivations. My interest then shifted to a concern with how I was able to make sense of the setting, its activities and participants. Because I doubted my initial ability to make sense of the activities, I attempted to discover the real significance to talk, events, etc.

In summary, I have presented certain impressions of a work setting which "any" observer might have made. I have also emphasized our ability to perceive the 'reasonableness' of activities and events without having any special knowledge about their organizational relevance. In an effort to discover the real significance of events, we shall now proceed to examine how the therapists themselves see these doings as something which
adds up to 'therapy'. I was assisted in this undertaking by the accounts and explanations offered by the therapists. In chapters two, three and four we will look at the organizational rationale as discovered within the setting and at the corpus of knowledge the therapists employ in the interpretive work of making sense.
Footnotes

1 This interest arose from a seminar with Matthew Speier.


6 For an example of this 'location' of the literature, examine the following bibliographies: United States Department of Health, Education and Welfare, Research in Individual Psychotherapy: A Bibliography, 1969; and E. D. Driver, The Sociology and Anthropology of Mental Illness: A Reference Guide, University of Massachusetts Press, 1965. The latter piece, although it is supposed to be a comprehensive survey, contains only one reference to children.


13 H. Ginott, Op. cit., p. 176. Earlier Ginott had said, "to a considerable extent the child's play is his talk and the toys are his words." p. 51.


20 Ibid., p. 109.


22 H. Ginott. Group Psychotherapy with Children, p. 91.


24 Typically, Child Guidance Clinics have a psychiatrist as director, a number of social workers and a lesser number of psychologists working under him.

25 During the writing of this report the children's service was in fact discontinued and staff members were distributed among other existing community services.

26 The therapist had contacted me to see if I had made a transcript of the earlier session since he had not made notes at the time.

27 I could frequently witness their arrival and overhear their conversations through the open door of the therapy room.

28 For a more thorough examination of this aspect of ethnographic studies see Gerald Berreman, "Behind Many Masks: Ethnography and Impression Management in a Himalayan Village", Society for Applied Anthropology, #4, 1962.

29 In addition to administrative duties, the director had a few regular patients and saw others on a consultative basis.

30 Those who take the intentional permissiveness of the setting very seriously argue that children should have the freedom to refuse therapy.

31 A therapist reported the following episode. Due to some unusual circumstance, he had to drive a patient home after therapy. At the patient's house they met some of the neighborhood children and the patient introduced the therapist as his 'teacher'.

32 The director has a sufficiently large office to enable him to use it as a play room.
The examples that follow are from field notes. An elaboration of this may be found in H. Ginott, "A rationale for selecting toys in play therapy", *Journal of Consulting Psychology*, 24 (1960) 243-246.

'Aggression' and 'dependency' were the two central emotional states ascribed to patients. They were typically referred to as a unit, i.e., one gets 'angry' because of unmet 'dependency' needs.
CHAPTER 2

THE PSYCHIATRIC INTERPRETIVE SCHEMA

Although the scenes portrayed in Chapter 1 appeared eminently reasonable and obvious they could not remain so for me as a sociologist. This was not simply a 'play' session, 'disturbed' children were present for the purpose of becoming 'better', and the adults were performing a task referred to as therapy. For them therapy was work—work requiring considerable skill and training. In short, I took it that there was some organizational significance to those sights and sounds. As a social scientist I felt obligated to reject the reasonableness of my first viewing and search for something behind the scenes that would make them eventful. I did not know what my search was for but I did feel I would have to discover how the therapists made sense of these scenes. Although I was able to attribute meaning to what I saw, surely that would not be the same meaning a professional therapist attributed to them. That is to say, I assumed that there would be a psychiatric interpretive schema which would enable the therapist to understand events in another way.

A great deal of my time in the field was spent searching for the ways in which therapists managed to make sense out of things that I as a layman found to be mundane and uneventful. Most of the material that I gathered was the result of my initial efforts to make myself a competent member of the setting rather than any deliberate effort to uncover the psychiatric significance of the situation. I found that I could conduct myself as a competent participant by asking appropriate questions,
offering adequate solutions, seeing the relevance of accounts given me, etc. In short, I took it that I had begun to see activities in much the same way as the therapists saw them. On the basis of my experience at the clinic, I was able to construct a rational account and description of the setting, specifically of the happenings in the play room. The reconstruction of this data occurred later when I developed a more clearly defined interest in occasioned accounts. It is the intention of this chapter to show how I was able to make sense of scenes such as those depicted in Chapter 1. First let me indicate how this was possible.

Not only did I observe therapy sessions, I was often a party to talk about the sessions that I witnessed, and about the child and the problems involved. These conversations occurred before or after a therapy session, at coffee time, at meetings, during informal talks, etc. Not surprisingly, people who play with children on a regular basis have standardized ways of talking about their activities. This came out in informal accounts or explanations of the children's behavior rather than in our more formal discussions about psychiatry, psychopathology, etc. This provided me with a way to make sense of the sessions that I had observed, that is, I looked for the relationship between the talk that I had heard and the events that took place in the therapy room.

Psychotherapy, like other professions (i.e., in contrast to occupations) is a theory-governed activity. The enterprise is related to and embedded in explicit (and sometimes diverse) facts and/or assumptions about human nature, the etiology and development of diseases (i.e. problems), personality development, the source or sources of problem
solving, etc. While most members of the profession participate in the actual doing of therapy alone, a handful of people devise, elaborate upon and communicate the theoretical structures of the practice. As I reported earlier in this study, I embarked upon a study of the relevant literature during the initial part of my research at the clinic and, later, members of the setting afforded me with further references to particular authors and to pieces of literature. I took it that one could, and should, see the relevance of this literature to the on-going, practical activities at the setting. The relation between the two should run something like this: "See the actual activity as an expression or document of the pertinent theoretical materials".

On a few occasions I was drawn into discussion about the differences between various models of behavior. The therapists to whom I talked would often contrast their methods with, for example, the work of other members of the clinic who practiced behavioral modification. I soon came to realize that their activities were governed by different sets of theories. That is, it was not only that some members accomplished their therapy in different ways but there was a fundamentally different theoretical structure which governed their actions. On the other hand, although I was able to discover some differences in the ways in which the therapists with whom I was involved practised play therapy, I did not see any contradictions here. Instead I saw these differences as differences in personality or style rather than as indications that they subscribed to different theoretical models.

In this chapter I will occasionally make references to the literature. This can be seen as a further aspect of my search for an account of the rationality of the setting. I found that I was able to see the
activities at the clinic as a document of the literature, and I felt that it was appropriate to do so.

I sometimes noted discrepancies between what therapists actually did and what the literature claimed that they should do. On one occasion, I told a therapist that something she did appeared to be a contradiction of what Axline had written. She did not question the fact that I saw the relevance of Axline's work to her activity, but explained that she did not agree with the point in question. As an observer, I had access to (a) actual sessions of play therapy, (b) therapists remarks and discussions about these events, and (c) theoretical explanations and accounts which resembled and seemed to bear upon the sessions that I witnessed. I found that the latter two allowed me to make psychiatric sense out of the former, i.e. out of the actual sessions that I witnessed.

This chapter then is a brief report on how I started with my first experience of play therapy and constructed an account and description of the rationality of the setting and its activities. I was looking for the psychiatric significance of happenings and I take my account and description to be a version of the psychiatric interpretive schema. The status of this schema is unclear since it was never explicitly referred to in the setting nor treated systematically. Rather it is my accomplishment based on member's talk, etc. While I am suggesting that to some degree what I report is how therapists make sense of events I would not argue that what I present is all they make of the episodes reported. It is always possible that therapists will suggest that they meant more than what I understood.

The following material is organized around a series of puzzles experienced as I first witnessed play therapy. As I became more familiar
with the setting these puzzles were replaced with a "psychiatric account" which made eventful what was previously uneventful.

I will begin to present this interpretive schema (rationale) by looking at what I first experienced: the patient playing with toys and the therapist watching, participating in, commenting on that play. The following transcript is from a session with a patient I had been observing for some time and who had been in therapy for several months before I arrived. He was playing in the sand tray with some vehicles.

2.1

1. T: You know that sometimes people get stuck just like, tractors and trucks.

2. C: What do you mean by get stuck?

3. T: Well, I think that sometimes people have things that bug 'em, problems that bother them/

4. C: Mmhmmm (+)

5. T: and sometimes they get stuck with them and they don't know how to get out of them, they don't know how to stop doing the things that bother other people. ((pause))

......

9. T: But you know that just like you can help a tractor to get unstuck that's the way it is with people sometimes too.

10. C: That wasn't the tractor that was stuck.

......

19. T: Oh I see. ((pause)) So, sometimes people can be helped to get unstuck too so they know how to cope with the things that are, ( )/
20. C: I think I'm going to roll my sleeves up.
   
35. T: mmhmmmmm (+) ((pause)) John, why do you think you come to the clinic?

36. C: mmmm ((pause)) Just to get out of doing my work at school.

37. T: Just to get out of doing work at school?

38. C: mmhmmmmm (+)

39. T: Is that what it feels like to you? Mmmm? ((pause)) Well, there are some other reasons that you come to the clinic too.

40. C: Why?

41. T: Well because we kind of think that, you weren't feeling too happy inside yourself.

Why Are You Here? The first puzzle for me was that of discovering what was 'wrong' with the patients whom I observed. A number of issues contribute to this puzzle and we can perhaps best begin to appreciate them if we consider the above transcript and, particularly U35. I found the session from which this transcript was taken to be 'reportable' (by this I mean that I saw it as different enough from other sessions that it seemed to warrant some comment). In contrast to the permissive and non-directive stance that I had come to expect in play therapy it seemed obvious here that the therapist was pushing the patient and confronting him with his problems. The therapist later agreed that this was true, but that he felt that they had been coasting long enough.

Although the therapist does not believe the patient when he claimed that he comes to the clinic (U36) "just to get out of doing my work at school", but chooses to see this as an evasion instead, we might ask how it is that a patient can spend several months in therapy without talking about why he is there. However, remember that the child is not a
voluntary patient; as the therapist says in U41, "... we kind of think that you weren't feeling too happy inside yourself". It is typical that children are not voluntary patients. Most adults would agree with Ginott when he tells us that:

The decision to receive or reject psychotherapy, like decisions concerning medications and vaccinations, should not be left to the child but to the adults responsible for the child. ... Little children cannot make wise choices in matters that are beyond their ken.\(^5\)

The child does not usually come to therapy with "something to talk about". Although it is assumed the child knows that he has a problem it is usually assumed that he is not capable of articulating it. Thus it becomes incumbent upon the therapist to discover why the child is "not feeling too happy inside".\(^6\)

Although I was interested in the noticeable absence of a problem topic and realized that the child's status as a 'child' may account for this absence, I also noted a further absence here. That is, Sullivan's *The Psychiatric Interview*\(^7\) suggests that the initial interview in adult psychotherapy sessions should, ideally, proceed through several stages. He calls the first of these the "formal inception". This stage begins with the first contact and may consist minimally of a therapist greeting a patient by name, inviting him into the office, and offering him a seat. It is recommended that the therapist then opens up the session by stating why he thinks that the patient has come to see him. This stage is terminated when the patient begins to provide some ideas about himself and his problems. The participants in this instance are immediately accountable to one another insofar as they must demonstrate some relevant and appropriate reason for the visit.

Not only is the child therapist frequently advised to avoid this
kind of talk during the early sessions but the same sense of accountability does not apply. Neither of the participants can be cited or rebuked for failing to mention the reason for the visit. Not only did I note an absence of talk about the reason for the visit but further, any sense of stages seemed to be absent. One session seemed much like the others except for the fact that the therapist and the child became more familiar with each other.

Now, consider this excerpt from a first session with a child.

2.2
1. T: ... a man who works with me sometimes.
2. R: Hi.
3. C: Hi.
4. T: That's Gary, this is Franz. ((pause)) Would you like to keep your jacket on or would you like to take it off?
5. C: (on)
6. T: You will leave it on, sure. What I thought we would do if we could spend a little time together and we would play together and then when we have had some time I could take you back to your classroom.

It is taken for granted that a child will be anxious enough when coming into a new or strange setting and should not be pushed to worry about why he is in that setting. Thus, treatment programs may proceed for quite a long time without any mention of the reason for the visit. As Ginott points out, "the child's conceptualization of the meaning of therapy can come only from experience, not from verbal explanations."

If, after a lengthy time, the patient continues to display a lack of concern or understanding for the "why" of his visits, the therapist may attempt to focus upon this issue. (As in transcript 2.1) Here, the therapist relies upon the patient's intuitive ability to understand why
he is in here and to act upon this insight.

The sequence above did not appear to constitute an unusual opening. This relative absence of direct talk about problems contributed to one of my first impressions of play therapy, i.e. I found that it was dull and lacked any noteworthy events. Field notes for an entire hour might consist of comments such as "played with toy soldiers", "had a game of darts", "asked what time it was", etc. Very little appeared to be happening.

Remember that it was the directness of the therapist's remarks that made the session reported in transcript 2.1 unusual. While one might expect an adult patient to talk about many personal matters, the typical child patient reveals extremely little about his life outside of the play room. Many hours of child therapy appear to be just play which is going nowhere. However, this raises a crucial question, specifically, How do the psychiatrists make sense out of this apparently mundane and uneventful activity?

For the stranger this raises the very question the therapist has asked the patient, that is, "Why do you think you come to the clinic?" Although most children are referred to the clinic because of behavioral problems such as bed wetting, anxiety, temper tantrums, doing poorly in school, starting fires, etc., therapists tend to regard such offensive behaviors as symptoms of some deeper problem. The real problem is assumed to lie somewhere in the child's self-conception, his feeling tone, his personality, or his pattern of development. In short, it is a problem which is not easily located or described. While we could all recognize a broken leg or a fever as a genuine medical problem this is not the case with 'disturbance' used as a gloss for intrapsychic problems.
One of my earliest discoveries was the discovery that patients appeared to be normal children and I was able to recognize their play sequences and other doings as documents which pointed to some underlying problem only when I listened to the therapists' reports. Thereby, I decided that the process of becoming a competent observer entailed acquiring the ability to turn the mundane world of a child's play into something which had psychiatric significance.

As I soon discovered this was not a problem for me alone. Groups of students from the social work school were often allowed to witness sessions of play therapy and students frequently remarked that they could see nothing wrong with the children. Although they could see that something was wrong with severely disturbed children such as autistic children, they frequently failed to see any problem with children who had a desire to fly, talked about dead birds, refused to hit the punching clown, took a doll for a walk in the hall, and so on. Instead they seemed to find such things to be reasonable and expectable instances of behavior.

It is never assumed that children are participating in play therapy by accident or by chance, instead there is always the explicit assumption that the patient suffered from some disturbance. This assumption of disturbance came out in many ways. However, it became especially clear through a popular joke which suggested that members of the staff were reluctant to bring their own children to the clinic Christmas party because they feared that other therapists would discover something problematic in their behavior. This seems to have many interesting implications for us.

Over the course of my study, I found that I was increasingly able to make psychiatric sense out of the children's activities in the
play room. I see this accomplishment as the central issue here. I suggest that we can begin to look at this accomplishment in terms of (a) the nature and consequentiality of children's play, (b) through the various meanings that can be assigned to a child's reasons for selecting particular toys and activities, and (c) through a conception of the child as an actor in a common-sense social structure.

However, there is a previous point which needs some clarification. I suggested that play sessions appeared to be dull, routine and uneventful. As it turned out, these were related to the very objectives of therapy.

Dr. Weininger, speaking about child's play and therapy, described the objective of play therapy and claimed that this objective could be and was achieved, in the following way.

(It seems that a relationship develops) between the therapist and child so it is sufficiently safe for the child to begin to explore some of the feelings that he has, and he can only explore them in the context of the relationship that exists between himself and the therapist. What he does is make use of certain kinds of play materials, these may be dolls or these may be other kinds of things, they may be animals, they may be bows and arrows, they may be paper and pencil, but he makes use of these materials to begin to explore the problems he has. Gradually, as he has the relationship between himself and the therapist, the freedom permits him to explore them in greater depth and experience some of the anxiety that he actually has which in fact he is defending against experiencing. The play therapy permits him, allows him to experience the anxiety because there is this safe person, there is this person upon whom he can have a dependency relationship. The child ventilates these problems, begins to explore them; ... In other forms of therapy there is no interpretation and the child is given the freedom and helped by reflection of some of the things he is doing, to begin to extend his play so it becomes a vehicle through which he can explore the problems, but primarily through which he can go back on, if there is such a thing, his own track of development, and have more adequate relations with other kinds of people, so he in fact no longer has a problem.13

How did I come to see this as a rational way to accomplish therapy? As a starting point, I discovered that therapists of other theoretical persuasions often cited the 'dullness' that I have already referred to
and thought of this as a "strange" way to do therapy. We can ask how it is that the therapist justifies calling play therapy 'work' when nothing extraordinary appears to happen.

I had to learn not only how to make sense of the patient's play, but also to see the implications of the therapy technique. That is, I had to learn to see play therapy as a good and rational way of making children with behavioral problems better. Again, the therapist's talk provided me with instructions on how to accomplish this. It seemed to involve, at least in part, some understanding of the child's emotional development, of the ways in which relationships within the family affected this development, and the child's need for love, acceptance, understanding, and so on are intrinsic parts of this development. I had to learn too, that the child would only be free to change within the appropriate relationship, specifically, in a relationship which allowed him to express his pent up emotions.

I began to see the rationality of this in the following way. Later, this allowed me to locate numerous other documents of it in the therapy events.

2.3

1. T: Janet?
2. C: What?
3. T: I can't really see from here, do you think I should move closer?
4. C: Do you want to try and see all the boats?
5. T: Yea, do you want me to?
7. T: Okay. ((therapist moves closer))

Here, I was puzzled as to why the therapist had asked the child's
permission to move closer to the sand tray in order to see what was going on. After the session, the therapist explained that children are under the constant surveillance and control of adults, however, the patient in play therapy should feel free of these restrictions. That is, the child should be made to feel an equal partner in the relationship which obtains between him and the therapist.

I will provide some further instances of the rationality of the relationship; for instance, in the following incident.

Since the relationship was to do some of the work of earlier parent-child relationships, therapists attempted to stimulate a high degree of rapport, trust, security, and confidence so that the patient could begin to experiment with his own actions and feelings. The importance of this relationship can be sensed in the satisfaction which is evident in the following statement. The patient had expressed her trust in the therapist and, soon after the session was over, the therapist said to me:

2.4

T: That's a tremendous tribute you know. I don't often get that kind of thing, where kids say you have my doll and I'll have yours. Because ah, well, it's got all kinds of, probably all sorts of sexual overtones, or undertones, but simply the recognition that this is something I can trust you with, that is I'm coming back, and it's going to be safe. And I think that she was grateful to me for having begun to deal with her concerns.

This short excerpt points to the importance of trust and its relationship to and importance in therapy and gives us some important ideas about how we find indications as the therapy progresses. Since the child can deal with her concerns without any direct confrontation, it is always difficult to ascertain whether or not the child has sufficient confidence in the therapist to be able to sense that he can act out and deal with his problems.
Or consider the following between a therapist and a student:

2.5

T: So that's the mo-, yea so the other things is that she hasn't really gotten anything from the mother, the father relates to her, the father relates to her and mum really doesn't, and mother handles her now by literally chucking her out of the house anytime of the day or night.

S: ( )

T: Yea. So that this is the thing you see ( ). She felt the anger, she feels the rage and she can't express it in the classroom, and that's okay, but you know what I think the teacher is doing in the classroom is to say "look I know you've been ( )

S: mmhmm (+)

T: I think for the kid who's so, who's been getting so much hell as a result of ( ) she needs to know that somebody knows that ( ) it's understandable you know.

The therapist is explaining why passivity and tolerance are called for in situations that would normally evoke some active response from an adult.

It was through instances such as these that I began to see that the therapist's actions, his passivity, tolerance, and acceptance, were intentional effects which were directly related to and had consequences for the child's actions.

It is obvious that such constraints present certain problems for the therapist. Some of these were obvious to me from the outset since the talk which I heard often appeared to be very strange. For example:

2.6

C: I'm putting, I'm putting a model together today.

T: You're going to put a model together today hey.

C: The one you gave me.

2.7

C: I want to go away.

T: Hmm/
C: I want to swim in the pool (at gym).

T: You wanted to go away from me.

I started to notice various kinds of repeat sequences and referred to them collectively as the echo technique. It was not uncommon for an exchange of several utterances to follow a pattern in which the therapist simply restated what the child had said. (For an example of this see transcript 1.6). In contrast, a therapist showed me how the following conversation was inappropriate in terms of the overall design of play therapy. It went:

2.8

C: I guess it's tough on grandfathers isn't it?

T: Tough on grandfathers?

C: Yea.

T: How is it tough on grandfathers?

C: I don't know why.

T: But it's tough on grandfathers huh?

C: (

T: Thank you Terry. Is it tough on grandfathers to work?

C: mmhmmm (+)

T: Grandfathers build roads? ((pause)) Humm?

She explained that:

2.9

T: . . . (this) left me spinning. I, I was really puzzled because he, usually when he's been building roads I've been saying "what kind of road is it?" and today I thought well hell I've been through that route, you know, so I'd just be quiet. And then he comes out with that bizarre statement, like, "It's really tough for grandfathers" and you know it was really bizarre.

R: I forget what you did, you did make, you did try and say, you just said "It's tough for grandfathers?" hoping he would carry on.
T: Yea, and nothing happened. And at one point I said "it's tough for grandfathers building roads?" and he said yea. But that was, that was bad therapeutically on my part because I led him into that, you know. I set him up with an answer. Whereas I would have been better off to say, like I say, I tried once though, I said "it's tough for grandfathers?" hoping he would embellish but nothing happened. But I should have said again, "how is it tough?"

Axline makes the following point about saying the child's words right back to him. She points out that this is often the correct procedure; had the therapist said instead:

"You are afraid and your mother doesn't pay attention to your fears and that scares you still more", she is getting ahead of the child and interpreting his remarks. Perhaps the interpretation is correct, but there is the danger of thrusting something at the child before he is ready for it.\textsuperscript{15}

So far, I have emphasized how the observer comes to see an order or rationality in a strange or esoteric setting. Although the central issue has been that of making sense of the child's activities in the play room, it is also essential that we see how the therapist's activities, as motivated accomplishments complement and in some way account for the child's doings during the session. The fact that I was able to understand what the therapist was doing was essential for my conception of what was going on in the episodes that I have reported.

I take it that the discovery of rationality amounts to the ability to provide adequate accounts of events. In this case, I am trying to show how events may be said to contain some importance for therapists.

Let us now return to our central problem, i.e., that of making sense of the patient's actions and activities. While I do not claim to have acquired the competence that a therapist would display in making sense out of these events, I gained some understanding of how children's play can be made into psychiatrically relevant data.

There are many instances in which adults use play with children to
mask other tasks. A school nurse might paint a face on the child's arm prior to giving him an innoculation, or the photographer often gives toys to children as a way to capture their attention so that he can take their photographs. However, it was not the case that the therapist uses play in order to mask some other more serious activity, rather, the play is itself the therapy. This became clear when parents ask: "Why does my child come here to play?" Therapists do not answer this question implying that they are using play to keep the child busy so that he won't resist the cure which they have designed for him. Rather, they talked about the ways in which a child communicates his problems via his play and uses play as a resource for resolving his problems. In short, although the layman might see the child's actions as "nothing but play", the person who was trained to see it as therapy could do so. This understanding is essential if we are to make these sessions meaningful.

Anthony, who is the mentor of one of the therapists at the clinic, says that play therapy is grounded in the fact that

it provides a transient, illusional transformation whereby the child is no longer a helpless homunculus in an overwhelmingly large world, but a veritable Gulliver among the Lilliputians, exercising his omnipotence over a malleable, non-resistant universe. The child often finds that he cannot cope with his adult-made environment and resorts to the non-resistant world of toys where he finds and makes for himself a manageable replica of that larger world. This provides him with the opportunity to find himself through his adventures.

E. Erikson calls the play room and its characteristic toys the child's microcosm. It is a world he can manage and is not swept along by forces that he cannot control. Since the child's play is fashioned after his image of the 'real world', it is possible for the observer to discover
the 'real' child in and by way of his pretend activity. Erikson says further:

What is infantile play then? . . . it is not the equivalent of adult play. That it is not recreation. The playing adult steps sideward into another reality; the playing child advances forward to new stages of mastery. I propose the theory that the child's play is the infantile form of the human ability to deal with experience by creating model situations and to master reality by experiment and planning.\textsuperscript{18}

While the child's activities may appear to be fantasy, pretence or make believe, Erikson instructs us to see that, in his apparent suspension of reality, the child is recreating his world and his real feelings, etc.

I take this to mean that, in a developmental sense, the child has the capacity to express himself, i.e., to communicate his feelings, to show his understanding of the world, and to reveal his wishes, wants, and fears, through his relationship to toys. Therapists refer to this as the child's natural mode of expression.

An important realization in the history of psychotherapy was that the techniques and tools used in adult psychotherapy, however successful they might be in that context, did not necessarily work as well when used with children, for they are fundamentally different creatures from adults and often cannot be treated in the same way that adults are treated. Hug-Hellmuth was the first to use play in treating disturbed children, but it was M. Klein who realized that spontaneous play could be used as a direct substitute for the verbal free association used so successfully by Freud in the treatment of adults.\textsuperscript{19} However, it should be noted that Freud, in treating "Little Hans", used Hans' play as a resource in order to gain insights into his problems. The technique of observing a child's play as a method for discovering his underlying problems has been greatly elaborated and a variety of different approaches have been developed. In
all of these, however, there is assumed to be a relationship between what
the child does with the toys in the play room and the state of affairs in
which the child will find himself when he leaves.

As a stranger, I became aware of the significance of toys and play
through a number of different incidents. For example, I saw that the room
did not contain simply a random selection of toys. Rather the therapist
selected specific toys and positioned them in the room. It was apparent
that the selection that she made was related to her understanding of the
child and his or her problem. For example, when preparing for a child
who was over anxious about a hospital stay and surgery, the therapist
spent considerable time in looking for some medical toys. She found a
doctor's bag with some instruments in it and placed it in the room which
the child would be using.

It might occur to the reader that this is similar to what a con­
cerned parent who wished to show a child what hospitals were like might do.
The parent might encourage the child to play with a 'doctor bag' in order
to assure him, and to make things familiar and less frightening for him.
However, this is not what the therapist had in mind in the above mentioned
episode. As soon as the medical toys were placed in the room all of the
child's actions became consequential for the therapist. If she chose not
to play with them, she was seen to avoid them and to demonstrate her
anxiety; if she played with them only towards the end of the session,
this could be seen as progress; playing with them in spurts could repre­
sent ambivalence; and, if she played with them creatively, this could
indicate that she was working through her anxiety in a realistic way.

Note that, in this instance, the medical toys became a central and
important part of the interactional environment in a way that other
objects did not. For example, no special psychiatric significance was attached to the fact that the child did not draw on the board or did not find the rubber ball in the bottom of the toy box. Over the course of my observations at the clinic, very few single objects came to assume the importance that the medical kit had held for this patient, however, every toy can be assumed to be as important under some circumstances. Thus, one way of providing an adequate explanation of the patient's behavior then is to posit a special interactional environment in which some objects are inescapably related to the patient in important ways. If a child is angry but does not play with the punching clown, it can be assumed that he is deliberately avoiding not only the clown but his anger. It is also possible to locate a child's problems by watching how he reacts to the toys in the play room, e.g., if he avoids the wild animals and plays with the domesticated ones instead, we could assume that he was avoiding his anger. However, before attempting to provide an account of the patient's reactions to the toys, the therapist will attempt to gauge his emotional level for his actions are to be interpreted in light of this.

My second naive observation was related to the observation above. During the early stages of my field work, I often became annoyed with the therapists because they appeared to be trapping the child. That is, I felt that the child had no escape because whatever he did was seen as significant. Therapists made (or tried to make) psychiatric sense out of all of his actions all of the time. On the other hand, I often thought that perhaps the child was tired, that he had to go to the bathroom, or that he didn't have that particular toy at home, and so on. That is, in contrast to the therapist, I often tried to provide a normal motivation for his actions.
What we have here is a clarification of what an "occasioned adequate explanation" amounts to, i.e., in order to be adequate it must be psychiatrically adequate. It may be perfectly adequate for a parent to account for his child's behavior by appealing to the fact that he is tired, restless, hungry, etc., but these would not be appropriate for the occasion of therapy. This became clear for me in the following instance.

Children often painted with watercolours at a large easel and the paint would often run down the paper while the child was painting. The finished picture would be treated as 'data' by the therapist. I proposed that perhaps the finished product was as much the result of the way that the paint ran down the easel as a guide to the patient's intrapsychic life. Although the therapist acknowledged that the flow of the paint affected the final shape of the picture, he claimed that with each stroke the patient was making a choice—even if it was an unconscious choice. Did he, for example, turn it into an angel or a monster, a cat or a tiger? Did he finish it or not? Did he incorporate the drip or leave it as a mess? etc. Thus, we can see that any adequate account of the play activity is built upon notions of the intentionality of the action.

A competent therapist would not claim that the interpretations made were necessarily the correct, or even that there was only one correct interpretation. Rather, interpretations are 'guesses', designed to help the therapist move towards a better understanding of the patient. They can be proved wrong and reconsidered, or they can be confirmed. The therapist's competence does not seem to rest upon his ability to interpret any particular, single action but on his ability to see the pattern behind the whole range of actions. Thus I realized that the way in which some particular action was judged in and of itself was far less important than
its place in the larger pattern. As one therapist said:

T: ... you get a pattern do you see, emerging, so that after I get something like this, um, it makes it, and after a few times it makes it easier for me to figure out what's going on.

I want to emphasize again how each and every one of the child's actions is consequential for the therapist. I will now briefly describe the therapist's interpretive schema.

As was suggested above, the therapist relies upon the fact that a child's reaction to the toys in his environment can be used as a resource in interpreting his hidden feelings and problems. Many of the toys were readily categorized. For example, guns were seen as instruments of violence, wild animals were seen as possessors of aggression, ambulances or police cars represented people who want to help others. However, objects like drawing or painting materials became meaningful for the therapist only after he could see what the child did with them. (However, it is also possible to see painting as an activity which allows the child to avoid the 'angry' toys). I take it that particular toys were selected by the therapist in the first place because they communicated these kinds of meanings. As Ginott says:

Since a small child's imagination makes urine of every fluid and feces of every messy substance, sand, water, paint, and clay provide excellent means of sublimating urethral and anal drives. No play room for small children is complete or adequate without such materials. Enuretic children should be given paint and running water, encopretic children, mud and brown clay. Firesetters should have capguns, sparklers, and flashlights. All children should find in the play room miniature utensils for cooking and serving as means to sublimate oral needs, dolls that can be dressed and undressed to sublimate sexual drives, and punching bags, targets and guns to sublimate aggressive drives. ... A child should be led to express anger by punching dolls and destroying clay figures, ... The therapy setting must provide materials that allow growth in the repertory of self-expression.21

While the toys are methodically chosen by the therapist to relate
to the child in a special way, the patient's own selection of them as play objects is then seen to be motivated by the nature of his problems and his state of mind. Ginott makes this clear:

Appropriate toys make it easier for the therapist to understand the meaning of the child's play, thus for example, children usually play out family scenes using dolls that represent mother, father and sibling. In the absence of such dolls, a child may symbolically play out family themes by using big and little wooden blocks. But the exact meaning may escape the therapist... However, when a father doll is put on top of a mother doll, the therapist has less room for misinterpretation.22

In searching for the motivation behind a particular selection, it is possible to build upon the character of the object that it is a substitute for. It is interesting that most toys are miniature replicas of real objects—guns, animals, people, vehicles, carriages, baby clothes, baby bottles, trees, fences, etc. (Exceptions appears to be monsters and games). If a patient takes a drink from a baby bottle it is not taken to be assumed that he is simply thirsty, but that he is pretending to be a baby having a drink, i.e., he is acting out of dependency needs.

This characterization of objects became clear in the following conversation between a therapist and myself.

2:10

T: Yea, I remember, it happens often that we're doing dinosaurs. It's funny like, John persistently chooses dinosaurs.

R: And there are other things to choose from?

T: Oh yea, there's cars, and boats, and planes.

R: Yea.

T: Yea. And generally the dinosaurs are ferocious things, you know, like dinosaurs are usually thought of as not, . . . they're mostly the most ferocious, dangerous creatures to walk the face of the earth, . . . I try to use that, . . . So I try, I try and tend to kind of see "okay, dinosaurs, now dinosaurs are ferocious beasts maybe we can get into John's anger a bit."
In this excerpt, we see how it is also possible to characterize the choice of an object as eventful according to the frequency with which it was chosen.

While it is possible to achieve some degree of understanding by attending to the patient's initial choice, one must also attend to the ongoing pattern of his playing. I will point out a few of the things that made this apparent to me. Consider the following:

2.11

T: Now that's the sort of thing where you've got a seven year old who simply pulls toys out and puts them into the tray, uh, and ignores relationships so no grouping occurs or very little grouping occurs, you know you may bring out a horse, and may bring out another horse, and yet the two horses have no relationship to each other. That sort of thing happens in only very young children who are just at the sort of object naming stage, children who are retarded, some children who are brain damaged, uh, who often actually go through the whole thing very quickly.

The reference in the above transcripts is to a patient who spent the whole session taking the toys from the box, naming them, and then placing them in the sand tray. For the therapist this kind of activity was noteworthy because of the patient's age. What is eventful is the fact that the child paid no attention to the structure of the sand tray placement, that is, what resulted from the 'play' was a random assortment of toys which bore no obvious relationship to one another. The toys the child was playing with were a part of Lowenfeld's "world picture technique," miniature replicas of people, animals, fences, etc. The resultant miniature 'world' created by the patient reveals the degree of his disturbance and gives some suggestions as to what the disturbance is. In this context, the above mentioned child's world view is chaotic, confused, etc.
This incident took place in the first therapy session that I witnessed and I strongly felt that the child's "naming game" could be explained by examining the interactions between the therapist and him. An examination of the transcript will show that the therapist initiated this naming ("what's this?") and it is possible that the patient thought that he was to continue. The therapist rejected this account and provided an explanation in terms of the intrapsychic life of the child.

Many other kinds of relationships were pointed out to me as well. Placing the parents in the house and leaving the baby outside; building a fence around a solitary person and then making the ocean splash dangerously near; engaging the wild animals and the tame animals in a battle; building a fence around the wild animals; getting one of the vehicles stuck; and so on. All of these were considered to be significant. Further, it was assumed that the patient always identified with one of the objects in these scenes.

These comments refer essentially to the content of the child's play but it was always necessary for the therapist to attend to more than this. For example, he would note the style of the play and whether it was tidy, orderly, personal, impersonal, etc. He would also note the effect that the play had on the player. Did the child become involved, reluctant, excited etc. Even the flow of the activity was meaningful for him. As a novice observer I simply saw large blocks of play activity and was surprised to find that the therapist could discover many meaningful patterns here. The essential problem seemed to be that of learning to see what counted as a unit of activity. One way of using the flow of activity went like this. Since the child's play is taken to have elements of reality in it, it follows that his fears and anxieties will intersect...
with the play at some points. Play scenes may heighten the child's anxiety and one could then discover something about his problem by examining the content of the play at that point. This was made clear to me in the following scene. The patient's immediate problem was expressed as extreme anxiety related to anticipated eye surgery and the therapist was obliged to hurry the therapy since the operation could not be postponed. Thus, instead of allowing the child enough time to work out her feelings and fears, he had to try and bring those anxieties to the surface so that they could be dealt with. The normal process had to be speeded up. One strategy which I have already mentioned was that of placing a medical bag in the play room. Another was to mention eyes or seeing while the child was playing. He might say, "Are you having trouble seeing that?" He could then see if her anxiety level rose by looking for any disjuncture in the play activity, i.e., did she move on to another activity? did her motions become more erratic? and so on.

At the mention of a sensitive area (i.e., feelings of anger or rejection) the play activity may be disrupted. Both of these examples refer to situations in which the source of disruption is located outside of the activity itself, i.e., in a comment by the therapist. However, it is also possible to see the disruption coming from the activity itself. That is, one could look for evidence of the disruption in the content of the play.

A therapist noted that a patient was making 'progress' for her previous session had contained the largest period of creative play that he had seen so far. In an earlier session he had described her play as follows:
T: Strange sort of, at one point she can deal with her anxiety very creatively in that she's you know prepared to adopt a very close imitation of reality.

R: mmm

T: And then, at the (worst) she goes back to the sort of regressive stuff with sand, mixing of paint, baby sort of stuff. It's fairly typical I suppose in a play therapy session to get this, these swings are very marked.

Here, however, the therapist saw the child's creativity, her relation to reality, and her regressive tendencies. Taken as a whole, these indicate that she is making progress. The characterization relies upon the symbolism of the play objects and upon a recognition of the kinds of play that she was engaged in, i.e., 'creative' and 'regressive'.

This sequence of changes from creative to regressive was seen as normal since it is assumed that the child works out current concerns in play activity. It is to be expected that the child will be able to cope with his problems for a while and then will regress to an earlier safer stage. Progress is evident as the regressive periods diminish.

In conclusion, there are two more puzzles that I would like to mention. I immediately noted that there appeared to be a special set of rules for the play room. One therapist told a child:

T: and, and you can also swear in the play room even if you wanted to do that.

C: Why?

T: Cause this is a place where kids can do pretty much what they want to.
2.14

T: Sometimes I bet you even swear.

C: No I don't swear.

T: Hmmm? You know, one place where it's really good to swear is right here in the play room.

C: I know.

T: That's right. ((pause)) Why you can even say fuck and all those things, right here.

C: (you want to the darts)

T: Hmmm? ((pause)) At home though I think sometimes it, bugs mom if you swear.

C: (watch this)

T: Yep right here in the old play room, that's a good place to, let it all out. You can swear, yell, and all those things. ((pause)) Wowweee.

C: The kick-off.

Other children were allowed to paint on the walls, to shoot the therapist with a water pistol, to make unbelievably loud noises, to smash bottles, to throw darts at a drawing of a teacher or the therapist, etc.

Some of this permissiveness can now be seen as the result of the idea that a child should be given the freedom to explore and experience his emotions. It is important that restrictions be held to a minimum since the child makes progress by (a) participating in an accepting and tolerant relationship, and (b) expressing his constricted emotional development within the safety of that relationship. The reduction of restrictions helps the relationship to develop. Ginott puts it nicely when he says:

Many children have been scolded or spanked for messing with mother's typewriter, fooling with brother's flashlight, or playing with father's tool kit. Nothing conveys permissiveness to these children as much as the presence of such materials for their own use.
Noisemaking toys such as drums, pegboards, xylophones, airrifles, and cap guns serve the same purpose. They communicate loud and clear the adult's basic spirit of tolerance.\textsuperscript{24}

Therapists also take it that there are some activities that relate to the child's problem. It is often profitable to allow the child to do and feel things that he has not been able to do in other settings. I once questioned a therapist about a child's actions.

R: Well how do you think the kid, what's going on for the kid when he throws darts at the balloons, and sometimes pretending the balloons are you?

T: Well, I don't know, I think he can get into it, you know, that is, that he can really kind of act out the feelings of anger he has towards me. And I think that's kind of a relief in a sense. I think for Chris too it might make him feel rather brave and daring. And I think he can get some satisfaction from that.

Some of the assumptions here should be pursued. It's a "relief" for the child to express his anger with the therapist because he was not allowed to experience anger in other relations. Perhaps when he got angry with his parents, as all children do, he was not permitted to express his feelings but was made to feel guilty for being angry with his parents in the first place. A child with too many restrictions of this sort may become timid, manipulative or many other things. However, if he is allowed to vent his feelings in the play room, he may come to see himself in a different way (e.g., 'brave', and 'daring'), and learn to keep up this image outside of the therapy session.

This relates directly to my final puzzle. As an observer, I saw the patient's problems and gained an understanding of them only by placing the child in a family context. While I have not talked about the patient's family to this point, I do not mean to suggest that it was not seen as an
important factor. Without exception, the talk about a patient included talk about the situation of his family, the child's sibling position, his father's occupation, the family's theories about child rearing, traumas in the family, and so forth. I assumed that none of these features were incidental but were relevant indications of what might be the matter with the child. Children's productions often related to their family situations. As a therapist told me, one patient typically produced paintings with a clear dichotomy indicated by contrasting colors (red and black) and often his talk suggested that contrasting people inhabited these two regions. This made psychiatrically relevant sense and could be seen as a symptom of the patient's problem only when it was seen as a document of his family's strict religious belief, his struggle with the notions of 'good' and 'evil', and his concomitant need to be naughty or mischievous, (i.e., evil).

Here is some of the therapist's talk about that child:

2.16

T: ... come on sounding very good, and I guess that's the way it is at home. I would guess from the way he's interacting in the play room that at home ( ) you can't do things because you would like to do that better or because you prefer, you have to be rather selfless about the whole thing and do it for the good of somebody else. You know, it's not legitimate if it has a selfish motive, at home I suspect. Certainly from observing him in the play room one would get that impression.

There is a constant attempt by therapists to see the patient's actions as outcomes of his everyday life and to give psychiatric significance to them. There is a great difference between assuming that a child is a manipulator and assuming that his behavior is the result of the problems that he has in his family. This provides us with some insight into his real problem. That is, given that the child is manipulative, we can assume that there is some problem in his home life.
This kind of evidence is useful not only in cases where the child's problems were vague, but also in cases where the problem appeared, at first glance, to be obvious. For example, a girl who talked of growing whiskers and of changing her name to John could easily be seen to have a sex identification problem. However, these symptoms were given a different significance when it was discovered how they made sense in terms of her family situation, specifically in terms of the differential attention given to her brothers, her positive feelings towards her father and negative feelings towards her mother. Now, we have quite a different picture of things.

I began this chapter by searching for the psychiatric relevance of events in the therapy setting and have provided a description of the rationality of the setting. I was able to do this because I was already (although unwittingly) a competent participant to the setting.

In summation, I made the following observations:

1. I found that all of the events in the play room were open to a psychiatric interpretation. This produced the following transformations for me. (a) I moved from a position wherein I saw patients as normal children to one in which I could see that they had problems. (b) Instead of seeing therapy hour as dull and repetitive, I began to see it as a systematic programme designed to help disturbed children. (c) I no longer saw the child's activities merely as play, but as documents of problems, as well as of trust, progress, etc. (d) To some extent, I began to make the same sense of events as the therapists. That is, I began to acquire a psychiatric rationality of my own.
2. I also learned that it was not sufficient to explain a patient's behavior in terms of the nature of paint, the time of day, body urges, etc. Rather, psychiatric accounts invariably lead the therapist to features of the patient's life outside of the play room (or to his intrapsychic functioning). These explanations came about by seeing the therapy room as an interactional environment in which all actions were the result of intentional (even when unconscious) choices.

3. To achieve psychiatric understanding one had to provide adequate motivational statements with respect to those choices. This was done in many ways, but the most frequent and most interesting were accounts framed in terms of the 'family'. All children are family members and consequently this provides an ubiquitous set of circumstances in which to find the motivations for the patient's play room behavior.

4. Thus we have moved from our initial interest in psychiatric relevance to a consideration of mundane knowledge about children, families, problems, etc.

As I became more familiar with the therapist's accounts, I became more dissatisfied with my new understanding of the setting. This disaffection stemmed from two sources. First, while there was a claim that the structure of psychiatric accounts was supported by a body of theory, this was never made explicit for me. Consequently, I felt that I could never acquire an adequate understanding of how psychiatrists make sense out of the events of the play room. Secondly, I became increasingly aware of, and intrigued by the set of membership categorization devices that appeared in this setting. One could, for example, naively assume that the occasioned categories of 'patient' and 'therapist' would be adequate
for categorizing the participants. However, I found the members were frequently referred to as 'adults' and 'children' and, further, that neither the category of 'patient' nor the activity of 'therapy' were ever mentioned to the 'child'. Related to this was the observation that therapists often talked about the possibility of sounding like a parent and having the patient respond like a 'child'. This led me to see that the corpus of knowledge represented by the therapist's accounts was one that contained a great deal of common sense reasoning—something that I shared with the therapists. That is:

psychiatric theory ←→ common sense
and relevance knowledge

This brought me back to where I had begun. I had started with observations on the reasonableness of what I saw and heard, doubted this reasonableness, and searched for its psychiatric relevance. At this point, we have come full circle to a new awareness about the embeddedness of common sense in this setting.

This raises some serious questions about the nature of the psychiatric interpretive schema, but before turning to these, I want to examine some of the features of the therapist's corpus of knowledge about children and families. This corpus is constructed from accounts provided by therapists and I want to emphasize the essential reasonableness of this explanatory structure. Up to this point I have presented a rather broad description of the rationality of the setting. The next two chapters will provide more detail.
Footnotes

1For a brief introduction to this literature see R. M. Pavalko, Sociology of Occupations and Professions, (Itasca: F. W. Peacock Publishers Inc.) 1968.

2By "rationality" I would like to employ Cicourel's usage: "... rationality means the observer's model of how the actor decides what is 'reasonable', 'proper', 'logical', 'acceptable', 'legal', and so forth during the course of action." As an observer, I was constantly engaged in the construction of a 'model' of what seemed reasonable, proper, logical, expected, usual, acceptable, etc. in this setting. This was based on the talk of others in the environment. I am talking about the background expectancies that made events reasonable, etc. See, A. Cicourel, The Social Organization of Juvenile Justice, John Wiley and Sons, 1968, p. 46.

3V. Axline is one of the major advocates of play therapy and her work is held up as an example of 'good' (if unattainable) therapy.

4This kind of therapy is sometimes referred to as 'non-directive therapy'. That this choice is theory governed is evident in the following statement by Ginott: "The difference between the two schools of thought is succinctly summarized in their definitions of permissiveness. According to one approach, permissive means the acceptance of all behavior as it appears in the (therapy) group. . . according to the other approach, permissiveness means the acceptance of all symbolic behavior as it appears in therapy. . . " "The Theory and Practice of Therapeutic Intervention in Child Treatment", Journal of Consulting Psychology, 23 (1959), p. 160.

5H. Ginott, "Play Therapy: The Initial Session", American Journal of Psychotherapy, 15 (1961) p. 74. Compare this to a recent letter to Ann Landers. Dear Ann: I am 35. My husband is 40. We are both very busy with careers. I'm beginning to feel a little selfish because our eight-year-old child won't have a brother or sister unless we get busy. My husband doesn't care one way or the other. I frankly don't like the idea of going back to diapers and bottles. But I feel guilty. Should we ask our daughter if she would like a brother or sister and settle it once and for all? - ??? Answer: Adults who would allow an eight-year-old to make such a decision sound downright foolish to me. I think you have more than you can handle right now. Vancouver Sun, Aug. 20, 1974.


8 F. Swanson advises: "Since technically the child is the patient, the therapist might begin by asking him what brought him to the clinic—what are some of the things he and his parents worry about. Relatively few children can verbalize their problem initially. . . . Most children are clearly aware of their problems only while the problems are happening. . . . Besides, young children have relatively little perspective about behavior, life, families. They have little basis for comparison. To them, 'this is the way life is'." Psychotherapists and Children: A Procedural Guide, Pitman Publishers Co., 1970, pp. 30-31. Schulman, et al, who criticize therapists for thinking of children as "immature, dependent, relatively helpless and to be protected", suggests: "our interview, therefore begins with an explanation of the role of the therapist. This merges into a discussion of problems in general and specific problems which the child is experiencing". The Therapeutic Dialogue, p. 146.

9 A continuation of this can be found in transcript 1.1.

10 H. Ginott, Group Psychotherapy with Children, p. 87.

11 Ginott says, "The aim of all therapy. . . . is to effect basic changes in the intrapsychic equilibrium of each patient". Group Psychotherapy with Children, p. 2.

12 This is a common occurrence. For example, L. J. Redlinger in his research in a residential treatment centre for disturbed children pointed out that some members of the treatment setting "treat as problematic the official view of the children as sick, and in some cases reject the diagnosis". "Making Them Normal", American Behavioral Scientist, 14 (1970) pp. 237-253.

13 From a talk given on C.B.C. Radio.


16 All therapists can provide an account of the function of play for children. For example, "play activity is the child's native tongue—his natural way of showing how he feels about himself and the significant persons and events in his life". Ginott, Group Psychotherapy with Children, p. 176: "Play, the child's most natural medium of expression. Since it is essential to provide the child with the opportunity to use his natural tools and modes of expression, we see at once that play activity is an important factor in therapeutic work with children". F. Allen, Psychotherapy with Children, New York: W. W. Norton and Co., 1942, p. 122.


"Whatever the child does or says is always used by the examiner to relate to the problem for which the child was brought by the parent". H. R. Beider, "Psychiatric Diagnostic Interviews with Children", *Journal of American Academy of Child Psychiatry*, 1 (1962), p. 658.


Ibid., p. 243.


When asked about the hesitation in the following the therapist said she never used the term "therapy" with a child patient.

T: 'Cause I think you really like to take a piece of our ther- our session home with you. ((pause)) You like to have something to remind you of our time together, huh.
CHAPTER 3

'NORMAL' CHILDREN AND THE THERAPIST'S CORPUS OF KNOWLEDGE

Chapters 3 and 4 are a further exploration and description of the rationality of the therapy setting. That is, they tell how I came to see the therapists' activities as meaningful events, or as reasonable, proper, logical, acceptable, etc.¹ My disenchantment with 'psychiatric theory' drew my attention to a primary and fundamental property of practical reasoning, that is, to "background expectancies".² The notion of background expectancies is vital for us if we wish to answer the question: "How do observers decide that accounts are adequate for understanding what is taking place?"³

It is clear that actors in the world of daily life not only do the proper thing but make it apparent that they have done so and are obligated to do this. Therapists as members of the life-world, are continually engaged in the process of making and showing that their actions and understandings are adequate. Thereby, I would like to outline some of the background expectancies that make this adequacy visible.

On the one hand, children who attend the clinic are seen as disturbed children or as children who have problems. On the other hand, and at the same time, they are also seen as children who are more or less normal. I found that our notions of normality are essential for making sense of the business of therapy. Specifically, I mean that although we may label the patients at the clinic as "disturbed children", we will also recognize that they are children and, as such, have and display many of those qualities

81
which we would expect any child to have. In what follows, I will give some examples of how notions of normality in regard to children come to have significance in the play room.

One of the first things that an observer might notice is that while the clinic deals with disturbed children, much of what happens here is relevant to and for the normal child. This is made evident in two important ways. First, therapists often make sense of phenomena by comparing and contrasting them to some standard pattern of behavior. Thus they might say, for example, that some particular action is "a normal and expectable thing for a six year old to do", or, conversely that "normal six year olds don't do that". Secondly, therapists usually saw their patients as normal children. That is, the patients were not considered to be disturbed in every aspect of their behavior. On the contrary, most of what they said and did could be and was thought of and treated as normal.

Let's consider the latter point made above. It is clear that the way in which contact was made with the clinic (i.e. how appointments were made, introductions to the play room and therapist were managed, etc.,) has nothing to do with the patients' problems but is oriented instead to patients as children. This is often made clear in psychotherapy manuals and in therapists' remarks on how to manage patients. Allow me to elaborate. Ginott begins an article on handling the first interview by saying:

4 the first encounter between therapist and child presents many technical problems that call for immediate decisions.4

He then goes on to offer the following advice.

The therapist faces his first psycho-logistic problem: how to lead a child to the play room with a minimum of shedding of blood, sweat, tears, and other fluids. The sensitive therapist understands the child's feelings in the strange situation, . . . He anticipates with sympathy the scene of separation between mother and child, . . . He knows that the children may cry, refuse to leave mother, decline to
enter the play room, or demand that mother comes with them; or that
mother may cry. . . . When the therapist meets the child for the first
time, he greets him with a brief hello, dispensing with formal intro-
ductions, and social amenities. . . . He extends his hand to the child
and off they go.5

Concomitantly, occupational resources abound with information on how to get
children's cooperation, what children like to do and what they don't like
to do, how to talk to them, and so on.6 Throughout the emphasis is upon
children.

This attention to patients as children is seen most clearly in the use
of toys as therapy devices. As suggested earlier, this is not based upon
the expectable features of patients, but upon our ideas about what all
children are like. Although therapists make a kind of sense out of the
child's play that the lay member normally would not, the acts of providing
for that play and of seeing a relationship between the child's play and
other things appear to be quite reasonable. I suggest for example, that
it is no different than the way in which a parent may see his child's
future career in the kinds of toys that he selects, or in his interest in
or ability to use particular toys.7 Similarly, it appears reasonable to
use toys in the playroom. The therapist's selection of toys, while
apparently justifiable on therapeutic grounds alone, appears to be based
largely upon ideas about what all children like to do.8 Furthermore, this
selection takes age and sex differences into account.

In the following instance, we see how age differences raise consid-
erations for the therapist.

3.1

T: If I go downstairs ((to the day care centre)) and there's a little
four or five year old playing with some puppets, and if I say, "who
is it?", they'll say "mommy or daddy". Ah, they get right into it.
But for some one like Chris or John ((older children)) it would be
very hard for them to tell you that that was mommy or daddy they were
just pounding with the hammer.
This follows from the notion that young children are honest and have not yet learned to mask their feelings, or have not yet learned about what information can be passed on to what categories of hearers. In a similar manner some therapists suggest that having a young child in family therapy is both beneficial and tends to speed up the process because the child is so honest.  

Attendance to the age of the patient was displayed by another therapist in the following way. He was seeing a patient for the first time in what was to be a demonstration session for a visiting group of public health nurses. I observed him preparing the room and was able to discover his intentions. He prepared a small room which contained a table and two chairs. Some paper and writing materials were placed on the table and one or two large toys were set in the room. The therapist's toy box was also placed in the room although it was not opened. The therapist explained that the child was of such an age that he might want either to talk or to play. If the toys were made too obvious the child may have felt obligated to play although wishing to talk. Some objects were necessary however, (drawing materials) to present a space that would look less threatening.

There were numerous other instances in which therapists spoke of age appropriate behavior. For example:

3.2

T: I'm really impressed with Tanya as a child to work with.

R: Yea, ah, I'm not sure what it is but she seems very unusual, I mean aside from the kind of things that maybe seem bizarre, or,

T: Yea, I think she seems quite precocious.

R: Yea, she seems to know what's going on.

T: More so than say some of the eleven year olds I'm seeing.
R: Yea, another thing that struck me today was the way she would stand and look at things.

T: Yea.

R: It doesn't seem to me to be typical of five year olds to contemplate. The conversation above concerns a very disturbed five year old who is nevertheless described as precocious,—a category that lay adults usually reserve for children who are acting in a more sophisticated or 'grown-up' manner than one might expect given their age.¹⁰

These examples demonstrate how reference to the age of the patient provides an adequate account of his actions. For example, it can be claimed that the difference between children who will admit that they hate their parents and those who will not is often due to a difference in age.

We can see the appropriateness of the way in which the therapy room is arranged because of our understanding of children. It should be noted that these assumptions about normality are always psychiatrically (or organizationally) relevant.¹¹ This practical relevance is seen in the choice of play as a therapy device and has other consequences as well. For instance, it is consequential for what will happen to the child in therapy. Our ideas about normality are typically used as a standard for deciding which behavior patterns are unusual, and will be given a psychiatric significance. The abnormality is a document of the presenting problem (development derailment), or of managing difficulties. For example, a therapist in describing a patient who persistently chose to construct a model of a dinosaur told me that:

3.3

T: ... Most kids will choose one, you know, maybe they'll do one dinosaur and then ( ) it's a bore. You've seen one dinosaur, you've seen them all.
The fact that most kids get bored with this activity is a document of this child's non-conformity. This in turn becomes translated into an understanding like the following: since he persistently chooses to build dinosaurs, there must be something which attracts him to dinosaurs in the first place. As the therapist says:

3.4

T: I tried to see, okay dinosaurs, now dinosaurs are ferocious beasts, maybe we can get into John's anger a bit.

The therapist decided that it is the angry nature of dinosaurs that attracts John's attention and this now stands as a document of his anger (i.e. of his problem). Everything now makes a new sense. The behavior at hand, the patient's problem and even the course of treatment all fit together.

There are many other instances in which the patients are compared to their age cohorts. The following descriptions all refer to the same patient.

3.5

T: That's right. There's no sort of, there's no exploration of the room. He settled down to this particular task for the whole time without much reference to anything else going on around him. . . . But compared with the sort of behavior which most seven year olds show, if they came into this room, for example, is certainly a wider range of styles in the play room. But, there'd be much more looking around and exploring and questions; "Gee look at this" or some surprise or excitement.

Or:

3.6

T: Uh, yea, uh, the kid's language itself is peculiar his syntax is a bit shaky which is the most that had been noticed in the classroom to this point, which isn't so now, uh, sentence structure, sentence composition isn't good. He's got some fairly good sentences; "I think that is a fish, yea that is", "There go a car, a wheel, two wheels, who don't got some wheels". So you know its pretty immature sort of syntax.
T: I think the first thing that strikes me is constriction in this child's behavior. What's he six or seven I guess? Seven. The range of language, the range of fantasy, the range of play, uh, the range of play room behavior, is quite narrow, uh, compared with other children.

Therapists, like the rest of us, don't see behavior in a vacuum but see actions as appropriate or inappropriate for a child of a particular age (stage). Thus, it's not just that the patient mentioned above uses different or incorrect verb forms, rather his speech pattern is heard as immature and the child is thereby characterized as 'constricted', 'inhibited' and 'depressed'. We look at children as adults-in-the-making and recognize that it is adult members who guide the child's development. We realize, too, that the process of development may go astray at any moment. Here, age and stage appropriateness is a powerful resource for making sense of patients' actions.

While we have been considering instances when 'deviance' from age-stage appropriateness was relevant in terms of the setting, the idea of age-stage conformity is also useful in the construction of therapy strategies. There is an anticipation and recognition of the child's actions as being motivated by age characteristics. This is similar to recognizing the normality of patient's behavior in terms of his family's rules, traditions, and so on. Both of these assumptions provide ways of making sense of, planning for, and managing, patients. Consider the following examples.

A therapist, reporting his treatment activities to a colleague and myself, explained why he had had the patient smash bottles against the wall. He explained that the bottle breaking activity was a procedure for getting the child to express his anger overtly and thus his anger, having been
released in this way, would not be expressed indirectly in his everyday relations. The therapist made reference to this as a particularly good choice of activity because it involved much "noise, destruction, and physical activity". This activity was said to be appropriate for a child because children often like to break things and make a great noise. Therefore, it both accomplished its therapeutic objective and was fun for the child. This also accounted for why patients were allowed to spill water, paint on the walls, swear, and so many other things which we would not routinely allow children to do.

On another occasion this same therapist told how he often took one of his patients to the swimming pool. The patient was inhibited, and a document of his inhibition was his anxiety about the water. The therapist said that it was good for children to work out their anxiety about some dangerous activity while away from their parents.

Somewhat related to this assumption are accounts of how the patient will test the limits of every new situation, either to see just how much they can get away with both now and in the future, or in order to find out about the nature of the setting and its participants. For example:

3.8

T: She's very interesting, she's been testing me, ah ( ) and, last day I told her this was the sort of place she could do, you know whatever your impulses are.

S: Yea.

T: And some kid had been and painted on that wall over there.

S: Oh dear.

T: So I assured her that the kid who did that didn't get punished for that either, and that was okay. So a half-hour later she said, "next week I'm going to paint", and she said, "on the wall" ((last phrase said in a soft voice))

S: ((laughs)) Yea.
The child's request is not to be heard simply as a request to paint on the wall, but as a 'method' for finding out if she could really do so without being punished. It is one of the child's methods for discovering the parameters of the relationship and/or setting.\textsuperscript{12}

However, this type of testing is time-bound. That is, it only applies when the occasion or participants are new for the child. If a patient continues to engage in "testing" in the early stages of the relationship, it may be seen as an attempt to annoy or manipulate other members of the setting.

On another occasion, a student speaking to a therapist about one of his patients, told him:

3.9

S: I think she really wanted you to take away the feathers, she didn't resist too much.

In this case, the patient had taken some feathers and hidden them in her clothing after the therapist had told her that she could not take them home. As the session drew to an end, the therapist was forced to "find" the feathers and ask her for them. How does the student's statement come off as adequate psychiatric reasoning?

Involved in seeing the patient's desire to have the feathers taken away is an assumption about how to interpret children's behavior, i.e. children like to be told what to do. They like to be given rules or boundaries and to have them enforced because they derive a sense of security from knowing where they stand. Even when the child is resisting discipline we can see an underlying need and desire to have the adult enforce the rules.

In reference to such limits Ginott says:
Both in therapy and in life, children need a clear definition of acceptable and unacceptable behavior. They feel safer when they know the boundaries of permissible action. Therefore, limits should be delineated in a manner that leaves no doubt in the child's mind as to what constitutes unacceptable conduct in the play room.\textsuperscript{13}

Many of the activities in the play room appear to be adequate, appropriate, reasonable, etc., only because we can use our background expectancies of and for normal children as a resource for determining their adequacy. I will refer to the kinds of accounts that we have been looking at as examples of practical psychiatric reasoning.\textsuperscript{14}

A feature of practical psychiatric reasoning is the reasonableness, transparency or common-senseness of its understandings of children. I would like to further clarify its status. We can assume that therapists have some methods for deciding if a patient's behavior is appropriate, reasonable, etc. As an observer, I felt I was gradually acquiring some degree of skill in understanding and using this reasoning. I found that our notion of normal children as reported in this chapter is a specific feature of practical psychiatric reasoning and, as such, is a part of the therapist's corpus of knowledge. In making sense of a patient's actions, in organizing for, and in responding to them, therapists frequently appeal to our common sense ideas about what normal children are like.

The next chapter is a further exploration of the practical reasoning of the therapist, and while centering on one of the most important features of that reasoning, namely our ideas about the family, it will uncover surprising ways in which it comes to be used as a resource.
Footnotes

1 I want to draw attention to the fact that psychotherapy reports and accounts are tied to the everyday practices of the working therapist in ways that are not captured by the idealizations of textbooks, theories, etc. I am attending to psychotherapy as practical reasoning.

2 See Schutz, Collected Papers 1: The Problem of Social Reality. The Hague: Martinus Nijhoff, 1962. See, too H. Garfinkel's "Studies of the Routine Grounds of Everyday Action", in Studies in Ethnomethodology, Prentice-Hall, 1967, for a detailed discussion of background expectancies. By background expectancies I refer to those sets of taken-for-granted ideas that permit the interactants to interpret these remarks as adequate accounts in the first place. For example, that which is taken-for-granted in seeing the adequacy of the therapist's statement, "What's he six or seven I guess?"

3 I will return later to a similar question: How does the reader decide that the accounts I provided of therapy and therapy sessions were adequate?


5 Ibid., p. 75. (emphasis added)

6 Some further examples of this are: "Some children are so accustomed to being asked questions by relatives and friends that they have ready answers, designed to please or annoy". F. Swanson, Psychotherapy with Children: A Procedural Guide, Pitman Pub., 1970, p. 34. "Talking slowly and deliberately is one of the first requisites of interviewing children. Children tend to hear verbs more acutely than other parts of speech". J. Goodman, J. Sours, The Child Mental Status Examination. New York: Basic Books, 1967, p. 38. "Children can easily be influenced by suggestion". Ibid., p. 33. In every case, the therapist is instructed to see his patients as children.

7 For an example of how this is used in everyday life consider the following letter to Ann Landers. Dear Ann: Our five-year-old son loves to put on my clothing, high heels and makeup and pretend he is "Mama". Jimmie is a beautiful boy, with a full head of curls and he prefers playing with dolls to the rough-and-tumble games of boys. Last Christmas I gave him a dump truck and a tea set. He never played with the dump truck but loves the tea set. I used to think it was cute, the way Jimmie got himself up like a lady, but I'm beginning to wonder if perhaps his little game might turn into something serious, and permanent. Can you advise me. Answer: Very young children often cross-dress, but by the time a boy is five or six he should be pretty well over that sort of thing. The most revealing clue was your subconscious encouragement. Why would a mother give a boy of ANY age a tea set? I suggest that you discuss this with a counsellor, learn why you are treating your son as if he were a girl and get some guidance on how to turn him around. Vancouver Sun, Nov. 9, 1974.
See my earlier comments on toy selection, pages 63-68.

See for example, V. Satir, Conjoint Family Therapy, Science and Behavior Books, Inc., 1964.

Precociousness is usually seen as a positive quality. "If on the other hand", as Swanson points out, "the child talks seriously of his worries, expresses a sincere wish for help for himself and concern for the welfare of the rest of his family, the chances are that he's burdened, depressed, too serious, and taking family responsibilities prematurely". F. Swanson, Op. cit., p. 31.

Notions of normal children appear in many other organizational practices. For example, Emerson in his study of Juvenile Court refers to "normal delinquents". "In contrast, delinquencies that give an impression of unplanned spontaneity and impulse suggest normal character. If the act appears as the product of a whim, of an inability to resist temptation, normal character is generally assessed. . . . In general, adolescents are assumed normally to engage in a certain amount of illegal activity". Judging Delinquents. Aldine, 1969, pp. 117-118.


CHAPTER 4
THE FAMILY AS A RESOURCE FOR PRACTICAL REASONING

This chapter is a further examination of the ways in which therapists make patient's actions understandable as therapeutic events. At the end of Chapter 2 I suggested that knowledge of and assumptions about the patient's family were an important part of the interpretive schema by which good psychiatric sense can be made out of his actions in the play room. I discovered that I had to rely heavily on what I learned about children's families in order to understand them. For example, while I could give behavioral descriptions of a child and his problems, I had to see these things in the context of the child’s family before they became significant for me. Thereby, I began to realize the extensiveness of the 'instructions' that I had received on the family. I began to look for what these instructions did and why they were important and, consequently, came to see the role of the 'family' as a resource for doing practical psychiatric reasoning. In this chapter I will show the reader why I consider this to be the most important aspect of the therapist's corpus of knowledge.

The reader who is familiar with the literature on psychopathology will know that theoreticians often invoke the family as an etiological factor in explaining the onset of emotional disturbance. While the family was used in this way in the clinic, it was also a much broader resource. I will display how the family (and the term is a gloss for a wide assortment of rules, relationships, expectations, etc.) was used as a resource in making psychiatric sense of the child's behavior, in managing
a therapy session, and also for providing 'adequate' accounts of the
events of the play room.

**Patients as Family Members**

An essential feature of the therapist's corpus of knowledge is an
ubiquitous awareness of patients as family members. This is a constit­
tutive feature of the category 'child'. While one may have patients
without families, one does not have children without parents.\(^2\) I shall
begin by outlining some of the ways in which I found the 'family' to be a
useful resource in understanding the clinic.

An examination of the following innocuous conversation between two
therapists will demonstrate that the connection between the patient and
his family is not always (or even frequently) a direct one. The follow­
ing statement followed immediately upon the departure of a patient. It
was directed toward a colleague who had just come to the play room to say
hello:

4.1

T: He asked me, he said "do you go to church?" I said "no". He
looked at me in despair and he said "sinner, sinner". . . . Yea,
I'm really, that's, now I'm really done, I'm finished.

The statement was made in a joking manner, but it reveals some interesting
things about the setting. In order to make sense of the child's statement,
one must know that his father was a minister in a fundamentalist sect.
Further, the family was seen to be very strict, that is, they practiced
what they preached. Although the child was not seen as religious, his
problem arose from the constraints and tensions which are expectable in
such a strict family. We do not typically think of children as being
religious and, if we did, we would likely take it as precociousness.
The joke then is not that a religious patient would not tolerate an 'atheist' (a non-church-goer at any rate) but that the family is the mediator of this information. The family can be a mediator in two ways. First, a child is typically assumed to have internalized his family's values. As a result he need not think for himself. Rather, his family becomes a set of ready made responses to routine situations. As a third party one can anticipate this response and recognize when a member of a family is taking the family-line. This explanation makes for a close fit between the child's behavior and what we know of his family. Alternatively, the child might relay the therapist's answer to his parents who could then hinder therapy by discrediting the therapist.

In either case, we see clearly that the patient is not seen as merely a child but also as a member of a family. Upon encountering a child, one can warrantably look for a family who manages him, is responsible for him, influences his beliefs and values, has contributed to his present problems, etc. Similarly, one may attend to what sense the family attributes to the activities of one of its members. The patient is, and must be seen as, a member of a family. I will return to the central question of how the therapist uses the family as a resource for understanding the child in a moment, but first I would like to give some further instances of ways in which therapists attend to how what takes place in the play room may get back to the family.

I observed that children often did things in the play room that one would not expect that they would be allowed to do at home and I wondered what their parents would make of this, for it seems logical to assume that whatever happens in the therapy setting will be transmitted to the child's parents. I asked a therapist about this.
4.2

R: It would be interesting to find out, or maybe you know, what the parents do with what he brings home from the therapy, because he must go home and talk about it.

T: Yea. ((pause)) I don't know. It's surprising, I tell you it's surprising how little kids talk about their therapy sessions at home. . . . So parents will come in desperation and say "what's going on in there?" ( ) Some of the more discrete parents will say "I don't ask him about it because I know he never talks about it and I never ask cause I feel that's his time". . . . Ah, one time I remember it was quite shocking, ah, ( ) had drawn a picture of teacher on the board and shot at it with pop guns. So, John really thought that was fantastic so he went running downstairs and the first thing he did to mum was say "hey mum we just shot the pop gun at Mrs. Jones". And like the mother looked you know, kind of taken aback, but she just dropped it.

Thus, there are occasions when the therapist sees that some fact or incident might be reported to a child's parents and has reason to hope that the family will show some discretion in handling the matter. Parents usually expect that there will be some reportable events and, if they do not receive any 'news' from their child, they often ask direct questions about what's going on in the play room. Some parents hesitate to ask since they fear that the child may be revealing matters which the family would rather not have revealed indiscriminately. And, as the following shows, other parents think that there is some information which they must know about.

4.3

T: In fact we have one mother who says, "you'll tell me won't you if he runs over me with a truck". ((laughs)) That's a pretty astute mother.

The fact that information from the therapy session will reach the family can also be psychiatrically relevant in other ways. For instance, it gives the therapist a reason to hope for a change in the home environment. This type of communication between the therapist and the home never
seemed to take the form: "Tell your parents that . . . ", but occurred in much more subtle ways. Therapists often hope that, because the patient has changed his previous disturbed behavior, the parents will therefore come to treat him in a different manner. It is assumed that, in many cases, the child's problem originated in the home and that it is possible to treat the family by changing the child so that this information will be communicated and reflected in the behavior of the parents. Thus, it is possible to deal with the family without having to confront them in a more direct way. Needless to say, this approach does not work all the time.

Historically, there have been alternations between the ideal of treating families and that of treating children. In the latter, the objective is to change the child and hope he can thereby come to cope in and with his family. Here therapy consisted in the acquisition of coping mechanisms. While families were seldom part of the therapy program at the clinic, there was always the hope that the parents would relate to and reflect changes in the child's attitudes and behavior in a positive manner. Many therapists felt that if therapy were to be successful, the positive involvement of the family was essential. I will discuss this later.

The relationship between the patient and a third party (the 'family') is organizationally important in the following sense. If other members of the family become patients, an effort was made to assign them to a therapist other than the one who was treating the child. Since it is taken that family members may have to report on each other, it is seen as appropriate that, at least on the surface, there should not be a channel from parent to child through the therapist. Interestingly enough, it is felt that this may be a more significant problem for the child since, not knowing anything about professional 'ethics', the child will assume that
the adults are talking about him. However, this is not always a major source of concern. Indeed I observed a therapist and parent talking about the patient, her progress, and their worries while the child played in the sand tray within easy hearing distance of them.

Through this notion of 'reportable events', we can begin to see how the patient is constantly attended to as a member of some family structure. This leads us to see how events take on the character of 'reportability' through an intrinsic feature of practical reasoning, namely that of background expectancies. It is background expectancies which allow us to see a joke in the therapist remarking that she "was finished" after having a patient tell her that she was a sinner. Contained in that report is the assumption of a family. Background expectancies also provide the logic of separating patients in the same family, the appropriateness of attending to concerns of the family, etc. Indeed, they are essential to any understanding which we may have as members of society.

**Bringing Notions of 'Mom' and 'Dad' to Therapy**

In traditional psychotherapy, with followers of S. Freud or M. Klein for example, there is a technique referred to as "transference neurosis". This is a kind of neurosis which is generated by the therapy situation. It allows and encourages the patient to transfer any deep-seated feelings that he has about a phenomenon outside of the therapy room (such as his parents) onto the therapist. This permits both him and the therapist to work on those feelings within the context of the therapy relationship. There has been a long standing debate in child psychiatry about the feasibility of using this technique with children since the
patient is actually living with his parents rather than remembering them.

The following conversation focuses on this issue.

4.4

T: But most people feel that transference neurosis does happen.

R: With children?

T: With children. (pause) But that by and large it's unnecessary in most cases to use it, in treatment. What happens before that, sure it is a very strong tendency to see familiar things in the relationship. Which is not surprising. Ah, or to try and create familiar things, ah, such as this girl was doing to me yesterday. Ah, or ah, "What make is your car? My daddy's got a Chev." Trying to get some similarities as a point of contact; or ah, at a slightly more complicated or deeper level, expecting me to behave in a way that a parent would. I had one child, a nine year old, who, the one I told you about who runs all over the place, and spends most of the time on the trampoline, ah she has pushed me time and time again to the point where I have to say no. "I want to take this. I want to take that. I want four boxes of candy". When I say it's time to finish she wants to go and do something else. So she's constantly pushing me to say no. Ah, now it turns out this is the thing she finds most difficult to take from her parents, and the thing her parents find most difficult about her. And they respond very harshly, so that, ahm, it automatically brings to her a feeling of 'nobody loves me'. And we talked about this and she got to the point where she could feel that my 'no' was different than mommy's 'no'. Except on occasions when I said 'no', and she said, "That's a Mommy's no".

R: She used that phrase?

T: Yea, and we had a look at it to see what the feeling was, maybe it was the way I said it or maybe it was the topic we were talking about, or maybe it was the way she was receiving it. But she had a tendency to repetition and ( ) and she's going to recreate situations here very much like the situations she creates at home. And she's going to anticipate that I'm going to react in ways that she's familiar with. And this is often of course the first ( ) that occurs to the child that we don't behave, I don't behave like her father, or mother, with behavior that she brings home. But there's the expectation, there's the statements of familiarity. You do this like Dad or Mom, or you look like Dad or Mom. Ah, then the expectation, oh yea, and sometimes there's a deliberate attempt to recreate a situation, even though it's an uncomfortable one, or one that's given them problems, given them pain. So ah, in those senses, I haven't worded it well, but in those senses there is a transference of sorts, in that the reality may be disguised by the child's work on it; what the child's perceiving may not correspond with what actually is, because of the expectations, the inner expectations that arise as a result of experience with her own parents. Ah, kid does something
and she says "you're mad at me". And I'm not aware of being mad nor of having an angry expression on my face. And ah, "Sharron, I'm not aware of being angry with you". Sort of looks a bit closer; "No maybe you're not". But she's expecting that sort of parental reaction from me.

The psychiatrist is saying in effect that, while therapists accept the notion of transference neurosis, it is not always necessary in play therapy since the patient can readily be seen to be treating him like "mom" or "dad" and does so without any encouragement. This is available to us not only in direct statements like "that's a mommy's no", but also in the child's demands. That is, there are events that take place in the play room which can easily be seen by the therapist as recreations of events in the child's home. For instance, the above mentioned patient's continued requests are not seen simply as questions but as instances of her attempts to "push the therapist" in order to recreate the parent-child relationship which obtains outside of the play room. Thus, expectancies about this child as a member of the family provide us with a resource for understanding her questions in a more reasonable and thorough-going way than would otherwise be possible.

The therapist anticipates that some things are going to be seen and heard by the child as instances of parent-like behavior. This, too, further shows how the patient is and must be seen as a family member. The therapist usually tries to avoid sounding like the child's mother or father for there is an effort to construct an atmosphere that contrasts to home. The patient must be made to feel that the relationship that he has with his therapist is essentially different than that which he has with his parents. This relates back to the rationale of the environment and the therapeutic relationship. In constructing this relationship the therapist can use his common-sense knowledge about what parents are like
and about what things might sound or look like the actions of a parent as a resource.

A therapist was recounting some of the difficulties involved here and referred to a case where a patient filled his hands and pockets with cookies and began to eat as if he were very hungry. (Candies and cookies were routinely a part of the play room supplies and were usually placed in the play room along with the toys. This was not done in all cases, or for all patients, but it seemed to be a rule rather than an exception). The child had been permitted to go into the supply room and take as many cookies as he wanted. (This particular therapist allowed the children to select their own toys). She said that this had annoyed her and, consequently, she formulated a rule saying that the child could only take three cookies. However, having said this to the child, she then realized that it sounded like a "parent's rule" and revoked it.

I take it that the therapist realized that the hearing that she gave to the rule was also available to the child and she revoked her decision because of this. It is not that the therapist simply has some notions about what parents are like and thereby avoids imitating them, rather, at any on going moment, she can attend to the potential hearing the patient may give to some account. Similarly, cancellation of the rule is not to be heard merely as a change of mind but as a document of the fact that she is not like the patient's parents.

On another occasion a patient was playing in the wet sand tray, an activity which is always potentially messy. Although I did not feel that she was being hesitant or overly cautious in her play, the therapist said:

T: I think mom won't mind us playing with the mucky sand and water. That's okay with her.
The issue here is not whether the child was displaying a concern about the possible consequences of her action. Rather we should note that one can warrantably expect children to worry about what their parents are going to say or do. That is not to say that they always worry about such things but that such a description is available to us as an account of their conduct. (I have also seen teachers reprimand children for playing in the mud on the way home from school, reminding them that "mother has to wash those you know"). It is always possible to see a child as failing to show enough concern, as showing too much concern, or as showing the appropriate concern about its parents. However, all of these possibilities invoke the idea of the child as a member of the family.

Numerous instances of therapy talk displayed the therapist's attention to the child's concern for what his or her parents might say. For example:

4.6

C: Yea, and he swears a lot.

T: Does he swear a lot?

C: Yea.

T: Hmm. ((pause)) Sometimes I bet you even swear.

C: No I don't swear.

T: Hmm? You know one place where it's really good to swear is right here in the play room.

C: I know.

T: That's right. ((pause)) Why you can even say fuck and all those things, right here.

C: (you want to play darts)

T: Hmm? ((pause)) At home though I think it bugs mom if you swear.

I will say more about permissibles later, but a possible interpre-
tation of the mention of "mom" in the last utterance is as follows. The therapist has been encouraging the child to swear in the play room and attends to the possibility that the child is thinking something like: "Here is someone saying that it is all right to swear. Now I know my parents don't say that. What am I to do?" The therapist provides for this assumed concern by recognizing the parental sanction, i.e., "At home though I think it bugs mom if you swear", and uses it as a device to display an essential difference between home and the play room. I take this to be an adequate account of what was going on in that conversation. I had never heard any reference which would indicate that this child had a swearing problem. Instead, I take it that the therapist was able to use her common sense knowledge in order to decide both that the child might like to swear and that the mother might object to it.

By formulating the patient as family member, the therapist is able to say what she feels has to be said: that this is one place where you can be 'evil'. Further, she is able to show the patient what therapy is about.

Consider the following:

4.7

C: Here, Paula.

T: So that's my cookie?

C: Yeeaa.

T: Do you know that I'll like you even if you don't give me things? Mmm? Even if you wanted to eat that cookie yourself.

What is at issue here is a notion of sharing. This is an activity which parents and other adults encourage children to perform. There are numerous ways to characterize someone who doesn't share but, for the
offender, the penalty may be the loss of friends. Here, the therapist is demonstrate that their friendship does not depend on forced sharing.

Another therapist complained about a patient who continually asked permission to do inconsequential things. This was seen as a document of the patient's constriction. Permission is typically given to children by parents and the child who asks for permission to do things that don't typically require permission can be assumed to have a troubled relationship with his parents.

The following is a final example of how notions of 'mom' and 'dad' are brought into the therapy room. We have been looking at one of the ways in which therapists interpret patient's actions, i.e. as motivated by the underlying idea that the therapist is like the child's parents. Therapists anticipate many of the motives that patients may ascribe to them on the basis of the standardized relational pair of parent-child. In the instances examined above the therapist does not simply formulate those motives but uses such ascription to encourage the child to play in the mud, to swear, etc., in order to accomplish the objectives of therapy.

Consider:

4.8

T: You know Dana, ((interesting tone of voice))

C: What?

T: I was really thinking about the last time you were here, and I think I must have been sounding like a, a naggy old mom or dad.

C: Unhnn (-)

T: Huhh?

C: Unnhnn (-)

T: I think so.
C: You weren't.
T: I was thinking that //</nC: ((noise))
T: that I wasn't really being quite fair to you.

The therapist went on to say that, in spite of having given instructions about the freedom to do your own thing in the play room, there were occasions on which she would have to appear demanding or unfair so that they could make the best possible use of the therapy hour.

The therapist is suggesting that while it may appear that the category of "naggy old mom or dad" goes with the activity the patient heard last week (being unfair), and it is appropriate to have heard it that way, there is a more relevant category--'therapist'.

Although her formulation of a proper hearing for the patient sounded like an apology, we should attend to its interactional consequence. To put the formulation in terms of a family category (i.e., a naggy old mom or dad), makes what the therapist is doing relevant for the child and allows her to explain that there are good reasons for those kinds of actions. To have couched the explanation in terms of the role of the therapist and the goals of therapy would have been inappropriate. This would have involved terms and concepts that a child could not be expected to understand. To my knowledge, such explanations were never used in the play room.

Family Structure and Making Sense

I would now like to look at how the patient's family was invoked for making sense of patient's behavior. I shall begin by describing how I often learned about patient's families in the course of therapy-related
discussions. For instance, I was a participant to a conversation between a therapist and a visiting student-therapist in which the patient who was to be observed in a few minutes was being described. The child's problem was that she did not want to be a girl. The following talk transpired.

1. T: So, and then in an (ethnic group) family to have a girl, is okay, to have a little girl who's a burden and says ((pause))
2. S: Yea, it's a little bit far out.
3. T: So I think for her she would rather not be a girl at all.
4. S: Oh really. ((tone and expression of recognition))
5. T: and ah, ah,
6. S: Is there anything ( ) when she does that?
7. T: Yea she does, she a lot of things like, she she would like whiskers, ah, all sorts of things like, ah, I'm looking for something to put water in, ah, and mother hasn't given a great deal to her I don't think.
8. S: How many children are there?
10. S: And she's the oldest?
11. T: She's the youngest.
13. T: And there's two older brothers.
14. S: Ahhh. ((again a voice of recognition))
15. T: Who are very nice, very polite, ( ).

If the problem is with the child we might naively wonder what all of this talk is about. That is, the child says she would like to grow whiskers and this is surely evidence of some intrapsychic rather than family problem. However, it is clear that both the therapist and the student saw a relationship between their talk about the child's family
and the diagnosis of her problem. This is made clear for us in the recognition activities done by the student-therapist (utterances 4 and 14). Let us look at these two acts.

I take it that utterance four ("oh really") is the result of a sudden realization on the part of the student. Prior to this excerpt, she had been informed of the child's difficulties and is now beginning to make some new or better sense of that information. Utterance one contains an assumption about the family's attitudes towards boys and girls—attitudes which are accentuated by the ethnic background of the family. This is an ethnic group that is said to attach more value to having sons than daughters so that when their expectations for a girl are not met, their tolerance for that child is further reduced. Not only is the behavior itself criticized, but the child's status as a girl is also called to account. Because of the prevalence of these attitudes and responses it is assumed that the child will feel that her family's reactions to her are related to her sex. And it is probably for these reasons that she does not want to be a girl.

This account provided by the therapist is not the result of some information which the parents had given him. Rather, the warrant for making these statements rests in his common-sense knowledge about how members of that ethnic group view children plus some personal knowledge of the family which indicates that they are representatives of that group, i.e., they are typical.

It should also be added that the therapist has only been involved in this case for a short time so that what we are hearing are her own discovery procedures.

There follows an effort by the student-therapist to discover other features of the patient's family that may be relevant. Thus, in utterance
eight, he asks, "How many children are there?". The student's guess that the patient is the oldest of the three (utterance ten) is, I suggest, reasonable, given the previous talk. Since this family puts more value on boys than on girls, it follows that the first born may bear the weight of this expectation in a way that other children would not. That is, the parents might be especially disappointed if their first child was a girl. Thus his question seems pertinent. Consider the consequences had the student asked instead: "She's the second (or third, or fourth, etc.) in the family?" No immediate relevance would have been attributed to that formulation. That is, it would not be seen as relevant. However, as matters stand, we can see that the student's "error" shows that she understood the situation properly in the way that a correct guess would not have shown.

Her second recognition (utterance fourteen) seems to indicate that she now sees some relationship between the patient's problem and her sibling position. That is, parents often respond to a child's intolerable behavior by comparing the child to his or her siblings. For the patient this amounts to wishing that she were a boy. The therapist confirms this by providing a further description of the brothers as "... very nice, very polite". One can now imagine the parents scolding the patient with something like, "Why don't you behave like your brothers", which becomes, "We wish we had three boys". This allows the patient to identify "self-worth" with sex roles. Of course, it also provides the therapists with a possible explanation for the patient's behavior.

I want to emphasize that this talk is not just small talk prior to a therapy session, it is a methodically constructed exchange in which the patient's family situation is scanned for clues to the patient's problem.
Further, it provides not only a possible but a reasonable and adequate understanding of the patient and her problem. Whenever there is a child, there is a family and one can expectedly discover a relationship between the child and his/her family structure.

Therapists see more than just play or behavior in their patients, they also see problems. Often they do so without any knowledge about the patient's actual family. That is, the realization that children are frightened, angry, have sexual identification problems, and so on can come about independent of any knowledge of the child's family. However, having found such problems, the therapist then looks at the child's family. This accomplishes several things.

First, it provides a reasonable account of the offending behavior and helps to transform it from a 'trouble' into a therapy problem. Such family-related accounts are organizationally relevant. This can be seen clearly in instances where the child is removed from his home, where the parents are told to enter therapy, and so on.

Concomitantly, it allows the therapist to make sense of the child's behavior by ascribing a credible motivational source to it. It shows, too, that the patterned actions of the patient follow from an understandable course of reasoning. That is, it provides adequate motivational accounts for the patient's doings. Further, it provides the therapist with some ideas about what is important to the patient and how he can best solve his problem.

In addition to such considerations, it provides a warrant for intervention into the life of the child. In an immediate sense, such a warrant is available to us in the presence of the child at the clinic, however, a further warrant may be required. Cicourel, in his study of
the juvenile justice system found that the families of offenders who were going to be charged with a crime were labelled much more severely than the families of youths who were not going to be charged. Given the relationship between children and their families, it may be necessary to provide a warrant in terms of some problem in the family. I suggest that this has something to do with our idea that families, and families alone, are or should be responsible for their children.

Constructing the Family

Although therapists use their knowledge about a patient's family to inform their diagnosis, the reverse also holds true, that is, given the actions of the patient it is possible to construct an appropriate family for him. Consider the following statement.

4.10

T: You know like, so I kind of feel given the family situation and what he is, he might have, to, his battles might be manipulative. ((pause)) He can't openly express that he'd like to do something (deviant). He has to do it kind of manipulatively. . . . He comes on sounding very good, and I guess that's the way it is at home. I would guess from the way he's interacting in the play room that at home, that you can't do things because you would prefer, you have to be rather selfless about the whole thing and do it for the good of somebody else. You know, it's not legitimate if it has a selfish motive, at home I suspect. Certainly from observing him in the play room one would get that impression. I do have other kids who say, "I don't want to do this anymore, I'm tired of blowing them up". . . . So I really get the feeling at least at home, the message he gets at home is that you think of the other guy first and then you have to act like that.

In this case the therapist did not know what kinds of messages the child received at home but was able to construct a possible description of the family by observing his patient. In the last play session the therapist had been manipulated into blowing up some balloons. The child would not admit that he did not want to do this. (The very seeing of this act as manipulation required more information than the act itself provided, e.g.,
I did not see it). This was seen as a further instance of the child's problem, i.e. the child always wanted to appear in a good light and, although he needed to express anger, frustration, etc., he could not allow himself to do so. The description of the family given in the transcript above seems to be consistent with this seeing. Here, the act, the problem, and the family cannot be separated, instead, each has implications for the other.

I observed another session in which the abovementioned patient was given a xylophone. Very early in the session the child reluctantly made a few noises with it and the therapist encouraged him to continue. Finally, in order to keep him playing, she agreed to accompany him on the drum. I was surprised to find that the therapist allowed the whole session to be spent in this noisy activity, especially since she had earlier complained of coasting with this patient. Later, she said that the xylophone playing had been good for the patient. It was clear that the success of the session was due to the fact that the child had been allowed to do something which would not have been done at home without irritating his parents. The child might be told that he was too noisy or, perhaps, that he was a poor musician. Remember that the therapist had intentionally placed the xylophone in the room.

This appeared to be reasonable even though I knew nothing about the family. Further, I suspect that the therapist did not know if the patient had actually been sanctioned for making too much noise or had been told that he was a poor musician. Nor was I able to tell if the session had been a good one. It became clear that, on the basis of the family's child-rearing activities, certain constant features could be assumed. That is to say, if the parents respond to action A in a known way, they will react
to the class of activities of which A is a member in the same way. For example, if the child cannot make a mess at home, it can be assumed that he is not permitted to swear.

I shall give two more examples of how I came to see the relevance of families for understanding patient's activities in the play room. The first of these instances refers to the patient mentioned above.

The child frequently engaged in painting and many of his pictures contained some object that was clearly divided into two sections which were painted different colors. While the therapist was able to see a great deal of significance in the child's choice of colors and even in the gestures that he made when painting, I could not even see why painting was a significant activity. How can one find indications of the patient's problem in these products? How can one begin to interpret these paintings? The "how" of the therapist's findings was based upon her knowledge of the patient's family, as I was soon to discover.

It was seen as relevant that the patient's family was actively involved in a fundamentalist religion. Because of this it was possible to see the child's paintings as representation of good and evil. They could be taken as an indication of his struggle with the religious teachings of his family and of his own wish to do evil. We can now see that his paintings might well represent the dichotomy between his feelings and those expressed by his family. At that point, it is possible to talk about the patient's problem apart from his family, and to find a solution for them. However, it was only with such instructions that I was able to see the painting as a document of the child's problem.

I take it that the therapist chose to tell me these facts about the family because she thought that they were consequential. That is, she
saw them as providing an 'adequate' account of how she made sense out of the painting. I take it that there are a number of ways to make sense of the painting. One could look at it in terms of its artistic qualities, the patient's former art lessons, its chemical composition, and so on. However, the problem here is that the motivated account that one chooses to assign it has to have relevance to the occasion of therapy. The accounts of the family as given above are adequate for such an interpretation. It is obvious that not just any piece of information about the patient's family is used in the telling, instead, some selection is done. It is possible that almost any information about the patient's family can become relevant but the adequacy of any particular piece of information depends upon its relevance to a particular activity.

What the therapist (and student) was doing in this work of making sense was providing motivated accounts of the child's actions and these accounts were framed in a psychiatrically relevant fashion. You will recall that, in my earlier observations, I frequently attempted to frame situated motivational accounts, that is, I looked for motivation in the patient's immediate environment. In contrast, the power of psychiatry lies in its ability to discover motivational structures outside of the immediate environment, that is, to see actions as influenced by external processes. This does not deny that the play room and the immediate relationship also provide motivation for actors, however, if this were all that was to be discovered psychotherapy would take on a different character. In child psychotherapy a great many of these psychiatrically relevant motivational accounts make reference to the family.

Let me provide one more experience which demonstrates how the family is used as a resource in therapy. I was making a video-tape for a student-
therapist who advised me prior to the session that the children whom we were about to observe were very aggressive and especially difficult to manage in group therapy. I took this as a warning about the chaos which I could be expected to see. During the viewing however, I noted that the children did not seem to be so bad after all. I assumed that the therapist was also aware of this. At the end of the hour, the student-therapist began to talk about some of the participants and how they had behaved during the first session. (The session we had just watched was the third). I took this to mean that although the session which had just finished had not been so bad after all, it was not to be seen as a typical session. I was told that one of the participants had sworn during most of the first session. This account included something to the effect that this was a child who could not swear at home so that he had to let it all out in the therapy room. If we see this in terms of what it does on the occasion in which it is told, we can see once more how the family is brought into play.

I discovered later that the person who gave this account knew nothing of the child's family and therefore did not know that he could not swear at home. However, a third party can expect certain behaviors to obtain in a family—a family being a set of standardized relationships. For example, a stranger can expect a parent to be responsible for his child and, if this is not so, then it is a warrantable absence. In a similar manner, one can expect (at least in middle class families) that parents will discourage their children from swearing.

We can see common-sensically that an equally plausible account of the child's swearing is that his family swears frequently so that what happens in the play room is no different from what happens at home. His swearing might then take on the character of 'so what'. While this would
be an equally plausible account, it would not be adequate on this occasion since it would not be seen as relevant to the child as a problem. It might have been adequate had the family been the patient insofar as it would serve as evidence of the family's poor or improper child-rearing practices. However, the account given by the student-therapist transforms the child's behavior to a problem because we can see swearing as a way of describing an aggressive child. Knowing that swearing is a sanctionable activity for a child, and noting that this child swears in the presence of those who could properly enforce this sanction, we can easily hear it as a sign of disrespect, hostility, aggression, etc.

I take it that children see sanctions about swearing not just as something that is of concern to their parents but to adults in general. The researcher has noted on many occasions that when children are in his own house and a visiting child swears one of the children of the house might say something like, "My dad's upstairs you know". This is interesting in light of earlier discussion about therapists sounding like 'mom' or 'dad'; perhaps it is inescapable.

The description of the family in the last example was not meant then to be a claim about that family but was an appeal to families, and children in families, in order to provide for the reasonableness of the account of aggressive behavior and by its reasonableness demonstrate the student's understanding of that patient.

Making Motivational Accounts Problematic

As we have seen, motivational accounts stated in terms of the family appear to be reasonable and to be based on our common-sense knowledge as members of society. However, it was some time before I began to see them
as interesting or important phenomena. I first became interested in them when I chanced to question the reasonableness of a particular account. My experience was informative and I shall report it for the benefit of the reader.

A child who was in the early stages of what both the therapist and I knew would be a long treatment program, delighted in an extensive program of activities that appeared to be designed to annoy the therapist. He continued to ask for things when it had been established that he could not have them, he deliberately spilled things, and so on and so forth. These were not just isolated incidents, rather, they occupied the whole session. While the researcher was able to provide a characterization of the activity as an attempt to annoy the therapist, he did not know why the patient was doing it. The therapist said that the patient was neglected and was not getting much love from his mother and therefore had established a manipulative approach that would get attention from his mother and allow him to express his anger indirectly.

I saw this as an adequate account, for we all know that children require attention and love and that if this need is denied they will attempt to get it in whatever way they can (even if they get negative attention). It also makes sense that he would be angered at this deprivation and find some way of expressing his anger. What did not make sense, however, was why the child was acting this way in the play room since the therapist was not his parent and was showing him attention. I asked the therapist about this. However, once having questioned the therapist, I experienced a definite feeling of guilt for having asked an inappropriate question and perhaps for suggesting that her account had not been an adequate one. My question also raised the implication that my declared purpose for doing
research at the clinic had been a false one and that my real purpose was
now in danger of being exposed.

As it turned out, there was not a more adequate explanation avail­
able. However, the therapist did add that the play room behavior could
be explained by a rule of consistency—the child will relate to other adults
in much the same way that he relates to his parents. I am not suggesting
that if one pushes the accounts given by therapists they will be found to
be insupportable; rather, on the occasion of their telling, accounts are
framed in terms of the patient's family and are adequate for all practical
purposes. That is, the adequacy of an account rests not in terms of a
theory of child disturbance, but in terms of its telling. I would also
suggest that these are warrantable sanctionable accounts and that their
reasonableness is so self evident that to doubt them is to question one's
competence as a social member.

To this point, we have been looking at how common sense notions
about the family are used by therapists in constructing reasonable psychi­
atric accounts. I have referred to this as practical psychiatric reason­
ing. I would now like to look at how 'family talk' is used in a somewhat
different way in the clinic setting.

Family Talk as Management

We will still be concerned with practical psychiatric reasoning in
this section but I want to show how talk of the family provides a way to
manage relationships. By way of introduction, it might be helpful to
compare the therapy setting to the halfway house examined by D. Lawrence
Wieder and to look at his attention to the "convict code" as a persuasive
activity.
There are two sets of participants in the halfway house, namely, the staff and the residents, and they stand in a relationship where one set is responsible for the other. That is, the former is supposed to be looking out for the latter, providing for their needs, helping them to fit back into the community, counselling them, and, in general, showing concern for their welfare. While only one set of participants is responsible for the other, both are accountable to each other and in various ways (e.g., to other staff, to the community, or the board of directors).

What I mean by accountable here is that the nature of the relationship demands that one can be called on to report on, justify or explain his conduct. This is similar to the parent-child relationship, wherein children are accountable for such things as their absence from meals, failure to do household chores, etc. While I am not sure that we can say that parents are accountable to their children in the same way, they are accountable to them through the community and to the community itself.10 In other relations of authority a superordinate may be placed in a position of accountability to subordinates if it can be demonstrated that the actions of the former jeopardize the latter's well being.

Consider how the residents and staff of the halfway house are accountable. The residents provide their own accounts for a wide range of their activities that the staff, the researcher, and others may see as rude, aggressive, trouble making, apathetic, etc. They explain or justify such actions by appealing to their relationship to other residents or convicts. For example, they often felt that they could not talk about something to the researcher because of the way that other residents might interpret this. Similar reasons were given for not sharing a beer with the researcher, for failing to attend meetings, etc. These were actions for which they were
accountable to other residents, either as a fellow convict or as a friend.

Since staff members were responsible for the residents, they were accountable for the way that they handled them, for program demands, for success or failure, and so on. That is to say, they had to be able to provide excuses, explanations, and justifications for the way things were going. For example, the staff had to justify the discharge of a resident who had not made arrangements to pay his bill when this was contrary to rules. In order to provide such accounts, it was necessary that they be able to make sense of the actions of the residents, including their uncooperative behavior.

It was discovered that the residents of the house had a body of "rhetoric" in terms of which they framed many of their accounts. This was called the "convict code". This code was referred to and talked about both by the residents and by the staff. Because of the relationship which obtained between staff and residents, this code was a pervasive and powerful feature of inmate life (and thus of the halfway house). Consequently, the staff (and the researcher) had to use it in order to account for the behavior of the residents and for their own actions with respect to them. The code was persuasive because accounts appealed to serious obligations of a system other than that of the staff and failure to meet these obligations may cost one his life. Since the staff had continually to demonstrate their competence, as well as their concern for the residents, they too appealed to the code.

In the psychotherapy clinic the patient is accountable to the therapist for some of his actions (he may make excuses for being away, for example) although the therapist tries to create an atmosphere of minimal accountability. (This is one way to make visible a contrast to the
patient's home). The therapist, however, is both accountable for the patient and accountable to others, e.g., parents, superiors, colleagues, etc. Like the staff of the halfway house, therapists are accountable for the progress of their patients. I want to demonstrate in this section that the family serves as a resource for these accounts and as such we can think of 'family talk' as a rhetoric.

Let me clarify what I mean by the therapist being accountable for the progress of the patient's treatment. In an earlier section I show how some typical features of therapy presented problems for me. I found it difficult to understand what was happening since there was a minimum of direct intervention, the treatment was not always obvious, many children did not display obvious signs of disturbance, etc. These were not problems for the therapist. However, there are many things which were and are concerns both for myself and for the therapist. For example, some children were not suitable for therapy and had to be discharged, others got worse or had a relapse, some patients made very rapid progress while, with others, progress was minimal. The therapist is accountable for recognizing progress or, conversely, for noting its absence and must be prepared to take remedial action if necessary. That is, the therapist is clearly accountable for outcomes.

I want to suggest that the family is frequently used as a resource to provide such an account, especially in instances of failure. This is not to suggest that therapists are never self-critical, they are. You will recall a transcript on page 60 in which a therapist described an action as "bad therapeutically". During my research, I witnessed numerous occasions in which therapists critically examined what they did and sought advice from supervisors and others. Neither am I suggesting that the accounts are an
act of deception or collusion.

A child whom I observed for a long time was of particular interest to the clinic because of the seriousness of her problem. The child was involved in a day care program at the clinic and came to play therapy sessions twice a week. After the Christmas vacation, during which the child had not had a therapy session, she behaved in a way that both the therapist and I thought to be worse than that which she had displayed the last time we saw her. When asked about this, the therapist replied very quickly that the child had been home with her mother for a month. How do we hear this as an explanation of the child's apparent regression? Why is it an adequate account of the reported behavior? I would suggest that this appears reasonable because it formulates the child as a member of a relationship pair (parent-child) which we know to have a powerful influence over one's life. As part of this, we know that it has the ability to block the possible influence of other adults.\textsuperscript{13}

In the instance cited the therapist had not spent the vacation with the family nor did she have a second-hand report on how it was spent; thus, it is not a factual statement about the way the family spent Christmas. It is possible instead that they all had a good time and that the child received much love and attention. Similarly, the therapist was not suggesting that one can use this feature of the rhetoric to predict the child's behavior. That is, knowing that parents influence their children in ways contrary to the therapeutic ideal is not to say that, after any long absence from therapy, children will necessarily regress. Indeed, it would have been equally possible for the child (who had developed a strong attachment to the therapist) to have been so pleased to be back with her that her behavior would be even better than before.
The account appeals to a notion of competing influences by which the work of one adult can be undermined by others. The therapist has the child for an hour or two every week, while the family has her for most of the remainder. This is similar to the discussion one hears at a PTA meeting during which some teacher invariably says, "We can only do so much if the parents don't care". The patient is inescapably a family member and that membership is seen to have consequence for the success or failure of the therapy.

While most patients came to the clinic only once a week, changes are sometimes made in this schedule. A child who is just beginning play therapy may be seen twice a week and then switched to weekly visits as things improve. On other occasions a patient may be switched to two visits a week if problems appear to be developing. It was not uncommon to hear therapists commenting upon the frequency of visits.

4.11

T: With little kids I find, well when I saw Terry remember when I first saw Terry I saw her twice a week, things seemed to go much better.

R: Yea.

T: Cause, from, a whole week in between is a very large chunk of time, but three or four days isn't much.

R: Yea.

T: And what happens here is significant enough to them that they get involved in it.

The therapist appeals to a child's sense of time in which a week can be thought of as a "very large chunk of time" while "three or four days isn't much". In some ways this account is built around a notion of how long the influence of a therapy session can be expected to last. This notion appeals to the competing influences with which a child has to cope.
There were also some patients for whom things weren't going so well. The therapist and others felt they were making progress and then, for some reason, problems developed. Unlike the earlier discussion of relapses the problems were not related to the length of time between visits but, rather, to changes in the patient's family.

One young patient had been making such progress that he was about to be returned to regular school and have his weekly visit discontinued. Suddenly he appeared to get worse and these plans had to be put off. Therapists attend to the fact that children may become manipulative when they anticipate the end of their therapy, but this was not thought to be the problem in the above case. Rather, the therapists attended to what was happening in the child's family.

4.12

T: Things aren't going well with, at Rufus'. Father is 59, foster father is 59, and he's lost two jobs in the last year due to change of operations on the job, changes of equipment or something. So he's been out of work a lot, and apparently now he's really depressed and the foster mother says a cloud of gloom hangs over the house... and what else is happening, when father gets like this he overindulges Rufus and Rufus hates him for it, and mother and father are fighting because he's letting Rufus walk all over him. So things aren't very well, in fact we might, we might have to pull him out of there which I really hate to do, cause he's been there since he was four months old. But they haven't done a very good job of him, you know, ( ) like I could go on having him work out the anger and so on he experiences daily but that's like putting on a bunch of bandaids... Things were going well because the parents also working in therapy for a long time, and then they were dropped, because they were doing well, and because ( ) and then they kind of back slid, you know, so... when kids say and do the kinds of things Rufus does they obviously have a lot of aggression, lots of anger, and the last two times I had Rufus in the play therapy room he, he's really, really been angry, like he takes Indian chiefs, or one of the Indians and smashes it into a corner, like really,... So we know it's coming from somewhere and we think it's related to father, and it's kind of hard to pin down why.

In this account there are a number of ways in which the interpretive
schema of the family is used, some of which are considered later, e.g., a change in the patient is identified with a change in his family's circumstances; the notion of treating the child without getting to the source of his problem is likened to "putting on a bunch of band-aids"; it is said that things were going well as the time when the family was also in therapy; the motivated nature of the patient's anger is thought to be found in his family relationships, etc.

It is also important to note that this concern with the family is neither superficial nor inconsequential. We are told that, if the family becomes a serious obstacle to the child's recovery, he may be put into a new foster family. A child's condition, his progress, and his family are intimately bound together. It is, perhaps, consequential that the therapist made a point of referring to the family as a foster family at the beginning of the conversation. She said "Father is 59", and immediately amended this to "foster father is 59". Later, this provided for the appropriateness of the option that they remove the child from the home.

Relapses could be thought of as unusual and problematic events which should be explored. One could explain relapses in terms of the genetic make-up of children, the paucity of our knowledge and the possible limitations of play therapy and the therapists, etc. Instead, we usually find that relapses are routinized and explained in a way that preserves the validity of the enterprise of therapy, its underlying theories, and the competence of its practitioners. Therapists invoke the same resources in understanding each and every patient so that such things as relapses and lack of progress become perfectly reasonable events attributable to a source outside of the play room.
The Difficult Patient

The very nature of play therapy ensures that most children will fit in simply because the expectations are so minimal; however, it is not always the case that therapy can even start with some older children. At some point children become resistant and can not be easily managed. Such children can not become patients. In all non-interventionist therapies, the patient can undermine the treatment program by failing to take it seriously, by failing to cooperate, or attend, or by some other means of resisting. If this persists, the patient will eventually be discharged even though he is still in need of therapy.

I was a member of a conversation in which a therapist and a student-therapist were talking about a problem patient. It seemed that the problem with the patient was that, while he had difficulties that could be treated in play therapy, he got bored with the program very quickly and would withhold his cooperation. The therapists had tried a number of strategies to get him involved but the patient repeatedly showed a lack of interest. The therapists pointed out that this seemed consistent with his family's way of handling problems. That is, not only was the child not showing an interest in therapy, the parents were equally uninterested.

The therapists suggested that, in order to treat the child, it would be necessary to involve the parents as well even though they had already shown their lack of interest. The conversation ended with the suggestion that an ultimatum was required, that is, if the parents would not enter therapy, the child would be discharged.

This was a frequent problem and, as one therapist commented:

4.13

T: I'm getting dismayed, in cases where I'm working with a kid and
nothing's happening with the family, because you can give them all sorts of nice messages in the play room, in that splendid hour a week, but.

This is a clear statement of how therapists see their work being influenced by, made easier, or obstructed by parents.

The following comments were made by a therapist concerning another case in which therapy did not seem to begin.

4.14

T: ... indicates to me anyhow, the parents need for involvement.
It's a Japanese family and the boy is 11 I guess, and he, and one, two, five kids in the family. There's a couple of teenage girls and a twelve year old, and George is the oldest son, Dan's a younger brother, Dan is five, who was born like five years after Arnold, had the sole claim to being the son and man of the family. But Arnold is like extremely inhibited and withdrawn, I'm just writing a report on it, he, he couldn't play with anything. There was nothing in this whole clinic that was interesting, you know, everything was ridiculous, and a waste of time, everything was ridiculous or too childish, or more, or something Dan, Dan would like to play with but not me. He did, all he would do was models and he would complain in this very adult tone about how awful it was at home and how his sisters put on too much make-up and the girls were always fighting and it's worrying mom and dad and it was making the whole household upset. So he would just really identify with the adults and have no part of being a child or kid. So I went on like that for a year, ah, the parents saw a therapist for awhile. They had a crisis with the 17 year old ( ). And they came in kind of on a crisis basis, but when it was solved they dropped out. Then they were also in family therapy with a psychiatrist and dropped out of that. So we couldn't do much with him, but we continued on with Arnold and finally, oh yea, I had a talk with Arnold about like he had this need to be such a big boy and he couldn't relax and be a child. And he said: "we don't do things like that in our family", you know. Which is I think a good picture of what happens at home, like, and father told me that a few years ago he said to Arnold, you're a big boy now, when you go to bed at night we'll shake hands, ... They're a perfect family, but they're so bloody constricted it's unbelievable, and, and it comes out in Arnold. He's afraid to be anything but the man in the family. ... So it occurred to me, okay he gets all keen and he gets excited and then he goes home, and he's back into a very stilted atmosphere, and he has a week of that between sessions, ... So it's really difficult and I don't really know how we're going to make it.

This is a powerful example of how therapists see the relationship between success in therapy and the patient's family. Not only do features
of the family produce many of the child's problems but, often, there are things about the family that make therapy impossible. Although the child has been in therapy for a year, one does not have the feeling that any start has been made with him. It is interesting that the problem was stated in terms of the patient being too much like an adult. He is so much like an adult that he can not participate in child therapy.

We could naively imagine a situation in which a therapist was faced with a child who, for some reason, was a difficult patient and who, upon being questioned by his supervisor about the matter, replied "How should I know?" This would be a naive scenario indeed since therapists are trained, expected and paid to know, and demonstrably do know, what is going on with a patient.

I expect that one indication of the skill of a therapist lies in his ability to provide reasonable descriptions and accounts of progress (this includes failure). There was an endless amount of this kind of talk among colleagues. Sometimes these accounts were formulated in terms of the sex of the therapist (especially in a cross-sex relationship), or the mistakes of a private psychiatrist. Most frequently however, an understanding of why things did not work out as they ideally should was formulated in terms of the family. This membership provided adequate motivational accounts that were both psychiatrically relevant and, as we can now see, it also furnished therapists with reasonable explanations about the status of the treatment program itself. Families can be seen as uncooperative, uninterested, reluctant, disturbing, etc., all of which might affect the patient's success in therapy.

I have been demonstrating some of the ways in which therapists provided accounts of how they made sense of patient's behavior, explained
relapses, recognized problems, anticipated difficulties, etc., by reference to the child's family. The family appeared as a powerful resource in the therapist's reasoning.

In contrast to the halfway house where the "convict code" was a construction of the inmate and because of its nature was also used by the staff, the family talk is not a child's invention but an adult construction. I would like to suggest that to some extent, it is a persuasive rhetoric in this setting. Unlike adult therapy, wherein the patient may be expected to talk of his family, the child patient was neither encouraged nor expected to do so. He was however, expected to demonstrate that he understood that his problem originated in his family. If he continued to act as if his family were irrelevant to what he was doing in the play room, he was seen to be avoiding his problems. Although children were never overtly challenged on this point, this is how the therapists interpreted it. Consider the following conversations in which the therapist uses talk about the family to relate to the patient's problem.

4.15
C: I don't care. ( ) I don't care. That's what dad would say. Say it exactly the same way I say it.
T: How would he say it?
C: Exactly the way I just said it.
T: Like, "I don't care".
C: No. "I don't care".
T: Does your dad ever get mad Simon.
C: No.
T: No!
C: Apart from when ( ) starts a fight.
T: Mmhmm, and then dad gets mad?

C: Yea. How do you like that for a picture.

... ...

T: You know it's okay for people to get mad Simon. And:

4.16

1. T: If you were nice to him he would follow you all the way home.

2. C: Hmmm. Your mom would probably scream though.

3. T: Do you think so?


5. T: Hmmm.

6. C: She'd probably say, "where in the world did you find that thing?"

7. T: There that's another leg all together.

8. C: She'd probably tell me ( ), probably tell my dad to come.

9. T: What do you think your dad might do?

10. C: Come out with his gun, and shoot it. But I won'd let Dad shoot it. If he shot it, I'd get dad to shoot me if he shot the dinosaur.

11. T: Would you? Why is that Simon?

12. C: Cause I like dinosaurs.


... ...

17. T: So if dad shot your pet dinosaur you'd get real mad at him hey.

18. C: Mmhmmm.


20. C: Get him to shoot me.

21. T: Get him to shoot you; maybe you'd feel like shooting dad.
22. C: No way.
23. T: No way?
24. C: If I did shoot dad, then I'd have to go to jail.

The therapist thought that Simon was "too good". She said that he was always under pressure from his family to behave himself. As a result, he never admitted that he might be angry with someone or expressed his anger openly. There was so much constriction from the family that he could not express his normal emotions, especially his anger, and this had become a pathological condition. The above two conversations are methodical attempts by the therapist to get the child to express his anger with members of his family. In the first instance, she tried to show Simon that if there were occasions on which dad got mad, then it was alright for other people (including the patient) to get mad as well. In the second transcript, the therapist capitalizes on a situation in which the child could imagine that he would be angry with his father and asks him how he would express his anger. The child's answer, "get him to shoot me", is a confirmation of his problem—he would rather die than express his anger. The therapist closes this attempt with a clear and relevant statement: "Maybe you'd be real angry at dad though". Thus, children were often tested indirectly to determine whether they recognized how their actions and feelings were influenced by their families.

Some of the transcripts that have been provided make it clear that parents, too, are expected to see the relationship between the family's circumstances and the child's behavior. If they refuse to recognize this relationship, they can then warrantably be classified as problems. And, if they do not care for the well being of their child, their child or
children can ultimately be taken away from them. I had no real contact with parents but, at one point, I overheard a mother expressing her concern about her ability to give her child the security that she needed in order to make progress in play therapy. The therapist later characterized this concern for me as follows:

4.17

T: You heard mother's concern right at the end, she said she's beginning to worry about her capacity to be level, ah, she thinks Robin is lacking still in basic trust and secondly that she herself is very worried about her reaction, she's jittery (and what not). ( ) she's a pediatric nurse herself so that's why I was making the little joke with her that our professional defences don't work anymore.

I suggested earlier that the family as an accounting device was an adult construction rather than a therapist's construction because it can be, and is, used in this way on other occasions. It is persuasively used in this setting however, since its denial by a parent can be consequential. Although it is possible to respond, say, to a teacher's queries about one's daughter with "She's not like that at home", such a response would be most inadequate in the context of therapy. I take it there may well be grounds for the popular complaint, "must the parents always be wrong?"

This section has been concerned with talk of the family and with how such talk is used as a resource to provide adequate answers to questions such as "What's going on here?" or "Why aren't we getting anywhere?" I am contending that there is some obligation upon members to see the relevance of such talk.

As my problem had become defined as attempting to describe how therapists understood their environment and, subsequently, how I thought that I had come to understand that environment, I found that the family, (as a gloss for the things talked about above), was used to make many different
situations appear to be natural, appropriate, understandable and so.

"Misbehaviors" and "Permissibles"

With some small exceptions, the examples referred to have been from conversations between therapists or between a therapist and the researcher rather than from actual sessions of therapy. I would now like to show how notions of the family are also essential for an understanding of the actual practice of therapy.

One of Freud's sociological insights was the understanding that there are normative ways of hearing, speaking and seeing. He suggested that, were therapy to be successful, it may be necessary that the participants relax some of these constraints. This strategy became a standard feature of psychotherapy and gives it a unique accent. Most people have come to accept and expect this.

One of the ways in which psychotherapy differs from procedures for treating strictly physical illnesses is that the talking that occurs as a feature of the doctor-patient relationship may be seen as the treatment. That is, it is not simply an activity which allows the doctor to get to the treatment proper, e.g., writing a prescription. It follows that this talk is treated differently by both parties and is given special attention. The early psychoanalysts were well aware of the work that members had to do in order to make their talk appear as 'therapy'. For example, Freud would advise his patients that:

Your talk with me must differ in one respect from an ordinary conversation. Whereas usually you rightly try to keep the thread of your story together and to exclude all intruding associations and side issues, so as not to wander too far from the point, here you must proceed differently . . . say whatever goes through your mind.

Member's concerns with sequencing and topicality are through and through
normative and moral concerns. Further, consider Menninger's advice:

He is talking in the presence of this person in a way in which he
would not speak in the presence of any other human being. This
unseen person acting in a completely unexpected way in that he is
not responding as any ordinary human being would to these very
earnest appeals.¹⁶

The therapist too, avoids those normative constraints of topicality, etc.,
by responding as no "ordinary human being would".¹⁷

One of the early strategies, namely that of "free association", was
based on these insights. This was initially used with child patients as
well as with adults. When it appeared that this strategy did not work
well with children (interestingly, this was accounted for by saying that
the patient's subconscious had not developed because of his general
immaturity), an essentially non-conversational therapy (play therapy) was
developed. We can see from Millar's statement how play is a substitute
for free association.

When unchecked by facts or demands of others, human behavior and
thinking is motivated by the wishes of the individual. In play,
in dreams, in fantasy, checks from hard facts do not operate,
they are determined by wishes.¹⁸

This is clearly a variation of the theme of free association wherein the
normative order is effectively subverted by allowing the child to act (or
play or dream) without the "demands of others" interfering with this pro-
cess. As with all other psychotherapies, the construction of this special
"moral accent" is an interactional accomplishment that has to be maintained.

It is typical for the patient to be told during the first play
session that this will be his room for the hour and he can do whatever he
likes here. This latter instruction may be illustrated and made concrete
by giving an example of some "misbehavior" that is "permissible" in the
play room. And this comes to stand for a class of actions. Of course,
depending upon what is known about the child, it may be deemed necessary
to set limits for him. These misbehaveables are clearly seen as a
feature of psychotherapy. Klein makes this clear.

More important still, I found that the transference situation—
the backbone of the psychoanalytic procedure—can only be
established and maintained if the patient is able to feel that
the consulting room, or the play room, indeed the whole analysis,
is something separate from his ordinary home life. For only under
such conditions can he overcome the resistance against experiencing
and expressing thoughts, feelings, and desires, which are incompat­
ible with convention, and in the case of children felt to be in
contrast to what they have been taught.19

Thus, there is a deliberate effort to establish that the therapy
room stands in contrast to the patient's home. In many cases, the contrast
is formulated by the therapist:

4.18

T: You know what?
C: (   )

T: Terri.
C: Mmmm.

T: I want to talk to you for a sec.
C: What?

T: Sometimes we can have these kinds of explosions here in the play room
hey.
C: Yea.

T: When there is flames come out of the caps and stuff.
C: Yea.

T: But the play room is different from home isn't it?
C: Yea.

T: And we don't want a
C: I'm gonna, my dad is making me a play room in the basement.

Or:
T: Okay, you know we can paint on the wall here but you can't do it at home.

C: (That's) good walls.

T: You can't do it at home, no, and you can't do it in the classroom, can you, downstairs?

C: No.

T: No, cause it's not good to do it there. And if you did it at home it'll make mom mad.

C: Yea.

T: But we can do it here. . . .

There are also numerous instances when the instructions simply say what can be done here.²⁰

Klein's statement above tells us why this conduct is permitted and encouraged in the play room. I would now like to make two additional points. First, the term 'here' is always to be heard as one end of a set which includes 'this' setting (context, occasion, location), and somewhere else. However, the 'here' operates in a more powerful way than this, since we can suggest that 'here' is only meaningful given the understanding of some 'there'. In regards to this, one can look at Emanuel Schegloff's paper on the formulation of place.²¹ Schegloff demonstrates that 'here' is a formulation of location which is methodically selected by the speaker for the hearer on the basis of their identities and locations. Thus, given the relevancies of the child, we can see how he locates the appropriate 'there' in his family. The child seems to be able to do this as a matter of routine.

Secondly, the specific instances of "misbehaviors" suggested by the therapist are to be seen as representatives of the whole class of "misbe-
haviors". Given the relevancies of the hearer, it is easy to discover other appropriate items in that class. It is never the case that the class is listed in full, (indeed, this would be impossible), rather, patients are able to see what kind of items might appear in such a list, i.e., things that adults, especially parents, could be expected to sanction him for doing. (These are usually violations of the adult environment, and include such things as making a noise, messing things up, destroying something, swearing, and making mistakes).

Patients have little trouble in discovering this class of "misbehaviors". Consider the following excerpt:

4.20

C: What's ya' name?
T: My name is Paula, what's your name?
C: Ellen' n I like you. ((said very fast))

T: You like me, I like you too. You know that, that I'll like you even if you do something that you really feel like doing in here. If you want to pound on things and so on you can do that, hum.

C: I like to paint on the wall.

The relationship between these two actions is that both of them are "misbehaviors". Note that, by requesting to paint on the wall, the child has demonstrated an understanding of this relationship. We can easily see that this was the intention of the therapist in formulating a misbehavior in the first place. We can make this sound strange by giving the first formulation an 'adult' hearing, that is, by asking what it would be doing were it addressed to an adult patient. The child's option to "pound on things and so on" may be seen as a license to do things within the play room that he could not do outside of it without facing certain serious consequences. Such a license easily includes permission to "paint on the
Some analysis of the first action must be done before a second suggests itself. Concomitantly, the child can be expected to look for and find the relationship between the first action and some feature or features of his biography.

It is clear that in constructing the "moral atmosphere" of the play room, the therapist takes an adult's view of children even while he is attempting to appear to be different from other adults. The "misbehaviors" that he cites are typical adult concerns even if they are given a positive rather than a negative connotation here. Adult notions about the family were an important resource in the very creation of the therapy room where, through 'here' and 'there' statements, the play room is contrasted to home, and the patient is encouraged to perform acts that would not be acceptable in his family. Further (and we must say "for the adult"), this appears to be a perfectly logical way to handle children.

Summary

We began this inquiry with a review of the everyday sights and sounds of the clinic. I proposed that most of these were transparent. That is, on some level, we already had an adequate understanding of what was happening, accepted it as reasonable, and so on. Along with this, we seemed to be able to make sense out of the conversations that occurred during therapy sessions. It was then proposed that we make matters puzzling by doubting their transparency and searching for their psychiatric relevance. During my field work, I acquired some measure of competence whereby I could see the psychiatric relevance of talk and events. That is, I came to see therapy in much the same way as the therapists saw it, and I was able to do this by studying the accounts that the setting provided. Chapters 2, 3 and
are intended as a display of practical psychiatric reasoning. Confronted with the problem of understanding what was going on, I looked for and found what I have referred to as the "therapist's corpus of knowledge". My findings were predicated on therapist's talk, and I take it that they understand and interpret the events of the setting in the ways depicted here. I also emphasized other essential features of that corpus of knowledge, especially, (a) how background expectancies are necessary for practical reasoning, (b) understandings of normal children and, (c) the patient's family as a resource. These enabled me to make sense of numerous events in much the same way that they did for therapists.

I would now like to look at the adequacy of those accounts. Although the preceeding information was presented as a representation of the psychiatric interpretive schema, it seemed to be both adequate and reasonable, i.e., actions appeared to be appropriate. How is it that, although the setting is organized for and revolves around a specialized task that requires much training and knowledge, explanations sound so reasonable, actions so appropriate, and reasoning so logical? This will be explored further in the next chapter.
Footnotes

1 In the history of child psychiatry one can discover a transition from a biological and genetic etiology to an environment (i.e., home) etiology. See, for example, J. L. Despert, The Emotionally Disturbed - Then and Now, New York: Grunner, 1965; or R. Crutcher, "Child Psychiatry - A History for Development", Psychiatry, 6 (1943) 191-201.


3 Interestingly this separation is also for the protection of the therapist. It is felt that such a sympathetic bond may develop between therapist and child that he or she may be less than understanding with the parent.

4 This was a concern shared by all members of the staff. On one occasion it was discovered that a parent would be arriving early to pick up her child. The therapy session had started later than scheduled and a colleague was concerned enough to slip a note under the play room door to advise the therapist. The therapist and patient were not in the room and returned 'late'. The staff later expressed some embarrassment about what the parent might think of the matter.

5 For an interesting discussion of 'transference neurosis' in adult therapy see E. Schegloff, "Toward a Reading of Psychiatric Theory", Berkeley Journal of Sociology, 8 (1963) 61-91.

6 Needless to say, in this particular example, the therapist did not have the mother's assurance that it was all right to play in the mud. However, it is often the case that adults can speak for one another when dealing with children.

7 It should be added perhaps that the adequacy of this account also requires some common sense understandings that could be characterized as 'sexist'.


10 There are many notions like 'accountable', 'rights', 'entitlements', 'justifications', etc. that are through and through member's notions. Such interactional issues are in need of sociological examination. There is some material on these issues in an article by M. G. Scott and S. M. Lyman, "Accounts", American Sociological Review, 1968, and, more indirectly, in the writings of E. Goffman, H. Sacks, and A. Cicourel; see particularly, A. Cicourel, "Delinquency and the Attribution of Responsibility", in R. Scott and J. Douglas (eds.) Theoretical Perspectives on Deviance, Basic Books, 1972.
I am using 'accountable' in a member's sense here. On most other occasions I am referring to Garfinkel's special usage: "When I talk about the accountable character of affairs or when I talk about accounts, I am talking about the availability to a member of any ordinary arrangement of a set of located practices". "The Origins of the Term Ethnomethodology", in R. Turner (ed.) Ethnomethodology, Penguin Books, 1974, p. 17.

For an interesting examination, although not supported by data, of those accounts we call "excuses" and "justifications" see M. Scott, S. Lyman, Op. cit. They also mention the use of family accounts in non-therapy conversations.

As another example of this consider the following excerpts from a letter to Ann Landers. Dear Ann: As a teacher, I would like to pass along a set of rules for parents. If followed they are guaranteed to produce a spoiled brat who will later develop into a thoroughly messed-up adult.

1. If your child has trouble with the teacher don't go to the school and talk to the teacher. Run directly to the principal, to the superintendent of schools, or to the head of the school board. It's always best to go straight to the top.

5. If your child reports that the teacher embarrassed him in front of the whole class for some little thing he did, phone the school and make it clear that you will not permit any teacher to discipline your child because he is very sensitive - "not like most children". . . . Vancouver Sun.

Schulman, et al., suggest that the child be given an account of the therapy enterprise which includes a reference to the therapist as a "talking doctor". The Therapeutic Dialogue, Springfield: Charles C. Thomas, 1964, p. 147.


For example: T: You know though that I'll like you even if you do something that you really feel like doing in here. If you want to pound things and so on you can do that, hum.

CHAPTER 5

REASONABLENESS AND THE ADULT IDEOLOGY

Although on my first viewing the therapy setting and activities struck me as being reasonable, I was torn between whether to accept or reject the adequacy of my understanding. I willingly ascribed an expert knowledge to therapists and doubted that I was making all there was to make of the events. Although both therapist and researcher "understood" the patients, events, etc., I doubted that we had reached that understanding by the same route.

For many months I visited the clinic attending to the play room events and the talk that transpired between therapists and patient. During that time I also heard a great deal of talk about patients, families, normal children, etc. I took all of these to be descriptions which were external to the play room activity and thereby to an understanding of it. For a long time I remained puzzled about the events that took place in the play room and tried to get behind the scenes to make some better sense of my initial observations.

While talking about my experience to colleagues I discovered that I could talk competently about the setting; that is, I could account for what I saw in ways which were adequate for-all-practical-purposes,—their motivations, etc. Further, I found I was able to give my accounts in terms of a resource I had failed to take seriously, namely, the very descriptions that the therapists had provided for me. At this point, I began to realize that the talk that I had heard about children, patients, therapists,
families, etc., might well do the same thing for therapists that it did for me. On the basis of this insight, I was able to construct what I have referred to as "the psychiatric interpretive schema" by way of which therapists make sense of their patient's problems, progress, and play.

I hope that the reader would agree that there does not appear to be anything esoteric in the reported corpus of knowledge. Rather, it too seems reasonable. Throughout that account I have emphasized its adequacy, logic, etc. Therefore, rather than try to remedy this reasonableness, I suggest it should now become our central concern. Instead of assuming that therapists arrive at their understandings by a different route than do laymen, I propose that both routes are the same since our vocabulary of motives, our accounts, our explanations, are shared ones.

I progressed from doubting the reasonableness and transparency of events and accounts to recognizing that I had a resource for making sense of that very reasonableness. That is, I began to see that the resource for my own practical reasoning about therapy events might also be the basis of the therapist's practical reasoning. I was then able to terminate my search for something behind the scenes.

If we look back at my accomplishment of seeing (and yours of reading) the reasonableness of that corpus of knowledge we will find that, like the therapists, we were able to recognize the conversations as being those of children (e.g., in inappropriate syntax, non-sequitors, etc.); we also saw such things as the sensibility of using play as a form of therapy, recognized characteristics of the child (e.g., emotional states) in their play activity, attributed family-based motives to their actions, recognized children testing the limits, understood why punishment for spilling drinks may not have been a good strategy, saw age-appropriate behavior, recognized
stages of growth, understood the reasonableness of children not being voluntary patients, accepted the reasons for my not being encouraged to talk to the children, etc. The lay person and expert operate in the same manner. The basis of my own practical reasoning skill in making sense of my first viewing was my common sense knowledge and understanding of 'children' and 'adults' as social actors. I used a set of typifications about these actors that enabled me to construct motivational accounts and to recognize typical behaviors.

Thus it was my stock of folk wisdom which accounted for the transparency of the psychiatric interpretive schema. With this insight came the recognition that this folk wisdom is also a feature of psychiatric reasoning. It is in fact a constitutive feature of the setting. Let me try to develop this insight.

In talking about the actor's practical interest in the events of the world Garfinkel suggests:

In everyday situations what he knows is an integral feature of his competence. What he knows, in the way he knows it, he assumes personifies himself as a social object to himself as well as to others as a bona fide member of the group. He sanctions his competence as a bona fide member of the group as a condition for his being assured that his grasp of the meanings of his everyday affairs is a realistic grasp.¹

If we start with the notion that what one knows is an integral feature of his social competence, and acknowledge that the above reported reasonableness is a result of what one 'knows', we can then ask in regard to this field setting "just what competence is at stake?" It is clear that there is some competence involved in the clinic setting other than professional competence. I will refer to this as an adult's competence, and contend that the reasonableness of our initial viewing of the setting and the transparency, etc., of the psychiatric reasoning is a result of an adult's interpretive schema of children.
Writers such as Thorne, Leach and Sacks have suggested that all seeing and hearing is normative and a violation of this normative order produces warrantable inferences, e.g., one doesn't know the culture, one is 'naive', 'foolish', 'stupid', etc. There are for example, normative ways to hear, see, talk to, organize for, children. Our common-sense notions of children being 'cute' or precocious are products of that seeing. The most central notion of this normative order is the adult member's notion of children as special cultural objects. It is this seeing-them-as-different-from-us which produces a characterization of 'cute' for an action that for other categories of actors would be uneventful or sanctionable (e.g., making your own doctor's appointment).

There is ample evidence to demonstrate that as adults we conceive of children as special cultural objects. This was suggested in a previous note about how information on psychotherapy with children is placed in the literature. The notion of children as special cultural objects is displayed, however, in the very organization of services. That is, adults see children as a special category within the population among whom special needs can be identified and services developed to meet those needs. This is not simply a reference to mental health services but applies to a wide range of activities and settings, e.g., sick children's hospitals, children's dentists, clothing stores, little league sports, children's books, children's movies, etc. (Although there are events described as 'adult' movies this description does a different kind of work than to differentiate it from 'childrens' movies). As analysts we can think of adults and children as comprising two distinct groups but for the adult members it is simply the case that there is the world and there are children. It would seem strange for example, to think of all hospitals as adult's hospitals.
(It may well be the case that this is the way the world appears to children, that is, that there are adult books, adult movies, adult hospitals, etc.) Further evidence of this is our belief that children need to be with other children.

A powerful extension of this feature of our culture, i.e., that the category of 'child' is a normative category, is that the categories of 'adult' and 'child' are omni-relevant whenever there is a contact between the two. The strength of this notion is attested to by the fact that regardless of what other categories are referentially adequate for the participants on any occasion, e.g., teacher-student, clerk-customer, probation officer-probationer, the categories of 'adult' and 'child' will cut across them. It is an inescapable feature of the paramount reality that these categories will not only be referentially adequate but referentially relevant. While the world appears to be organized on the basis of one category being referentially adequate for a person on any occasion this does not mean that on every occasion only one category will be relevant. I am arguing that with children it is always the case that at least the category 'child' will be relevant. The significance of this fact then is that not only do we have normative ways of hearing and seeing children but that this is always a sanctionable hearing and seeing. This feature is particularly striking in talk about child psychotherapy where the patient is routinely referred to as the 'child' and the therapist, with remarkable frequency, as an 'adult'.

Invoking the category 'child' is not without consequence. As with all other categories its use provides solutions to the basic problem of how an actor constructs his own actions and understands the actions of others. It provides solutions to the problem of making sense. Schutz
has brought to our attention the study of the natural attitude as a subject of inquiry and has given us many insights into member's procedures within that attitude. The natural attitude furnishes the resistant objective structure which must be reckoned with in a practically adequate fashion if projects of action are to be affected successfully. It appears as a massively organized structure into which the actor must gear himself. For members then, the world is experienced as already being organized and this structure is seen as having consequence for what one accomplishes in that world. The notion of 'childhood' is part of this objective structure and, further, is a categorization given substance through a process Schutz called "typification". In reference to this term McKinney says: "Typification, perceiving the world and structuring it by means of categorical types, is evidently an essential and intrinsic aspect of the basic orientation of actors to their situations". These folk typifications provide members with a massive amount of knowledge about the world; for example, they provide us with the typical characters of persons, what one can expect from various actors, typical biographies, ways to talk to people, how to avoid offending, typical motivations, etc. All of this provides us with a way to understand actors and actions.

It is this kind of knowledge that we refer to as 'common-sensical', or "stock of knowledge", and we can now show how this knowledge is used to solve those "issues and technical problems" which psychotherapists encounter when confronted with a child-patient. Two points of clarification are necessary: (1) I am not suggesting that these folk typifications in some strong way represent the way children 'are' nor that there is complete cultural agreement among members on the features of these typifications, rather, I want only to suggest that all members, psychotherapists
included, engage in a great deal of common-sense talk about children and this knowledge is interactionally vital. For example it provides for adequate accounts, demonstrations of logic, instances of appropriateness, etc. (2) Further, I am not arguing that there is no 'scientific' knowledge about children. If we consider scientific knowledge to be the product of scientific rationality there are clearly such inquiries into, and accounts of, children. However, the practice of psychotherapy exhibits not scientific rationality but common-sense rationality. 8

The work of psychotherapists, like that of all members of the culture who work with children, is embedded in the natural attitude and its notions of childhood. As a researcher and an observer my activity was also built on that member's understanding (or background expectancies); I, too, was geared into that same massively organized structure. My awareness of my ability to make sense of the setting's activity and seeing its reasonableness amounted to seeing that both myself and the therapist were operating as adults. It is our status as adults which accounts for the adequacy of what has transpired.

These folk understandings of children have been talked about by Sacks 9 and Speier 10 as an "adult ideology of childhood" and I suggest that we use this idea to further our inquiry. Before examining their usage let me clarify what I mean by the term 'ideology'. 11 By this notion I intend to point to the normative ways adults have of seeings, (hearing, talking to, organizing for, etc.) children. These notions of what children are like are deeply embedded in the natural attitude. This is not to suggest however, that this simply represents a body of knowledge. Rather, it is a schema for viewing the world and for making sense that is shared by a category of actors. It is essentially ideological insofar as it is a
viewing for which one can be held accountable. The viewer's status as a competent member of the group hinges on it. In the case in point, one's competence as an adult is at stake. Let me given an example.

During my observations I watched a patient playing basketball using the wastebasket as a hoop. After he had made several unsuccessful attempts, the therapist positioned the wastebasket in a way that would assure success. He later explained that the child would feel better after having accomplished a successful throw and this would allow him to go on to other activities. To have helped another adult in that manner would have been a very different matter—even though adults too like to be successful. Not only was the therapist's explanation seen as adequate, but it would have been odd for me not to have understood it. Although I could have challenged it on grounds that children feel more confident if their achievements are their own, this is very different from saying to the therapist, "your explanation is such that it makes no sense to me". Both the therapist's explanation and my reasonable challenge are built on an understanding of the ways in which adults are supposed to look after the child's development, happiness, etc. Let us now look at how the term "adult ideology" is used in the literature.

Sacks and Speier have both drawn attention to the adult ideology by turning our conventional wisdom of children on its head. A few years ago, Sacks delivered a lecture which contained the beginnings of an unconventional way for formulating questions about children. He asked questions such as "where did 'children' come from?" or, "As 'ex-children', why do we know so little about them?" He posed questions about the nationwide spread of children's 'culture'; the control of adult competence by children; the warrantable consequence of not treating children like children;
etc. This appears to be a strange set of questions because it completely ignores areas that we see as central to any inquiry into this segment of the population, i.e., it ignores both the development of competence in children and the process by which they become adults under the guidance of their parents, teachers, etc. As adults we are warrantably concerned with the fundamental problem of how our children are growing up—are they making satisfactory progress, are we providing the right kind of care, stimulation, etc., is the wider community doing all it can to assist in the growing-up process, are we protecting our children from danger, etc. How we handle these issues is reflected in the characterizations of good parent, over-protective mother, negligent parent, concerned citizen, etc.

Sacks also began to talk of the distinct "culture of childhood" (rather than a miniature version of 'our' culture) and this, like the questions that he posed above, is insightful because it challenges many of our taken-for-granted assumptions. For example, we all know that children cannot have their own culture since their knowledge, skills, activities and attitudes are just child sized replicas, or pre-competent versions of adult culture. Surely children are dependent upon adults rather than the other way around as Sacks suggests! Do children really pass on knowledge without the intervention of adults?¹²

The notion of a culture of childhood¹³ is potentially unsettling partially because it bypasses the usual concerns about what adults do (or should do) to and with children. This concept has been explored recently in a book by M. E. Goodman.¹⁴ Goodman is worth looking at because she demonstrates the notion of a 'culture of childhood' without positing Sacks' notion of an 'adult ideology'. She begins with a statement not unlike one that Sacks might make:
The literature on child development, including a scholarly journal published under that name, is enormous. So is the literature on child rearing - on socialization. These and other studies report what adults see when they observe children, and what adults do for and to children. Culture of childhood studies, in contrast, report on what children see as they observe the world in which they find themselves.\textsuperscript{15}

Goodman goes on to proclaim the need for a science which would be a corrective for the fallacious assumptions of adults. "Systems built upon them are likely to be faulty at best and disastrous at worst," she says.\textsuperscript{16} So, rather than attempt to discover what either adults or children see, she clearly addresses herself to the adult's problem and concerns with "child rearing and pedagogy". Goodman then looks to science and scientific reasoning for solutions to these problems. While this may appear to the lay reader to constitute a challenge, it does not present a threat to the social sciences.

Interestingly enough, Speier has provided a further twist and questions the social scientists' concern with children. For example, he says of the field of socialization:

A set of working assumptions is deeply engrained in the choice of research problems and findings that result. I would like to refer to this set of suppositions as the classical formulation of socialization. I treat it as classical because it is a formulation that is rooted in adult folklore or common-sense understandings about children. Adult professionals doing sociological studies have oriented their work around a set of implicit conventions. Taken together these conventions differ from lay ideology only in so far as it is systematically working out professional problems and solutions that are responsive to the ideology, i.e., how scientifically correct the ideology is, how effective it might be, how could it be remedied, etc.\textsuperscript{17}

Like Goodman, he is trying to radicalize our approach to the study of children but it is clear that Goodman has not escaped the 'adult ideology'.

Although it is impossible to escape the ideology entirely, it can be made into a topic as well as a resource.\textsuperscript{18} That is, one uses the
ideology to discover and explicate the ideology. Thus, the researcher who is interested in the culture of childhood can minimize the influence of the ideology by refusing to formulate problems in terms of such things as child rearing or developmental models. Rather, he can choose to examine the productions of children in terms of children's knowledge. For example, Speier has looked at children's devices for 'getting the floor' with adult speakers. This approach, however, still requires one to employ the ideology since I take it that Speier did not have to learn a new set of rules for recognizing 'children'. To begin with the notion of a "culture of childhood" is to bring to light some of the features of the adult ideology, but it does not provide a new way of seeing 'children'.

Speier's interpretation of the adult ideology appears to deal essentially with the formulation of research problems even though he recognizes that there is a much broader interpretive schema. He claims that we have done little more than elaborate upon and solve problems formulated from within the adult ideology.

Before leaving this topic, I would like to make one clarification. If one accepts my previous statement that the categorization of 'child' is omni-relevant (both Sacks and Speier also make this point), we cannot say, as Speier appears to, that "taken together these conventions form an adult ideology". A possible reading of this is that the ideology is simply a set of finite common-sense assumptions that can be found, listed, or escaped. However, one cannot see children other than through this ideology. For the ideology is an interpretive schema that is continually ad hoced to make sense of children's actions. In that sense, the ideology would be continually employed and displayed. I will say more about this later but I would like to emphasize at this point that I mean more by
ideology than a specifiable way of looking at children, I mean to imply an
inescapable way of looking at children.

In drawing attention to the "implicit" conventions mentioned above,
Speier has offered five themes that he took as central to the ideology.
These are to be seen not just as features of the social scientists ideology,
but of the adult ideology. They are worth listing as an initial view of
what we mean by the ideology.
1) Children are adults-in-the-making.
2) Children get socialized or 'made' into adults mainly by adults who
teach 'culture', 'norms', 'values', 'roles', 'behavior systems', etc.
3) Children progressively develop into competent social members.
4) Children's development can be either successful as they grow up through
stages of life or it can be deviant anywhere along the way.
5) Children are defective social participants by virtue of precompetence
at behaving properly.\textsuperscript{19}

The implication of these conventions is that the child is seen as
having a special status in any adult-child contact. The most significant
interactional features of the ideology are contained in the notions of the
child as a defective social participant and in the idea that it is adults
who provide children with the skills and knowledge by which they are to
become competent participants. One can easily see how interactions get
-fashioned around these resources in order to 'socialize' children. (This
applies particularly in the household but holds for other settings as
well). On the other hand, it is possible to learn something of the
child's defective participation by observing adult concerns with helping
the child to participate in conversations and other affairs.\textsuperscript{20} One can
see how the ideology is a major feature governing contact between adults
and children.
Speier has begun to demonstrate how this ideology is reflected in the properties of conversations. He is particularly interested in the interactional consequences of "restricted rights" of the child in his dealings with adults. For example, how does the child solve the problem of initiating and maintaining a conversation with an adult or how does he get to be a speaker in an ongoing conversation.

I would like to repeat that, while these conventions provide a way of cutting into the ideology, the ideology is not a definite object which can be listed, learned and used. That is, it is not my intention to draw up a list that shows how adults conceive of children. Rather, it is our claim that the ideology is an interpretive schema and, as such, consists of a continuous process of ad hoc ing by which new occasions, events, actions, and problems can be brought under its auspices.

Returning now to my field work puzzle, I contend that this notion of an adult ideology can be used to account for, or to make sense of, therapists' actions, accounts, explanations, etc., as well as for our experience of their reasonableness. While therapists may provide accounts in terms of therapeutic goals, the bureaucratic organization of the program, the biography of the patient, etc., we would argue that the adult interpretive schema is the foundation for all of these accounts. The notion of an adult ideology will be used to focus on the interpretive schema employed by the members of the setting. The nature of this schema can be determined through an examination of actions in the setting. The ideology is offered as a device for making sense of both the events and the organizational rationale. The adequacy of accounts, the appropriateness of responses, the validity of reasoning, the transparency of motives, etc.,--all are provided by the adult ideology.
In review, the adult ideology is an omni-relevant device for making sense of (children's) activities. Both the layman and expert subscribe to it and from it derive their status as competent members of the culture. Although the therapist's talk is on occasion more technical than that of the lay person, the consequences of their decisions are often more pressing, and although they may appeal to 'scientific' findings, their explanations remain occasioned uses of the adult ideology.

The adult ideology provides a solution to our early query about how it was possible for activities that take place in a specialized work setting to seem reasonable to us. The talk, activities, etc. are consistent with other situations where children are found. As adults we are able to understand those events by using the same interpretive schema that we use in our everyday life.²³

My Discovery of the Ideology

Let's look at my puzzlement and discovery to see how I constructed the previous display of psychiatric reasoning which I now argue is a manifestation of the adult ideology. Before I began my research at the clinic, I was aware of the notion of an adult ideology as it had been developed by Sacks and Speier, however, I failed to appreciate its implications. It was only after much time in the field that I saw that I and the therapist may both be using this ideology. Although the notion of an adult ideology was not clearly formulated in the literature, I began to treat it as a social science finding. Then, realizing that I may be dealing with an instance of that notion, I began to develop it. I began to see accounts given by the therapists as instances of the ideology and to piece them together to form a pattern. That is, I resolved my puzzle
about what was happening in the play room and I claim that the materials presented in the preceding chapter are an adequate account of therapy related concerns.

Here is an example of how I discovered a pattern in the explanations, accounts, and actions of the therapist. I noted

1. A patient's talk about dead birds was accounted for in terms of his father's death.

2. A patient's sex identification problem explained in terms of family responses and structure.

3. An apparent relapse was accounted for in terms of the time spent at home with mother.

4. A patient's painting was explained in terms of the moral character of the family.

5. A patient's swearing was explained in terms of the existence of a family rule sanctioning such behavior.

6. A session was said to be good for the patient because it provided an activity not permitted at home.

7. A patient's anger was explained in terms of the father's employment status.

8. A patient's lack of progress was explained in terms of the need for the family to be in therapy.

9. I also found myself contributing to this pattern, e.g., offering an explanation of a patient's apparent non-sequitor in relating a rocking chair to "somebody old" by positing the possible existence of a grandmother who used a rocking chair.

There appeared to be a rather long list of instances such as this.

Using the documentary method, I began to see events such as these
as a document of the multi-consequential nature of the family and was then able to use the idea of multi-consequentiality to find further instances. If the reader looks back at the previous chapters he will be able to use the notion of the multi-consequentiality of the family to find further other such instances.

For example, when I reexamined my field notes and tapes I discovered that one patient's apparent exaggeration of his possession and skills was seen as the consequence of the existence of an older brother who was successful and much praised by his parents. This exaggeration was seen as an attempt to appear to be someone who he was not so that he too would be accepted. When I was introduced to the case of a very disturbed child, I was told that the mother is "crazy too". I saw the therapist's effort to convince a patient that it was not important to keep score in their dart game as a strategy to display to the child that unlike home, there was no pressure to succeed in the play room. These instances are further documents of the underlying pattern.

It was clear that these accounts depend upon our common sense for their meaning and relied upon our shared understanding of the 'family'. To take this further, let me develop what I will refer to as features of the adult ideology. These are all features that were constructed in somewhat the same manner as the above. To demonstrate that the reasonableness of these features are consistent with everyday happenings I will also provide some non-therapy related examples.

Features of the Ideology

1. All of the above instances of using the patient's family to explain behavior are instances of a feature I will call the omni-relevance of
family membership and its multi-consequentiality. The instances above constitute an occasioned application of this feature and are of the same character as a parent's concern that the "public" will judge the moral character of the family on the basis of their children's manners in restaurants, or as a teacher's concern that children from "deprived" families need special attention. 24

2. The fact that the child is an involuntary patient (and often does not know that he has a "problem") and is occasionally forced to go (and sometimes carried) into therapy is a feature of what everyone knows; i.e., that children can not be responsible for making decisions since they do not know their own emotional or physical states. It is of the same character then as the parent's ability to see that his child is tired, even when he is making a noise and running around and denying his tiredness. Or, the parent who knows that a child must be hungry. 25

3. The therapist's characterization of a patient as a "player" or a "talker" and his ability to see the immaturity (regressiveness) of play activity is an occasioned application of notions of age and stage appropriate behavior. We know that children have different skills, think different thoughts, experience different emotions, and so on, according to their age. These differences are referred to as stages. This reasoning may be compared to that of the parent who thinks that their daughter is now too old to enjoy, appreciate or play with dolls, or to the businessman who acknowledges that children go through a stage wherein they are especially likely to do some shoplifting. 26
4. The therapist's use of play as a form of therapy, and ability to determine the moral character of the player, derives from the idea that there is some special relation between children and play; that it is in some ways an activity which is uniquely theirs. This is of the same character as is the reasoning of the parent who infers the moral character of the children in the neighbourhood from the way that they play, or the father who sees the concerns and/or abilities of his children in their "playing school".27

5. The therapist's seeing of human needs (such as dependency) and the effort to help the child get back on the proper track so that he can experience such needs and work through them can be seen as an application of our notions about developmental derailment. We know that children are creatures who go through stages of development which, at any point can be stopped or be side tracked. Derailments are typically attributed to certain significant adults whereas rehabilitation is assumed to be the responsibility of all adults. As such, this reasoning is of a similar character to that of the parent who tells his doctor that his child does not seem to be a normal child, or the teacher who evaluates the emotional state of pupils and advises parents on how to remedy the problems.

6. The therapist's frequent praise of patient's appearance and the frequent physical contact is, in part, an occasioned application of the notion that children can be commented upon, evaluated, touched, etc., at any time. As such, it resembles the actions of the sales clerk who admires the clothing of a child-customer, the house visitor who praises a child's coloring ability, or the stranger who ruffles the hair of a young
7. The therapist's selection of play objects which allow the child to make a mess, to express his anger and aggression towards the therapist, to make a noise, and the approval of those activities is an occasioned application of the notion that children are violators of adult "environments" and that they may have a "need" to be like this. As such, it is of the same character as the reasoning of the family that has a play room for their children, the parental approval of play schools, and even the frequent assignment of old clothes to children as well as the negative sanctioning of violations. Whether or not one approves or disapproves of children disturbing the normative environment with their noise, fighting, breaking things etc., they are routinely seen as creatures who can be counted on to do such things and are unable to control themselves. One either punishes them, or provides special items, clothing, and so on for their activities, or ignores them. However, one is always aware of their presence.

8. The therapist's awareness of the patient's need to test the limits of a situation and his efforts to help him discover those limits in a healthy way is an occasioned application of the assumption that children always try to discover the limits and need to know them so self-control is possible. As such, they are related to the reasoning of the recreation leader who "comes on strong" with his followers so that they will know that they cannot get away with anything with him, or the group leader who realizes that he has lost control of the group by being too "soft".
9. Therapists often took some patients to the gymnasium as a final part of their therapy hour and allowed them to jump on the trampoline. This was explained as a way of letting the child "let off some steam". It was felt to be especially necessary with those patients who had built up a lot of emotion (e.g., anger) during the therapy hour but had not released it effectively (by talking about it, hitting the punching clowns, etc.). Rather than send the patient home in this state, the therapist gave him some exercise. This is an occasioned application of the notion that children are victims of their bodies and/or emotions and need physical activity to make them civil. As such, it is somewhat like the reasoning of the recreation leader who has his charges run around the gym before he tries to teach them the rules of a new game.

10. The therapist's assistance in making the child's activities successful for them, for example, his moving the "hoop", giving the child a second chance in a game, making mistakes in adding up scores, failing to outperform the patient in competitions, etc., while done for good psychiatric reasons--such as removing pressure from the child, not frustrating the patient and thereby side-tracking the session, speeding up activities which are not productive, etc.--are occasioned applications of the assumption that children are pre-competent actors. As such the therapist's assistance has the same character as that of the parent who regulates a child's diet, teachers who help students with their winter boots, or the sport coach who deliberately fails to hit the ball.

11. While the therapist's provision of cookies, candies, or soft drinks may have some psychiatric significance in that it establishes an
atmosphere of trust that comes through sharing, it is also an application 
of the notion that children can be won, pacified, encouraged, etc., by 
giving them treats and sometimes should be rewarded for no reason at all. 
As such the therapist's actions are somewhat akin to those of the store 
clerk who gives the child a balloon, the stranger in the park who shares 
his popcorn, or the dentist who gives his small clients some trinkets 
(something which he would not do with adults).

This is not meant as a definitive listing, rather it is offered as 
an example of how the events of the therapy room are instances of the 
general features of the adult ideology. It provides us with some of the 
notions of the adult ideology and shows how the therapist's reasoning is 
an occasioned application thereof. If the reader goes back over the data 
he will be able to find innumerable other instances of these features and, 
of course, to find events which suggest different features. I would 
suggest that that activity could continue for a long time. What we would 
be doing is explaining the events of the therapy room in terms of the 
understandings that we all share. As I have suggested previously, this 
is the same way that the therapists operate. This is because the adult 
ideology is a resource for both the lay person and the expert, and this is 
necessarily so. Thus, the earlier distinction between lay and expert 
members now takes on a different character.

It is common for laymen and experts to each see their knowledge as 
different from, and sometimes as in competition with each other. Experts 
are often said to or claim to have the truth about human or other types of 
behavior. It is often assumed that the task of the expert, because of his
specialized knowledge is to remedy the knowledge of the layman. For example, our earlier mention of the child rearing literature on socialization and child development characterized it as an effort to correct the false assumptions and incorrect practices of the layman. In a similar way the therapist can be thought of as someone who is supposed to remedy the mistakes made by the lay person. An examination of the practices of such experts as sociologists and child therapists demonstrates that experts ultimately use the same resources as the lay person does. Zimmerman and Pollner suggest that:

Sociology's acceptance of the lay member's formulation of the formal and substantive features of sociology's topical concerns makes sociology an integral feature of the very order it seeks to describe. It makes sociology into an eminently folk discipline. . . .

While I am suggesting that the sociologist, like the therapist, is an adult member of the society, I am not arguing that there are no distinctions between the two. The differences lie in the activities that they do. The sociologist who is interested in, say, socialization practices shows his expertise by answering questions based on the very resources that all adults know and share in common. Questions such as "How do children become competent social actors?", "Why do some children become deviants?", or "What is the influence of social class on personality developments?" rely upon members' common sense knowledge of the world. Similarly, the child therapist practices his expertise by attending to problems which arise from and rely upon this same resource. The questions that he is concerned with - "How can we make the child feel better?", "How do we remedy the child's self-concept?", "Why did this child become disturbed?", etc., are also concerns which the lay adult/parent and the expert have in common. Relatedly, they share assumptions about children being socialized
or made into adults by adults who teach them values, roles, behavior systems, and so on. Therefore, the lay expert dichotomy is not based on special or esoteric knowledge, but on the occasions of its use. Folk wisdom is a resource that is and must be used by either party to explain such things as the behavior of children.

Let us take a second look at what the adult ideology accomplished for the therapy occasion.

The Ideology as a Source of Explanations of Patient Behavior

In a similar fashion to the way in which I was able to explain this setting to colleagues and others by reference to typifications of families, children, etc., therapists were able to explain the behavior of their patients, and themselves. That is to say, the patients' behavior could be explained because it could be typified.

A similar use of the ideology could be seen in the "story telling" in which the trouble with a particular patient could be made familiar by showing it to be an instance of a pattern. For example the patient who made unreasonable demands, disrupted the session, etc., was not seen to suffer from something peculiar to him alone but was taken as an example of a familiar problem with new patients and his behavior was seen as "testing the limits". What may have appeared to be a special problem is now familiar. Similarly, the patient who swore continuously was transformed from a unique into a familiar case by telling how this was to be expected of a child who could not swear at home. The disruptive behavior now stands as explained and unproblematic (in terms of understanding if not management) since it fits into a known pattern. Finally, the patient who has a relapse, while problematic in that the goal of therapy is made more distant, does not
discredit the therapy program. Rather, it becomes another instance of another familiar pattern, that is, that influence of the family has subverted the therapist's efforts. The family of the patient is offered as an explanation of the patient's behavior, thus making it typical. 32

These explanations of troubles also serve to make the therapist's treatment of, or response to, them appear to be rational and the outcome one of deliberate choice. While the explanation makes the patient's behavior familiar it also makes their response reasonable. For example, the therapist is very tolerant of the disruptive behavior of the "new" patient and, with some exceptions, goes along with his demands. Since the setting is supposed to have a permissive atmosphere and since the above behavior has been explained as "testing", it now appears reasonable that the therapist should go along with such things. After all, it will only last a short while and will help create an open relationship. However, when this same patient continues with his disruptive behavior it becomes transformed by the therapist, into bugging the therapist, or manipulative behavior and, thus, the therapist's response to it becomes less tolerant.

Those things for which I am using the term "adult ideology" (and the term is itself a gloss) are offered as explanations of patient's behavior, and make that behavior sensible or rational. That is, they made the behaviors appear to be the reasonable outcome of some set of circumstances which the patient was directly or indirectly influenced by. Indirectly since it is not always taken that the patient is aware of the reasons for what he is doing. It structured the therapist's environment by giving meaning to events or by placing them in the context of a pattern so that they became an instance of a "kind of action".

For example, the action of the patient who symbolically painted the
struggles of 'good' and 'evil' becomes seen as "that kind of action" by virtue of the account given. That is it is seen as the action of a child (and children are naturally mischievous) who is struggling under a puritanical patriarch. This provides for the symbolism of the painting and a plausible motivational structure for the patient.

In more general terms then, what the "ideology" (appeal to family, etc.) does is structure the therapist's environment in such a way that the actions of the patient appear to be the reasonable outcome of a correct (adequate) course of reasoning by the child. Knowing that course of reasoning enables the therapist to understand the patient, to explain his actions, to provide an appropriate therapeutic response or environment for him, etc. This was displayed in dramatic form in the therapist's concern with the patient who was undergoing a relapse. The therapist explained this in terms of family troubles and saw the relapse as the outcome of a "correct course of reasoning" by the patient. The therapist also saw that the child might have to be placed into a new foster family in order to obtain the best possible results. Similarly, the behavior of the girl who "wanted to be a boy" is seen to be the expected outcome of the family's structure and values. This is seen as an adequate explanation or motivational account of her actions and, via this explanation, treatment becomes obvious and reasonable.

We could look at the adult ideology (talk of the family, talk of normal children, and other features displayed earlier) then as simply a way to explain child-patient behavior. However, the talk I have offered as a display of the ideology was not an external description but was itself a constitutive part of the setting. It occurred in talk between therapist and patient, therapist and colleague and therapist and researcher and
should be examined in terms of these relationships. To do so would be to suggest that the ideology is more than an external explanatory device but, whatever its function, is consequential on the occasion of its telling. While I suggested earlier that the ideology was consequential for me while out of the setting it was also consequential for me and others, in the setting.

The Consequentiality of the Ideology

My own talk of the family etc., was consequential in the setting insofar as I was able to ask appropriate questions, see the relevance of explanations, actions, etc., and, through this, came to be seen as a competent member of the setting. The reader will have to take my competence on faith and I hasten to add that this competence does not imply that I should be seen as (or feel like) a therapist. Rather, I was seen as some one who understood what was going on, knew something about therapy, etc. As a result, I was seen as a person who could be asked for opinions, used as a sounding board, etc. The ideology was for me then a way to manage my competence.

Similarly, as we saw in transcript 4.9, a student-therapist could appeal to the ideology (talk of the family) to construct a set of questions about the patient which were relevant to his problem. On another occasion a student observer upon watching a session in which a young patient left the play room several times during the therapy hour, commented to the therapist:

5.1

O: Does she say good-bye a lot herself?

T: No. No, nor normally, this is a separation theme, it's partly a
hospital thing, I think also that she recently started kindergarten, she has been in our day center downstairs so she,

O: She says good-bye a lot around the home now too. Does she say goodbye to mother?

While I saw this student's questioning as 'overconfidence', it was clear that, in watching the doll playing routines, he had focused on the issue at hand, that of separation anxiety. I (and presumably the therapist) heard his talk as a display of competence. By identifying some action and then looking for an account of it in the patient's family situation, it is possible to generate conversations and manage them in such a way as to appear to be an adequate and competent colleague.

How was this ideology consequential for the therapists? By appealing to child development patterns, to their uses of play, toys, fantasy, etc., their responses to strangers, their testing of limits, significant categories for them (e.g., parent), their needs, desires, etc., the therapist is able to make the patient's behavior in the play room the rational outcome of factors broader than those that obtain in this particular situation. The behavior seen as an instance of a pattern which exists independently of any one patient. This enables the therapist to think in terms of 'patients' rather than of the unique persons who enter the therapy room. This is not to suggest that therapists are unconcerned with the unique person, they are. However, to treat each patient as a unique person alone would mean that everything which is known about how to organize and prepare for a session, how to understand the patient's talk and actions etc., would have to be acquired anew on every occasion of their use.

Conversely, by appealing to the knowledge of children in general, the therapist's actions appear to be the rational outcome of a motivated
consideration. To appeal to age-and-stage typifications in explaining why
the play room has been prepared in a particular way is to show how one's
actions are rational (rather than haphazard, accidental, habitual, etc.).
On many occasions, such accounts were provided by the therapists, but I
also came to provide them for them. That is, I could make the therapist's
actions rational by appealing to statements like, "that's a good way to
handle children", or "I suspect you have to do that with children". I
made innumerable actions of therapists rational outcomes of an appropriate
collection of the nature of the child-patient. For the therapist, and
for the observer, the ideology served to make visible the rationality of
the setting.

Further, while student-therapists could appeal to the ideology in
order to generate a conversation, therapists could use it as a way to
authoritatively end a line of questioning or a topic. For example, by
providing an account whose appropriateness and relevance was so trans­
parent that to request a further explication was to risk one's competence.
I provided one instance of the 'trauma' I myself experienced from ques­
tioning such an account and, in retrospect, I suggest that there were
many occasions on which I did not feel that I could reasonably ask for
further accounting even though I was dissatisfied with the account that
was given.

The 'ideology' was also useful for the therapists in transferring
the causes of events like relapses and lack of progress from their prac­
tices to situations external to the therapy room. As suggested earlier,
the therapist-patient relationship is one in which the therapist is
responsible for the patient's treatment, progress, etc. That is, the
therapist, by virtue of his special skills, training, knowledge, and so
on, is in a position to intervene in the life of the child to solve (that is, to help the patient solve) his problems. They are accountable for knowing what is happening with their patients, being able to report (add to the case file) on the status of each patient, to know when it is appropriate or inappropriate to discharge patients, being able to reasonably predict the patient's moods, needs, emotional states, etc.

If, for example, things appear to go wrong with the treatment program or if progress is not made after a reasonable time, it may be appropriate to suggest that the program has failed. That is, that in some way the therapist has failed. In such cases the therapist will typically appeal to the family as a set of forces that are beyond his control and have subverted the therapy program. What this talk does then is manage the relationship between the teller and hearer (therapist and researcher or colleague). An adequate account is provided to display that the therapist is aware of what is happening and transfers the blame to a place outside of the setting.

This may appear to raise questions of deceit, i.e., although the therapist knows that he is at fault, he accuses the family. However, this is not what I am suggesting. It is always the case that a hearer has to evaluate the adequacy of others' accounts and, as members, we attend to actions such as 'passing the buck', 'false accusations', 'incompetence', etc. (As the therapists do as well). The accounts we have heard appeared to be eminently reasonable and adequate. Without adequate grounds for thinking otherwise one would risk his status as a competent member of the society to suggest that families don't matter. I suspect that therapists acquired their notions of the adequacy of these accounts in the same way the researcher did.
While it is possible to refer to the adult ideology as simply an interpretive schema for making sense of behavior of therapists and patients, it should not be thought of as simply a schema which is to be applied to the play room scenes, etc. It was used in that setting by therapists, students, researcher, parents, etc., and its use was consequential in other ways as well. It was a way to manage conversations, relationships, and organizational activities. The success of that management work is clearly related to the reasonableness of the ideology in explaining patient behavior.

Summary

Starting with a puzzle about my ability to make adequate sense of play room activity I constructed a reasonable account of psychiatric reasoning. I discovered some of the methods which therapists use for achieving understanding and explaining their actions. I then proceeded to claim that the reasonableness of psychiatric reasoning (my account of it) was to be found in our background expectancies or the adult ideology. Not only is the adult ideology adequate for providing reasonable accounts for therapy related events, it is interactionally useful and consequential for all of the relationships in the setting. It is in part a management device for handling conversations, relationships, organization, etc.

While all of the above appears to be coherent and all-of-a-piece, i.e., the ideology ties together many seemingly unrelated events, it should be remembered that the account of the ideology was the solution for an intensive practical problem. That is, it solved my puzzle of discovering a way to adequately understand and describe the way that therapists operated in the field setting.
The adult ideology solves the therapist's problems of managing patients and it clearly solved my problem. My claim for the explanatory power of the ideology should be seen in relation to the solution of my practical problem. Let us reconsider the status of this ideology.
Footnotes

1."We propose to suspend conventional interest in the topic of members practical investigations and urge the placing of exclusive emphasis on inquiry into practical investigations themselves, lay or professional. The topic then would consist not in the social order as ordinarily conceived but rather in the ways in which members assemble particular scenes so as to provide for one another evidence of a social order as ordinarily conceived". D. Zimmerman, M. Pollner, "The Everyday World as a Phenomena", in Jack Douglas (ed.), Understanding Everyday Life, Aldine, 1970, p. 80. H. Garfinkel, Studies in Ethnomethodology, Prentice-Hall, 1967, p. 273. For a discussion of 'doubt' and the activities of practical theorists and scientific theorizing, Garfinkel, "The Rational Properties of Scientific and Common Sense Activities", In Studies in Ethnomethodology, 1967.


9. H. Sacks, in a tape recorded lecture delivered in the summer of 1968 to the conference on "Language, Society and the Child", sponsored by Department of Anthropology, Berkeley.


11. This is a concept with a long and difficult history and I use it with hesitancy but it conveys my essential point well. I realize that this term is used by Dorothy Smith in a very different manner and I do not challenge that usage. See particularly, "Women's Perspective as a Radical Critique of Sociology", Sociological Inquiry 44, (1974) 7-14; and "Theorizing as Ideology", in R. Turner, Ethnomethodology, Penguin Books, 1974.
While the exciting work of the Opies has been available for some time sociologists have made little of it. See for example, I. Opie, P. Opie, The Lore and Language of Schoolchildren. London: Oxford University Press, 1959.

The notion of a children's culture was first brought to my attention by H. Sacks and M. Speier. See for example, M. Speier, "The Everyday World of the Child", in J. Douglas (ed.) Understanding Everyday Life. Aldine, 1970. It is almost impossible to find use of this notion in the social sciences although the concept of culture has been applied to innumerable other populations. There appears to be some recent interest in the notion as evidenced by the work of M. Goodman, M. Speier, and more recently R. McKay; see, "Conceptions of Children and Models of Socialization", in R. Turner (ed.) Ethnomethodology. Penguin Books, 1974, pp. 180-194; and H. Dreitzel, Childhood and Socialization: Recent Sociology #5. New York, Macmillan, 1973.


Ibid., p. 2.

Ibid.


For examples of this the reader can look back to the materials presented earlier, particularly those pieces of advice on how to talk to children, how to greet them, etc.


The notion of 'ideology' has been used in medical sociology to distinguish between 'schools' of therapy. Strauss et al have been able to group therapists into three groups (somatherapy, psychotherapy, sociotherapy) by the analysis of questionnaire items they believed reflected the ideologies. Presumably one could do the same with child psychiatry. What this notion of ideology points to is a set of sanctionable beliefs, assumptions, knowledge that supports one's membership in some professional community. It was not simply that the researchers were able to reconstruct professional ideologies but it was taken that those beliefs, etc. were shared, transmitted, reinforced, sanctioned, etc. by colleagues. For examples of this usage see, A. Strauss, L. Schatzman, R. Bucher, D. Ehrlich, M. Sabshin, Psychiatric Ideologies and Institutions. Free Press, 1964; or

23 For a discussion of the documentary method see H. Garfinkel, "Common Sense Knowledge of Social Structures: The Documentary Method of Interpretation in Lay and Professional Fact Finding", in Studies in Ethnomethodology. "The focus on practical reasoning emphasizes that the talk accomplishes scenes and their contained activities; it emphasizes that members are - as a condition of their competence - rendering scenes intelligible, reasonable, accountable, that their world is a constant doing and achieving. 'Practical' actors make and find a reasonable world; their doing so is topically available for the social scientist". R. Turner (ed.), Ethnomethodology, Penguin 1974, "Introduction", p. 10.

24 Consider the following conversation reported by a local newspaper with a mother whose 13 year-old son had killed a store employer the night previously. "She said the boy rarely stayed out late except when he stayed at a friend's house. Monday he left to go to school at about 8:30 a.m. after leaving her a note saying he was going to see his father. She did not see or hear him again until Tuesday afternoon. Not until 4:30 p.m. Tuesday did he arrive home telling his mother, she later told the Vancouver Sun, that he had been staying with his father. Unsatisfied the mother took him to police headquarters". Vancouver Sun, December 4, 1974. The concern of all readers of this story was puzzlement over why a 13-year-old would murder. Although we learn that the mother and father do not live together, the mother's report portrays a 'normal' family life in which she has control of her son, i.e., she was a good mother.

25 This is further displayed in the treatment philosophy inherent in juvenile delinquency legislation.

26 Consider the opening lines of The Way to the Stars, a book for boys (and parents) in the cub program: "cubbing is a program for boys of 8, 9, and 10 years of age working with adults who understand and have an appreciation of the nature and needs of boys of this age". National Council of Boy Scouts of Canada, (rev.) 1968. One can also look to Dr. Spock for descriptions of the 'terrible twos', 'trying threes', etc.

27 See footnote 4 in chapter three.

28 Consider the reader's problem for Ann Landers. Dear Ann: We have a four-month-old baby who is very cute. She has a darling personality, is very friendly and is always smiling. The problem isn't the baby's, it's mine. I hate it when people try to touch her. Especially if they appear to have a cold. Sometimes they have just coughed into their hands and then they want to put their germy fingers on my child's face. It drives me wild. Salespeople who handle dirty money all day are the worst offenders. How do they know who was the last one to touch that money? He or she might have had some terrible disease. Hands off. Answer:
Your preoccupation with germs goes beyond a mother's natural concern. Please discuss this with your pediatrician and hopefully he can remove the klinker from your thinker. Vancouver Sun, June 11, 1974.

29 One can discover ample evidence of this in letters to the editor where citizens complain about the need to control those who occupy parks, roam in packs, break windows, make loud noises, etc. For example, consider this description from a letter titled: "Vigilantes Form Around Slocan Park". "Night after night, 30 to 50 youths come to break things and keep the taxpayer awake. Metal garage doors with the wrinkled look, windows are non-existent, garbage cans flat, contents everywhere, cats with throats cut, rocks on sun-decks". Vancouver Sun.

30 Op. cit., p. 82.


32 I have also found that physiotherapists working with cerebral palsied children will explain the patient's lack of progress with his walking skills on the way the parents handle the child at home. A document on this handling is the fact that parents carry their children from the clinic to the car.

33 At one point a supervisor suggested I help her in making a film about play therapy, she appealed to my "sensitivity" to what transpired in therapy sessions.

34 It should be noted that I am not suggesting that the adult ideology has the same status the convict code does in the halfway house as reported by Wieder.
CHAPTER 6
THE STATUS OF THE IDEOLOGY

In the preceding chapters I showed how the adult ideology is a resource for making sense of the therapy setting. It allowed me to satisfactorily terminate my inquiries about what was behind the sights and sounds presented in the first chapter. Further, it provided the key to the practical reasoning of the therapy enterprise and proved to be a continuous resource for examining and explaining phenomena. It formed a gestalt which enabled me to bring further aspects of the activities which I observed in the setting under study.

Upon finding that the adult ideology allowed me to make sense of the setting, I began to treat it as a 'real' finding. Often, I found myself defending its function in the therapy room. Although the members of the setting had not spoken of the ideology, I began to make references to the "of course" nature of their actions in dealing with children—"of course" they had to think of, treat, talk to, etc., patients in the way that they did. I had occasionally argued with colleagues that the adult ideology provided an account of "what was really going on". This may have come through to the reader, however, we must now stop and consider the status of that ideology.

Earlier in this report it was suggested that child psychotherapy is a theory-governed activity. That is, there are bodies of theoretical knowledge (e.g., theories of personality development) that can be appealed to. I have also demonstrated that a major consequence of the therapy encounter is explanation. That is, therapists are constantly answering
'why questions' about the patient's activities in the play room and can answer similar questions about their own actions. For example:

The therapist must be alert to reflect the unspoken wishes of the silent child. The child's handling of the doorknob may be safely interpreted as "you want to go out". While we can see that this is an 'explanation' of the handling of the doorknob, we could ask in what sense it is theory-governed. That is, are the explanations found in the therapy setting the consequence of the application of some specific theory which therapists resort to? Do events, actions, etc. follow necessarily from a theory?

As was the case with the adult ideology, this psychiatric 'theory' was ever explicitly laid out for me (although reference was made to it insofar as I was directed to the literature, i.e., to notions of child development, etc.) During my field work I also acquired a certain competence which allowed me to see things in much the same way as the therapists did. I have referred to this as the "psychiatric interpretive schema". The reader will recall that the status of this schema remained a puzzle for me. (The puzzle which I resolved by appealing to the adult ideology). My problem with the schema can now be identified as a two-fold concern: (1) What was the 'evidence' for the explanations provided in the setting? and (2) What were its boundaries?

Although other laymen with whom I discussed my field work pressed me to make evaluative statements about the adequacy of psychiatric theory and its effectiveness (they asked, "Does therapy really work?") this was not my interest. I had trouble getting hold of the psychiatric schema because of difficulties in obtaining evidence for it and this forced me to think about its status. As Hutten in speaking about explanations says:
We say that we have explained a phenomenon if we can satisfy at least two conditions. First, we must provide a theory and a law, or set of laws, by means of which we can describe the phenomenon and relate it to other similar, phenomena. And, second, we must be able to obtain from the theory a prediction, i.e., a hypothesis about a future occurrence of the phenomena; if the event duly arrives, we regard the hypothesis as confirmed and we accept the theory as a valid explanation of the phenomenon.\(^2\)

Prediction is a kind of evidence because it allows us to expect a relationship between different phenomena. What I did come to see was a number of individual relationships—relations between some kinds of family situations and anger, between some kinds of family situations and dependency, between relapses and new problems, between relapses and parents terminating their therapy, or paintings and religious symbolism, etc. The puzzle was that, having only these relationships, I did not know what would happen next time, for each new occurrence had to be authoritatively explained by the therapist. Whenever I asked, for example, How do you know that the child's playing with the doorknob indicated a desire to leave? the answer that I received went something like, "If you've seen it as many times as I have you come to know about it", or other statements that appealed to previous experience. Given the explanations that I had, I was not able to tell which would work next time. Even if I had known all of the 'independent variables', I would not have been able to tell what would count as an instance of an event related to those variables simply by watching the sessions. We can refer to my puzzle as the observer's problem. That is, the observer must transform events (explanations) into instances-of-a-pattern-of-behavior. This was the problem which the adult ideology solved for me.

The relationship between events and explanatory variables was not a predictive one. Before returning to this, let me introduce the second aspect of my puzzle: knowing what the boundaries to the explanatory schema
were. I suggested earlier that I felt that the schema was both relentless and inescapable, that is, every happening was a possible data source for the therapist and it was not clear what or when something would come to be relevant. Obviously, every event was not relevant in every situation for the therapist would be overwhelmed. However, some things became important in unexpected ways. Here is an example of the detail with which an encounter could be screened:

Even before the interview itself, much can be learned about the relationship between mother and child. . . . What is her manner as she helps a little child with a difficult zipper and buckles? Does she take full care of the outer clothing for a capable older child? Does he swish and hit his mother with his coat as he takes it off? Do they sit close together on the couch or as far apart as possible. . . . Is there irregularity in the child's walk; does he limp, walk on his toes, or drag his feet; does he slap the furniture as he walks by; does he race ahead, cling to his mother, or lag far behind.  

Nothing seems to escape the eye of the therapist. Any event could become data for the interpretive schema so that something could be made of any of these actions. Which would become important however was not easy to see.

The therapist does not predict which of these action sequences will go with which child; i.e., the therapists do not say that "this child" (or "a child with this problem") will "slap the furniture as he goes by". The theory does not allow him to predict which of the innumerable possible outcomes will come to pass. Rather, the significance of the action is discovered "after the fact". Recall the patient with a sex identification problem. The therapist did not predict that female children who were the last born would have such problems. Rather, given a patient with a sexual identification problem, it could then be partially explained by reference to this child's sibling order. Similarly, therapists did not predict
that children who had been traumatized by a death in the family would talk of "dead birds". Rather, they explained the talk of dead birds by referring to a death in the family. The fact of a death in the family became relevant only after it was related to a specific event. Finally, a patient's continual requests for permission to do things in the play room were seen as documents of his constriction and his possible feelings of responsibility for his father's death and a therapist could not have predicted that a bereaved son would ask for permission to get toys from the toy box.

The psychiatric interpretive schema was not used predictively, but was used for the post hoc discovery and description of rationality in the patient's behavior. It was precisely because of the post hoc nature of explanations that I had some difficulty in understanding this schema and coming to terms with it. An obvious implication is that of its indefinite status whereby it can not be predicted what it will be used to explain next or how it will explain it.

These features continued to make the status of the schema puzzling. It was only after a number of months in the field that I discovered that I had achieved a solution to my "observer's problem". Specifically, I saw that I did have a method for transforming events into instances—of-a-pattern-of-behavior. The adult ideology accomplished this for me.

Clearly, the adult ideology allowed for accounts and explanations that were adequate for all practical purposes. It allowed me to make satisfactory sense out of the setting and its events and, as such, is a display of practical reasoning. Accounts are adequate, satisfactory, etc., precisely because they trade on our folk wisdom about children. For example, whatever the therapist's attribution of motives to the patient
when he told a patient that:

T: I think mom won't mind us playing with the mucky sand and water. That's okay with her.

it was reasonable to explain his statement as an effort to reassure the child that it was alright to go ahead and make a mess. We all know that children often get dirty. Perhaps they enjoy it, but more often than not, they get into trouble for it. Similarly, although the therapist's explanation for a patient's increased disturbance by referring to the patient's having been with his mother may have some theoretical grounding, it also seems adequate to suggest that the therapist was attending to the influence of parents on the emotional state of their children.\(^4\)

It is interesting that, in a setting which is theory governed and provides accounts and explanations in terms of that theory, the adult ideology also provides a reasonable account of what is going on. Regardless of what therapists say they are doing, the ideology makes perfectly adequate sense. Therapists too have an observer's problem and, for some time, I thought that my discovery of the adult ideology was a discovery of how they solved their observer's problem.

If this were so, one way to view the adult ideology would be as a 'theory', for it does what we expect a theory to do— it explains things. As a theory it might challenge the psychotherapist's accounts of what they were doing. They explained their actions and made interpretations in terms of psychiatric objectives, theory, and techniques, and, as I have demonstrated, these explanations were \textit{post hoc} accounts. The 'real' explanation and interpretation might be based on the adult ideology. For example, while therapists recognize the child's emotional state in his play, I have suggested that this is an occasioned application of the
special relationship seen to obtain between children and their play. Moreover, while their interpretations appeal to the value structure of the family and to the psycho-developmental needs of children, I suggested they were occasioned applications of the omni-relevance of families.

If we were to treat the adult ideology in this way, a further characteristic that we could expect, indeed, demand of it, would be predictability. That is, on the basis of the ideology, one should be able to predict behavior in the therapy setting. This is clearly not the case however. One cannot take a feature of the ideology that suggests that parental influences on children can be seen in their emotional and behavioral displays and thus predict that therapists would blame a patient's unusually disruptive behavior on a prolonged stay with his mother. Similarly one cannot assume that a certain moral environment in the child's home will account for a child swearing in the therapy room. To say that "since he cannot swear at home, he will deliberately swear in therapy", or that "since everyone swears at home, he will swear as well", or that "he is showing disrespect", all seem adequate. Finally, with reference to a patient whom we have mentioned earlier, common sense notions about the influence of sibling structure on behavior do not allow one to predict that one's first born status will be used to account for sex identification problems. In a previous transcript, it appeared to be equally probable that one's first born or last born status were adequate accounts of sexual identification problems. I will give it again here.

S: How many children are there?
T: Three in the family.
S: And she's the oldest?
T: She's the youngest.
S: The youngest.

T: And there's two older brothers.

S: Ahhh. ((tone of recognition))

While the therapist may have seen the adequacy of these two alternatives in terms of a psychiatric theory, I found their adequacy to be obvious. For example we know that being a first born child (oldest) may present some difficulties, therefore the oldest child alternative seems reasonable. The youngest child alternative also makes sense because we know that being a girl with two older brothers can make for a difficult situation.

The adult ideology does not have this kind of predictivity. If we expect a theory to aid us in selecting the correct alternative from a list of competing alternatives, we should look elsewhere to satisfy that requirement. In the previous example it did not allow us to choose between competing alternatives--first born or last born. What it does accomplish is the discovery of 'appropriate' behavior, that is, given a behavior, one can see that it makes sense, is appropriate, etc. It allows for the post hoc discovery of rationality. That is it allows for the discovery of 'reasonableness', 'appropriateness', 'logicalness', 'properness', etc. Rather than a finding, it is a method of making findings.5 It allows us to see the adequacy of accounting for a sexual identification problem, in terms of either first born or last born status, etc. It allows us to see the reasons for a child's constriction given the death of his father; the adequacy of a child's anxiety about hospitalization because of separation; the appropriateness of providing cookies and pop for patients; the logic of having trampoline time. It also accounts for the reportability of the patient who made his own appointments; the necessity for having a rule
about not taking toys home; etc. Obviously this list could be extended to cover many other activities in this setting.

Further, note that the behavior displayed in the play room does not allow one to predict which features of the ideology will be used to account for this display. In the previous chapter we made reference to a number of these features. We talked about the omni-relevance of families and its consequentiality; the denial of responsibility in children since they do not know or understand their body states; how behavior is seen as appropriate for a particular age or stage of development; the awareness of development derailments; children's need to test the limits, etc. Any particular behavior could reasonably be accounted for by appealing to many of these features. For example, the young patient who engaged in particularly disruptive behavior may be seen as an instance of acting out, as developmental derailment, as stage-appropriate behavior, as testing the limits, etc. As a matter of fact, it was explained as a result of having been home with mother for a month (the omni-relevance of family membership). The ideology allows one to suggest that the display is a result of the family environment.

Because the ideology does not have the predictive power to select a single set of behavior outcomes, and because the features of the ideology are not predictable on any occasion, we can not treat it as a 'theory'.

What then is the ideology?

What I am claiming is that the ideology formed the basis of my practical reasoning in the setting and enabled me to construct a rational description of the therapist's work and reasoning. It was a resource by which I was able to find rationality in the therapy setting. It provided a solution to my observer's problem but not necessarily that of the
therapists. Let us look back at how I assembled the ideology.

How I Put the Ideology Together

The reader will recall that I put the ideology together after realizing that I was able to make adequate sense of the setting, and used my common-sense understandings of children to accomplish this. After becoming aware of this, I noted that this resource had been previously referred to as an "adult ideology of childhood". I then started to look for further instances of this ideology. I began to transform events into instances-of-a-pattern-of-behavior. This amounted to recognizing that 'explanations', 'accounts', 'practices', 'behaviors', etc. were based on common-sense understandings. I suggested that this accounted for the reasonableness of the therapist's accounts, the setting's organization, and so on. In other words, I saw that the researcher and therapists shared a vocabulary of motives.

Starting with this understanding, I accumulated instances of accounts whose reasonableness was built on a normative view of children. The first and most important group of common-sense accounts that I collected were those framed in terms of a causal relationship between children and families. That is, I take it that it is a piece of folk wisdom that the relation between parents and children is transparent or easily available to us.

I referred to this as practical reasoning and assembled a number of instances of such reasoning in the therapist's work. I showed how their reasoning was an occasioned application of folk reasoning. Folk accounts were offered as an alternative to psychiatric accounts. These instances were not assembled predictively but were assembled as they were used.
began to see that a number of the accounts that were formulated in terms of the family appeared to be reasonable and looked for and discovered other such instances. I did this by noting the correspondence between a family's emotional state and that of the children, by seeing that a patient's disruptive behavior may be motivated by his having spent a month with mother and so on. The family then became an environment of motives, and the instances displayed were taken to be documents of that environment.

Suggesting that the ideology was the resource for this practical reasoning, I was able to locate innumerable other documents of this—preventing patients from crying, the selection of toys, the recognition of age appropriate behavior, etc. It should be noted that this analysis was not imposed from outside of the setting, rather it was employed within the setting. That is, my display of the adult ideology in the reasoning of the therapists was offered as an account of how members made sense of the setting. Its use was discovered in the setting. One way to look at the previous chapters (and the way I initially saw them) is as a report of research findings. The findings could be instances of the ideology as it is used in the setting, or they could be seen as the ideology itself. I now want to discredit this initial conclusion and clarify the relation of the ideology to the setting.

It should be recalled that the ideology was not external to my assembling of instances of practical reasoning. I used the ideology to display those instances as documents of the ideology. It was my own folk knowledge about children that enabled me to see the reasonableness of accounts and to assemble and display the practical reasoning of therapists.

The display of the ideology was clearly assembled within the therapy setting. I discovered events that would count as instances of the
ideology and could be used as a document of the underlying pattern (the underlying pattern being the ideology itself). This solved my observer's problem. Having those documents of an underlying pattern, the pattern itself was then used to discover additional instances. While I was aware of the notion of an adult ideology I was able to construct the reported accounts only upon seeing and hearing something which I was able to take as a document of the ideology. I found that I was able to discover instances of the ideology only after the fact. Although the ideology is a part of an adult's "stock of knowledge", it was not possible to predict what would come to count as instances of it in the setting. The ideology is not properly a finding but rather a method for making findings.

The ideology is an interpretive schema that is open to continuous ad hoc ing in order to bring further pieces of behavior under its auspices. This is not to suggest that the ideology itself is the finding since the finding is the ability to use the ideology to provide adequate accounts of events. It is the continuous act of discovering and describing rationality that is of interest.

While I initially felt that I was providing a way to demonstrate what the therapists were doing, i.e., displaying their use of the adult ideology, it is now clear that it is not the therapist's work but my work that I am displaying. This report is itself a display of the adult ideology! We might add that your reading is itself a further display of the ideology. It is not the display itself that is of significance but the continuous acts of displaying; it is not the find that is of interest but the acts of finding. The acts of finding are the ways the researcher and reader were able to discover the rationality of the setting. For me, the ideology provided a solution to a very practical problem. The
therapists too have immediate practical problems (in understanding, managing, etc.,) for which the psychiatric interpretive schema provides a solution.

We now have two kinds of accounts for the events in this setting. We began with the psychotherapeutic accounts as offered and used by members of the setting (or, the psychiatric interpretive schema). These continued to have a puzzling status since they were seldom made explicit and appeared to have a flexible structure which allowed them to work for any and every occasion. Because of these puzzles and the apparent lack of rationality, I attempted to get behind those accounts in order to find out "what was really going on". To accomplish this I provided an account of the adult ideology and treated it as both a finding and as a description of the 'reality' of the therapy setting.

As has been suggested in the preceding paragraphs, however, these accounts are not to be seen as competitors. Rather, they should be seen as two accounts of the same events. The adult ideology is not and should not be taken as a replacement for psychotherapeutic accounts (and, of course, vice-versa). I would now like to suggest that these two accounts are demonstrably similar and have the same status as accounts. While one of these accounts made more sense for me, they have essential features in common.

It has been pointed out that neither of these accounts are predictive. Neither the therapist nor the researcher could know beforehand what was to become an instance of the schema. The therapists could not know that a child whose father had died would talk of dead birds, or that a child's apparent relapses would be explained with a reference to his having been home for a month. In both cases, the schema enables the user to see
these events as instances-of-a-pattern-of-behavior. They are both methods for the post hoc discovering of rationality, and both are resources for seeing the adequacy, appropriateness, logicalness, properness, etc. of events. They clearly have the same status as accounts.

Let me now clarify the relationship between these two sets of accounts.

1. It has been suggested that my initial puzzlement with psychiatric theory could be resolved by proposing that, as an interpretive schema, it was not a predictive theory but a resource for the post hoc discovery of rationality.

2. Initially, I terminated my search for an answer to this puzzle when I noticed that I could provide adequate accounts of the setting by means of the adult ideology. And this was a resource that did not rely on the psychiatric interpretive schema.

3. I proposed that the apparent reasonableness of the setting could be explained through the adult ideology which is a resource that is shared by the researcher, therapists, and reader alike.

4. It was proposed that the adult ideology is also an interpretive schema which is used for the post hoc construction of rationality. In this respect, both sets of accounts (i.e. the adult ideology and the psychiatric interpretive schema) are essentially the same.

5. It was shown how the adult ideology as developed here, constitutes a display of my own practical reasoning (rather than that of the therapists).

6. We can now propose that the adult ideology is related to the work of the therapists in the same way as the therapist's use of the psychiatric theory is related to the activities of the patients. The adult ideology allows me to make perfectly adequate sense of the therapist's work just as
psychiatric theory seems to allow therapists to provide perfectly adequate accounts of the child's actions.

While it may have appeared that the two account structures were in competition, or that I was suggesting that therapists were really only adults, we can now see that that is not the case. The adult ideology does not undermine the skills or the training of the therapists and I am not suggesting that all adults are or could be therapists. Therapists' skills are real ones. The adult ideology provided a solution to my problem of constructing an ethnography of the setting and not for the problems involved in the enterprise of therapy. My task, as a researcher, my relevancies, responsibilities, criteria of adequacy, organizational placement, and output all differ from the corresponding tasks of the therapist. First and foremost of these is that I am interested in constructing an ethnography; the therapist in treating children.

Thus, the adult ideology is the researcher's account of what happens in the setting (including the behavior of the therapist) and its appeal derives from the fact that it provides a key to the ethnography of the setting. Psychiatric theory is a therapist's account of what happens in the setting, i.e., of the emotions and behaviors of patients, and it is responsive both to treatment procedures and to organizational assessment.

Thus, the fact that the two interpretive schema have the same essential status does not make them interchangeable or alternatives. To suggest that this was so would be to miss the occasioned use of each. This is the very thing which an ethnography is supposed to explicate.

Accounts can not be separated from the situation, intentions, biography, etc. of their author. They are always occasioned. For example, the therapist in treating children is placed in an organizational structure,
and becomes responsible to parents, supervisors, other community agencies, etc. Further, he operates in terms of criteria of adequacy which are shared by his colleagues. Further, the social researcher's task is to portray what is going on in a setting. As a part of a student-university system he is responsible for providing a sociological study according to a criteria of adequacy which is shared by his academic colleagues. Although the setting is the same, the practical tasks of the parties differ. Accounts must be evaluated, understood, etc. in relation to the practical tasks for which they provide solutions.
Footnotes


4. I am suggesting that it is this resource which gave a sense of reasonableness to all of chapters one through four.

5. The 'finding' is that the adult ideology enables one to make sense of this setting.

6. It should be clear that I have never seriously suggested that we consider it a theory; it is an interpretive schema.

7. This does not deny that one can act as though the schema is predictive.

8. It is clear that to check what I see against my reading of the theory simply has no relevance to the operation of the clinic. Therefore, I cannot comment on the inadequacy of the theory but only on the irrelevance of my assessment of the task of therapy. 'Predictivity' is not required for the task of therapy. What matters is that therapists, post hoc use of the schema enables them to do whatever has to be done, said, etc.
CHAPTER 7
CONCLUSION

It may have occurred to the reader that this journey through the task of making sense has in fact only satisfied the practical problem of producing this document. It is my contention that it does considerably more. This study 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 (e.g., the 'convict code', the 'adult ideology') and then, (b) treat that discovery and explication as a practical accomplishment. The impression was left in the previous chapter that the production of the adult ideology was all there was and having said that nothing remained, i.e., there was no 'discovery'. The social scientist as 'con-man'. Although the production of the ideology is a practical accomplishment there is some further sociological residue.

It will be recalled that I claimed the ideology was a solution to my practical problem although it may not have been a solution to the therapist's task. What can not be retained is the explanatory power of the ideology in this setting. The explication of the ideology remains however and is the further sociological contribution of this study. My treatment of the ideology is not just that of an 'adult' nor is it the same treatment the therapists may give it. The explication is that of a social scientist. I would like you to treat the explication of the ideology then as a sub-
stantive 'discovery'.

Before concluding let me briefly retrace the structure of this report. Recall that on my first viewing of the activities of the therapy setting (and exposure to advice, literature, etc.) I experienced a sense of its reasonableness. The advice on how to greet, lead away, manage and talk to children was eminently reasonable. I recognized the conversations as being those of adult and child and felt it appropriate, for example, to not talk immediately about why the child was in therapy, to use various strategies for getting the child to talk, and so on. This list could go on and on since the first viewing was through and through reasonable, transparent, and common-sensical. If the reader were to look back to chapter one this transparency would be obvious. One could read the transcripts there with some level of understanding.

Invoking the categories of 'expert' and 'layman' I suggested that psychotherapists would have an interpretive schema to accomplish their work that would not make the same sense of events that I had. I recognized that the activities I witnessed would have to have more significance than I had initially attributed to them. After all, this was a work setting, the activity of therapy was theoretically grounded, and the practitioners had acquired their skills through training. When I began my task of producing an analysis I realised that I had acquired a skill which enabled me to understand what the patients and therapists were doing and was able to provide an adequate account of therapy happenings. I took this to be a portrayal of the psychiatric interpretive schema and reconstructed this schema in order to show how therapists transform routine events into psychiatrically relevant and significant data. Chapter two then was presented as another way to look at the materials reported in the first
chapter—a psychiatrically meaningful way.

With the realization that I could make reasonable psychiatric sense (but not do therapy)—presumably in the same way therapists did—came the awareness that the accounts on which I had constructed this schema made sense because they were common-sensical. It was this which enabled me to discover a pattern in those accounts. In chapters three and four then I constructed two features of what I referred to as the therapist's corpus of knowledge which I claimed was supported by taken-for-granted-views of children. Two features were continuously used to make sense of therapy happenings, namely, the notions of 1) patients as 'normal' children, and 2) patients as family members.

Concentrating on the second notion, I demonstrated in chapter four that it is eminently reasonable to think of children as family members and I show how accounts of the family are used in the setting. The 'family' was used in many ways, some of which would not have been expected. It is a resource to construct conversations, offer advice, fashion relationships, interpret children's motivations, explain relapses, propose therapy-relevant actions, etc. Although it appeared reasonable to use the notion of patients as family members, and this is a resource we all share, it was not available to me beforehand to know when or how this would be used.

It was necessary to ask the following question: how was I able to construct this account and description of the rationality of the setting on the basis of my experience in the setting? All social actors face the problem of seeing events as instances-of-a-pattern-of-behavior, and presumably this is what the psychiatric interpretive schema accomplishes for therapists. However this schema was never made explicit for me. What was available to me was a constant flow of accounts which I took to
represent the psychiatric schema. Hence, it continued to be a puzzle for me although the scenes did not.

I proposed in chapter five that what enabled me to provide the preceding account of the setting's rationality was the adult ideology—those normative ways of seeing children shared by adults. This allowed me to see events as instances-of-a-pattern-of-behavior. That is, I could see events as instances of adult-child interaction. I claimed that this provided for the reasonableness of my first viewing as well as the adequacy of the therapist's corpus of knowledge. By treating this seriously I was led to the realization that there are not two interpretive schemas but only one, i.e., the adult ideology provides for, or supports, the psychiatric interpretive schema. I then went on to examine how the ideology was used as a source of explanations of patient behavior as well as how it had consequences in terms of managing conversations and relationships. The adult ideology provides a resource for justifying decisions, explaining why some patients were discharged, providing adequate accounts of relapses, demonstrating competence and understanding, controlling conversations, dealing with uncooperativeness, and sounding knowledgeable.

If the reader were now to go back through the first two chapters of this document it would be clear that the ideology was employed extensively to provide for the reasonableness of almost everything reported.

Having presented what I took to be a display of the therapist's use of the adult ideology I suggested that we examine the status of the ideology. After reviewing the activity of constructing the display of the ideology I concluded that the ideology was in fact only a solution to my practical problem of providing an adequate description and account of the setting, i.e., making sense of the therapist's descriptions and accounts. The
ideology was an interpretive schema that enabled me to provide an adequate account of the setting and as such is not to be confused with the psychiatric schema. I had not acquired the psychiatric interpretive schema then, but only discovered that I had a resource for making adequate sense of therapist's actions, reports, explanations, etc.

The psychiatric interpretive schema and the adult ideology were responsive to very different tasks, i.e., treating children on the one hand and preparing a dissertation on the other. (Or for the reader, judging the adequacy of this report). It is this embeddedness in practical activities that must be considered in understanding any account (description, report, explanation). The psychiatric schema enabled therapists to make sense of (see instances-of-a-pattern-of-behavior) their patients while the adult ideology enabled me to make sense of the therapist's activities.

There are some potentially unsettling implications suggested by this 'discovery' that I would just like to mention, rather than explore, at this time. One can find many instances in the social sciences of this phenomenon--thinking that one's interpretive schema as a scientist can replace the schema of the members. We can consider the anthropologist who produces an ethnography of a 'foreign' culture. While the members of that culture are going about the tasks of their everyday lives, the scientist is trying to make sense of those doings. To see events, etc., as instances-of-a-pattern-of-behavior (religious behavior, property relations, ethnicity, etc.) may satisfy his practical problem (and his criteria of adequacy) but it may not reflect the schema of the member producing those events, etc.²

Similarly, while Durkheim produced an adequate account of suicide rates which saw those rates as instances-of-a-pattern-of-behavior this may not reflect the scheme of those who 'commit' suicide nor of those who
'produce' suicides. Finally, while criminologists may see the decision of some members of our society to become policemen as 'class' behavior (an instance-of-a-pattern-of-behavior) this may not be a replacement for how those members make their choice appear reasonable, etc. One has to be sensitive to the location of accounts.

If the two schemas identified in the setting are simply responsive to different tasks we may be accused of having a solipsistic methodology—there is no way to make claims about the world. In beginning this chapter however I suggested that this report be seen as having two themes, the first being the discovery of occasioned accounts which concluded that the account of the activities in the play setting presented herein be seen as a practical accomplishment to solve my problem in an adequate fashion. There is no claim about the explanatory power of the ideology in this setting then. There is a claim however, and this is the second theme, that the adult ideology is a feature of the social world and the explication so presented is a contribution to our understanding of an omnipresent interpretive schema which we, as cultural members, share.
Footnotes


BIBLIOGRAPHY


