Objectivity and Commitment

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Response to Marilyn Strathern's paper ' Thick description and the challenge of objectivity," given at ESRC Methods in Dialogue Seminar, held at Huntington, May 19 2005, and written up in this fuller version in October 2007.

Marilyn Strathern's shell is an object that 'belongs' in many contexts and frames of reference - she has indicated many of them. 'Found objects' like this are a good way of illuminating one might call latent frames, perspectives, ways of seeing. Didn't primary school teachers - I am not being disparaging, I know that Marilyn is a Professor at Cambridge University - have things called 'object lessons?' Perhaps they were something like this. (Are primary teachers still allowed to have them, with all the prescribed learning that has to be done?)

Such demonstratioins are especially appropriate for sociologists and anthropologists. The reason for this is that the idea that there are many different sense-making frames and perspectives - as many as there are communities and 'forms of life' - is one of the most important understandings that sociology and anthropology have to offer the world. In the inspirational days of sociology in Britain, in the1960s and1970s, we all students and staff alike - used to get quite high on this insight - the idea that things which were normally taken as given, were socially constructed, and therefore could be different from what they are. Some found that their lives were turned upside down by this insight, often they thought for the good. Instead of merely inhabiting a social position - say in a social class - they could see it, as if from outside. A bit later women students came to see how they were being 'constructed' by their courses, (as silent and passive, for example) and were able to challenge this definition of themselves, as of course women did in many other situations, to the discomfiture of many men.

An example of such a perspective is the audit culture, of which Marilyn has written anthropologically in an illuminating way. (Strathern 2000, also Power 1994, Rustin 2004). She has shown that these rules and procedures need not be read only in their own terms, as we go through the obligatory routines and play the necessary games, but as a new kind of social system. What we might call a 'regime' or a form of governmentality, after Foucault. I agree however with Marilyn that Niklas Luhmann's idea of autopoeisis best explains the workings of this system. (Luhmann 1993). That is, the tendency of institutions to impose control of the flow of information across their boundaries, to 'convert' the world around them into categorical forms which they have the capacity to process in their own terms. Thus, those subjected to the audit culture, and made to submit to its routines, are required to transform themselves into entities that conform to its definitions rather than their own. It becomes easier for many in this position to become performers and subscribers to these games, to become 'converts', than to go on trying to resist them. This is one way in which these systems continue to grow in power. The operation of the audit culture is a good example of the sociological insight which Marilyn is suggesting.

Let me now refer to a different kind of object of knowledge, or 'particular', than the illustrative 'objects' that Marilyn has presented to us. I am thinking of a hypothetical child patient in a Child and Adolescent Mental Health Services (CAMHS) Clinic. I am interested in this because I work with child psychotherapy trainees in helping them to develop doctoral research projects, based often on their clinical practice. They are aware that the framing perspective in which they are learning to 'see' , talk, and work with a child, which is psychoanalytic - is different from that of other professional staff in their Clinics. So when a child presents with problems, there is a lot at stake in his or her classification and categorisation. What kind of 'object' is this, and in what frame or frames of reference does it properly belong?

Think of a child who is referred because of a tentative diagnosis of Attention

Deficit Hyperactive Disorder (ADHD). One specialism in the Clinic - the psychiatrist's - may think of this as a disorder best controlled with a drug, Ritalin. Another, trained in clinical psychology, may conceptualise the child's problem primarily as a cognitive disorder, the outcome of an insufficient capacity for self-monitoring and self-reflection. A course of Cognitive Behaviour Therapy might be prescribed to address the child's problems, thus defined.

The psychoanalytic child psychotherapist may well be more sceptical about the diagnostic ADHD label in the first place. She might suspect it to be a catch-all category invented to gather together conditions which have in common mainly the susceptibility of a collection of symptoms to a particular drug. Instead of the illness having led to the discovery or invention of the drug, they may suspect that in this case the discovery or invention of the drug has led to the classification of the 'new' illness, whose incidence does indeed seem to have risen dramatically since this drug came on to the market.

The psychotherapist's alternative conjecture may be that the child is suffering from floods of unconscious anxiety that overwhelm his capacity for thought. This state of being overwhelmed, and the ensuing behaviour - lack of attention, restlessness, difficulty with relationships - also overwhelms or wears out the thinking and emotional containing capacity of those close to the child - family, teachers, friends. So the child is effectively alone with his anxieties or terrors, driving people away as he tries frantically to connect with them. The preferred course of action may be to try to establish a relationship with the child which enables him to feel that his anxiety is shared and understood, to enable the child to start to recognise and think about his feelings. (I say 'he' at this point because the ADHD child is more likely to be male, girls being more likely to present with different, more withdrawn and depressed symptoms.)

Someone more sociologically-oriented might note other aspects of the current ADHD epidemic, which unsurprisingly manifests itself on an even larger scale in

the USA than it does here. There is more stress placed on children, to perform in school and meet specified learning objectives, at an earlier age than before. Their may be less encouragement and space to play, which some (Panksepp 2003) holds is an innate need of human children, as of other mammals. Parents are busier, because of the demands of work, and have less time to be with children. (Hochschild 2001) There may only be one parent, or substitute parents. Thus ADHD may be in part the response to a lack of fit between the developmental needs of children, and what is available to meet them. The remedy here would call for some redesign of the family, educational and play systems, at a societal level.

One hears about individual cases. I heard for example about a very young child placed for adoption, who seemed quite uninterested in his adoptive parents' care of him, other than in regard to his basic physical needs. He hardly seemed like a human child at all. What were they to do? They desperately wanted a child, but this experience was driving them to distraction, nearly to the point of not going through with the adoption, of 'sending him back.' The parents and the child met with a psychotherapist and a social worker. What is the matter with him, the parents wanted to know? Is he brain-damaged? Will he ever get better? The child careered around the room, knocking things over, apparently not relating to anyone, least of all his adoptive parents. The therapist had some toys, including a doll. She started a game, in which she gave a drink to the doll, placed on her lap. The little boy became interested. He joined in, also offered a drink to the doll. Mother's eyes widened, as she saw this 'ordinary little boy game' with the therapist. The therapist herself thought, here is something to start from. This little boy has a concept of a baby that needs to be fed, of a mummy's lap on which a baby can be held, can even for a moment wants to be the mummy that feeds the baby. More theoretically, here is a capacity to symbolise. For a few moments, this apparently feral, unsocialised child, became a normal child, in both the therapist's and the mother's eyes, with a conception of a mother and a baby which in his behaviour he had seemed to be forcefully denying. The parents'

terror of diagnoses of brain damage, infantile psychosis, or autism, were somewhat relieved. Another possibility could be glimpsed, that this little boy had experienced a very difficult beginning, but that he possessed some of the capacities of ordinary children, all the same.

What was the child psychotherapist's method here? How did she think of her 'object'?

She had a concept of a child's 'internal world', of his conceptions of what his environment did and did not have to offer, which had been established in his difficult and rather neglected early year or two of life. Getting what he could, and managing with the minimum of contact with or dependence on others seemed to be his inner script, at this point. The psychotherapist thought of this as a defence against anxiety, also as a numbing of feelings to avoid hurt. Separations had no doubt led to further self-protective withdrawal.

The child psychotherapist's method is to create the space for a relationship in which a child will feel 'held in mind' and can find ways of expressing his feelings,desires, and terrors, so that these anxieties can be understood and given some symbolic expression, through play, drawing, enactments. In the situation described above, it was essential that the child's mother and father remained present, not only so that they could observe their child while someone else was sharing responsibility for him, but also to provide additional security for the child, who was far from indifferent to their presence as they imagined.

One primary object of attention here is the child's internal world. This has to be allowed to make itself present in its own way, to take its own form. There is a stable setting for this therapeutic encounter, but no script, no formula or instruments, no protocols. The child has to find his own way of being, through the possibilities for relationship (which can express hostility as well as interest) which are offered. It is not surprising that professionals who are trained to work

with a more definitely specified kind of object, amenable to pre-tested measures or interventions, find this degree of uncertainty and unpredictability hard to understand or justify.

One can see how contentious categorisation of something like this, a child and his family referred to a mental health clinic, can be. Many possibilities do have to be held in mind. In the instance mentioned autism and brain-damage were possibilities. Whatever confidence one may have in the diagnostic category of ADHD, there are child patients who may be helped by drug treatments, and certainly there are patients who benefit from Cognitive Behaviour Therapy. We know there are social causes of mental as of other illnesses, for example those related to inequality, and situations of stress and disrespect. (Wilkinson 2005). But when individual sufferers appear, we nevertheless have to do what we can for them as persons, even if we believe that society should be changed.

Given these differences of perspective, one might ask where 'objectivity' lies in this situation, that of the CAMHS clinic. There is some. All the mental health professionals work in the same setting, with the same manifest purpose. There will normally be a lot of agreement on what it means for a patient to get better. The perceptions and feelings of patients, families, and others in contact with a child count for a lot in everyone's mind. Since there is a lot of practical consensus about 'ends', there can often be an acceptable 'division of labour' in the CAMHS on 'means', de facto agreements about what treatment modes, what perspectives, might work best for which kind of patient. Generally the child psychotherapists now find themselves working with the most disturbed and difficult patients, those for whom more routinised interventions don't work, or who cannot even be persuaded to co-operate with them.

But there are also deep-seated disagreements between professional perspectives. The psychoanalytically-trained child psychotherapists believe in a

process of open-ended learning, concerned primarily with states of feeling, and taking place throughout life in emotionally intense relationships. An idea of imaginative, symbolic creativity as the essence of life is their core value and conviction. That may be why they choose to take up this work. This view is in some conflict with the implicit viewpoints of other professionals, mirroring differences and conflicts of world-views in the wider society.

There is no 'objective' or 'consensual' perspective on the horizon which is going to resolve all these differences. They depend at root on values, conceptions of how lives should be lived, even how institutions and societies should be organised. Such differences can be creative. The most interesting kinds of human science have emerged from commitments to values. I don't think we should worry overmuch about the continued existence of such differences, the fact that we see 'objects' through so many different lenses. Rather we should see the human sciences, like the parallel discourses of the humanities, as ways of elaborating and clarifying differences, of extending our understanding of possible worlds and possible ways of life.

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