

The University of Hull

**TOWARDS AN ANTHROPOLOGY OF  
CHILDHOOD SICKNESS: AN ETHNOGRAPHIC  
STUDY OF DANISH SCHOOLCHILDREN**

Being a thesis submitted for the Degree of Doctor of Philosophy  
in the University of Hull

by

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January 1999

## Summary

This thesis is an analytical ethnography of children, aged between six and twelve, who live in Vanløse, a local district of Copenhagen, Denmark. The data were produced during fourteen months of fieldwork in the children's homes, their local school and two after school centres. The methodological insights produced through this point to the importance of a dialogical, reflexive ethnography in conducting research with children. The thesis develops synergies between two theoretical frameworks: first, a reformed anthropology of children; second, critical medical anthropology, in particular the notion of sickness as cultural performance. The study focuses on children as individual and collective actors in interaction with other children and with adults during everyday illness and minor accidents. The cultural performance approach allows illness to become a lens revealing key aspects of childhood in contemporary Danish society. The substantive chapters of the thesis are organised around the five themes that emerged during the fieldwork: illness as a variety of 'time-off' and its cultural similarities and differences with family holidays; children's collective action in help-giving at school and after school centres; children's cultural learning about the body in its subjective and objective forms; the cultural constitution of children as vulnerable and the implications of this for interactions during illness; and, finally, the constitution of children's competence in illness and treatment. A key theme developed through the thesis is the cultural representation of children in the past, present, and future. It is shown that children's present lives and subjective experiences tend to be subordinated to understandings that give priority to childhood as a symbol of a nostalgia for the past or as a hope for the future. The thesis ends with a discussion of children's greater potential as contributors to health and self care and its implications for their wider participation in social life.

To the children who said, 'We want to be world famous.'

To their friends, families, teachers and staff at two after school centres in Vanløse.

To my own children, Josefine and Tobias.

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## PREFACE

‘Ethnographic fieldwork and writing take a long time. They depend on intimate ties and attachments, and they entail a good deal of travelling.’

(Scheper Hughes 1992: 534)

When I began this research in the early nineties, it was the first ethnographic study focused on children's own perspectives of their social and cultural world to be conducted in Denmark and, at that time, only a few studies had been published internationally. Within the last few years, interest in the field of anthropological and sociological studies of children has burgeoned. I have seen this as an exciting support and confirmation of the relevance of my own work and its approach.

During the last six years, in particular, research milieux in both Denmark and in Britain have emerged, developed and been established. I have followed these developments and participated in them very closely. Workshops, seminars, conference streams and whole conferences have been dedicated to work within the new social studies of childhood. These are significant achievements for anthropological and sociological child research. Also, national and international networks have been created and intersected across Europe and North America. Most recently the growing awareness that this represents has been made evident in the funding of some large, multi-disciplinary research initiatives. The British ESRC Research Programme ‘Children 5-16: Growing into the Twenty-first

Century', announced in 1995, was followed by the Danish Research Council's Programme 'Children and Welfare'. Both of these relate in some ways to the Norwegian Programme 'Family, Youth and Children', which includes, rather than focuses on, children's own perspectives. However, it is worth noticing that, of the three research programmes, the British Programme is the one most radically committed to the newer research perspectives, formulated as seeing children as social actors and childhood as a diverse rather than as a unifying category.

Over these years, I feel that my work has been well received, appreciated and critiqued. However, I have found that to begin such an endeavour in a relatively unexplored empirical and theoretical field of studies has proved a sometimes challenging affair. This experience does not relate to occasions where my work has been criticised or discussed from a theoretical or methodological viewpoint but to those where my academic work has been challenged by commonly held convictions, such as 'We all know how children are and how they behave.' Such convictions are often based on people's own childhood experiences or their experience as a parent, rather than in anthropological insights and knowledge. Although I agree that one's own experiences as a child or a parent may well be uniquely important for the development of personal understanding, it cannot form the basis of an anthropology of children. In other words it cannot substitute for critical, systematic and detailed ethnography.

Today, however, it also seems like a long personal and professional journey from 1991, when I gave my first presentation on this subject, to 1998, as I complete the writing up of this thesis (as well as take part in other pieces of ethnographic research on children). In my first public lecture in the Institute of Anthropology at the University of Copenhagen, I considered some theoretical and methodological consequences of working with children's own perspectives in ethnography by questioning their, hitherto, 'muteness' and lack of visibility in anthropology. This preliminary work formed part of the skeleton for my doctoral research. This was in the summer 1991 and marked achieving my degree as Magister in Ethnography. The lecture, entitled 'To be as a Child: Reflections on the Representation of Children in Anthropology' was dedicated to my six-year-old son, Tobias. (The English Pronunciation of 'To be as' is equivalent to the Danish pronunciation of Tobias). Josefine, my daughter, was still only a baby. Today, I have other research studies behind me and years signified by what, sometimes, seems like endless travelling between Denmark and England: Denmark, which embodies my home and cultural inheritance; England, which has hosted my home and work for the last six years. Travelling between close relatives, family, friends and academic colleagues has tied me to both sides of the North Sea.

I came to Britain in August 1992, having finished the main part of my fieldwork in Denmark. I was to present the first piece of my doctoral research at the Conference of Medical Sociology, in Edinburgh, and afterwards take up a Visiting Fellowship in research at Brunel, The University of West London. My stay in London brought me in close

contact and connection with colleagues (around Britain but also internationally) who are engaged in the sociological and anthropological study of children. After the first six months I decided to stay in England in order further to explore this new academic environment. During the following years I went on frequent visits to my family in Denmark and spent the first two summer holidays each year carrying out additional fieldwork among the children in the institutions where the main body of my research had taken place.

The analysis and writing up of the large body of data produced during fieldwork in Denmark have been at universities in London and Hull, England. During the writing of the thesis I have changed supervisor twice. First, after about half a year in England, because I saw that formalising my links to the University would provide a more secure ground for the supervision and the direction of my work. I had to change supervisor for the second time in spring, 1995, when I moved away from London to take up a full-time research post at Hull University. This was, again, to overcome the geographical distance between my work and its supervision.

My years in England have been characterised by 'struggles', for example, in familiarising myself with English academic language and culture and in personal endeavours to bridge the gaps that my travels and movements have inevitably caused in my relationships. These many shifts and turns have not always helped me to establish a sense of continuity in my own work or consistency in working with a supervisor. However, having said that, it has allowed me to develop my work with great independence and I have always found myself

working with colleagues who have shared, or have come to share, my own ‘burning’ interest and engagement. Therefore, these years in England have been crucial for the way I have been able to develop my work and academic career. I feel fortunate and grateful for the opportunity it has given me to work, in research and publications, with some of the key persons within the sociological and anthropological field of childhood. These include, in particular, Allison James, Reader in Anthropology at the University of Hull, who has been invaluable as a supervisor, colleague and friend, and someone with whom I share values about and enthusiasm for conducting ethnographic research with children and Alan Prout, Reader in Sociology at the University of Hull, for his inspiration, sharp insights and, in particular, consistent encouragement and care during the last stages of writing this thesis.

I am also grateful that, during the first two years of my stay in England, I was a member of a department at Brunel, headed by Professor Adam Kuper. I worked there among a group of anthropologists notable for their vigorous interest and engagement and whose enthusiasm and critiques helped me to sharpen my understanding of genuine anthropological enterprise. It also included the opportunity to work with Professor Ronald Frankenberg whose work within medical anthropology was, for some years, influential for my thinking. Not least, however, I am convinced that I would not have been able to initiate and carry through my doctoral work had I not benefited from a firm basis established during my years at The Institute of Anthropology in Copenhagen. Its well established tradition within ethnography and high standard of anthropological work marked the guidance and inspiration that I have received during my years of education,

research work and collaboration, in particular with Professor Susan Whyte but also with other lecturers there.

I am also grateful to the Health Insurance Foundation (Sygekassernes Helsefond) and the Danish Research Council for the Humanities who awarded me a research grant for the study on which this thesis is based.

While I am indebted to many individuals who have contributed in various ways to my work. I am, of course, responsible for it and any shortcomings it may contain. This also applies to my translation into English of the words of the children and adults who participated in the study and of the various Danish authors on whose work I have drawn.

## Chapter 1

### TOWARDS AN ANTHROPOLOGY OF CHILDREN

#### Introduction.

This thesis is an analytical ethnography of children, aged between six and twelve, who live in Vanløse, a local district of Copenhagen, Denmark. It focuses on children as social actors, specifically in interactions with other children and with adults during everyday illness and minor accidents. By using a cultural performance approach to sickness (see Chapter 2), these events are used as a lens through which to look at children and childhood in contemporary Danish society. The substantive chapters of this thesis are organised around the five themes that emerged during the fieldwork: sickness as a variety of 'time-off' and its cultural similarities and differences with family holidays; children's cultural learning about the body in its subjective and objective forms during illness and accidents; the cultural constitution of children as vulnerable and the implications of this for interactions during childhood illness; the constitution of children's' competence and incompetence during illness episodes; and children's collective action in help-giving

This chapter begins to situate my thesis, and the work on which it is based, in the theoretical frameworks that have influenced and informed it. In this chapter, therefore, I examine the development and key notions of an anthropology of children, especially recent attempts to create a space for understanding children as social



actors. My discussion starts by noting children's lack of a voice in their own social representation. This, I suggest, is related to a central concern, running through the whole thesis, with how children are conceptualised in time: the past, the present and the future. I argue that the dominant discourses of childhood in Europe and North America identify the present value of childhood in relation to children's future potential as adults. This future orientation is reflected in much social science, especially the notion of socialisation that has, until recently, dominated anthropological and sociological thinking on the topic of childhood. Against this I pose the possibility of seeing children and adults as coevals, sharing the same social time and space.

Although my fieldwork took place in the children's homes, the school and the two after-school centres they attended, I have constantly borne in mind the connections between the everyday illnesses and minor accidents that occurred there and the other ongoing, social interactions and relationships of children's everyday lives. I have related what Nader (1981) calls the 'horizontal slice' of local processes and interactions with the 'vertical slice', the position of children in society and the cultural constitution of childhood. In parallel with this I employ the concept of cultural performance, proposed by Frankenberg (1980, 1986, 1988, 1992) and discussed in Chapter 2. This is central to a critical medical anthropology because it aims to locate the interactional level of illness experience (the horizontal slice) within its social, political and cultural context (the vertical slice).

## **Representations of Children**

In setting out the theoretical background to this study I first turn to the anthropology of childhood; children's lived experiences, actions and understandings are the central focus of the thesis. The ethnographic methods, which comprise its methodology (see Chapter 3), are used to amplify the voice of children, just as they have been for other social groups such as ethnic groups and women (Prout and James, 1990). Whilst recent pioneering work in anthropology and sociology has begun to address the problems of the representation of children (see below), the depiction of children, even in ethnographic studies, remains problematic. Later in this chapter I will discuss examples of earlier ethnographic work in order to highlight some of these problems and question some preconceptions and conceptualisations of children and childhood that have pervaded the field of child research. This investigation can also be seen as part of a plea for a broader understanding of the lived world of social persons, be they adults or children. A focus on the lives and experiences of children from their own perspective implies a critique of cultural understandings of what it is to be a child. Attention to children's perspective, I suggest, promises to yield insights into broader social and cultural processes. In this sense childhood ethnographies do not form a field exclusively focused on the social worlds of children but, rather, aim to contribute to general social anthropology.

From this point of view, one general problem within social science research is children's lack of visibility and their muteness in social and cultural studies (Hardman, 1973). This situation is similar in some respects to the earlier recognition of the position of women in

society and reflections of this in the social sciences (for example, Ardener, 1975a, 1975b; Moore, 1988). This awareness, pioneered by feminists, brought the particular perspectives of women, their social position and everyday experiences to the attention of social scientists (Alanen, 1988) and led to changes in their representation. In contrast, the similar need to make children 'visible' in the social sciences may seem superfluous in view of the children's apparent centrality in Western cultures, exhibited, for example, in the highly staged material and symbolic worlds of modern childhood. However, what may be challenged are those traditional perspectives that neglect the fact that children have little or no influence over their own social representation. The importance of this is emphasised by Dyer's statement that 'how we are seen determines in part how we are treated, how we treat others is based on how we see them; such seeing comes from representation' (1993: 1). If the child can now be thought of as a subject who is both acted upon and acts in the world, then most earlier studies have emphasised the former. This focus leaves more or less unaddressed the child as a social person in their own right, to be understood through his or her perceptions and actions in the social and cultural world.

Changing the position of children in the social and cultural sciences requires a re-examination of the conceptual frameworks that influence children's representation. Supplementing the frameworks offered in contemporary sociology and social anthropology, such an approach explores the ways that children are constituted in social and cultural theory. For, Jenks (1982) an examination of how children are dealt with in social theory reveals a ceaseless paradox. He writes:

The child is familiar to us and yet strange, she/he inhabits our world and yet seems to answer to another, she/he is essentially of ourselves and yet appears to display a different order of being.

(Jenks, 1982:9)

The child cannot be imagined in the absence of an idea about what an adult is just as it is impossible to picture the adult and his or her society without positing the child. The ambiguity in the relationship between the child and the adult is encapsulated in the notion of 'difference'. This perception of difference, Jenks suggests, may be attributed to a conventional theoretical focus on the social processes of overcoming it - that is socialisation. It is an underlying Western cultural premise that people are made, not born (Riesman, 1990). In this view people are made what they become through the influence of their parents and through education, with both being seen as essential for their successful development and future life. The emphasis is therefore put on understanding children in terms of 'becoming' rather than as 'being' a social person (Qvortrup, 1991).

At the same time as child and adult are seen to form a continuum, there is an implication of a socially and culturally constituted opposition. This marking of boundaries between the categorical positions of child and adult forms a part of cultural ideas about their fundamental separateness - a point well evidenced in popular culture that addresses generational and familial problems. It is shown, for example, by the portrayal of the boy toddler in the film 'Look Who's Talking Too' (1990). In the final sequences of this popular American film, the boy ('Mikey') is portrayed as having eventually accepted the

presence of his baby sister in the family. In the symbolism of the film the implication is that he adapts to the culturally acceptable image of the relationship between brother and sister and, as a consequence, establishes the cultural opposition between adults and children  
Mikey says:

The way I see it there's us and there is them (the parents). We got to stick together. You and me we are kids!!

In its portrayal of 'middle stream values' the film attempts to picture everyday family life from the perspective of two children portrayed as too young yet to have any speech of their own. They are given voice by two adult actors who represent to the audience the intentions of children as imagined by adults. Similar examples can be found in the wealth of television soap operas such as 'Cosby and Co' and, in the UK, productions such as 'Two point Four Children' and 'Next of Kin'. Danish productions would include very popular films 'Min Søsters Børn' ('My Sister's Children').

The central plot of all these productions is the constant contrast made between the world of children (and young people) and the adult world. Traditional (op)positions and commonly perceived conflicts of everyday family life get highlighted by twisting around 'child' and 'adult' power, control, competence and responsibility and by exaggerating elements of these dichotomous relationships. Such depictions often portray the embarrassing, weak and preposterous adult in relation to the lively, clever and smart child or demonstrate the adults' shortcomings when confronted with children's manipulative

powers and alternative worldviews. The fictional representation of familial combats and their arbitrary solutions tends to favour children over adults and allows qualities such as logic and power to be dislodged from its usual site in the adult. Eventually, however, the story line finds its equilibrium when children and adults are again reinstated into their 'usual' roles and positions.

These examples demonstrate how cultural conceptions of 'child' and 'adult' are seen as inseparable and at the same time as equally constituted in terms of 'difference'. Crawford's (1994) suggestion that stigmatising images of the other are founded in a social self which needs this other may, with regard to children, suggest that to establish the norm of the 'adult' in terms of an independent, responsible and active person necessarily constitutes its opposite, which at the same time, is its complement. This can be seen through notions of dependency, incompetence and vulnerability in children, a range of conceptions that this thesis has at the heart of its inquiry. Fabian's (1983) notion of coevality serves to summarise these points. Adults are coeval with children; that is, they live and share with them the same historical moment. However, at the same time, emphasis is given to childhood as a phase of development and preparation for future adult life that establishes an 'other-time-worldliness' in which the child's present tends to disappear. This implies that the present value of childhood is to be read off (in relation to) a future in terms of a past.

Jenks (1996a) suggests that the constitution of children through futurity is connected to the core features of modernity. He writes:

The modern family enabled the modern state to invest in 'futures'. The ideology of care both lubricated and legitimised the investment of economic and cultural capital in the 'promise' of childhood. (Jenks, 1996a: 15)

However, he also suggests that this modern formation is being superseded under the pressure of the changes that he characterises as 'postmodern'. In part the changes he includes under this heading are cultural. These refer to a new mood of uncertainty, risk (Beck, 1992) and ontological insecurity (Giddens, 1991) as fluidity and relativism replace the more rigid notions of identity, authority and morality that characterised the earlier part of the twentieth century. In part he argues that these changes are also social and institutional, linked to new patterns of family life, marriage and divorce, labour market participation and work. The effect of these changes has been to create a new image of the child that acts as a repository for nostalgic longings for stability and certainty. He concurs with Beck (1992: 118) that the 'child is the source of the last remaining, irrevocable, unexchangeable primary relationship'. In this view adult relations with children are constituted as a sphere that overcomes disenchantment with the modern world and recaptures an experience of an irreducible social bond.

The suggestion that contemporary society is moving, or has moved, from 'futuraity' to 'nostalgia' as its dominant representation of children is an interesting one and I will return to it in the conclusion to this thesis. However, at this point I want to highlight the difficulties that these dominant images of childhood create in trying to treat children as

ethnographically present. In this respect, Frankenberg (1988, 1992) has brought attention to the problems associated with the way in which people create spatial and temporal distance from others. This may not only be seen as the basis of control and power but as also serving an obstacle to understanding others and oneself:

The decision to see children as social persons acting in the world is not related to some essentialism about the nature of children but is determined by a time-based understanding of the nature of ethnographic practice. We have to assume that all those we study are always living in and experiencing the present, influenced by their perceptions and memories of their past and their predictions and perceptions of their future. At the moment of fieldwork we strive to share in that present. The danger is not that we as competent researchers might fail to observe their present but that we might prematurely, contextualise it in our equally real but less relevant perceptions of our experienced past and our anticipated future.

(Frankenberg, 1994)

The attempt to understand children's present social lives in this way was central to my fieldwork and remains so in its analysis.

### **The Development of Western Ideas of Childhood**

The propensity to contextualise children through the past or future rather than the present



can be understood as consistent with the historical and ideological development of the idea of childhood first noticed by Aries (1962). The child in the Middle Ages, he argues, did not occupy a particular social status and the idea of childhood did not exist. Archard (1993) criticises this conclusion for 'presentism'. He suggests one cannot infer that European medieval societies had no notion of childhood from the premise that they did not share the modern concept of it. Rather they must be seen as having a different idea of childhood. Children formed a part of society and participated in work and other social activities as soon as they did not need constant maternal care and attention. The word 'child' implied a structured lineage, i.e. a relationship and position in the family, and did not refer to a hierarchy of age. Children from the age of six or seven-years-old were regarded as adults - little adults or deficient ones - with relevant rights and responsibilities. During industrialisation (1700-1800) there was a shift in values and childhood became constituted through a notion of the intimate and private family and the value placed on learning. These ideas developed into a number of practices and schedules of child-care and training. Childhood became a 'quarantine' period where particular protective care was necessary. The child prepared and learned for a future adult life and developed to become a full and accepted member of society. Aries concludes that the care and control thus enacted by family, church, moralists and trustees deprived children of the freedom that they had previously enjoyed among adults.

This constitution of modern childhood was associated with the formation of features of contemporary European society: motherhood, the early mother-infant relationship and the separation of play, school and work (Alanen, 1988). This furthered the development of a

professionalisation and expertise in relation to children that was based on observing this new social world and viewed children as different from adults. Two sets of ideas may thus be suggested as forming the basis of the general European and North American cultural view of children and the structuration of childhood (Ennew, 1986:20). One set of ideas separates children from adults and defines the ideal family as a nuclear unit that is seen as the appropriate setting for children's socialisation. The family as social institution became the locus for undertaking the proper development and sustenance of both child and parental health (Crawford, 1994). Within the family these perceptions implied the positioning of adults as responsible providers and carers of the child, whilst the child, as 'not as yet part of society', received care, protection and training. The other set of ideas separated children from adults in the production processes, that is work. Perceptions of children meant that they were formally protected from work. The child had the status of a 'non-worker', was not expected to work and in fact children (depending on their age) were gradually becoming legally excluded from it. Contemporaneously the child must not and is not expected to work, but has instead the right to play, learning and knowledge.

Notions of modern, European and North American childhood are, then, characterised by dependency, care, incompetence and vulnerability, conceptions, which tend to constitute the child as a passive recipient. These views form a remarkable contrast to the position of the child in cultures that are dependent on and emphasise children's contributions to family economy in the form of work, support of the elderly or care-taking for younger siblings (see for example, Rodgers and Standing, 1981; Qvortrup, 1995). However, even in industrial societies like Denmark and the United Kingdom, these understandings of

modern childhood actually underestimate and render children's contributions to the economy invisible (Morrow, 1996). They deprive children's actions and contributions of any genuine and 'serious' impact or importance for societal life. That the contribution children make may be considerable but still not be sincerely valued, was demonstrated by a British study which showed that about 10,000 children under the age of 16 were carers of an adult family member (Fallon, 1990). The invisibility of this work, carried out by the children, was underlined by the fact that, unlike adults doing the same work, persons of this age cannot claim a care allowance from the state. Consequently the exact figures of children involved could only be estimated. The social non-recognition of their work was accompanied by a frustration on their part because, as children, they were frequently excluded from having any part in negotiations and decisions. The professionals believed that they were too young to be involved. More recently theoretical reformulations have been suggested which, together with the empirical evidence, counter such assumptions. On the theoretical front Qvortrup (1991; 1995), for example, argues for the radical view that learning should not only be seen as a 'right' of children but also as a social expectation and duty of children. 'Schooling', therefore, may be viewed as children's (unpaid) 'work' without which the continuity of society could not take place. In this view children do not only acquire and duplicate knowledge but also actively contribute to the production of and refurbishment of knowledge in society.

Despite these examples, the value of children remains largely invested in their future, as adults rather than them being present members of society, a view emphasised in the concept of 'socialisation'. This designates the social processes by which the child

internalises cultural values and, through learning and development, prepares for adult life. Originally, however, socialisation was defined through a more sociological concern with conceptualising 'society'. It referred to the social forces that drew people together in a society (Durkheim, 1950/1903). Socialisation was perceived as a primarily social process, which had as secondary the individual psychological process of internalisation. By shifting its meaning towards internalisation, socialisation has now come to imply a fundamental polarity between an uncivilised and asocial 'human nature' and a civilised and 'social being', a distinction that places the child at the uncivilised pole.

This reinterpretation of socialisation as a psychological process has proven to have particular conceptual power. In psychology, socialisation is redefined as an individual process of internalisation reducing social reality to externally given conditions or milieu. In contrast to earlier understandings of the term, socialisation became understood as involving a passive recipient (almost always a child) instead of an active social person in their relations and interactions with others. The child was more or less seen as an empty vessel with 'potential sociality' that would develop through the influences and guidance of significant others (such as the parents and the school). Even though later theories incorporated ideas of socialisation as an interactional process, the main concern for socialisation research remained to determine the processes by which the social and material environment and the cultural system that the child grows up with (and which is treated as an external given) is internalised by the child and thus reproduced (Denzin, 1977, MacKay, 1973). Socialisation processes are thus held to provide a seemingly convincing, but in fact misleadingly partial, framework for understanding children in the social world (Alanen,

1988).

Dominant perceptions of childhood in European and North American cultures can be summarised as follows: childhood is ascribed special meaning as a phase in human life; the child is surrounded with care and concern for the child which endeavour to prepare and protect the child; at the same time these perceptions attribute value to childhood and the child mostly in relation to a future adult life through the status of 'non-adult'; the child is more valued as a being in process, that is being socialised towards a goal, through which to take his or her place in society than in his/her present state.

### **The Culture Personality School**

Within anthropology the interest in children has most often merely served as, so to speak, 'part of the decoration' in ethnography. The life of children and children's play is used more or less only to colour the background or sketch the atmosphere for what the anthropologist sees as of main concern - namely the adults, their relations and the culture at large. As Hardman (1973) notes, children did not form any significant part of anthropological studies. We can see this exemplified in the great interest focused on studying initiation rituals in different cultures. Entry into adulthood is when the social and cultural life of the child is implied to begin. Marcus and Fischer (1986), for example, have recently pointed out that these studies have neglected to include the initiands' perception of the ritual, underlining the suggestion that the perspective of the child or young adolescent is absent.

In so far as children have been present in ethnographies, it has been through an interest in socialisation, most notably in anthropology through the work of Culture and Personality School during the period 1930-60. This school of thought was influenced by Freudian psychoanalysis and focused on cultural child rearing practices as the basis for the formation of the adult personality and the nature of adult social life. The emphasis was also on children as those who would ensure the continuity of the community, and thus the Culture and Personality School was concerned predominantly with how children were enculturated or socialised and how cultural values, traditions and social organisation were maintained. The prevalent idea of children was thus as persons who were moulded and shaped into social beings. In this perspective anthropologists observed adults, and especially mothers, caring for and training children as part of society. Adults were interviewed about their perceptions and ideas and, eventually, the anthropologist supplemented his or her interpretations by observing children's behaviour in play and other social activities.

Influential examples of this genre include Benedict's monograph about Japan (1946), where it is argued that contradictions in the Japanese character can be understood through childrearing practices. She noted that the adult Japanese personality contains a dualistic view of the world: throughout life, with all its disciplinary regimes, adults retain a memory of their privileged and psychologically tranquil experience as infants in which they did not know the concept of shame. Equally prominent is the work of Whiting and Child (1953) who argued that there was a thematic connection between habits of socialisation and illness explanation across two different cultures. They noted that there was a significant

cross cultural concordance between customs that facilitate so called 'oral socialisation anxiety' in childhood, that is between too early or too strict weaning, and the occurrence of illness explanations where the cause of illness is perceived to be oral, encapsulated, for example, in the phrase 'it must have been something I have eaten'. Whiting and Child concluded that there was a consistent relationship between cultural differences in socialisation and cultural differences in explanatory models of illness. However, Shweder (1979), citing an unpublished reanalysis by Costanzo, subjects their conclusions to both a methodological and interpretive critique. The overall important point is that these studies often attempted to categorise and explain adult behaviour by connecting certain socialisation patterns in childhood, concerning oral, anal and sexual practices, to the development of adult personality.

Within the Culture and Personality School, Mead's studies of child rearing in Samoa and in New Guinea were also very influential. In a description of her fieldwork in New Guinea Mead recounts:

'I watched the Manus baby, the Manus child, the Manus adolescent, in an attempt to understand the way in which each of these was becoming a Manus adult.'

(Mead (1930/1968:16)

The general focus of Mead's cultural studies was on child-rearing practices, gender roles and adolescents' emotional lives. Mead, whilst suggesting that child-rearing patterns had

later effects on personality, argued that universal values of childhood can be found through cross-cultural comparison and she concluded that there were biological similarities in growing up, in mother-child relationships and in children's fundamental needs. For Mead (1955) there is a universal pattern in which adults perceive the child as weak, helpless and in need of protection, guidance and education (Mead, 1955; 1962). This view was expounded in a Samoan study of 1929 in which Mead analysed children's drawings. Her methods were, however, a simplified version of the Piagetian approach, devised for clinical experiments in Europe and North America, but given to children who were asked to make drawings but who had never used pencils and paper before (Hardman, 1973). However, despite these problems, in this study Mead did begin to recognise children as informants and saw child thinking as interesting in its own right.

By the late 1970s, however, Culture and Personality studies began to be criticised for their mechanistic and deterministic model that assumed that events at one point would produce a given result at a later time. In an important review paper, Shweder (1979) concluded that a clear and consistent relation could not be found between child rearing practices in the first years of the child's life, and the adult personality prevalent in a certain culture. Nevertheless, studies still continued to inscribe themselves in this tradition, suggesting the persuasive power of the idea of a cultural connection between the socialisation of the small child and adult life (see, for example, Levine et al 1994).

Thus, whilst in general anthropology the understanding of adult self and person (and related concepts) has changed, this dominant view of children and childhood has to a great



extent remained. Jerome Kagan (1980), an American psychologist, has suggested that the notion of early childhood having such an important influence for the adult life is grounded in a Western perception of and faith in 'continuity'. This belief, so central to the Culture and Personality School, makes us suppose, without questioning, that qualities that exist at one time have a connection to, or are founded in, qualities evident at an earlier point in time. Once again, then, it can be seen that the present lives of children are understood primarily in relation to their future as adults.

### **Autonomy and Separation in Modern Ideas of Childhood**

The association suggested by Kagan between social scientific ideas and Western cultural perspectives on children and childhood can also be found elsewhere. Shweder and Bourne (1982:131), for example, consider the extent to which scientific literatures concerned with the child as developing into an autonomous person, where autonomy is linked to notions of individualism, have their origin in the institutionalisation of privacy. They argue that independence, integrity and the security of privacy are a product of how other people behave and react towards us, and are also a product of the rights and privileges that others guarantee us in relation to numerous 'personal territories' (Goffman, 1971, in Shweder and Bourne, 1982). This can be illustrated with some Danish examples. A common feature of the Danish middle class family is that the child gets his or her own bed to sleep in from when they are born and, perhaps, even their own bedroom. To have one's own playthings is a given, although children eventually learn they also have to share with others whilst, at the same time, retaining a sense of their ownership. The gradual delegation of

independence from adult to child (as seen from the adult perspective) is conducted in accordance with considerations and expectations of the child's development and maturity. Accounts from parents that I collected during my fieldwork (see Chapter 3) suggest that a child of three years old may be told 'You may decide your dinner' and 'Choose the clothes you want to wear', or asked 'What do you want in your packed lunch?' and 'Who should be invited to your birthday party?' At this age, and almost certainly as the child grows older, she or he gets their 'own bedroom'. The closed bedroom will, in some families, signal that adults, sisters and brothers have to knock before they enter in order to demonstrate their appropriate respect for the child or young person's privacy. Later, if household finances permit, the child is provided with a room with its own entrance, before he or she eventually moves from their parental home to form their own family. Likewise in growing up, children experience that adults have their private and independent lives to which the child is not, or only seldom, given access.

From the adult (and researcher's) perspective the child runs through a developmental process - a process of learning, training and maturation – which ensures the move to autonomy and separation. However, there is no reason to assume that the child experiences their life in such terms. From the child's perspective these are lived experiences of social relations, situations and actions to which they may attach their own particular meaning, which may or may not be congruent with adult desires to inculcate autonomy and separation (1).

Viewed as a social process, children's development is closely linked to the child's gradual

emancipation and separation from their parents. Modern psychologists and psychiatrists understand this as a 'natural' step in the child's move to be an autonomous individual. An underlying notion here is that 'we seem to assume that in order to be independent we have to be separate' (Riesman, 1992:221). The perception of a grown up person who has not moved from home within a 'reasonable' time frame, or a young person who expresses too great a dependence on their parents at a stage when he or she is not expected to do so, are, in Denmark (and elsewhere in North America and Northern Europe), characterised as 'clinging to their mother's skirts' and 'not had the umbilical cord cut'; a person who has not yet become a 'real' adult (wo)man, (Riesman, 1983; 1990).

However, in other societies a completely different view may predominate, as Riesman (1983, 1990) has shown in the case of Fulani society. Riesman conducted his fieldwork in a Fulani society in Burkina Faso, on the southern edge of the Sahel region in West Africa. Amongst the Fulani people, a child was not expected to live through such a separation process that would inevitably conclude with the child moving from home and forming his or her own family. The child stayed in or close to the community and continued to live with their own family there. Furthermore, the Fulani denied that their parenting had any influence on how the child would be as adult. In a concluding point Riesman writes:

Fulani parents are not in the least trying to produce or manufacture a human being who will eventually and on his own exemplify and embody their ideals. Rather, they are caring for a child because it is one of them; it is a relative, and it will always be so. The very structure of Fulani society, as is generally the case in

small scale traditional African societies, consists in the relations that relatives and the groups they constitute maintain with each other. (Riesman, 1990:187)

On the basis of these observations Riesman (1983) argues that separation is a premise that parents in European and North American cultures confront and live with from the time the child is born. The cultural perception of the important value of early childhood for later adult life is one of the ways in which parents are able to maintain their relationship to the child long after their actual separation. Childhood is the point in the life course when parents believe they can have an impact on their children's lives and, through the idea that this influence will remain permanent, parents imagine a continuation of their relationship with children despite their limited contact with them. Riesman emphasises that the ideology of the individual and the independent self, as well as the experiences of separation from other people that are experienced throughout life, also affect the child's self perception. It establishes the idea of a connection between childhood and adult personality that is widely influential in Western culture. This he argues does not confirm that there is a substantial link between childhood and adult social identity: rather, it indicates the power of our ideologies to form the ways that we create meaning out of our experiences.

In this section, therefore, I have argued that ideas about the determinant character of socialisation processes, especially of early childhood in relation to adult life, and the constitutive effect for social relations among adults in a society, tends to obscure important aspects of children and childhood. In relieving childhood from these presumptions and traditional values in this thesis I ascribe to the idea of childhood and of

children's relationships a sense of present value. I wish to argue against seeing childhood as a purpose for a future goal or as part of a relationship of cause and outcome but rather to take a perspective that emphasises the current value for children, their lives, values and relationships.

### **Children's Cultural Learning: From Individual to Collective Processes**

Recent theoretical advances, especially those derived from ethnographic studies that view children as actively participating in the interpretation and reproduction of cultural knowledge, form an essential background to the task of focusing on children's lives in the present. In order to explain this current thinking it is necessary to sketch the argument made by contemporary sociologists and anthropologists of childhood. They have suggested that the notion of 'development' is the dominant discourse of children within European and North American thought (Jenks, 1982; Prout and James, 1990; James, Jenks and Prout, 1998). As Burman (1994) points out, one particular version of development, the Piagetian, has gained a near hegemony, eclipsing other variations on this theme (for example, social learning approaches) which for a period coexisted with it. Although some critical voices within this psychological tradition emphasise the importance of the social and cultural context of child development (see, for example, Richards and Light, 1986; Bradley, 1986, and for a Danish example, Sommer, 1988) generally speaking they are in a minority.

Although fostered within psychology, the developmental approach has until recently

formed the implicit basis for most sociological and anthropological work on childhood (James, Jenks and Prout, 1998). Central to this mode of thought are three elements: 'naturalness', 'universality', and 'rationality'. This trio has until recently been thought convincingly to tie the biological facts of infancy and growth with the social aspects of childhood. As a consequence, Jenks (1982; 1996b) suggests, the child is seen as progressing from simplicity to complexity, from irrational to rational behaviour, from a stage of biological immaturity, passing through a developmental process and moving into a fully developed human status as adult.

In the sociology of the 1950s, however, current ideas about child development were directly transferred into theories of socialisation. At a time when the social sciences were greatly influenced by positivist and functionalist thinking 'socialisation' offered a convincing account of how children 'become social'. (James and Prout, 1990). The theoretical preoccupation of sociology with the reproduction of the social order replicated the individual-society dualism presupposed by the psychological view of children. The individual was seen as a pre-existing 'cogito' outside of society (Ingleby, 1986); children were seen as immature, irrational, incompetent, asocial, and acultural whilst adults were regarded as 'mature, rational, competent, social and autonomous' (McKay, 1973:27-28). As suggested above, children and adults were thus made to appear as two different instances of the same species. Socialisation was seen as the process that transformed the one into the other.

In this model children were the passive representatives of the future generation and, in the

social processes involved in socialisation, and adults were, as Elkin critically describes it, the active and constituent end:

The socialising agents teach, serve as models, and invite participation. Through their ability to offer gratification and deprivations they induce co-operation and learning and prevent disrupting deviance. (Elkin, 1960:101)

In such traditional views the notion of children as 'outcomes' became the principal concern at the expense of attending to the socialisation process in itself or even of exploring the possible contradictions and conflicts involved in such processes. In the 1970s, however, the work of socialisation theorists was undergoing critical appraisals. Shildkrou, for example, argued that:

Child culture is seen as a rehearsal for adult life and socialisation consists of the processes through which, by one method or another, children are made to conform, in cases of 'successful' socialisation or become deviants in cases of failed socialisation (Shildkrou, 1978: 109-10).

Shildkrou's critique points to the overarching determinism characteristic of socialisation studies, a point echoed by her contemporaries and challenged in much of the newer work on socialisation that employed an interactional perspective and aimed to investigate children's own part in the processes (see, for example, MacKay, 1973; Denzin, 1977).

It can be seen, then, that in socialisation theories the child has traditionally been seen as passing through a transition from biological and socially immature existence into a socially competent adult being. This was facilitated through learning taking place during childhood and youth that, eventually, would enable the child to take up membership of their social groups and institutions. In this view socialisation was seen as a process through which the child individually came to internalise the external (adult) culture.

On the basis of the critiques developed in the 1970s children came to be seen as much more active in the process of cultural learning, as interpreters and creators of meaning rather than simply absorbing the meanings of adults. Contemporary approaches to the ethnography of children depart from this point by seeing socialisation as a collective rather than an individual process, by emphasising the importance of children's peer relations and by placing socialisation in the public rather than the private domain. Corsaro (1992;1997). has theorised this approach as 'interpretive reproduction'. He emphasises children's active participation in both interpreting and reproducing culture through three particularly important elements: first, language and language use; second, cultural routines that provide actors with a shared understanding of belonging to a social group and provide the frames within which a wide range of socio-cultural knowledge can be produced, displayed and interpreted; and third, by seeing development as reproductive rather than linear. Taken together these dispense with the idea of seeing the child as outside of society and societal institutions (Cook-Cumperz , Corsaro and Streek, 1986). As Corsaro puts it:

...children do not simply imitate or internalise the world around





them. They strive to interpret or make sense of their culture and to participate in it. In attempting to make sense of the adult world, children come to collectively produce their own peer worlds and cultures

(Corsaro, 1997: 24)

Here, then, both children and adults are seen as part of culture and both make contributions to its reproduction and (re)interpretation. This happens both through children's negotiations with adults and through the creative production of a series of peer cultures with other children. Individual development thus becomes embedded in children's collective weaving of their places in the webs of significance that constitute their culture.

### **Reconstructing the Study of Childhood**

My study draws on and contributes to recent developments in the anthropology and sociology of childhood. Within these the child is studied as a social person in his or her own right, on the basis of the child's own perspective and the child's perception of, and actions in, the social world. However, this focus on children's practices and constructions does not mean that their life world can be understood in isolation from the life world of adults. Prout, for example, in a study of children's health and illness concludes that the:

.. children's world strongly paralleled features of the adult one, cannot (*sic*) be understood outside of it and possessed only a highly circumscribed autonomy

from it. Nevertheless, the meaning of sickness was refracted through specific childhood practices and institutions. (Prout, 1989:353)

An ethnography of children and childhood must, therefore, acknowledge the interplay between the adult's and the child's perspective on culture. Thus, whilst, as I shall suggest below, it may be useful for some purely methodological and analytical purposes to acknowledge the singularity of the child's perspective, this does not imply a theoretical commitment to the notion of childhood as an isolated world of the 'other'.

In a sense this is a consequence of James and Prout's (1990: 7-9) argument that childhood cannot be understood as a natural or as a universal phenomenon but must be seen as a social and cultural construction of a specific society, distinct from ideas of biological immaturity. This idea forms the basis for an examination of childhood as a social construction. At the same time, however, it portends the deconstruction of childhood as an autonomous phenomenon. What James and Prout seem to envisage are studies taking the perspective of children which, when fitted together, would create a new picture of contemporary childhood. When looking at this picture we would be able to see the whole as well as the individual components that constitute its diversity. Childhood in Denmark, England or Africa may be recognised as differently constructed, differing precisely because each depends on its point in time and space, that is on its social, cultural and historical constitution. Prout (1996) suggests that the perspective of a unitary childhood should be replaced with an understanding of the constitution of several 'childhoods' even within one setting (see also James, Jenks and Prout, 1998). These various childhoods are embedded

in factors such as social class, ethnicity and gender that influence both the constitutional elements and children's experience.

Gender, for example, may be an important analytical variable influencing the construction of childhood and may also be important for the distinctions made among children and between children and adults. The importance of this is underlined when children appear as if they were ungendered beings, for example in much statistical analysis where children are categorised by age but not by gender (for a recent example, see Ditch, Barnes and Bradshaw, 1998). Findings are presented without attempts to distinguish between data from males and females, a practice that would now be seen as inconceivable in the study of adults. However, once taken into account, the significance of gender may become manifest. Prout (1986), for example, showed that the different form and content of friendship and peer relationships among girls and among boys is an important context for creating meaning for children's sickness absence from school. This, however, does not mean that gender is always central. Thorne (1993), for example, argues that gender divisions in Californian children's play can be mobile, shifting and fluid. Similarly Bluebond-Langner (1991) has shown, in a study of North American children suffering from leukaemia, how girls and boys interacted across presupposed gender boundaries on the basis of their perception of mutuality in their illness and life situation. Other sets of social categories such as family, status, siblingship and friendships were more important than gender for these children. Although neither of the above studies downplays gender, or questions its potential importance, they both underline that in approaching children's social action it is important to be sensitive to the factors which seem actually to shape their

experience rather than assuming in advance that these are known

As suggested above, an important point addressed by the social constructionist approach to childhood was the inappropriateness of childhood as a unified concept. In its place was the proposition that the term 'childhoods' could be used to account for the multiplicity and diversity of children's lives and experiences. However, this recognition has not necessarily lead to more empirical precision within the field. For example, in her book 'Children, Health and the Social Order' Mayall's opening statement is:

This book is about children's childhoods: how they are experienced and understood by children and adults. (Mayall, 1996:1)

However, throughout the book Mayall does not explain any further why or how she uses this conceptual plurality. The usage 'childhoods' appears (and here my critique is not exclusively aimed at Mayall) as a glossing over of social analysis. The term is a convenient way of indicating that there are differences in the experience of children – but what these are and how they are constituted is not fully explained. These questions are, I argue, of fundamental importance for the continuing development of the field of study. More precision is needed about the culturally and historically different forms of children's lives, the different 'life conditions' (social, political, economic, ideological, discursive and material) that are constitutive of children's everyday life and experiences, and the different ways children experience and act in relation to these. It is only through these detailed considerations that different

'childhoods' could be compared and contrasted.

At this point it is useful to remember Thomas's (1993) call for attention to the distinction between, on the one hand, empirical and descriptive categories and, on the other, theoretical and analytical ones. If the concept of 'childhood', or even 'childhoods', is mistakenly treated as a theoretical category then it tends to appear as an irreducible and pre-given sociological category that reflects a supposedly autonomous aspect of the social order (2). Used in this way there is a tendency to make the concept do analytical and explanatory work rather than being the object of analysis and explanation.

In my approach, however, childhood is a descriptive category. It is, so to speak, an empirical phenomenon, the form and content of which requires analysis and to which the anthropologist brings methodological, analytical and theoretical tools. Part of the importance of this is that in some societies (such as Denmark) 'childhood' is used to categorise a particular phase in the lifecourse of a person, to define a generational relationship, and to identify a particular section of the population. As such it has all kinds of discursive, political, economic, legal implications. However, in other societies this way of conceptualising and classifying does not apply, as Aries' work (1962), discussed above, demonstrates. Furthermore, other cultures may conceptualise the category of children differently. If, however, the field of study is defined empirically, it becomes possible to describe children's experiences, understandings and practices, outline their position in society and identify the multiple, different forces (including the different conceptions of childhood) that

influence their lives. In so doing 'childhood' is recognised as an empirical phenomenon which requires analysis by other theoretical means.

By looking at children as social actors in this way, they are far from being seen as passive subjects in social structures and processes (as depicted in Culture and Personality and socialisation studies). Instead they are seen as active in the construction and determination of their social lives, active in the lives that other people lead around them and the societies in which they live. Rather than looking only at how children are formed by social life, children are seen as social actors whose actions can both shape and change social life. Giddens (1979:69) argues that an action that serves to reproduce structure is a productive action, and as such it may initiate social change by transforming structure, at the same time as it reproduces it. Thus, to acknowledge the simultaneous reproductive and transformative relations between human conduct and culture, one must perceive the person as not only a 'product' of his or her own culture, but also as a co-writer of reality (Hastrup, 1988:137) and the interpreter as well as mechanical reproducers of society and culture (Cosaro, 1992, 1997). It is important to recognise children as both restricted or encapsulated by social structures and as persons acting within or towards the structure (James and Prout, 1990). The following section outlines the value of adopting such an approach.

### **Institutionalisation and Fragmentation in Danish Childhood**

In European cultural contexts, for example, children generally may be seen as within and between several domains and relations: that of their family and peers, their schools, day-

care institutions, sport, music and other activities. In Denmark, in particular, children's every day lives are framed by social institutions represented in the family, the school and day-care institutions. Modern childhood has been characterised as displaying a simultaneous increase in institutionalisation and fragmentation (Qvortrup, 1991); children's everyday life is distributed between, takes place within and is restricted to institutional settings, such as school and after school centres, and the family. Even leisure time is framed in this way for most children up to fourteen years old because participation in activities, such as sport or music, takes place within some kind of institutional setting. These multiple institutional settings form the context of children's social and cultural worlds and are, as this thesis will show, constitutive of the interactions and social positioning between child and adult.

Public debates on TV and radio at the time of my fieldwork (and after) about children's welfare in Denmark expressed the views of professionals, parents and politicians about the possible effects of this increasing institutionalisation and fragmentation on children and the potentially undesirable outcomes of growing up in such diverse social environments. Fears were expressed that it may hinder children in forming and developing stable and coherent worldviews and relationships. The highly institutionalised schooling and professional day-care system for children was suspected of creating and sustaining generational divisions in society and, in particular, of creating a gap between children and their parents (who spend most of their everyday life apart). This view was highlighted in a recent interview with the childhood sociologist Jens Qvortrup published in a Danish newspaper ('Weekendavisen', 3<sup>rd</sup> April, 1996). Qvortrup argued that it signals a fundamental change

of society in which children's and adult's lives are becoming more separated.

It follows from this that in understanding children's relationships with the adult world, three analytical levels may be articulated: the personal, the local and interactional, and the societal levels. Although this thesis necessarily has had to set a particular focus on the local and interactional level, all three levels of inquiry will be considered as being in principle of equal importance. My analysis, however, brings them all together by applying Nader's (1981) notion of the 'horizontal' and 'vertical' slices (or perspectives) in social analysis. The former is the processual or interactional level, whilst the latter refers to the relation between the person and society. Nader argues that ethnographic studies tend to focus on a horizontal level, leaving out of the analysis the vertical perspective. In relation to studies of children this has resulted in a lack of attention to the complex relation between children and institutions and the formal and informal hierarchies that influence children's lives. By contrast, historical studies of childhood have attempted to make these connections, for example either viewing social institutions as suppressing (Aries, 1962) or as liberating children in society (Demaese, 1974). In this thesis I suggest, following Nader, that it is important to substantiate both the nature of the relationships between persons and social institutions and to understand the structure and meaning of these relationships in the lives of children and their families.

## **Conclusion**

In this chapter I have outlined one of the main theoretical influences on my work and the analysis presented in this thesis. At its heart is a refurbished anthropology of childhood,



which looks at children as social actors. This, I have argued, requires an understanding of their 'being', their coequality as social persons sharing present space and time. It thus necessitates a shift away from an emphasis on socialisation and development, which in line with dominant Western ideas about children, highlights their 'becoming'. In turn, I have suggested, this implies a change from seeing child-adult relationships as necessarily the most important ones to seeing children's interrelationships and interactions with all others (children as well as adults) as equally important. In considering how children are thought of in terms of their future and past rather than present lives, I have identified some central aspects how children are culturally constituted in European and North American societies: as especially vulnerable, in need of protection and as lacking competence. I have also emphasised that constituting children in these ways implies its relational opposite in that adults are seen as competent and protective. These themes, so pertinent to understanding health and illness, will be taken up in later chapters of this thesis.

I have also emphasised that addressing children as social actors does not imply treating them as autonomous beings. On the contrary, it entails tracing through the links between their interactions in the milieu of their everyday lives and the institutional context of these - in Denmark, the family and the schools and after-school centres which occupy most of their time. Nader's (1981) notion of the vertical and horizontal slices presents a way of thinking about childhood that highlights the analytical need to hold these links together. This necessity to combine attention to interactional processes and their wider context has also been identified in medical anthropology through the idea of sickness as a cultural performance. In the next chapter I will set this out as the second main theoretical

framework of the thesis.

### Notes

1. This does not mean, of course, that I do not acknowledge the importance that even young children attach to their development and achieved maturity in order to gain privileges or that they do not experience signs of their own increased competence and achievement. In this sense an understanding of children requires attention to them as both beings and becomings.

2. Lee (1998) has recently warned of the dangers of this strategy for the sociology of childhood. He argues that the attempt to put children into the mainstream of sociology risks the discipline's tendency to look upon social order as finished and complete.

## Chapter 2

### UNDERSTANDING AND INTERPRETING ILLNESS: CHILDHOOD

#### SICKNESS AS CULTURAL PERFORMANCE

##### Introduction

The second main framework for my study is drawn from medical anthropology, within which the approach I have taken can be considered as an example of what Frankenberg (1980, 1986, 1988, 1992) has called the cultural performance of sickness. This, together with recent work addressing the body as lived experience (Csordas, 1994; Scheper-Hughes and Lock, 1987; Shilling, 1993; Turner, 1984; 1992), constitutes an important critical trend in medical anthropology that began in the late 1970s. It marked a turning point in medical anthropology, bringing it back from a peripheral position as an applied subdiscipline to one, which shares the central concerns of social anthropology. At the core of the notion of sickness as a cultural performance is a concern to broaden the focus away from small-scale and immediate interactions between doctors (or other healers) and patients that had become the mainstay of medical anthropology. Instead, in an argument that closely parallels Nader's notion of the vertical and horizontal slices discussed in Chapter 1, it was proposed that illness is part of and brings into play a much wider set of social and cultural relationships; for example those of gender, class and ethnicity. I will argue in this thesis that an adequate anthropological understanding of childhood illness must therefore locate it within the wider context of children's relationships with other

children and with adults. My aim, therefore, has been to work on the synergies between the anthropologies of medicine and childhood, made possible because they have both been concerned to connect local or small-scale interactions with broader social and cultural questions.

As well as outlining the notion of sickness as a cultural performance, this chapter develops its theme in two ways. First, I give an outline of the development of medical anthropology. Here I suggest that the close relationship between medical anthropologists and biomedical practitioners restricted the range of questions that were asked. Nevertheless, this produced much that was of value. In particular, I suggest that Kleinman's cultural model of health care systems is useful in illustrating the position of children. The model gives children a place in the 'popular' sector of the health care system. It thus suggests the importance of investigating two possibilities: how children are active in their own and others' health care; and how they experience the hierarchies of the health care system as these are reproduced in everyday health care interactions such as those at home, in school and in the after-school centre.

Second, the critique of socialisation, and the alternative view of children as social actors individually and collectively participating in society, developed in Chapter 1, are used critically to evaluate sociological and other literatures on how children learn about health and illness. Taken together, these arguments set out the theoretical and methodological prerequisites for understanding children as culturally performing sickness.

## Towards a Critical Medical Anthropology

It has always been central to anthropological inquiry to explore the different ways that people in other cultures respond to disorders and changes centred on the body. Medical anthropology was established as a sub-discipline during the post-war period primarily, and most markedly, in the United States but also, though to a lesser extent, in some European countries especially England. In Denmark, as in some other European countries, the field took off some time later and, although it has been of growing importance, its more formal establishment has been somewhat slower.

In charting the origins and development of medical anthropology it is, however, important to recognise that until recently biomedical science and its practitioners occupied a dominant position. Pioneer anthropologists, such as W.H.R. Rivers, were also physicians and a medical background continues to be not uncommon amongst key writers in contemporary medical anthropology: both Arthur Kleinman and Byron Good, for example, came to anthropology from medicine. For other anthropologists, however, the inclination towards biomedicine originated in collaborative work with doctors in particular field studies. Janzen and Arkininstall's (1978) study of therapy management in Lower Zaire is a good example of such work. Much medical anthropology also took place largely around practical concerns about health development in post-colonial countries and the place of medicine within aid programmes. Medical anthropology 'at home', especially in the United States, has continued the tendency to have a close relationship with biomedicine because concern with how medicine might be made more effective in different

clinical settings has been an important underlying motivation of research. It has been argued that this can be accomplished by giving physicians a better cultural understanding of the way people respond to illness (Helman, 1990). In a similar vein, studies have been undertaken in order to inform physicians about the social and cultural aspects of 'non-compliance' among patients.

Through these kinds of studies medical anthropology became seen as a largely applied discipline working with a comparative social and cultural perspective on health and illness. On the basis of ethnographic studies of health care systems, illness categories and therapeutic traditions in different societies and cultures, medical anthropologists generated concepts and analytical models useful in this quest (see, for example: Kleinman 1980; Janzen 1978). However, because medicine was implicitly granted a superior position by providing what was seen as an universal and scientific account of the human body and its disorders, many studies contrasted the knowledge and curative practices of biomedicine with the belief systems and healing traditions of other cultures. This approach not only promoted a reductionistic view of other cultural healing systems but it also meant, as Good (1995) argues, that the dynamics of biomedical practices remained largely uninvestigated and biomedicine's kinship with other healing traditions became obscured (see also Lock and Gordon, 1988).

By the late 1970s medical anthropologists were pointing to the diversity or plurality of medical systems within a local setting, a phenomenon which could be observed cross-culturally. This 'medical pluralism', as it became known, constituted a scenario of

contrasting, sometimes even contradictory and incompatible, understandings of bodily ills and healing practices. It was noted that people seemed to accept and act with an intriguing ease within what appeared to be a complicated and blurred medical scene. Thus one direction medical anthropological work took was to investigate the syncretism of complex medical systems emerging in the relationship between 'folk' and 'popular' traditions and biomedicine (for example, Leslie and Young, 1992). This work focused on the transformations of traditional knowledge and practices and the translations of biomedical practices and technologies in specific local cultural settings (for example, Good and Good, 1992). Another direction research took was the understanding of ill persons as consumers of health care. This body of work looked at how people conducted self-care, used different therapies and consulted different practitioners within one local setting. These studies (for example, Chrisman, 1977) focused on different aspects of the health seeking process and investigated, for example, the internal logic between the illness explanations and the therapeutic trajectories of ill persons.

Kleinman was a key writer of this period. He defined a cultural model of the total health care system, which became greatly influential within medical anthropology. Kleinman's (1980) analysis distinguished three basic sectors of the health care system: a popular, a folk and a professional sector. The professional sector consists of the institutionalised diagnosis, care and treatment originating in Western (that is, European and North American) societies and based in natural science and biomedicine (although in India and Asia this sector would also include Ayurvedic medicine). The folk sector includes what has been called complementary medicine or alternative medicine, and traditional healing

systems. The popular sector defines the family-based lay management of health and illness, which studies supposed would account for approximately 70-90% of all treatment in both Western and non-Western societies (Chrisman, 1977). In Denmark, for example, a large-scale study of the health and ill-health of the adult population stated that most people handled symptoms themselves. Only 12% of the population had contacted their physician within a two weeks period because of symptoms they had experienced (Rasmussen et al, 1988).

Kleinman's model may now appear almost crude and mechanistic in its distinctions but its strength and originality lies in the way that the influence and importance of all three sectors are put on an equal footing. Although the model does not allow a close analysis of the interactions and progressions within each sector, Kleinman was able, nonetheless, to throw important light on the dyadic relationship between doctor and patient (1). Moreover, it provided a framework for exploring the character of social relations and the relative social position of patients and healers within different clinical realities (Whyte, 1992). Important insight was also brought to differences between lay and professional knowledge, language and perceptions of health and illness. The terms 'disease' and 'illness' were crucial definitions in this part of the work: 'disease' defined diagnostic, medical and biological pathological classifications; 'illness', in contrast, defined the ill person's emotional and bodily sensations or subjective experiences, including the social recognition of illness.



## **Children's Social Position in the 'Health Care System'**

As outlined above the dominant mode of analysis in medical anthropology for the last decade or more has been Kleinman's cultural model of health systems. At the beginning of this study his model provided a useful (but ultimately limited) starting point from which to begin to think about children's position in actions and interaction during illness. In relation to Denmark, Kleinman's category of the 'professional sector' consists of both primary (for example, general practitioners) and secondary (for example, hospital based) health care. Each of these is firmly based on biomedicine. Since the 1980s, however, the health care scene has also seen a growing field of 'alternative' or 'complementary' medicine and practitioners, including a range of therapies stretching from chiropractic and reflexology through to faith healing. In some localities this 'folk sector' (as it is described in Kleinman's model) works alongside doctors and other health care staff but in others practitioners operate independently, with few or no links with biomedicine. In part this also depends on the type of alternative therapy with variations in the willingness of both biomedical and alternative practitioners to become involved with each other. Over the same period the 'popular sector', Kleinman's term for the great variety of health care which takes place in the home and community, has been a particular focus of concern and interest for health care professionals, social and health politics, and medical and social scientists (including medical anthropologists). When my study began the level of information and knowledge about popular sector self-care and lay agency in health and sickness was widely described in public and professional debates as revealing only the 'tip of an iceberg' (see above) acknowledging that by far the largest part of health care work

takes place outside the professional and folk sectors.

As this brief tour of Danish health care suggests, Kleinman's model was developed as a way of recognising the plurality of perspectives within a health system, countering the assumption that it can be characterised solely by its professional sector. Encounters, for example between a patient and a doctor, are then seen as representing contacts between different sectors of the health system, each with their own explanatory models about illness and therapy. This has the merit of treating the different sectors as (at least potentially) of equal importance but it is also rather too rigid and inflexible in the way it assigns people to different sectors. For example, it underestimates the circulation of biomedical information among lay people (especially those with a chronic condition who become experts in it, see Bury, 1991) and it downplays the extent to which in their work biomedical practitioners draw on lay understandings of disease (see Helman, 1978).

Nevertheless, it is a useful starting point for thinking about the position of children within health care. In the pluralistic Danish health care system (as in the rest of Europe and North America) adults are self-evidently seen to be located in all three sectors: as care givers of various kinds, for example as medical personnel, healers, or as lay people giving care in the family. Children, however, can only possibly be located in the popular sector because medical personnel and folk healers are, in Denmark, never children (2). In seeking to understand children's experiences and actions in health and illness, an examination of their role in the popular sector is thus very important.

However, even within the popular sector it is frequently assumed, as in the studies of family health that will be discussed below, that children do not do health care work and are only cared for. However, as will be shown in the following chapters of this thesis, children are involved in health care, usually alongside others (whether these are adults, like their parents, teachers or the staff of the after school centres, or other children). This active involvement can be in giving care to others (such as siblings, friends or in some cases parents) or in receiving care and attention from others. In this sense health care does not divide easily or neatly into givers and receivers but has to be seen as a co-production. This point has been made in relation to adult patients in hospital who have been characterised as 'unpaid health care workers', simultaneously consuming and producing health care (Stacey, 1988). Where children are concerned, however, the same point needs highlighting for their role in the popular sector.

However, a focus on children's participation in and contributions to child and family health care has also to take account of the dynamics of the health care system as a whole. By using a 'vertical' view alongside the 'horizontal' (Nader, 1981), as noted above and outlined in Chapter 1, it becomes possible to appreciate the complex relationship between children and the formal and informal hierarchies that influence their lives. In doing so I suggest that the hierarchical relationships of biomedicine can be seen as reaching into the family (see especially Chapters 4, 5, 7 and 8). Children's position within these formal hierarchies is constrained and dependent because children's status is constituted as inferior to adults in general and by health professionals in particular. This point is implicit in studies of children in clinics (see, for example, Strong, 1979; Davis, 1982) which, through

careful observation, reveal the processes by which children became muted actors in clinical consultations. Whilst doctors and parents specifically encouraged the enrolment and collaboration of babies and infants in clinical examinations, in relation to older children, who might well be expected to have gained more competence, adults would paradoxically seek to constrain the active and independent participation of the child. Similar evidence of the dependent and constrained position of children in relation to parents and professionals in medical encounters is shown in studies by Silverman (1987) and Aronsson (1991).

Children's location (according to Kleinman's model) in the popular sector of health care suggests, therefore, that in studying children and illness it has to be acknowledged that children's lives are, in important ways, determined and/or constrained by adult organisations and adult control. Thus, children appear as doubly constrained in health care. Because children do not obtain any professional status they become inferior to both adult and professional knowledge, control and power. An examination of the complexities of these relationships must include the acknowledgement of the formal and informal hierarchies that influence children's everyday lives. A vertical perspective on the health care system may, for example, suggest that children are constrained and dependent. However, taking a horizontal view can substantiate the nature of these relations and reveal how children in different social interactions may be able to negotiate and alter social positions and relationships during sickness.

## Critical Medical Anthropology: Sickness as a Cultural Performance

Kleinman's work on the complexities of medical systems was driven by an interest in applying theoretical conceptions to medical and psychiatric practice. In the following years it sparked off a range of developments but, at the same time, provoked some important critiques. Most sharply, Kleinman's approach was criticised from within medical anthropology for its inclination towards an exclusive micro-processual perspective and its lack of attention to the broader socio-economic structures of health care. Pioneers such as Frankenberg (1980) and Young (1982) argued that the distinction disease/illness maintained a preference for focusing on the perspective of individuals (for example, in examining their different explanatory models of illness). This meant that studies concentrated on the individual conceptual and perceptual aspects of ill health. In effect, they argued, this emphasised the psychological, including emotional, aspects of illness at the expense of the social relational ones (Young 1982). They insisted that, through this focus, the relationship between illness experience and wider social, cultural, ideological, political and economic processes was largely excluded.

Their suggestion was to include a third distinction that they termed 'sickness'. This analytically located both disease and illness in their wider social and cultural context (Frankenberg, 1980, 1986; Young, 1982). Sickness defines the transformative and distributive processes through which different worrisome biological signs or emotional and behavioural changes get a socially recognisable meaning, one which constitutes them as 'symptoms' and 'sickness' in a culture (3). It thus provides a framework for studying and understanding what medical anthropologists had long noted: that categories of sickness

vary between societies and cultures; and the same society or culture might manifest many and shifting sets of meaning and practice around specific diseases. These processes are understood as performative: discursive, expressed through bodily and verbal action and interaction and found in thought and affect. Shifting distributions in performance can then be understood in relation to social divisions and historical processes. For example, Farmer (1992) demonstrates shifting productions and distributions of 'AIDS' in a Haitian village and their relationship to social, cultural, economic and political interests and Nichter (1987) has made a similar analysis of South Indian epidemics of Kyasanur Forest Disease.

Sickness as a cultural performance, which is a central concept to this thesis, expresses theoretically the ways in which ill-health is socially and culturally performed (Frankenberg, 1988:16). This allows for Goffman's thesis, that all social interactions in everyday life can be usefully theorised as staged and performed (1959; 1968) but more directly it derives from Victor Turner's early work on the Ndembu cults of affliction. Turner (1968, 1974) suggested that sickness might be seen as a social drama, which expresses wider social conflicts and contradictions. Through ritual performance the afflicted person is freed from their sickness by dramatic enactments which locate sickness (as analytically distinct from 'illness' and 'disease') within a social and cultural context. Although recognising, as did Turner, that contemporary industrial societies are far less rich in such condensing rituals, Frankenberg, nevertheless, suggests that medical anthropologists should look beyond the dyadic interactions (for example of doctors and patients) and investigate '...a possible systematic correlation between economy, polity and ideology, and performance in social encounters' (Frankenberg, 1986: 613) (4).

Using the notion of sickness as a cultural performance implies a focus on the interpretive processes through which child illness is conceptualised and practised by the actors involved, as well as attention to the wider social and cultural context which shapes and influences them. I will show that this entails looking at childhood sickness as a broad social and cultural event. Understanding it in this way involves an enquiry into a wide range of phenomena that can be seen as entangled in its constitution. These include cultural representations of children; the different social positions that children and adults (parents, teachers and after school staff) occupy; the different experiences and perspectives they have on illness; and the social and economic pressures on contemporary Danish families.

### **Children and Childhood in Social Studies of Health and Medicine**

Until recently studies of children and illness have left an understanding of the child as a social person with their own experiences, perceptions and actions in the social and cultural world more or less unaddressed. Anthropological studies of childhood health and illness are rare (5) but an examination of the psychological and sociological literature on children and illness shows that it has, until recently, reflected such the dominant developmental and socialisation approaches discussed in Chapter 1. The intention here is not to provide an exhaustive review of the literature, but to point to some of the problems and advances in the field by highlighting key examples and illustrations from this body of research.

My first observation is that throughout the literature as a whole, there is a clear preoccupation with identifying the factors important in the health socialisation of children and in children's internalisation of approved health beliefs and behaviours. In part this emphasis on future outcomes reflects the dominance of socialisation as a key concept in research about children but it is also consistent with the aims of child health policy. For example, a government report on child health services in England and Wales was entitled 'Fit for the Future'. It explained the importance of child health in the following way:

'It is development, with the potential for improvement and susceptibility to damage, that makes childhood such a special period of life.' (HMSO, 1976)

The purpose of research has largely been to identify the most important influences in children's social environment in order to predict and shape their future health behaviour as adults (see, for example, Bush and Iannotti, 1985, 1988, 1990). This clearly places an emphasis on children's lives as having importance through the implications for their adult futures (see Chapter 1). Children have thus been one of the targets for intervening to promote and to improve the population's health status as a whole. Within the field of health policy and health promotion, children's health has been linked to their exposure to different health risks. The focus has, therefore, been on efforts to change the behavioural patterns in families (traditionally directed at the mother, assumed to be the key person in determining child health behaviour and beliefs), and in limiting negative influences, for example by censoring advertisements. In Denmark, for example, this is manifest in the prohibition of adverts for cigarettes on national television and rules specifying that children



cannot figure in adverts for any products that are not exclusively aimed at children. Research on childhood health and illness in this mould is largely based on quantitative survey material (in the Danish literature see, for example: Langsted and Sommer, 1988; Uldal, 1986; Holstein and Ito, 1987; Madsen et al, 1991). Generally the analysis of such studies includes some measurable assessment and observations of children's health and identifies external factors and conditions of children's lives that, it may be suggested, are determinant of their wellbeing.

Second, it can be noted that research has traditionally focused on adults' perspectives, for example by gathering data about children's health through the accounts of mothers and health professionals. Such studies rarely include children's own views and perspectives. In the cases where children have been included in surveys, the interpretation of the data has often borrowed directly from developmental psychology, in particular from Piagetian notions of cognitive stage. Children's accounts have been interpreted as products of their stage of cognitive development and researchers have framed their findings in terms of 'stages of thinking about health'. These stages are derived from and matched with the concrete formal operational stages of child cognitive development (Bibace and Walsh, 1979; Palmer and Lewin, 1975; Steward and Regabulto, 1975; Gellert 1962; Nagy, 1953). This is done by the post hoc categorisation or sorting of children's replies into these stages, which they are then claimed to instantiate. These studies must generally be considered methodologically weak. Apart from the obvious problems of reliability and validity involved in the post hoc categorisation mentioned above (see also Burbach and Peterson, 1986), the researchers tend to take Piagetian stages as taken-for-granted. Often

working before the publication of the powerful critiques of Piagetian clinical and experimental procedures and assumptions, such as those of Donaldson (1978) and Light (1986), the researchers see the stages as an unvarying and rigid sequence that operates independently of any social or cultural context. In consequence they do not usually consider alternative interpretations of the children's words. When this is done, for example by Bibace and Walsh (1979), the result tends to undermine the Piagetian interpretation. Their more sophisticated approach compares children's replies with those of adults, aiming to demonstrate what the researchers thought would be a marked difference between the cognitive stage of development in adults and in children. One of their findings is that both children and adults frequently make statements about sickness, which in Piagetian terms are 'magical' in their cognitive base. However, this finding raises the possibility, conceded by the authors, that children's replies might, like their adult counterparts, express broader culturally based ideas about illness rather than stages of cognitive development. Whilst these studies have a strength in that they collected and attended to children's own perceptions and accounts, they did so in a manner that excluded the social and cultural context of children's understandings.

Another group of more sociologically inclined studies has attempted to link the influence of children's immediate social environment with children's knowledge and understanding of health and illness. Whilst escaping the conventions and restrictions of the Piagetian model and paying attention to children's social environment, these studies see children as more or less passive products of the socialisation processes. Some studies set out to establish a relationship between children's understandings and different putative independent variables

such as age, gender and aspects of parental status such as education, occupation and socio-economic class. An early example was conducted by the medical sociologist David Mechanic (1964). He focuses particularly on psychosocial variables such as maternal personality and values but fails to find a relationship between maternal psychological characteristics and specific child health attitudes. This finding is broadly supported by Campbell (1975,1978). In these studies he interviewed a sample of children about their health attitudes and beliefs and attempted to link these to mothers' accounts of their child's social life, their child rearing practices, the child's health status and history and socio-demographic data. The study relied on closed questionnaires and attitude inventories, which already methodologically constrained the data and analysis. The outcome of these studies is largely disappointing. The statistical verification of significant links between children's attitudes to health and the different independent variables remains, on the whole, elusive. No statistically significant link between children's attitudes to illness and either their current health status or their health history is found, although there is an association between the level of a mother's education and some aspects of children's views about sickness. In a second study Campbell (1978) attempted a more sophisticated analysis of the possible pathways between children and their social environment as a means of understanding the factors that influence children's health beliefs. He suggests, for example, that a 'developmental' style of parental child-rearing practice, in contrast to an 'authoritarian' one, results in children taking up more approved preventive health behaviours. Although this second study is more suggestive than the first, it did not develop understanding much beyond Mechanic's conclusion, expressed over a decade earlier, that:

...one of the most interesting impressions this study yields is that the child has considerable resources to resist the influence of particular persons within his environment...The view of the malleable, fragile child is one that has great popularity; but the child is probably neither as malleable or as fragile as current psychological theory sees him. (Mechanic, 1964: 453)

Rather than showing any substantive links between children's beliefs and their social environment these studies demonstrate the necessity of a different theoretical and methodological orientation. The theoretical assumption that needs amendment is the one discussed in Chapter 1: rather than being passively socialised, children are individually and collectively active in the formation of their views and in their engagement with a complex social world that includes, but is much more extensive than, their immediate family. Methodologically, this requires a much more fine grained view of children's lives than is usually obtainable through survey questionnaires and to which the ethnographic methods discussed in Chapter 3 are better suited.

Parallels with the neglect of children's perspectives and actions found in child health research can also be seen in the wider literature on family health. This body of work has long emphasised the role of mothers as the main health care provider in families (Graham, 1984; Stacey, 1988). As well as generally neglecting fathers' roles in family health and illness, the child's role in self-care, and as a health care provider for family members, remains largely unexplored. A few studies, however, have stressed that the emphasis put on women as main health care providers conceals the interactive character of family health

work. This necessarily includes the perspectives of both men and children (e.g. Prout, 1988; Backett, 1990).

The few studies that have closely examined children's involvement reveal that children develop their own ideas and strategies of (inter)actions in relation to health and illness in different social contexts such as those in the family, at school and in hospital. This ethnographic work specifically investigating children's agency in illness confirms that children can no longer be comprehended as passive recipients but must be understood as active participants in illness. Two studies that were published before my fieldwork began looked at children's relationships with parents and health professionals in hospital (Bluebond-Langner, 1978) and children's everyday social negotiations of sickness with mothers and teachers (Prout, 1988). Prout's study of school sickness absence in a small community in England shows how children, although not having any formal power in decision-making about illness had, nonetheless, an important influence through informal interaction. Children could make persistent claims on illness, including feigning symptoms and, conversely, disguising symptoms in order to continue with a favoured activity. Bluebond-Langner's (1978) study of leukemic children in hospital addressed the different sources that children use in making sense of their illness. This study made evident how children involved each other in conceptualising their illness and how they read clues from the pharmaceuticals that they were prescribed, from adults' behaviour towards them and from the treatments they received in order to make sense of their illness. They then exchanged and discussed this information with their peers in the hospital ward.

Two further studies were published during and after my fieldwork. James's (1993) study of younger children's perception of and constitution of 'significant difference' (including bodily difference arising from illness) embeds the understanding of childhood 'illness' and 'difference' in a larger field of children's perceptions, cultural practices and social relations with peers and friends. Mayall (1996) makes a comparison of children's experiences at home and at school. This covers a wide range of aspects relating to children's everyday experiences and health practices, especially children's interactions with mothers and school staff. She argues that children's health cannot be seen as taking place, or belonging to, specific domains but has to be seen as crosscutting the different sites of children's everyday lives. The school and the home mutually constitute the main emotional and social context of children's health experiences. Mayall explores children's different scope for agency in each of these settings, arguing that this is greater in the home than it is in school. Although she recognises children's efforts to make and shape their lives, this is tempered by her emphasis on their 'powerless' position. Thus, her sociological work is combined with a feminist political agenda in which children as well as women are seen as fundamentally lacking power in a male dominated society. Children's greater scope for agency in the home is seen as a result of women's close involvement in child care, their closer attunement to children's individual personalities and emotional well-being.

Each of these studies investigates children's specific contributions to and negotiations of health and sickness in different contexts of their everyday life. My study follows on from these pioneering North American and English studies by looking at the cultural

performance of childhood sickness in a Danish setting by focusing on children's constitution of help, and their interactions and social relations during sickness and minor accidents in the family, school and after school centre.

## **Conclusion**

In this chapter I have set out the medical anthropological background to my study. I have done this by outlining the development of medical anthropology away from its origin as an applied sub-field dependent on biomedicine towards a position in which it shares the central concerns of the discipline and applies them to health and illness. There were two key developments in this process. The first, associated with the work of Kleinman, distinguished between 'disease' and 'illness'. By focusing on the subjective experience and (inter)actions of the patient the notion of 'illness' defined an area separate from biomedicine's concern with disease process. It thus created a distinctive subject matter. At the same time Kleinman's cultural model of health systems pointed to the popular sector (rather than the professional or folk ones) as the one in which most health and illness actions take place. Although somewhat crude, this model was also useful in highlighting the importance of the popular sector as the one in which children are, in Danish society, present as health actors. As such children are also doubly constrained, both by the hierarchies of the professional sector and by their inferior status as children.

The second key development was the critical reaction to Kleinman's ideas from within medical anthropology. This argued that Kleinman's approach placed too much emphasis

on the local interactions between healers and patients and neglected the wider social, economic, ideological and political context. This critique resulted in a further distinction that specified 'illness' as the individual experience of disease and 'sickness' as the effort to understand experiences of illness, and the interactions around it, in terms of the social relations into which they were inserted. This perspective, like Nader's injunction to ethnographers to trace both the 'vertical' and 'horizontal' aspects of children's lives, opens up the way, therefore, for a study of children's health and illness in the popular sector. By using a cultural performance approach, this is now able to take account of the ways in which children experience illness, the interactions between them and the adults involved and the wider processes through which children are socially positioned and culturally represented.

An examination of the social science literature on children and illness shows that, until recently, it has drawn heavily on the concepts of childhood discussed and critiqued in Chapter 1. Drawing on contemporary ideas from the sociology and anthropology of childhood, I have argued that the notions of socialisation and development displace children's present lives and their coequality with adults by projecting their importance forward into their future as adults. In discussions of health and illness this means that children are seen primarily in terms of being 'fit for the future'. Reflecting the wider representation of children as incompetent and vulnerable, and therefore suggesting and reinforcing the notion that children are incapable of contributing to their own care, it simultaneously constitutes adults as the competent and powerful carers.



The first and second chapters of this thesis have set out, then, the theoretical background to my work. By combining insights from the anthropology and sociology of children with critical medical anthropology, I have defined the aim of my ethnography as being to investigate the cultural performance of childhood sickness in a specific Danish setting.

Whilst studying for my Magister in Anthropology I had specialised in medical anthropology, where increasing concerns had been with the importance of people's selfcare actions. Although these centered on the family and household setting as a whole it was apparent that studies took for granted their main focus as being on adult members and, in particular, mothers. It was apparent therefore that children were absent from such discussions. Children were included in many studies but they were only seen at the receiving end of adult care and guardianship. This was the initial impetus for this study. Later, in spring 1991 I was invited to participate in meetings as consultant for a European study about younger children's use of medicines. This study had as its starting point the omission of children's understandings of the use of pharmaceuticals in much earlier research. In my own study I wished to balance these more medically informed perspectives by my concern to treat children as social actors. My point of departure became, therefore, a focus on child health that could expose children's active involvement in health care at home and at school, that is through adopting a much broader perspective on children's help and care of others in everyday life. I focused, in particular, on three kinds of everyday episodes: minor illnesses, accidents and conflicts among children. These events would, I expected, involve children in giving help, or refraining from doing so, and provided me,

methodologically and analytically, with a sharp focus when exploring the flow of children's everyday life in the family, school and afterschool centres.

Thus in this thesis I intend to examine the relationships between how childhood illness is experienced and enacted, including the different perspectives of adults and children, and the wider social and cultural context. Its foreshadowed themes are those identified in the discussion so far: the fragmentation and institutionalisation of children's everyday lives in Danish society; close attention to children's actual role in health actions and care-giving; and the representation of children as vulnerable and incompetent. These themes will be taken up in the substantive chapters.

Within this framework I have placed particular emphasis on the importance of understanding children's experiences and actions. Ethnographic methods appear particularly useful for the study of children and childhood: they give children a more direct voice and part in data production than is usually possible in experimental studies or surveys (e.g. Alanen, 1988; James and Prout, 1990). However, involving children as informants, and paying attention to their actions and perspectives, also challenges ethnography by posing new methodological and analytical demands. Ethnographic studies of children thus further not only our understandings of children's perceptions, actions and social relations but also potentially advance our understanding of the interplay of different actors perspectives on culture in general. It is to the methodological challenges of studying children ethnographically that I turn in the next chapter.

## Notes

1. In Denmark during the 1980s medical anthropological research became strongly influenced by Kleinman's work and at the same time there was an increased sensitivity to these questions among medical practitioners. The studies undertaken at this time focused primarily on the dyadic relationships between therapist and patient and between the lay and professional sectors.

2. The exclusion of children from the practice of healing is not universal. Reynolds (1996) shows that in Zimbabwe children generally have an extensive knowledge of the cosmologies, techniques and materia medica of traditional healers. In addition some are chosen as acolytes and assistants to the healers. In this process a few children are seen to reveal their calling, that is to say that they have already been selected for possession by a healing spirit. It is through the movement of healing spirits from person to person that healers are made. Training builds on but does not replace this basic requirement.

3. In the thesis I use 'illness' as a general term for ill-health but I employ 'sickness' as an analytical concept in the sense suggested by Frankenberg and Young.

4. Frankenberg and Young's central point that a focus on doctor/healer-patient interactions neglected the broader social, economic and political context was widely

debated in medical anthropology, see, for example, Johnson and Sargent (1990). Their call for a broader approach is at the core of the highly influential paper by Scheper-Hughes and Lock (1987) that sets out a 'critical-interpretive' approach. This argues that all knowledge of the body, illness and health is a cultural product undergoing constant negotiation within a socio-economic setting.

5. Beyond the ones noted in this chapter (Prout, 1988, Bluebond-Langner, 1978 and James, 1993, and, though much more sociological, Mayall, 1996), one can also mention Scheper-Hughes (1987), although this is more concerned with young infants and their care than with children as actors in health. Reynolds (1996) (see also Note 2) is also pertinent to my work. She discusses the ways that children share 'a general knowledge of the community's ideas about possession, vulnerability, inheritance and other matters' (1996: 114). This she, suggests, is not a matter of children simply repeating adult formulas but showed that they had reflected on these in relation to their own experiences. Reynolds takes a similar approach to me in at least two ways. First, she emphasises children's own views and perceptions and, second, she shows how children's experiences were partly shaped by the ways the healers with whom they worked conceptualised children. I have not included discussion of her work in the main body of the text partly because it discusses a cultural context, the Zezuru people of Zimbabwe, very different from Denmark and partly because I obtained her book only in the latter stages of writing up my own material.

## Chapter 3

### THE ETHNOGRAPHIC STUDY OF CHILDREN

#### Introduction

In the ethnography, on which this thesis is based, children's experiences and actions form its main core. My fieldwork shows that recent developments in methodology, which stress that data are the product of 'dialogues', that is interactive processes between ethnographer and informants (Gudeman and Rivera, 1990; Poole, 1994; Tedlock, 1979; Tedlock and Mannheim, 1995), are especially important in working with children. The fieldwork engagements between the children, adults and myself in a local area of Copenhagen (Vanløse) over three years in the early 1990's had this dialogical character. Indeed, as my work took place, it became increasingly clear to me that research with children becomes most productive when they are approached as partners in a dialogue. This applies not only to methods and data but also to interpretation and analysis which, rather than forming distinctive parts of the research process, are in practice overlapping elements of it (Grillo and Rew, 1985). In this chapter I address these themes through an account of the methodological context of the study. This includes a brief description of the field site and study design and goes on to highlight some particular points relating to working with children and my role in the field.

When I initiated the research in 1991 it was a rarity in ethnographic work to let children's experiences and practices form the main core of the study (Hardman, 1973; Van der

Geest, 1995). Therefore my focus in this chapter is primarily on methodological topics that highlight explorative and innovative aspects of the study. In this way I will avoid repeating well known methodological discussions, concentrating instead on what was special to my work. For this reason some of the basic information about my fieldwork (for example, numbers of interviews) is confined to notes at the end of the chapter. The last section in particular discusses some issues of more general importance for ethnographic work that aims at giving children a more central position in anthropology. Later chapters of this thesis will also consider methodological issues in the description of particular observations and events and thus the discussion, in this chapter, is intended to provide a platform from which these incidents can be understood.

### **The Fieldwork Site**

The study was conducted in Vanløse, a local district of Copenhagen, Denmark. Vanløse covers a good five square kilometres and has a population of 36,000 people (Copenhagen Statistics, 1992). Of these 3.5 %, or about 1300 persons, are migrants to Denmark, mostly from the EEC and other Scandinavian countries, with relatively fewer from other parts of Europe, Turkey and Southeast Asia. This is rather lower than for Copenhagen as a whole, where the total proportion of residents from other countries is about 8%. Generally speaking, Vanløse is considered to be 'middle class': parents are skilled workers, teachers, nurses, clerical workers, small businessmen and professionals like doctors, lawyers and architects. Few parents are unemployed or receive social security.

My knowledge of Vanløse is as a participant as well as an observer. When I began my

fourteen months ethnographic study among some younger school children, their families, school and after-school centres, I had lived in Vanløse for about twelve years. I was well acquainted with the institutions as a parent; my then seven year old son attended a school and after school centre in the area. Many of my own friends and neighbours had children who also attended these institutions. I have lived all my life in Copenhagen, where I was born and brought up (1).

In autumn 1991 I made contact with one of the local state schools that I will call 'Egeskoven'. This school is situated in a residential area with no heavy traffic. It is close to the local shopping centre, 'the heart' of Vanløse, and near to the railway station and buses. Four schools cover the same local district from which Egeskoven recruits the children. Like others in the Danish school system it gives children 10 years of basic level education. Unlike Britain, children in Denmark attend the same school throughout this time, usually keeping the same form teacher. As they move through the different age grades this teacher continues with them, although they also receive more and more specialist teaching. At the time of the study, Egeskoven had 439 pupils ranging from pre-school classes (five to six-year-olds) to 10th grade (sixteen to seventeen-year-olds) and through it I made contact with children, their families and two after-school centres.

In Copenhagen most after-school centres are now linked to a specific local school (2). In 1988 two such after-school centres were linked to Egeskoven one of which is situated on the school site sharing outside facilities: playgrounds and playing fields. The other centre is situated approx. 300 meters from the school. As in other parts of Denmark, children can attend the centre from when the school finishes (between 12 and 2 p.m. depending on

the age) until the centre closes at about 6pm. The centres are not another form of school but, rather, aim to provide a variety of leisure and recreational activities, which contrast with schoolwork. This means, for example, that the children were not usually allowed to do homework there, even though the children sometimes wanted to do so, especially if working together collectively would help them. The centres are staffed by adults of different kinds: the majority, referred to in Denmark as 'paedagoger', have over three years of professional education; they are assisted by a number of unqualified staff, and in addition there may be others such as unemployed people on temporary work and students training to be paedagogs. In this thesis I will refer to all of these as 'after-school staff'.

During the first three months I had several meetings with the teachers at Egeskoven, staff at the after-school centres and parents to discuss the practical issues, ideas and the conceptual basis of the study. These discussions allowed me to explore early hypotheses and I came to appreciate their suggestions, critical comments, doubts and experiences. During this time I also spent some weeks doing pilot 'drawing-interviews' with six or seven-year-old and ten or eleven-year-old children and their families from two school classes at the school. During the following two years I conducted eleven months ethnographic fieldwork in the school and after-school centres. The field study was thus carried out among children in different situations and contexts but covered the main institutional contexts of their everyday life.

In the first period of fieldwork, seven months in 1992, I participated in the daily school-life of a class of 1st graders, who were six to seven years old, and a class of 4th graders, who were ten to eleven years old. I attended the lessons at school together with the



children, observed classroom interactions and activities, and participated in manual work tasks in art or music and, occasionally, in specific projects conducted by the children. When the school finished, after lunch for the youngest children and in the early afternoon for the oldest children, I went with a group of children to one of the two after-school centres connected to the school. Each after-school centre was divided into two departments. One department was intended for children aged five to nine years old and one department for children aged ten to fourteen years old. During the vacations I spent all day in the centres and participated in four of the one-week summer camps arranged for each age group. In 1993 and 1994 I returned during the vacations for shorter fieldwork periods.

The methodology consisted of general anthropological fieldwork methods: ethnographic interviews and participant observation supplemented with more purposeful data production. With regard to children these included drawings, essays, dramatised plays and peer group discussions. These task-oriented methods resonated with school and other activities, which most children were familiar with, and they therefore happily joined in. Such methods provided a concrete focus for their engagement and at the same time also made it possible to explore a particular subject from different angles. My fieldwork was, therefore, not confined to verbal accounts requiring conversational skills but instead enabled children to use a diversity of means to express themselves in the communication between us.

## The Study Design

At first I explored children's sickness episodes in the family by doing two interviews with the parents and children. I was interested in examining children's and parents' perceptions of health and illness, with a particular focus on therapeutic actions and self-care in childhood sickness. This included investigating children's active role in health care and the social interactional aspects of sickness episodes in the family. This part of the study was necessarily based on interviews and, although extensive material was produced with the families, I have never doubted that it was the in-depth fieldwork that followed which eventually provided a broad understanding and context also of this initial data. I interviewed children at school and at home. I also spoke to parents. In a few cases I interviewed both parents at the same time (sometimes the whole family would be present) but in most cases I would talk with either the mother or the father, depending on their preference. Before the second interview I had asked parents to keep a diary on their children's health, sickness and family care for two weeks. Since the diary in all families was kept by the mother, I usually only talked with her during my second visit. From the interviews I also gained some socio-demographic data on the families and the local area. All interviews were audio recorded and transcribed (3).

After this initial fieldwork I kept contact with the families, while developing my relationships with the children through our daily contacts at school and after school centres. My contacts with parents settled into a more casual pattern, which meant that I only occasionally had more intensive contacts with a parent and for shorter periods: we met at parents' evenings or social events at the school and after-school centres; we chatted

when we met in the streets, at home or when parents came to the institutions. However, at this point of the study, the main aim was an ethnography of children's everyday sickness and minor accidents at school and after school centres in the context of their everyday life. Thus the focus of the study was shifted from a particular child and their family towards groups of children, child-adult interactions and to the particular representations of the dyadic and triadic relationships of child-family-institution. Data from the families were now supplemented with interviews with teachers and health personnel at school and members of the staff in the two centres. We talked about general topics such as the school/institution and the local community, about professionals' work with children and families and had more specific conversations about their experiences and practises during children's every day sickness episodes and minor accidents. In addition to data produced during my observations and participation in everyday interactions, the school nurse kept a diary of her consultations with children over a three month period and the staff in one after-school centre kept a diary of children's sickness episodes and accidents during a summer camp, which I did not attend.

### **Children's Consent to the Research**

I was particularly concerned that children were asked for their consent to participate in the study (for a discussion of some of the issues involved see Morrow and Richards, 1996). It is often assumed by researchers that children's consent is given by their parents. However, although I sought and received parental consent, I did not feel that in itself this was satisfactory. My main informants were to be the children themselves. Not only would it be respectful to gain their consent but also I was interested to in their active participation

in the work. I therefore spent a lot of time explaining the research to them, answering their questions and discussing it with them. During my first visit at the school I told the first and fourth graders about the study and discussed the general aims of the project. Before each interview I would then once more explain about their anonymity and they were invited to decide whether they wanted to participate or not. Whilst most children agreed to take part, a few did not or expressed reservations. For example, Frank, a six-year-old boy with whom I usually had good contact with at school, decided not to participate in the second drawing interview to be conducted in his home.

It was also Frank, who during the first interview at school expressed the most insecurity and shyness about being interviewed. He articulated concerns about the presence of the tape recorder that I had noticed more generally among some of the youngest children. We had talked for a while when Frank suddenly said: 'It looks like a monster'. I was puzzled and asked 'What? Which one?' He pointed to the Walkman-size tape recorder between us. As many children were in fact very concerned with the fact that the tape recorder was 'turned on' (and therefore recording) I began routinely to let them familiarise themselves with the tape recorder. They could test the tape recorder, touch or examine it and I would record a short conversation with them that they listened to individually on the headphones before we started the actual interview. The children also frequently asked to hear the recording of the interview, listening to it alone or with a friend. A couple of children, whom I had known for some time, would sometimes attempt to shift the roles of interviewer and interviewee by simply taking the tape recorder and beginning to ask me different questions.

A central feature of the research process was the ongoing formal and informal discussions of my 'findings' with children, parents and professionals. I initiated and encouraged this throughout the study in order to accomplish a continually reflexive and systematic comparative analysis (Glaser and Strauss, 1967). The importance of this method lies not only in its centrality to the specific research design but in the viability of the method in relation to children. Many educational researchers working with adults feel an obligation to discuss their data and interpretations with those involved as, for example, teachers taking part in classroom research (see Pollard, 1987), but children have not usually been considered as discussants when researchers wished to rehearse or reflect on data with their informants. Today, however I believe it is of inescapable importance in developing an anthropology of children (see also Alderson, 1993, 1997; Johnson et al, 1995).

### **Researching Children**

The first few months of the study gave me important insights into child-adult research relations. From the beginning I knew that it was important as a researcher to establish relationships within which children felt they wanted to participate throughout the research process. For example, an underlying notion when conducting the more formal interviews was to facilitate a continuing dialogue over which children had control and which would allow them independence in our conversations. Children could introduce their own themes and conclude an interview on their own terms. Thus when first I interviewed six to ten-year-old children at school our conversations were relatively short and set around a specific topic or task. The children, in groups of two to five, were asked to make a drawing of 'the last time you were ill' and then they were interviewed individually (except

for two ten-year-old girls who wished to be interviewed together). Each interview took about 15-20 minutes with the youngest children and 30-45 minutes with the oldest children. Each child decided when their drawing was finished and the interview would stop when the child wanted it to, although sometimes I eventually suggested that we finish because I felt they were beginning to feel 'fed up' or tired.

Among the group of children the task of doing the drawing would immediately spark off discussions and comments from them. During this they often did not take much notice of my presence but seemed, nonetheless, quite comfortable with me there. Some children started to tell about an illness episode, which was supplemented by other children with similar experiences or descriptions of an incident from a television programme. They would copy, discuss and criticise each other's drawings. However, although the drawings had clearly engaged the children and were a useful starting point for a conversation, most children were shy and spoke with a low voice during the individual interviews that followed. This was in a remarkable contrast to the liveliness and spontaneity I had previously experienced in the group. However, none of the children commented on this difference and only later did I come to understand its significance as a sign of hesitation about taking part (see below). During the second interview in the children's own homes they were generally more talkative, expressive and relaxed and would show me their toys and rooms.

It was only in later interactions with children, when they knew and trusted me, that I learned that not only had their initial discomforts been because I was a stranger and an adult but also, as they now confided, because they thought the subject of my questions

were sometimes 'peculiar', 'rubbish' or simply 'boring'. I was, therefore, presented with the problem of how to understand children's puzzled, though not altogether disengaged, responses to my interest in their experiences of health and the everyday management of illness. On reflection, both in the spontaneous group discussions sparked off among the children while making the drawings and in the conversations I had with them individually afterwards, it became obvious to me that the children's openness and engagement had been conditioned by their shyness and occasional mild disapproval of the subjects we talked about. Whilst I was able to carry out the interviews because of the children's co-operative and accepting manner, this experience was an important point at which I began to reflect seriously on the considerations to be taken into account when researching children's perspectives.

In part this was also because it was made evident, during these interviews, that the various observations and ideas that the teachers and the school nurse had shared with me during our first conversations were not reflected in the interviews with the children. The adults, for example, talked about the patterns and strategies of help that they experienced among children when relating to each other in the occurrence of illness or a minor accident at school. However, my attempts to relate these questions to the children, in order to evoke their reflections, proved more or less unsuccessful. This only became possible when I had done some direct observations of the children's interactions, had informal conversations with them and then reflected on the insights thus gained as a basis for further discussions with the children. In this way the interviews alerted me to the very constraints of relying on narrow communicative means in research and, in this particular instance, on verbal communication when conducting research with children. I had shared with them the sense

of polite uneasiness and distance that coloured our first encounters and I became determined to conduct a 'proper' ethnography. I came to see that this more patient approach would allow me an in-depth understanding of their experiences and practices around health and illness and help me to place these in their broader social and cultural context.

The second phase of the work came to reveal another set of related questions. A few weeks after I had begun the fieldwork at school among the fourth graders (the ten and eleven year old children), the children responded to my questions with a straightforward rejection of my agenda: they refused to 'stick' to it. During that period I was engaged in understanding the social and geographical environment of the school which, in the beginning, seemed confusing and inaccessible. For me, this included some very simple and practical questions such as finding my way around the school or knowing where to go next when a lesson finished. It also concerned understanding the rhythms, schedules and routines of children's school day; for example the differentiation between school time and free time when children were in the school's playground. Admittedly, I was, first and foremost, concerned with the process of 'my' research for, although I also wanted to fit in at school and get to know the children, my approach was mainly self-directed.

These attempts at understanding often involved asking the children questions. By the end of the second week these received a very clear-cut response. One day, returning to the school with the fourth graders after a trip to the Danish Aquarium in Charlottenlund, a group of the girls spontaneously dashed away from me when I attempted to walk with them through the school gates. This incident was quickly followed by some of the other



In the course of the fieldwork I developed my ability to 'listen attentively' to children both during our conversations and their conversations with each other. That I choose to make this point may seem perhaps both crude and somehow naive. However, it was crucial to the way my relationships with the children developed and formed in the study. In the interactions of a crowd of children it is often difficult not to be distracted and, therefore, while listening to half a sentence from one child not to respond to the interruption of another and to continue to listen to his or her point instead. This can actually be seen not only as a common 'bad habit' of adults when dealing with children but it also relates to the way in which adults may not necessarily themselves be deeply occupied with the kind of questions and issues that engage children. They will therefore allow themselves to be distracted and, especially in the case of professional adults working with children, often feel that they have to intervene or keep control. They do this by keeping an 'overview' of what is going on around them, even while they concentrate on their interaction with one child. It therefore became a challenge and an opportunity to 'relearn' or refine my skills in listening and looking with attention.

This also related very importantly to the way I explained and presented the intention of the study to the children. I started saying, for example: 'I am interested in how children live their everyday life. Its important for me to get a better understanding of what it means for children themselves. What you think and do!'. I tried, in this sort of way, to explain the emphasis I put on their own perspectives. To perform and demonstrate such an interest, in a way that was genuine and convincing for the children, meant that I engaged equally with what each of them wanted to tell and show me. In playtime at school I sat on the benches

at the fringe of the schoolyard and waited for the children to engage with me. These seats at the edge of the schoolyard were used by children as a place to fall down, out of breath, after running around the playground. In chasing games the seats acted as 'Helle' (literally 'refuge' or 'home'), a sacred ground where the children could seek safety and temporary respite. Some children also used to crawl around or stand up on the seats performing difficult balancing acts. It was also the area of the playground where the older children, in particular the girls, sat together in twos or in a small group talking, giggling or moaning to each other. They sat there during every break-time, engaged in performing complex finger-games or just sitting cuddled up, seeking each other's warmth during a cold winter's day. In this way I took on what was, in some respects, a more restricted but, because of my constant attentiveness, not a less passive role, although being less outgoing and active than my usual way of engaging with others, children or adults. I found this a valuable and successful way of working and conducted myself according to it throughout the study.

My own awareness and learning process about methods was, therefore, prompted by the children's explicit refusal to engage in the research. Underlying this was an ambiguity about me: I seemed to be an adult conducting myself like other adults and was therefore an 'outsider' in terms of their social relationships with each other. At the same time I seemed to want to engage with their lives in a way different from most adults (Fine, 1987; Mandell, 1991). In a way the children's reactions were calls for me to take a final side. Their mockery showed me very directly that I was not seen as part of their group. At the same time a 'choice' was made clear for me: I could decide to engage with the children from the position of an adult, calling on its status like the other adults they knew and thus, perhaps through the means of authority, engage the children; or, on the other hand, I

could invent a form of communication and interaction which resonated with their own practices and that, therefore, could be seen as acceptable by the children.

The lessons to be drawn were manifold. Most importantly, it reminded me that research questions are very rarely posed at the request of the subjects of our research. The questions were posed by me and were central to my interests and concern, not theirs. These first interactions sharpened my understanding leading me to make ideas and questions conceptually understandable for children and to ensure that our interactions took on a reciprocal form. I also realised, with a humility and gratitude that still remains, the way in which the children engaged with me, taking great effort to include me in their everyday lives, explaining their activities and relationships and even, as some children did, developing a sense of what I wanted to know. These children would, during the final stage of my fieldwork, be able to guess my questions and often began to answer them before they were spoken.

The theoretical implication that I draw from this underlines my earlier point about ethnography as a dialogical enterprise. One of the main features of my methodological approach was to attend to what I will here call the 'cultures of communication' that I encountered in the field. This approach replaced the idea of researchers developing and using particular methods for particular groups of people. Rather, my work emphasised the importance of seeing fieldwork as a practical engagement with local cultural practices of communication. Thus, by observing children's language use, their conceptual meanings and their actions, I pieced together a picture of the social interactions and the connections between people. Through getting to know about

different codes of conduct and communication, I myself learned how to behave and interact with and among children. This also enabled me to avoid ways of interacting with children and adults that were counterproductive. As described above, I learned what to do when joining in different activities and how to behave appropriately, for example when I had unknowingly overstepped conventional boundaries. At the same time, I was able to engage with the differences among children and adults and their understanding of my 'otherness' in relation to them. In this way I gained important clues about how people saw each other and how they perceived me. This included my appreciation of how different contexts, for example the school or the home, constitute a set of positions from which children and adults 'speak'. This also enabled me better to understand how I became integrated into their everyday lives. I suggest that my readiness to join in with and respect the communicative forms of children established reciprocity and, therefore, created a route for them to enter into a dialogue with my particular questions and ways of communicating.

### **Talking About Health with Children**

As described earlier the youngest children responded to my interest in their illnesses with puzzlement and as if illness belonged to the category of rather mundane and uninteresting events in everyday life. Among the older children I sometimes experienced resentment towards illness as a subject to talk about. These attitudes resonated with my observation that teachers and staff insistently reminded the children not to retreat into or dwell on times they did not feel well (see Chapter 5). They preferred that children should engage in their everyday activities with their friends. This perspective held by the adults

corresponded to some popular perceptions of illness in Denmark, which say that one should not invest too many thoughts on experiences of poor health because that will, in itself, influence one's sense of wellbeing negatively. In this respect illness is not seen as an appropriate topic for everyday conversations.

However, this observation also raises some important methodological questions for the study of children's health. The first is that the inherent power relation between researcher and researched in childhood research is reinforced by more general cultural notions of power and control between children and adults (Alderson, 1995; Mayall, 1995). This means that research based on one-off interviews with children, whether these be qualitative or quantitative methods and with or without the use of any task oriented tools, will be at risk of not providing the context for children to respond in concordance with their own views. This is so despite the fact that children may have given informed consent and are engaged in the research on this basis. For example, they may well agree to take part in the research because they are used to compliance being expected of them. However, in such research children may be left little scope for engaging in a critical way with the research questions and the research process. At the very outset, research with children requires sensitivity to the implicit relations of power and status of the research process.

It is worth reflecting on the kind of data that are likely to be produced through research that is more or less solely directed by the researcher's interests rather than the priorities and agendas of the respondents. This calls for a sincere consideration of whether the subject of the research makes sense to them and how it may be made to reflect their experiences and perceptions. Put another way, the problem is to ensure that research topics can be

placed in and understood in the broader context of their everyday life. In my research this meant that I had to be sensitive to how, for example, children's health and illness might be related to how children formed friendships and how this was reflected and performed during illness episodes or accidents.

Addressing the problem of children's reluctance to answer questions, Mauthner (1997) reports her experience that younger children aged five to six years old will either remain silent or answer 'I don't know' when interviewed on their own. This, she says, can also occur with older children when researching abstract notions such as 'poverty'. Therefore, she argues, it is necessary for the researcher to formulate their questions in such a way that they appear as experiences familiar to the children. She suggests that:

The 'draw and write technique' and structured techniques can be effectively integrated into group discussions and interviews in order to provide a focus for children especially where the research topic is abstract or not immediately salient in children's lives. (Mauthner, 1997:26)

Health and illness would seem to be similarly abstract to the youngest children as 'poverty'. My own experience of conducting research with children makes me agree with Mauthner on the usefulness of such methods in constituting a focus of attention and thus their usefulness as a mediating device in the communication. However, I do not agree with her implication that moving away from the abstract to the concrete in talking with children is without consequences for analysis and interpretation. It is my observation that,

if the researcher asks a concrete question, it is most likely that the respondents, if they have understood it, will answer it in a similarly concrete fashion. This creates a problem if the analysis then jumps from the concrete answers to the abstract concept. For example, Mauthner describes how, instead of asking children about 'poverty', a study on which she worked translated this concept into a number of more concrete tasks. She writes:

...a series of six photographs of different types of housing and (the researcher) asked each child to indicate which if any the child would want to live in and why. (Mauthner, 1997: 24).

However, I suggest, the answers that the children gave may not necessarily tell us what the children think about 'poverty' but rather about what kind of house they would like to live in.

To begin to understand the broader framework of children's thinking, the researcher would need to use a variety of methods (Geertz, 1975; 1983). Furthermore, to achieve a deeper understanding of children's perceptions, their accounts must be related to how children conceptualise, develop and apply their understandings of their social and cultural world. For example, it is important to consider whether or not they know about a particular sort of experience, to find out whether they call it something different, do not know what to call it and whether it is significant for them. I attempted such detailed investigation during my fieldwork. This led me into detailed questions and reflection on their sometimes puzzling replies to my questions and their seeming lack of knowledge. This persistence was rewarded and in parts of this thesis (see, for example, Chapter 5) I

base my analysis on an understanding of children's views that only emerged after much puzzlement and effort on my part. When I conducted my ethnography I felt it was necessary to investigate the topic of health from a variety of different angles, on different occasions and over a period of time. Sometimes I used and adopted some of children's own vocabulary and formulations to better understand their concepts and practices and in order to place these in the context of their everyday experiences and relationships. It is through such processes that the researcher can prevent him or herself from making analytical jumps in research with children (see also, Geertz, 1973/1993: 6-10).

### **Group Discussions**

I decided to conduct the interviews about illness, recovery and the role of pharmaceuticals and home remedies as peer group discussions. Whilst I was doing the fieldwork among the ten to eleven-year-olds, nineteen children (including the six children who did the drawing interview) participated in these discussions. One girl did not want to participate in an interview and one of the boys was off school sick. On the basis of the experience gained in conducting the drawing interviews I decided that the groups should not be larger than 4-5 children. The children themselves decided the composition of each group. They were most likely to form groups with their closest friends and in gender-separated groups. In the peer group discussions I first introduced the theme I wanted to investigate. Sometimes the children would begin to discuss the suitability of the subject with me and occasionally they might propose another angle to it. However, when their conversation finally took off, my role lay in creating an encouraging atmosphere, one that conveyed that 'all that is said is important to listen to and all is of equal value and interest'. The children quite 'naturally'



took on an interviewing role in these circumstances, asking each other questions about a particular subject or story and discussing the answers. In these situations my role was primarily to facilitate their conversation by guiding them towards particular subjects which I would like them to throw more light on or detail for me.

My role was also to ensure that each child's view was heard in the discussions. Sometimes it meant trying to shift the focus away from the most active or talkative child in a group to draw in a quieter child or one, whom I knew from everyday interactions, was somehow seen as marginal among the children. This does not mean, however, that I had any intention of changing their opinions or relationships. It simply eased my interactions with them by demonstrating my interest in hearing what they each had to say. In directing their contributions I used an indirect form which would secure the children's control of the process rather than attempting to discipline the discussions through 'keeping peace and quiet'. The dynamics of the group relied on the children wanting to know more about each other and they were deeply engaged in hearing each other's experiences and opinions. It also meant that I could participate in a somehow less invasive way during the conversations. The particular advantage of this method was the possibility of discussing the themes from a number of different perspectives provided by the children themselves instead of working with more specific questions. The subjects were often extensively detailed through children's active engagement with each other's stories. Furthermore, these discussions provided me with children's everyday expressions, formulations and comprehension of different concepts and practices. These were valuable insights that would feed into other parts of my fieldwork with both individual children and groups.

## Privacy

During my first conversations with the children, I observed that they were concerned with, and actually cherished, the privacy of an interview. Before each interview I routinely reassured them that only I would listen to the tape with our conversation and I promised ‘not to tell anybody’, neither other children nor any adults. I explained that I would write about what they said but would change their name or make general points without naming particular people. I am convinced that reassurances such as this are important when researching marginal or subordinate groups such as children. Not only are they aware about the possible ‘exploitation’ of the information but confidentiality has a particular resonance among children whose relationships and friendships are often performed through the engagement with telling and keeping secrets, revealing secrets to each other and telling adults. We, therefore, ensured that other adults (and other children) could not overhear our conversations unless the children themselves gave their permission. This was illustrated, for example, in a conversation I had with two ten-year-olds, Anna and Linda, in the after school centre. The two girls suggested that during the interview we occupy a room, called ‘Hyggeren’ (in English ‘The Cosy Room’), where children usually could go without adult supervision (see Chapter 4 for the significance of ‘hygge’ in Danish culture and illness experiences). During the interview Mette, Linda’s six-year-old sister was present, but was commanded to remain quiet by the two older girls. The following extract is from the first few minutes of the interview. Linda and Anna asked to borrow the tape recorder. They held it between them and spoke into the microphone, as if they were imitating a television interview. When they expected my response they pointed the microphone towards me. The transcript is as follows:

*'Anna and Linda: Yes, and we welcome Pia Haudrup, she would like to make an interview with Anna and Linda - and Mette sits quiet, quiet, quiet as a mouse (in Danish their formulation is: 'musse, musse, musse stille' which would be equivalent to 'mousy, mousy, mousy quiet'). And now we'll just make an interview with Pia, before she begins the interview with Linda and Anna. OK! What would you like to ask us in the interview?*

*Pia: Well, first I would like to say that what we talk about today on tape, I will be the only one who will listen to it. I will transcribe it when I go home, but no one else will hear it. When I use it I'll change your names.*

*Anna and Linda: OK, but we would like to ask if they also can hear it, Anna and Linda?*

*Pia: Hear the tape? Yes, they can hear it, too. If they also make sure to listen to it in a place where no one else can hear it.*

*Anna and Linda: .. and now Pia has found something ... and now she would just like to say something.*

*Pia: What I would like to ask you about has to do with medicines - how you have used them. And about how you help each other as children? How children help each other, when something happens?'*

As in this situation, children would occasionally let another child hang around quietly during our conversations. After the first individual interviews with children I would often encourage children to bring a friend around for our conversations. I noticed that it

generally made the children relax and would help if they felt shy or insecure. However, in most situations the children would preciously guard our conversations either individually or as a group. The children generally seemed (as I did) to enjoy our talks, a point indicated, for example, by the fact that the children themselves would ask me to interview them. Very importantly, however, children's right to privacy is a contested value in the everyday life of institutional settings and the children were keen to protect the privacy of these interviews. Adults, apart from me, were never allowed to stay. If a teacher or staff appeared the children would immediately stop talking and wait patiently until he or she had left the room again. In the children's home we sat in the children's own room or sometimes in the lounge with the door closed. Most parents helped to safeguard the privacy of the interview so we would be able to talk alone and without interruption from other family members. On the few occasions that a mother was present the children did not make any attempt to restrict her listening in on our conversation, but a younger or older sibling would immediately be told to leave.

### **The Researcher's Role**

I have previously suggested that this thesis, and the research on which it is based, departs from traditional ethnography in a number of ways. Above I have described how I fundamentally changed my approach to the children after their refusal to engage with the research process. Here I will relate this to wider discussions about conducting ethnographic research on children. These discussions have raised questions about the possibility of doing ethnographic research with children, the fieldwork role adopted by the researcher and how it can be argued that such work renders a more 'truthful'

understanding of children. In response to these I will discuss the position of the adult as 'other' in relation to children.

The study raised at its outset some particular issues of methodology about studying children's everyday life from the child's perspective that included the need to be accepted by both children and adults. This is a problem that has received some attention in the (still small) literature on ethnography with children and one to which several sorts of solution have been attempted. Most focus has been on the relationship between an adult ethnographer and children. Fine (1987:222) has noted that differences between adults and children such as size and place in the hierarchy of organisations make it almost impossible for an adult ethnographer to 'pass' as a child, thus making it difficult to become, as for example Geertz (1983) maintains, a native insider to their social and cultural lives. Fine and Sandstrom (1988) suggest that the ethnographer of childhood has to find a way of straddling the divide between adult's and children's worlds and they suggest adopting roles such as that of adult 'friend' to the children. This maintains their adult identity but softens it so as to allow a partial access to the children's experiences and perspectives.

The attempt to modify their adult identity and status is taken much further by writers such as Mandell (1991) and, from a feminist perspective, Thorne (1993). The most radical view is that of Mandell, who advocates finding the 'least adult role', which in her work she attempted by rejecting opportunities to exercise adult authority over children and engaging as a participant in children's activities, most notably spending hours with the children in their sandpit games (see also Laerke, 1998). This strategy must be commended for its wholehearted effort to enter into and participate in children's social relations but is open to

the criticism that it seems simply to wish away the real differences between children and adults as they are currently constituted (4). Furthermore, it has little to say about children's participation in the interpretation and analysis of data.

I basically aimed to be recognised as an 'adult' without being perceived as, or being given any, well defined and established 'adult role' (for example a teacher, a member staff or a parent). In this sense I developed an approach, later given support by Mayall (1998), that adults doing childhood research should present themselves as an unusual type of adult, one who is seriously interested in understanding how the social world looks from children's perspective but without making a dubious attempt to be a child. At one level of interactions with children, I followed the 'rules' set for adults in the school and after-school centre - for example regarding participation in children's play or games. In the school adults did not participate in children's play itself. Thus, during playtime I just observed and talked with children in the playground. However, in the after-school centre the staff can take an active part in different forms of play or games and so in this setting I participated in what the children were doing. At another level, my participation, in general playing or in a particular game, relied on following the children's 'rules' and practices, for example in relation to joining in or leaving a game. At the same time I refused to adopt traditional adult roles such as setting the rules of a game, telling children off, solving conflicts among the children or protecting and looking after them.

One especially important implication of being an adult anthropologist studying children concerns being 'let in' on secrets, particular games or 'dubious' practices by children from which other adults are usually excluded. As discussed above, in everyday interactions with

the children my general approach was to be direct, open and attentive but in such a way as to appear non-intrusive. Working with groups of children is an engrossing experience. Its almost constant busyness leads one to feel in a fusillade of noise, tempo and activities. Through this I became aware of the importance of 'looking and listening' when the children asked me to. I developed a great 'rigidity' in not letting myself be interrupted by something or somebody else until a child had completed what he or she wanted me to see or hear. I supposed that, from the children's point of view, this confirmed that I was genuinely interested and wished to learn and understand about their lives. It is, however, a practice that often runs contrary to institutional assumptions that talk between adults takes precedence over talk with children.

In my work with ten to twelve-year-olds I became aware that my gender had some influence on my contact and communication with the children. Although children at this age were, at first, generally more circumspect and retiring than the younger children. I was able to establish and maintain contact with girls relatively easily. However, particularly in the beginning of the fieldwork, individual contacts with boys took a longer time to establish and participant observation of boys groups was more difficult, although not impossible.

My aim was, therefore, not to assume the status of a 'child', which, from the point of view of children (or other adults), might have been perceived as patronising and insincere. Thus the study was conducted as a constant balancing act between being recognised as an 'adult' and avoiding the preconceived ideas, practices and connotations associated with 'adulthood'. This status as an 'other' was inevitably negotiated and renegotiated with both

children and adults during the entire process of the study. As one illustration of this negotiation process I encountered a few situations where a child, having understood my role as 'unusual' but still acceptable, would attempt to safeguard my position. For example on several occasions a child insisted that I told somebody off, for example by saying, 'Pia, say something to him!'. However, another child would intercede immediately and say, for instance, ' No, you cannot ask Pia to do that, you must ask Kirsten (one of the teachers)'.

The apparent complexity of my role was illustrated by a mother of a boy from fourth grade. We met on the football court outside the school on one of the last days of the fieldwork. While watching the game she said goodbye to me and then she added:

*'The children will miss you !! But I'll tell you something they didn't always know what to make of you. I mean you haven't been an adult in an usual sense. They knew you weren't a teacher and that you weren't a mother, but I think sometimes they forgot that you weren't ten like themselves.'*

Whilst this attests to the general success of my approach, another example, which took place quite late in the fieldwork, testifies to the difficulties that my role involved. It shows how the attempt to suspend the usual adult role and be 'unusual' can encounter severe tests. At the time of the incident, which I describe below, I had known some of the children for a period of one year and others for the seven months and had spent time with them every day in their school and after school centres. I had returned to do additional fieldwork in the summer of 1993 after an interval of almost a year. Below are the events



as recorded in my fieldnotes. It is a long extract but one which I reproduce in full in order both to show the complexity of the children's practices and the sharpness of the dilemmas it presented me with:

*'It is a lazy afternoon in the after school centre for ten to fourteen-year-old children. Two weeks after the school started after the summer holidays, 2-3 boys sit around the television set playing a video game, another few girls sit drawing and cutting some papers. Two of the staff play cards with a child, a few children sit next to them in the settee and watch their game. A twelve-year-old boy and I sit on some chairs at the end of the table and watch them, too. Suddenly a boy comes running into the room. He stops a few meters from me and urges me to come and have a look. He seems very eager. I get up from the chair and accompanied by the twelve-year-old boy we follow him to the cloakroom.*

*There are four ten-year-old boys in the cloakroom. Two of them are standing a little way from a boy lying on the floor. The boy, Peter who called me - points to the boy on the floor and kneels down beside him. The boy on the floor, who has been firmly strapped round by tape, half lies on the ground unable to sit up properly because his body has been fixed in this position by the tape. I am astonished to see what has happened and how his body has been transformed. The way he is fixed with the tape holds his body firmly in an awkward position. He is*

*energetically occupied trying to remove the tape. The tape has been fixed in strategic places like the ankles, above the knees, around his hands and wrists and around his chest and arms. He is wearing jeans and a short-sleeved T-shirt, and the tape makes the skin on his arms stand out. He is laughing and has a silly smile, but he is mostly engaged trying to remove the tape, which holds his knees together. He has already succeeded in breaking some of it off. The other boys laugh and comment on his manoeuvres to get free, and Peter checks the bindings.*

*I ask them what they are doing, and in relation to Danny on the floor I ask them whether he accepts what is happening. They say 'Danny is being wrapped up'. The atmosphere is feverish and the boys are excited but not aggressive. Peter's hair is wet from the sweat, which drips down his forehead. Bending over Danny, Peter shouts with his face close to Danny's: 'It's funny, eh?! - Do you think it's funny, Danny !?'. The boy on the floor seems tense, but giggles.*

*Leaving the table I had noticed that a father of one of the boys in the cloakroom was approaching the entrance of the after-school centre to collect his two boys, one of whom was in the cloakroom. When I realised this, I felt even more uneasy and made sure that I would not to be found in the cloakroom with the boys. I realised this may be perceived as problematic because I could not stay there without being*

*part of what was going on - and thus implicitly sanctioning it. I asked the boys: 'Why do you call me to look - Why don't you call one of the other adults and show this to them'. Peter laconically answers: 'They will just get angry!' As if further explanation is unnecessary.*

*The twelve-year-old boy and I leave the stage. Before he leaves, he points to the boy's bindings that are nearly off his knees, and he calls authoritatively on the other boys to fix his legs so he cannot move. He doesn't involve himself in the actions as if he is thus confirming his status as an older boy. He leaves the place saying to me (I think acknowledging my anxiety or uneasiness): 'These are things that boys do, and they also fight with each other'. We walk back to our seats by the table where the games of cards are taking place. - I am in deep confusion about what has happened and I am terrified, however the twelve-year-old is relaxed. He does not seem affected. It is as if he has already forgotten what has been happening. I feel deeply worried and consider what to do. The staff are playing cards, and I think about whether I should tell one of them. Perhaps I should casually suggest to Elsa that she should take a walk up the corridor, which undoubtedly would mean that she would discover what has been happening? However, I did not do anything, for I realised that I would then break the confidence of the boys, and thus destroy the loyalty that had been built up between me and the children during the long time that we had spent together.*

*Peter returned to ask me to come back and see that 'now he has got a dress on'. One of the staff looked a bit surprised at this request, but did not ask anything. This time only Danny, 'the victim', on the floor and Peter and John, who laugh scornfully, are left in the cloakroom. Danny's body, still strapped up as before, is now covered with two white petticoats from the Centre's box that contains 'dressing up' clothes. He has a wig of long fair hair on his head, and a piece of pink tulle is completely covering his face like a veil. I have difficulty in seeing his face to check if he is still feeling all right. The two boys are handling him and rolling him around, I catch a glimpse of his sunburnt face. Danny is lying on his side now - and John who is wearing training shoes, touches on Danny's neck with his trainers as if he was going to kick him or stamp on him. This made me say almost involuntarily: 'Don't do that! - I am not going to tell you what else you can do or not - but don't ever do a thing like that - it is too dangerous!'. John stops without further comment. He stands next to me and tells me that they had done the same thing in the house of one of his schoolmates, where he had been strapped like Danny, with the only difference being that the tape was much wider. I ask him: 'What did his parents say?'. John answers: 'Victor's father doesn't care what he is doing'. I ask: 'What would your parents have said?' He shrugs his shoulders and says: 'I don't know'.*

*Peter is hot, excited by the atmosphere and by what is happening. He does not express happiness, but laughs, shouts and screams, putting his own face up to Danny's face, interrogating him in the same way as earlier. I ask them 'When do you know how to stop this?'. And I ask Danny: 'Are you able to stop this if you want to ?' Danny confirms that he can just tell them 'when he doesn't want to go on with it any more'. Peter answers: 'When he has said stop a few times, and if he then starts to cry a bit, then we will stop'. There seems to be a mutual understanding of this agreement between the boys. Danny does not object and even laughs a bit. Suddenly Peter starts to open Danny's schoolbag, and Danny shouts in a threatening and a surprising way at Peter: 'Don't do that, Peter!' Then he explains to me: 'They are taking my toffees, they are stealing my toffees'. Peter takes the box out of his bag, mumbling that Danny has eaten the sweets without giving any to the other boys. Danny has eaten them all by himself, Peter says in justification. Peter squats on the floor next to Danny. He takes two toffees from the tin, one of which he hands to John, and he takes one himself. Danny shouts out wildly against this action. He is angry and says in a threatening way: ' Don't do that, - I will tell the adults, if you take my sweets.' Peter hesitates seemingly uneasy about the situation but in a persuasive manner he asks: 'Can we have one?'. Danny refuses persistently and says: 'Don't do it!'. Neither John nor Peter unwrap the toffees. Peter shouts at Danny who lies physically powerless on the floor. While they are talking, Peter collects the toffee*

*from John. Peter has calmed down, but he still wants to continue with his aim, he asks Danny earnestly several times whether John can have a toffee. Peter holds the toffee up to Danny's nose teasing with questions like: 'Can we have it - who is going to have it?' - Danny says persistently: 'I am!'.*

*At last Peter seems to agree to give Danny the toffee. Still teasing Danny he unwraps the toffee and putting it on top of the veil by Danny's mouth. Danny opens his mouth, and tries with his tongue to get the toffee through the tight netting. The game continues a bit longer, and eventually Peter stuffs the toffee into Danny's mouth behind the covering veil. Danny then gives his agreement. The toffees are freely given out. John and Peter eat their toffees. Danny satisfied chews his sweet. Then Peter takes the last toffee from the tin, and asks Danny: 'Who is going to have this one?' Danny answers firmly: 'I am!' Without any objection, Peter repeats his teasing act with Danny who is trying again to eat the toffee through the veil.*

*For the second time I leave the boys, walk back to the room where the staff and children are still occupied as they were before. Finding the situation too unbearable and confused I walk outside to the playground and sit down by the sandbox where two of the ten-year-old girls are playing. Soon afterwards Danny, who has now been released, and Peter come running towards me as though they are the best of*

*friends: 'Pia, he is free now!'. I say 'Yes, I can see that, how did you get free?'. Peter explains 'John accidentally banged his head against the wall, so then we stopped.' Danny adds: 'Yes, then I didn't want to be in it any more'.'*

The shock and panic I experienced on this occasion contrasts strongly with the days when conducting the study seemed to have become the equivalent of 'routine work'. It was a confrontation with a world I had not seen before. Even though I knew of discussions, interactions, playing, games and secrets which were part of the children's lives, I was not often let into, or very far into, these 'private worlds'. I had not foreseen or imagined this particular experience and how it would produce personal doubts and confusions about my role and my involvement. The event threw light on ideas of the conventional world of children as being an acceptable and 'nice' world. In this view of children's worlds not only is the depth and elements of the 'nasty' world of children relatively impossible to conceive, it is also relatively inaccessible to most adults. The event that I had been made to witness represented the complexities of children's lives substantially challenging the dichotomised adult understanding of 'nice' or 'nasty'.

The complexity of this event is reinforced in the context of conducting research with children. It problematises ideas about the exchanges between researcher and informants and also the set of ethical values, such as confidentiality and trust, and the important element of control that underlies research relations. My privileged position as a special kind of adult, and even at times 'an honorary child', was accompanied by the trust that they showed in me. I wanted to give loyalty and trust in return. The event further indicated

an important turning point in my relationship to some of the children symbolising my possible admission to the traditional 'secret' world of boys.

The event also pinpointed key cultural ideas about being 'an adult'. Adults are perceived, at least in Denmark, as not only responsible for securing the wellbeing of the children with whom they are involved but are also expected to protect other children from the consequences of their involvement in similar situations in the future (see Chapter 1). I was caught between these conventional adult responsibilities and my relationship of trust built up with the children. I imagined, for example, the moral and legal implications that might have occurred if other adults had discovered what was happening or if the episode had developed in such a way as to harm one of the boys. Both staff and parents realising my knowledge of the event might have expected me to suspend my role as researcher and act in a responsible 'adult' way; that is either to have intervened myself or informed another adult. For some time I doubted whether I was able to, or indeed had the right, to keep this secret from other adults as the children were able to do. At the same time, I realised that the children's consciences were not affected in any way about this event. They showed no signs that they felt guilty, upset or worried afterwards. Only I did.

### **Fieldwork and the Generation of Analytical Themes**

Despite the personal shock that this incident posed for me (and may also present to the reader), some elements of it stimulated my ideas about the nature of the responsible and protective adult, ideas that became an important part of this thesis. These have implications not only for dramatic events such as that experienced by Danny but also for



the more routine and everyday practices around children's accidents and illnesses. These are more fully discussed in my discussion of children and vulnerability (see, especially, Chapter 7). The incident also questions the categories we use to describe children and childhood. Whilst superficially the story may be seen as one which reinforces some recent images about the dark side of childhood (see, for example, James and Jenks, 1996), it is a story in which the complexity of children's relationships with each other (and with adults including the role of the researcher) elude any easy interpretation.

Here I will suggest how trying to unravel this particularly difficult part of my fieldwork provoked new lines of thinking and in which data production and analysis were thus inextricably linked together. In the months after the incident, as I struggled to understand it, I began to look afresh at adult taken-for-granted notions about the vulnerability of children. It was apparent to me that my own reactions to Danny's treatment by the other boys (and the fieldwork dilemmas it presented me with) were not shared by the boys - including Danny himself. This led me to explore both adult notions of children's vulnerability and the potentially very different perspectives which children hold themselves.

At the same time, the density of practices on and about the body contained in the incident focused my attention on the body, how it is subjectively experienced and its different meaning for children and adults. The incident led me to reflect on how the notion of protecting children informs its opposite in defining cultural notions of their vulnerability. These twin views constitute the child as an essentially vulnerable being in need of care and protection in order to survive. Adult understandings of the child as vulnerable see him or her as exposed to diverse dangers and, in particular, to those dangers posed by external

factors in the environment or in the behaviour of others. This is, I will argue in Chapter 7, culturally expressed through a particular perspective on the body, which distinguishes between the exterior and the interior body of the child. This perspective sees the body surface as the protective outer shield of the vulnerable interior. Thus an intact and unchanged exterior is indicative of the well being of the child whilst a damaged or transformed exterior exposes the vulnerable interior body. One important aspect of understanding the child as vulnerable is the extent to which the body surfaces are transformed, through change and damage. I am thinking here of Danny's constrained and pacified body and its covering in female clothes which underlined its fragility.

In recollecting the above event I also began to see how the surface of the child's body acts as a symbolic stage on which cultural understandings of the child and of the structural positioning of child and adult can be explored. The transformation of the exterior body exposes the opposing but still complementary values of vulnerability and protection. From an adult point of view (including my own), the transformed body surface represented the child's inner vulnerability and the moral demands on adults to protect, be responsible for and to care for children. In the boys' imagining of other adults' reactions it was possible to further position the complexities of the 'careless' and the 'caring' adult. The way that Danny's body was bound and thereby transformed, combined with the other boys intimate interrogation of him, seemed from an adult perspective to connote violence and terror centred on the bizarre surface transformation of his body.

Nevertheless among the boys, including Danny, this seemed to be only one part of the event. Danny's smile and the fact that he indicated he had voluntarily participated in the act

presented a different image in which his and their pleasure, strength and involvement were all elements. In an important sense Danny exercised power in allowing this to happen. His sudden reappearance as a powerful participant and as the actual ruler of the process, despite his humiliating posture and the total restriction of his actions, was constituted through his social status as owner of the sweets. He asserted his right to distribute the sweets according to his own decision. In this way all the boys were established as equals through the inter-changeability of different forms of control and power. This analysis of the situation was further confirmed by Peter and Danny's later conversation with me in the playground after the incident. They proclaimed themselves 'best friends' a relationship that, in other situations, they would show by putting their arms around each other, play fighting and defending each other in interactions with other boys.

There also appeared to be a clear gender dimension to the incident. Danny's initial fight to try to set himself free actually led to the immobilisation and covering of his entire body. His passive body was restricted in time and space and thus enveloped his vulnerability. An element that established the significance of the body surface was the other boys acting upon his passive body, constantly testing their control and exploring the access they had been given. Choosing to cover his body in women's clothes, for example with the petticoats, the wig and the veil, symbolised the final surrendering of his physical male strength and active body. In the boys' behaviour, the body's surface was an arena for the trial of strength and weakness. Their external involvement with the body served to test the limits of nerve and strength thus locating a subjectively experienced body. Through the particular covering and clothing of Danny's body, the boys' actions were expressing specific ideas of gender in a symbolic representation of a physically powerless and passive

girl. Thus covering the surface completed the picture of the victim, at the same time as it communicated the caricature image of a female body. However, Danny's seeming acceptance of being physically pacified was countered by his demonstration of psychological and social power and evident control over the event. He thus, to a certain extent, reinforced and framed himself in the passive feminisation of his body whilst at the same time expressing control through verbal demands and remarks. As I thought about it I began to see in this highly dramatised event some of the features of the different ways in which the boys and girls related to each other in their everyday activities. In particular I began to appreciate how the girls relied less on physical actions and more on verbal interactions in their conflicts with each other (see Chapter 7).

### **Conclusion**

Apart from describing the setting of my study and its basic design, this chapter has focused on the issues that arise when children are the main subjects of ethnographic research. I have suggested that the participation of children in such work requires a special emphasis on the dialogical qualities and potential of ethnography. It may be that a dialogical approach is also fruitful and necessary with adults but my work has shown the issues which arise specifically when working with children. If children are to be actively involved in research, care must be taken to explain it to them, to gain their consent and continually renegotiate it, to respect their privacy and to feedback the interpretation of fieldwork material so that the children can comment on it. It also requires the ethnographer to 'retrain' their attention so that the frequently found assumption of adult priority, for example in conversation, does not undermine children's sense that they are really being

taken seriously. Patience and care are needed to discover whether the ethnographer is making adult-centred assumptions in their questions to children and one needs to be able to respond to the insights and surprises this can produce.

The adult ethnographer may be tempted to try and pass as a child but my experience is that children are well aware that this is a ploy. They are very sensitive to adult-child differences precisely because they encounter them throughout their everyday lives. It is, however, possible to be a different sort of adult, one who, whilst not pretending to be a child, tries throughout to respect their views and wishes. Such a role, as I have discussed, inevitably involves a delicate balance between acting as a 'responsible adult' and maintaining the special position built up over a period of time. In everyday routines this is not too difficult to accomplish but it can, as in the circumstances described above, be very testing. The glimpse into the boy's world that I had at this time was at first shocking. However, it was at the same time one of the key moments in the fieldwork. Its highly dramatised form, and my own reaction to it as an adult, eventually enabled me to reflect on key aspects of child-adult relationships, vulnerability and gender which are also present in the more mundane and less intense interactions around everyday childhood health and illness. In the next two chapters I will describe and analyse how everyday illness and minor accidents were performed in the settings of home, school and after school centre.

### Notes

1. My work was, therefore, an example of 'anthropology at home' (see Jackson, 1987; James, 1993: 10-14; Okeley, 1992; Okeley, 1996). I have, however, chosen to focus in

this thesis on methodological aspects related to the anthropology and ethnography of childhood rather than those concerned with doing anthropology in one's own society. In part this is because the latter has received substantial attention whilst the former can still be considered as underdeveloped (see, however, Christensen and James, forthcoming 1999).

2. The two after school centres did of course show some differences in organisation, approach and practice. However their similarities overshadowed these differences and I decided during the fieldwork that I would not analytically distinguish between them. In this thesis, therefore, they are dealt with together.

3. Twelve children from the 1st grade and 6 children from the 4th grade were interviewed on the basis of a drawing they made of 'the last time you were feeling ill'. Group interviews (2-5 children in each group) and one individual interview were conducted with 19 children from 4th grade. The particular issues of the interviews were related to illness and the children's perceptions, knowledge and use of pharmaceuticals and home-remedies. During the same period spent with the 4th graders in the school, the children wrote essays and constructed plays on subjects suggested by me e.g. about friendship, illness and minor accidents, care and help and about their perceptions of differences between children and adults. These data were supplemented by a semi-structured interview with the parents of children who conducted the drawing-interview. The parents in 18 families (17 of the initially recruited families and the parents to a child in 4th grade who later agreed to participate in this part of the study) kept a diary for a period of two weeks on their children's health, sickness and care. In the diary the parents were requested to state the children's present medication if any and to describe episodes of sickness, periods of

weakness, lengthy colds or similar conditions that had occurred during the last 6 months.

I interviewed teachers, the school nurse and staff in the two centres. The subjects of these interviews were focused around issues such as the school in the context of the local area, work and social interactions with children and families, and more specifically about the adult's perception of and actions during children's sickness episodes and minor accidents. On one summer camp the staff kept a diary of incidents of children's sickness or minor accidents and the treatment that were conducted. During three months in the beginning of school term a school nurse kept a diary of children's requests, the treatment and actions carried out, and the self-care practised by the afflicted child and his or her friends.

4. There are here, of course, underlying issues of power and control between adults and children. Whilst I consider these to be generally important topics for the anthropology of childhood, I have decided not to dwell on them in relation to the methodological discussion of this thesis. The reader is referred to discussions by Thorne (1993), Morrow and Richards (1996), Alderson (1995) and recently in a paper by Mayall (1998).

## Chapter 4

### CHILDHOOD ILLNESS AT HOME: THE CULTURAL PERFORMANCE OF CHILDHOOD SICKNESS AS FAMILY HOLIDAYS

#### Introduction

The focus of this chapter is on the ways that children's illnesses and accidents were understood and acted upon by the families participating in the study (1). As noted above, children's everyday life takes place in and across a number of different settings, and in Denmark this includes the family or home as well as the institutional settings of the school and after school centres. Accordingly, because illness may take place in any of these settings, the cultural performance of childhood sickness must be recognised as a spatially fragmented process (Frankenberg, 1985; Prout, 1989). However, as I will show in this chapter, for an understanding of childhood health and illness the distinction between home and institution remains important. Children's health and well being is a concern of the school in as much as the school is seen as an essential basis for learning and sickness may prevent this. Nevertheless, both in principle and as an everyday phenomenon, children's illness is of somewhat marginal interest to the school (or any other educational and leisure institution). Illness is primarily seen as being dealt with at home and in the family, perhaps supported by the expertise of medicine. Although children's illnesses do sometimes occur at school, and thus initial precautions and preliminary care can be observed taking place there, the main care, therapy and health recovery of the child takes place at home in the family. Therefore, although the framework of my analysis is similar to Mayall's (1996), in that



it draws on the understanding that children's health has to be seen as crosscutting the different sites of their everyday lives, I suggest that home and school must, nonetheless, still be distinguished in terms of the significance that illness has for each institution and its responsibility for cure and treatment.

In sum, this chapter argues that in the analysis of the everyday experience of children and their parents, the school and home respectively represent the main sites for health and illness: children who are ill at school are sent home and children who are healthy must go to school. This boundary or distinction necessarily locates illness at home in the family, although in the following chapters I will explore the social interactions among children, and between children and adults, that occur around those illness episodes and minor accidents that happen at school and after school centres. It will be shown that in all the sites children and adults define, classify and deal with their wellbeing in ways which distinguish between health and sickness, and in doing so they simultaneously establish the spatial boundaries that can enable action.

### **Family and School Connections**

However, whilst children and parents would recognise the institutional boundaries described above, it does not mean that school and home can be treated analytically as if they were completely separate. In the home, childhood sickness is performed through the interactions between children, adults and material artefacts which, in the process, acquire expressive symbolic meaning (Frankenberg, 1986). In its original formulation, the concept of cultural performance seeks to embrace this total set of social relationships and interactions involved in a performance. This raises an

important analytical point, for the sets of social relationships involved in the cultural performance of sickness within the home and family setting are themselves partly shaped by the institution of the school. For example, when a child feels ill in the morning, and both parents have paid employment outside the home, a typical scenario takes place. The family has, within a limited and pressured time period, to investigate and classify the child's complaints and eventually arrange childcare. This time frame is fixed by the organisation of the school and work place; for example, it involves meeting times and work hours. Thus, already, the ambiguous meaning of an illness episode is underlined such that parents, although they suspect the child is ill, may still send them to school.

In the families involved in the study this situation was depicted as bringing about a 'clash of loyalties' between the child, the parents and their work because of the parents' limited possibility to care for a sick child. For example, Inger, a mother in the study, told me:

*'We share looking after the children when they are ill. Equally, to avoid discussing whose work is most important...I don't really want anybody else to look after them, mum or dad has to be there, perhaps grandparents.'*

In Denmark many parents who work in the public and private sectors have a legal right to leave on a child's first day of illness. During that first day off the parents are supposed to arrange for someone to look after the child on any following days of illness. Legally only one parent in the family is allowed such leave during each illness

period. However, for many families involved in the study illness often created great problems in arranging for the child's care. This meant that parents had to be both creative and flexible. Some parents decided that they would both use their 'legal right' and, consequently, the first two days of care of the child were secured. A few parents arranged to carry out their work at home or they were able to alternate their working hours so that one parent could work in the morning, whilst the other could work in the afternoon. However, a more common practice, which immediately provided a definitive and clear-cut solution, was that one of the parents took time 'off sick' him/herself. Alternatively, some parents 'ignored' the problem as pressing and chose to send the child to school, arguing that her/his symptoms and complaints were vague.

In this manner the totality of social negotiations and interactions between child and parent in the home around a sickness absence inevitably involved both school and workplace relationships. Prout (1988) makes a similar argument in his investigation of the representation of 'good motherhood' through the 'normally healthy child'. Not only are mothers seen as having primary responsibility for school attendance (see Shaw, 1981; Gregory et al, 1984 in Prout, 1988) but their competence is also put on display in ensuring children's regular attendance at school. For mothers, making decisions about keeping a child off school sick involves:

...the impression management of their own maternal competence in the provision of 'proper' health care for their children, a provision that was made under the gaze of the school. (Prout, 1988:783)

This suggests that child health has become, in fact, a very wide field of surveillance;

norms and discourses are not simply located in particular sites or in the practice of health care workers. They are pervasive in society, undertaken in different ways by health care, education, social work and the popular media. Mothers' practices of child health care and decisions about school attendance must, therefore, be seen as located in a complex setting of different demands and pressures. Thus, although the family home is recognised as the main setting of children's illness, other locations such as the school will also be represented there and, thereby, become part of the total cultural performance of childhood sickness at home. Similarly, the home and family may be represented in the interactions that take place at school when a child becomes ill (see especially Chapter 5). An understanding of the family/home intersection as a main location of the cultural performance of child sickness involves, therefore, both the horizontal and the vertical perspectives (Nader, 1981) discussed in Chapter 1. Through this it becomes possible more fully to recognise how the everyday life of children and their families at home are influenced by wider social institutions, structures and organisations.

### **The Cultural Performance of Childhood Sickness**

My discussion so far has sought to recognise a paradox: on the one hand social institutions are bounded entities and the boundaries have real meaning and effect; on the other hand it is important, analytically, to trace the overlapping of social and cultural practices and the connections between one sphere of life and another. An important example of these interconnections is given in Frankenberg's (1985) study of over two hundred essays, entitled 'What happens in your house when someone gets ill?', written by eleven to thirteen year old school children in a Northern Italian

village. It suggests that the cultural performance of sickness there can be seen as taking on the form and content of the annual cycle of local (Catholic and Communist) Festa celebrations. These performative events, both sickness and Festa, are shown to be 'bracketed-off' periods of time apart from everyday life. Through them, it is argued, people express, reproduce and reinforce, in ceremonial form, 'the diurnal proprieties of individual roles, places and times within the context of the Paese or Commune' (Frankenberg, 1985:5). The Festa reveals ideas of the community or unity of the village and some of the wider economic forms and activities of Tuscany. In an analogous way, he suggests sickness demonstrates the strength of the family and, through its performance, the boundaries between family concerns and the 'outside' community are demarcated.

Frankenberg's analysis obviously refers to phenomena specific to Italian society, and in particular to the community festivals that are so widespread there. Nevertheless, his insight into the parallels between sickness and other social or cultural practices is highly suggestive for the interpretation of my own Danish fieldwork. This also showed similarities between the practices and symbolic meanings of child sickness and other ambient social forms. In the Danish case, however, the parallels are between how child sickness was dealt with at home in relation to aspects of the family holiday.

Both of these involve 'time off' and take at least some of their meaning from their similar constitution as a disruption to the routines of ordinary family life and from the time pressures on child-adult relationships in contemporary Danish society.

In relation to this latter point, Qvortrup (1995b) has argued that the importance of time for parents and children to be together derives from the fragmented experience

of modern family life, signified, for example, by changes in employment patterns and by family breakdowns. Parents and children spend more time apart than the previous generations did, everyday family time together is scarce, and an ideology of spending 'quality time' together has emerged. In Denmark in the early 1990s these points were discussed widely and a national campaign run by day care institutions featured the slogan 'Have you talked with your child today?'. This reminder greeted parents on posters on the door entering the after school institutions in which I did my fieldwork and it was also displayed in the children's cloakroom as well as on car stickers.

Although my analysis owes much to Frankenberg's general idea that sickness can be understood in relation to other forms of bracketed-off time, it differs, however, in two important respects. In Frankenberg's analysis, it is implied that social interactions around sickness are embedded in a hierarchical order or pyramid that places sickness at the base whilst its primary referent and shaping analogy is in a dominant cultural form, 'the Festa'. It is this that shapes the performance of sickness and not the other way around. In support of this he cites the work of Bakhtin, who argues that festa is a fundamental form:

The feast (every feast) is an important primary form of human culture. It cannot be explained merely by the practical conditions of the community's work, and it would be even more superficial to attribute it to the physiological demand for periodic rest. The feast has always an essential, meaningful philosophical content. No rest period or breathing spell can be rendered festive per se; something must be added from the spiritual and ideological dimensions. They must be sanctioned not by the world of

practical conditions but by the highest aims of human existence, that is, by the world of ideas. Without this sanction there can be no festivity (Bakhtin, 1968:8-10 in Frankenberg, 1985)

The first difference between Frankenberg's approach and mine is that I hesitate in embracing the implication that one feature, whether it be a 'macro-structural' one, such as economy, political ideology and religion, or a hegemonic cultural form, such as that of the festa, has a determinant influence over small-scale interactions. My approach, instead, leaves this question open, placing the performance of every day sickness in symmetrical relationship with other social practices. These then take on a reciprocal relationship in form and symbolic meaning, without one necessarily being the dominant factor. My argument, then, is that the parallels between the cultural performance of everyday childhood sickness and family holidays reveal the symbolic meanings of holidays and sickness as overlapping, related and resonating in the celebration of 'time off' and the 'family'. More specifically, it connects time off, and its associations with freedom and control over time that is not work time, and 'the family', in its associations with preserving personal well being and the maintenance and rejuvenation of family social bonds and values such as togetherness, enjoyment and affection. In this network of connections I do not, however, single out one sphere as determinant but rather see them all as symmetrically and mutually constitutive.

The second difference is a related one. I suggest that child sickness is polyvalent in the forms that its performance can draw on and parallel. Although, especially with the younger children, the family holiday and its associated notions were most frequently

evoked, this was not unambiguously so. Conflicting with this were notions of the discipline necessary for regular school attendance and, as the children became older, anticipations of paid employment and work. Parents also sometimes linked allowing children time off school with their criticisms of the school system, especially the use of substitute teachers and the introduction of an earlier starting age for children going to school (2). My study shows that sickness was too varied to be understood through a single and simple parallel between sickness and family holidays. Rather it is central to my argument in this thesis that diverse exchanges of meaning take place between sickness and other spheres.

### **Holidays and Sickness in Everyday Language**

In Vanløse the most striking parallel was not between sickness and local community festivals per se (which do not take place to the same extent or with the same communal involvement). However, it was clear from my fieldwork that sickness and the idea of 'holidays' were intertwined in a mutually constitutive cultural process. Everyday childhood sickness took on aspects the cultural performance of family holidays and, vice versa, family holidays took on significant aspects of everyday childhood sickness. A key to an understanding of how these processes may take place can be found, I suggest, in notions of 'recovery' and 'recreation'. Mental, physical and social rest and recovery are seen as fundamentally implicated in both sickness and holidays. For example, consider, first, the ways that sickness and holidays are more generally referred to in every day language in Denmark. When a person returns to work after holidays or a sickness absence the collegial and friendly greetings and comments are identical. In both cases people will typically say 'Have



you recreated yourself?' or 'Did you have a good rest?'(3). Their meanings connoted here are even clearer in the case of a colleague returning to work after sickness when he/she is often teased or disbelieved with a remark such as: 'So, did you have a nice holiday, then?'.

In arguing for such parallels it can be suggested that what both sickness and holidays do is to perform structural breaks (Turner and Turner, 1978). Whether childhood sickness or family holiday, both produce feelings of family togetherness, relaxation and harmony. At the heart of this similarity is the fact that recurrent periods of planned holidays and unplanned (acute) child sickness provide families with 'time together' as well as 'time off' or 'free time'. Holidays are regarded as a 'recreation period', a 'well-earned or necessary break' which provide families with regular relief from the rush and strains of every day life and recovery from them. Urry, in his work on tourism, writes:

It is a crucial element of modern life to feel that travel and holidays are necessary. 'I need a holiday' is the surest reflection of a modern discourse based on the idea that people's physical and mental health will be restored if only they can 'get away' from time to time. (Urry, 1990:5)

In the same way (acute) everyday illness and recovery, despite their inherently unwelcome aspects, also provide family members with an unexpected and immediate relief from the burdens of every day life.

These points can be illustrated in a conversation that I had with one of the parents

during my fieldwork. Karen, a forty-year-old social scientist, is married to Peter, thirty-eight years old, who works in marketing. Their two children are Tim, seven years old, and Marietta, one year old. Almost one year ahead, the family had planned to go on a skiing holiday with some relatives. A few weeks before the holiday, in early spring, their plans were cancelled. I talked with Karen a few days after they had received the news:

*'Karen: I think we should take that week (off) anyway. Off course I haven't talked with Peter about it, yet. We hardly see each other at the moment. Because either he works or else I work - and then I have gone to bed when he comes home. Take some time off and do something together!*

*Pia: What?*

*Karen: Maybe we could take some days in Helsingør or something. (The family has a summer cottage in Helsingør). We could take time off and use some days to do something on the house (their residential home). Tidy it up, some of all the things we have been missing. Have some time to nurse our relationship. That would be nice, we need to! And, Marietta, she could be home from the nursery and Tim wouldn't need to go to the after school centre. He could come straight home when he finishes school.*

*Pia: It doesn't leave you much time to 'nurse your relationship'? Why don't you take a few days off on your own and have another few days where the children are at home.*

*Karen (exclaims passionately): But! I will miss my children! (Karen continues thoughtfully) But, maybe they could have a few holidays with*

*granny and granddad. That would be nice.'*

In this conversation, when Karen reflected on her plans and expectations, she emphasised time off in relation to three essential issues: family time together; activities and work to establish their home and material context; recreating her relationships with husband and children. From Karen's point of view these important aspects of family life were not only suppressed by the pressure of everyday life, but also her choice of words and her emotional engagement suggest that everyday life involves experiences of suffering that temporarily may be consoled during holiday time. Interestingly, in our discussion, Karen specifically described her intentions as 'at pleje vores forhold' (to nurse our relationship) (4). This expression has in more recent years entered into every day Danish language and relates in, its popular understanding, to the idea that relationships have to be worked at. 'The couple' within a family needs, at times, to invest particular attention and innovative efforts into their relationship. This would for example include organising the 'release' from constraints such as arranging for someone to look after the children. Thus spending 'quality time' together is seen, quite literally, as a way to maintain or restore the health of the relational bonds between a married couple and, more fundamentally, to ensure the 'survival' of the relationship.

### **Time Off School.**

The recognition that family life with children and work is busy, constrained and pressured was woven through the parents' accounts. In this respect I was particularly interested in how families perceived and managed children's time off from school for

holidays, sickness or other reasons (5). In Denmark, the main legal reasons for adults to have time off from work and for children to have time off from school are sickness and holidays. Most parents participating in the study had five weeks annual holidays (in addition to the traditional Bank holidays) according to general regulations in the labour market. Parents employed in the educational sector followed the scheme that was obligatory for school children. They had seven weeks holidays in the summer and one week at half term in autumn. In addition they had Christmas and Bank holidays and a few other days distributed over the year. Although most parents asserted that children generally only had time off from school during the holidays or due to sickness, there were exceptions to this rule. Time off for family and festive kinship events, such as birthdays and anniversaries or taking an extra holiday during the spring term, was generally seen as 'legitimate'. In recent years skiing holidays (in late winter or early spring) have become increasingly popular in Denmark, although it is not all schools that have made this vacation compulsory. A couple of parents suggested that the unequal opportunities, which these variations in school rules created among families even in neighbouring districts of Greater Copenhagen, justified their own decision to take a week's holiday in the winter term.

In conversations about occasional time off from school, parents expressed some hesitation and ambivalence. They emphasised how important education is in preparing children for the ethics, disciplines and norms of the labour market. Standards such as attendance, punctuality and precision, as well as learning to organise and prioritise work tasks, represented, for parents, some important requirements for children's future adult working life and were consequently seen as an important form of basic learning. To some extent most parents shared these points of view but their

considerations and the practical implications for children varied according to the child's school grade. Parents of children in first grade put most emphasis on time off from school as being important and capable of justification in relation to children's well being, whereas parents of children in fourth grade emphasised time off from school as an exception.

Teachers' expectations and attitudes were also an important indicator for parents in making their judgements about whether it was appropriate that children had extra time off. Karen's view was shared by several of the parents of younger school children. She said:

*'The school doesn't take it very seriously if children have extra time off at this stage.'*

Parents saw the readiness with which Egeskoven school responded when they requested time off as an informal legitimization of their attitude. The academic work performed by the youngest age groups of children did not, as yet, occupy a significant place at school. In this respect it is also worth mentioning that the youngest children would not have homework to do over a vacation, whereas this would usually be the case for older children. Thus in 'børnehaveklasse' and in first grade (equivalent to reception classes in the UK) children are expected to achieve some basic learning skills. However, as both teachers and parents emphasised, the importance of the first two years at school was that children adjust to school life such as school relationships, rules and rhythms. In this respect it was commonly the case that parents emphasised children's social relationships as a particular and important aspect of schooling. For

example, Lars, father of seven-year-old Mette, told me that he would not hesitate to let Mette have a week off from school when the family went on their annual skiing holidays or occasionally in relation to a family event. Lars explained that he was not particularly concerned that Mette would miss important teaching while she was away from school or that she would experience any difficulties in catching up with the work at school on her return. His main concern was that Mette would be able to develop and sustain her social relationships with the other children, which was based on her actual attendance at school.

Parents of the youngest children appreciated that children have to attend school, but they also expressed the need to balance this view against maintaining children's health and well being and sustaining parental bonds. This was illustrated by Karen and Peter, parents of seven-year-old Tim:

*Pia: How do you feel about letting Tim have time off from school?*

*Peter: We feel fine about that. I haven't got any problems with that.*

*Karen: Not too much, though.*

*Peter: Yes, not too much - but it's not because he'll miss anything. If I have any concerns, then, it is that if you took him out of school for a month or so, he would get out of the context... (pauses)... his friendships with his peers. The social context. I don't think, it's at all hazardous to miss a school day now and again.*

*Pia: Is this a principle for Tim's time at school or do you relate it to the particular period or stage he is at the moment?*

*Peter: It is a principle for his time at school. At least as long as he is at*

*the childish age when one needs freedom in one's life. At a certain stage you (as a parent) ought to say, and we actually already do, that 'You have to go to school, that's your work'. Kind of bringing him up with that you cannot just do what you want to. But if there is a good reason - a good reason may also be enjoyment - then, I don't think it is wrong to miss a day at school.*

*Karen: The principle for the future is: of course, he should have time off from school to stay at home or do something else with us, which you (he) also learn from.*

*Peter: Basically, I believe, you always need to take days off. You just have to do it with different attitudes. If you choose freedom in 7th grade you do it different to how you do it in 2nd grade. In 7th grade he (Tim) will know the consequences himself, and he will be more conscious of what he misses or gets free of. He may choose in order to gain something, rather than choose to avoid something... When you (Tim) begin to choose something to avoid it and we don't try to influence (him) in another direction. If it is something we don't think one should miss, German for example, ...*

*When he begins to take time off from something rather than to something - then he needs resistance.' (original emphasis)*

Like other parents, Karen and Peter emphasised the importance of children's peer relationships at school but, more particularly, they stressed the value of time off for maintaining personal health and wellbeing. In our conversation Peter was especially engaged in questions about the fine balance that they felt had to be kept between children's (understanding of) every day obligations and their need for free time.

Lena, a nurse and mother of six-year-old Gitte, was, however, more discerning when she raised the issue of time off in relation to children's personal health and well being. She said:

*'Children may need a 'psychological' day off sick.'*

Lena continued by explaining how usually one of the teachers would suggest that Gitte had a day off from school when they felt she needed it. The need for time off was recognised by observing Gitte's behaviour. As Lena told me:

*'She completely changes her behaviour: everything is a problem.'*

In their conversations with me both parents and staff at the after school centres referred to the importance of time off from school for maintaining children's health and wellbeing. The staff of the after school centres emphasised the essential benefit of this for children, in that parents used time off as an opportunity to attend and care for their children and to reinforce and restore family bonds. Their concern was expressed particularly in their disapproval of those parents who had a day off from work or even took holidays when their children were still using the after school facility. This point of view was also stressed in conversations with the school nurse, when she underlined, in various ways, the importance of parental (and in particular maternal) care of children and of attending to their emotional and psychological needs. For example she said:

*'Why does a child necessarily need to be ill or have a fever before you can stay at home with them? It ought to be just as legal to stay at home with a*



*child, who hangs around and is miserable and hasn't felt well for a few days  
- and obviously needs to have a day off from school together with mum or  
dad.'*

Thus, the important link between time off, family life and children's mental health was made clear from parental as well as pedagogical and nursing perspectives. This suggests the interplay of at least two more general aspects of thinking. One of these relates to recent developments within the area of child health which recognises the interconnectedness of children's psychological, social and physical wellbeing (see for example Giødesen, 1976; 1979; Stenbak, 1979; 1981). The other refers to a more general defence of and attendance to issues of mental health and well being (Kelstrup, 1983) initiated in the work of the national user organisation, Landsforeningen Sind, founded in 1960, which today is called Sind (and is equivalent to the UK based organisation MIND). Similar work is also done by the more radical movement, Galebevægelsen, active since 1979. These two Danish organisations have led the efforts in Denmark to increase the awareness, visibility and normalisation of mental health issues in the population. This effort has been part of the protest against the social stigmatisation of mental illness as well as a more general endeavour to put physical and psychological health on an equal footing.

A different set of factors contributing to parents consideration of and decisions about children's time off from school related to parents experiences of the significant changes wrought in everyday family life once children begin to attend school. Most Danish children and their families are familiar with the different institutional settings of children's everyday life even before entering school. Already, from a very early age, children will have attended a crèche, childminder and/or a nursery. However, young children's socialisation

into the organisational and relational context of the school was regarded as having a profound influence on the child and their family. It introduced a whole new set of demands and constraints on family life, in that every day routines had to accommodate to the temporal, spatial and organisational demands of the school. Daily routines had to adjust to a new pattern of punctuality and precision, just as, for example, their planning of annual holidays had now to fit in with the schemes at school. Spontaneity and flexibility around 'time off' needed to be balanced against regulations about attendance. For children, one of the most fundamental changes in their every day life was the move from playing to schoolwork, a change that to some extent also affected parents as they became involved in children's every day activities such as homework.

At the same time, however, the spatial and temporal organisation of the school also works to separate the every day world of children and their families (Qvortrup, 1995a). Parents, for example, have only little intimate knowledge about the child's daily life at school and only limited access to it. Thus the radical change in the lives of children and their families initiated when the child begins school, together with the recent introduction of an earlier age for the start of school in Denmark (which means that children are now admitted at school from the age of 4.8 years old), were perceived by parents and the staff in the after school centres as being both demanding on and constraining of young children. They considered them 'a bit too young, really' to go to school. This viewpoint, therefore, also entered into parents' decisions about children's need to have occasional time off for leisure activities.

The above understandings of the different contributory factors to children's need for time off from school were expressed particularly by parents of six to seven-year-old children.

By contrast parents of ten to eleven-year-old children (and the older ones) emphasised instead the relationship between serious work and school attendance. In general these parents were more hesitant to let their child have time off from school. This underlined that their main concern about sickness absence was increasingly oriented to their child's future. They were worried that the child would not be able to keep up with the academic pace of their class if they were away from school too much. This is a finding consistent with Prout (1988) who showed a similar pattern in the perspectives of mothers towards primary school children in the negotiation of absence from school in England.

One final consideration relates to the social organisation of the school itself, as a conversation with Merethe, mother of Nina, a ten-year-old, and Dorte, a fourteen-year-old, revealed. Merethe works as a college teacher and talks about her decision about time off in the following way:

*'Once we took Nina off one day to visit her grandparents, because it suited us best at that time. But, usually, I think they must go to school. Even though I can see it might sometimes be a waste of time. If so and so (the children's proper teacher) isn't there, then they have any odd teacher.'*

Merethe then went on to express her concerns about teachers' absences in more detail, a concern she shared with several parents of the children in fourth grade of Egeskoven. They felt that the allocation of a substitute teacher, with perhaps a less professional credibility, inevitably influenced not only how good and effective the teaching was but also how content children were at school. They would repeatedly bring to my attention those occasions when they saw the school as not providing a stable organisational context for

their children's education. At times the school relied on supply teachers, a state of affairs which many parents were dubious about and thought may lower the quality of teaching. More generally, their concern was that a reliance on supply teachers at Egeskoven affected children's every day sense of stability and continuity.

Thus, with regard to the question of time off from school, the parents' experience of the school and their increased concern with the children's attainment and future career in school sometimes struggled with the recognition that children would not necessarily 'miss out if they were away from school'. Often parents justified their decisions to allow time off school by referring to what they read as the school's lax attitudes to teaching and the importance of children's education.

### **Family Holidays**

Having discussed how children's absences from school appeared in the accounts of parents, teachers and after-school staff, I will now explore the family holiday as another form of time off which in certain important respects parallels some of the themes around mental health and wellbeing raised around sickness. Recent years have seen a growing interest in sociological and anthropological studies of tourism (for example, Turner and Ash, 1975; Feifer, 1985; Cohen, 1988). Urry (1990:141-42), a leading sociological writer on the subject, traces the origin of the family holiday. He describes how, up until the nineteenth century, travel was a privilege solely for men of the upper classes but gradually, partly as a result of women's own economic activities, the independent woman traveller became visible. Later still, this was followed by the couple-based holidays that formed the basis for early forms of mass tourism, such as the popular holidays in the English seaside

resorts taken by the working classes. During the nineteenth century holidays also began to include children and, by the inter-war period, the family holiday became particularly child-centred. In England this development often took the form of the holiday camp of the 1930s with its many organised activities for children. Today one of the predominant advertising images is:

The 'family holiday', that is a couple with two or three healthy school-age children. (Urry 1990:142).

In Denmark this sort of image is common in the months leading up to the main holiday seasons when newspapers, television and magazines bring out advertisements aimed at 'mainstream' families. These seek to persuade families to exchange their daily routines and constraints with family-centred experiences and activities. The aim of creating a family idyll is emphasised by colourful pictures portraying traditional values of harmony, happiness and joy (Frankenberg and Hunt, 1991). Happy families are situated in ideal environments where, in the words of the advertisements, 'children are no hindrance' and the local people are 'fond of children'. These settings thus promise that family members, while relaxing or engaging in different activities, will be able to restore their personal well being and revitalise their social relations. Travel and accommodation arrangements are often featured as comfortable and inexpensive, even homelike, and acknowledge that conventional family holidays involve the consumption of special foods, drinks, sweets, entertainment, toys and special holiday issues of children's magazines.

Another large group of publications advises parents to plan their annual holidays in such a way that the needs of both children and adults are met and the inherent problems of

holidaying together are addressed in advance. These articles consider practical arrangements, including guidance on specific prophylactic and curative medicines, and they often point out the conflictual aspects of family holidays. One theme, for example, suggests how a dynamic balance can be achieved between the personal and collective interests of family members during the holiday. A newspaper headline in 'Søndagsavisen' (February, 1994) captured this typical theme. It read:

Winter Holidays - Children's Dream, Parents Nightmare.

The article contained specific advice and suggestions on how parents could entertain and engage the children during the holidays so they would not get bored or whine and thus become a nuisance for adults. Holiday companies, who have recognised the potential conflict of interests between adults and children, will organise day care facilities, special play hours, game-activities or whole day arrangements (one, for example, is called: 'Viking/Pirates Day'). Here children participate without the supervision of their parents, which allows adults some spare time to relax and spend on their own terms.

For most Danish families to be on holidays means to be outside and 'close to nature'. In winter families go on skiing holidays and in the summer they go to the beach or woods in a foreign setting such as the Mediterranean. Holidays spent in Denmark, in the familiar settings of the countryside, in a summer cottage or at a campsite, are also popular. Holidays are seen as a time for indulgence in pleasure and entertainment. 'Eating out' means consuming drinks, festive and 'junk' food in a less regulated way than at home. Holiday time allows family members to focus on their own needs and interests because what is at stake is both the creation of togetherness and the recuperation of personal well

being. In this recreative endeavour, the restoration of familial bonds and values with children are central, and parallel the recreative acts that, as described above, can take place within the family when a child is sick and takes time off from school. Family holidays aim to affirm the statuses, positions and roles in the family and, although it is publicly performed, its focus is to maintain the inter-relational aspects of family life. In sum, family holidays are family time together. This is so despite the fact that, as mentioned above, conflicts and different expectations are foreseen and are the subject of social negotiations between family members. These include how time is best spent, together or separately, and how time is allocated between children's interests and those of adults (6).

### **Time, Sickness and Social Relationships: Child Illness in the Family**

That time and sickness are intimately related became clear for me in the late 1980s when I carried out two different studies in Denmark on people with stroke and their families (Christensen and Rasmussen, 1990; Backer and Christensen, 1992). A key feature of the data was that in the event of stroke, family members experienced sudden temporary changes, as well as permanent disruptions and alterations, to their usual time structures. A stroke instigated a situation of interdependency in which family members found that previous time structures both collided and became diffused. The time structures, which families previously experienced as fixed and rigid, would be confronted with structures that were suddenly flexible, flowing and unpredictable. These changes occurred on a number of different levels, from existential questions relating to an alteration of their life course perspective to the everyday organisation of time, with its changing patterns of rest and work and problems in the planning and accomplishment of ordinary tasks. Although the poignancy of this situation derives from both the disruptive and permanent character of

stroke, I suggest that in the performance of everyday child sickness a similar, although transient, pattern can be seen. For both children and adults an illness event involves the loss of their usual and everyday time structures and routines.

In the first place, this is because 'rest' and 'recovery' replace 'school' and 'work'; every day routines have to be adjusted to medicine schedules, altered meal times and sleep patterns. Second, it is because children's sickness episodes are, as described above, seen as sociable family events like holidays. This has a particular effect on the experience and structure of time. The time that a child usually spends on their own influences their perception of control over their own time and of their general independence (Solberg, 1990). Families also define 'togetherness' in and through time. Thus changes in the time that parents and children spend in each other's company will inevitably impact on the symbolic meaning of 'togetherness'. Time spent apart may, thus, lead to a weakening of togetherness, such that it comes to be seen as intermittent. Time spent together may, on the other hand, symbolise the intensity and strength of their relationship. In this respect everyday sickness constitutes a break in the usual patterning of child-adult relationships. When children and adults usually spend most days separately at work or at school then, as I show below, a child's illness episode provides the family with time to spend on activities together.

Children and parents outlined for me two contrasting images of family sickness. The first was when an adult in the family was ill. The keywords of adult illness and care were those of individuality and isolation. These were to be provided with only a minimum of interruption for the necessities of food and drinks. The adult preferred to be left alone, letting the body, a prescribed medicine or a home remedy fight the disease while body and



soul suffers in isolation. During recovery the adult preferred to spend time on individual activities, like reading or watching television, which require concentration and silence. A mutual consideration characteristic of care-taking within the family was to follow and fulfil the 'patient's' wishes and demands of care, limited only by what the care-taking adult family member defined as 'possible' or regarded as preventing or non-beneficial to the recovery.

The second, contrasting, image was the typical illness of a younger child (from infancy up to about twelve years old). This was presented as a sociable event. In the time of illnesses such as a severe cold, flu, a viral infection with fever, or childhood diseases such as rubella and chicken pox, the ill child became the centre of family attention, especially from parents. This was marked in both space and time in the home. During the day the child was the literal centre of family life and activities. He/she was placed in the lounge on the settee in front of the television or sometimes moved, with their bedclothes, around in the house to accompany their parent while he/she was busy doing domestic work or had to complete professional work tasks. During the first few nights some of the children slept in their parents' bed or parents' room, though usually the mother chose to sleep in the child's bedroom to comfort or to assist if necessary.

Children's drawings (7) of 'the last time you were ill' typically showed a child lying in bed surrounded by stacks of dolls, teddies and children's comics such as 'Donald Duck' (See Figures 1-3, as examples). The child was in front of the television and in some pictures they were receiving presents or sweets from a parent. In my conversations with children they talked with contentment about the time they spent with a parent or a grandparent during illness. They enjoyed being at home and their descriptions of the unexpected break

Lea  
Zat

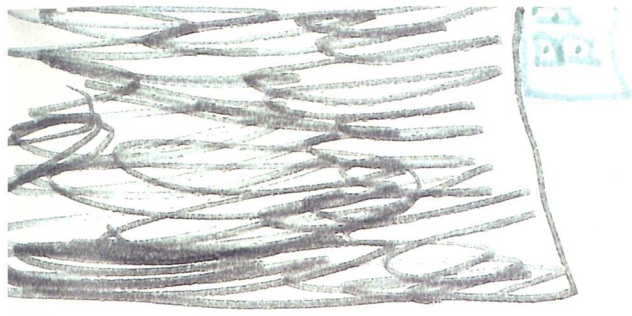
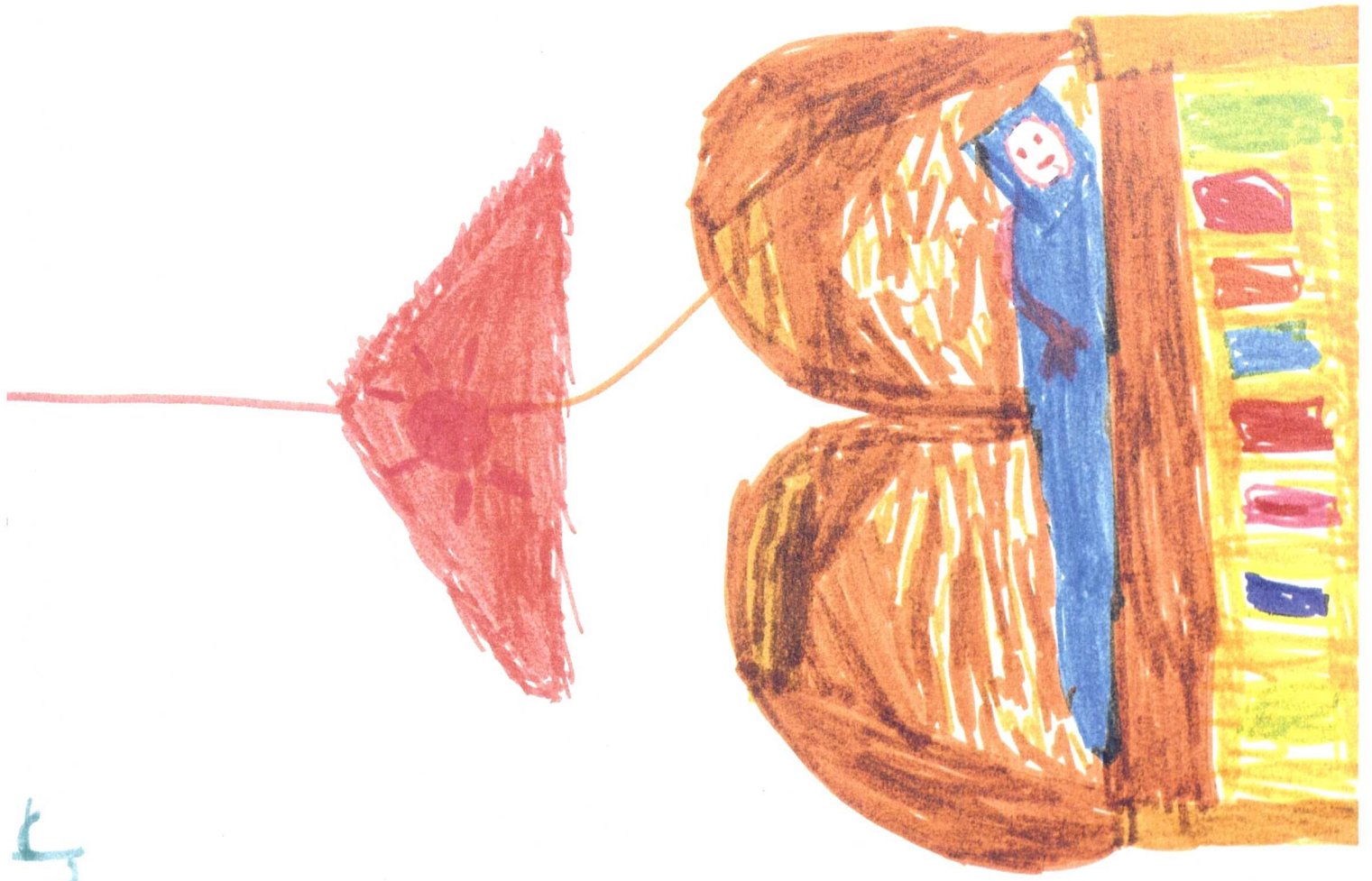


FIGURE 1

Morten

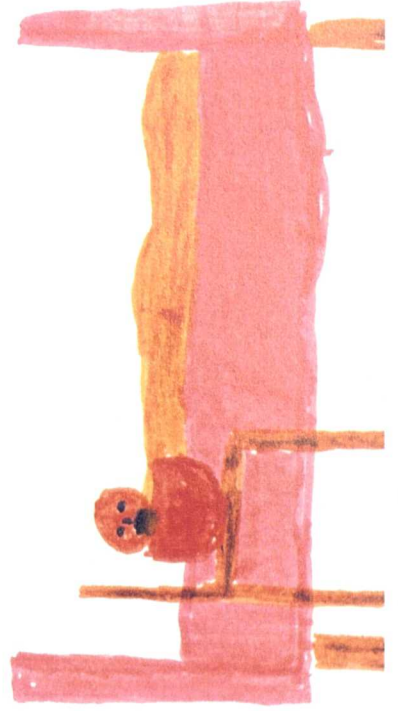
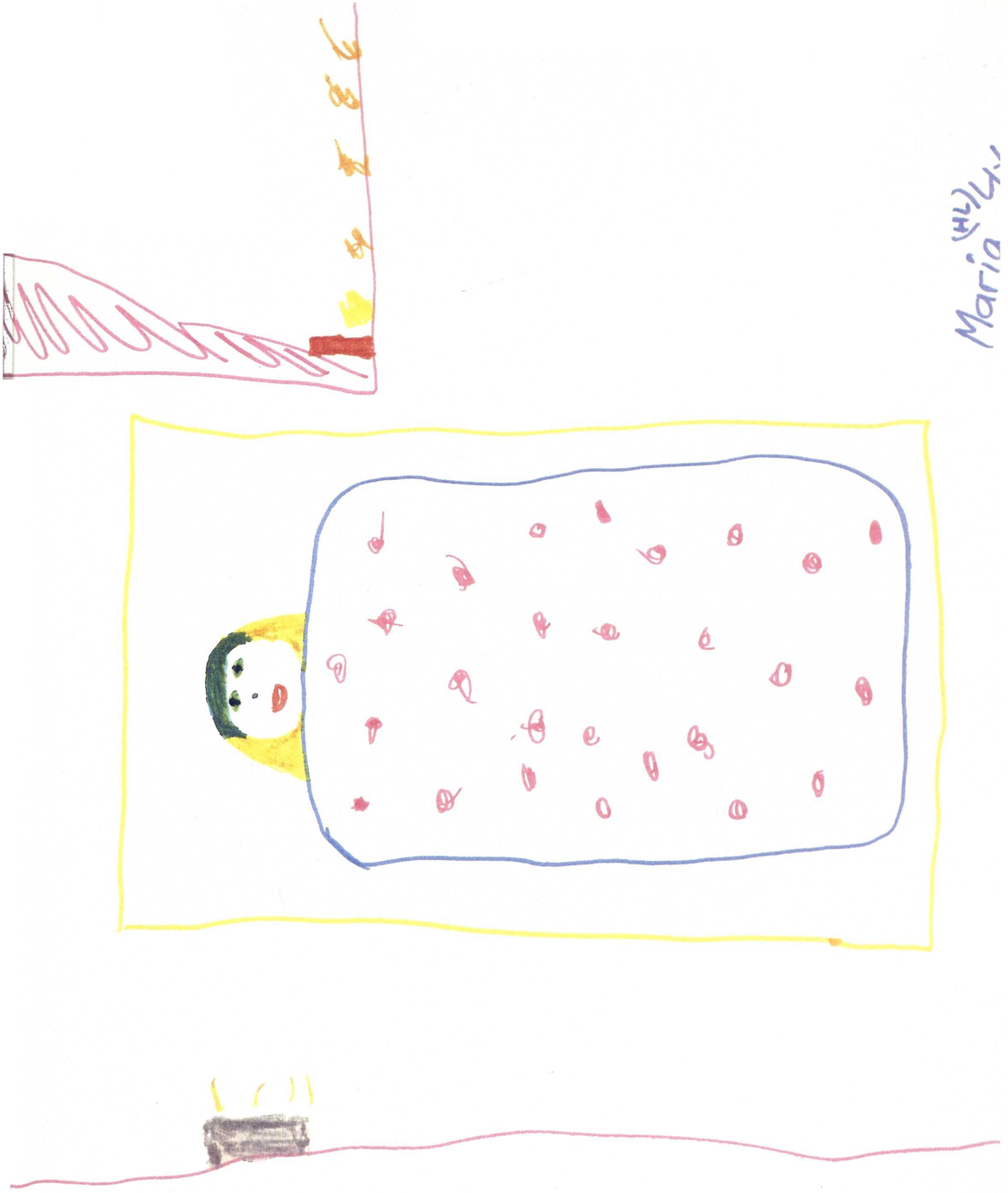


FIGURE 2



Maria (44) 4.1

FIGURE 3

from school resonated strongly with how adults also described illness as a relief from work demands. The centrality of the bonds between members of the immediate nuclear family was further accentuated in that children did not usually receive visits by their peers or even grandparents during illness. Some children added that they were not allowed to play with a sister or a brother, or even allowed in each other's room, during illness because their mother thought the ill child needed to rest. This suggests that during illness a significant emphasis was put on the meaning of the social bonds between child and adult and, in particular, on the maintenance of the bond between parent and child. Lena, for example, explained how she and her husband prioritised the importance of parental care during their children's illness episodes. She said:

*'We don't really want anybody else to look after them. We move the television into our bedroom so they can lie in our bed.'*

In many ways sickness events call up the key parental values such as affection, protection, care and responsibility. In the practice of these, cultural conceptions of children as vulnerable beings are emphasised (see Chapter 7). This creates the second contrasting image in which sickness, paradoxically, both brings child and adult together but at the same time serves to polarise their different positions (see also Chapter 7 and 8). Thus childhood sickness provides parents with an occasion explicitly to communicate what is seen to be otherwise understated in everyday life: parental 'worship' of the child, a phenomenon which is essentially unidirectional, from the active worshipper to the worshipped, and implicitly passive, object. For parents, who often felt occupied or tied up by the demands of everyday life, and not able to focus intently on their child, illness episodes were, therefore, in a sense welcomed as 'an opportunity to spend some time

together'. During illness and recovery children and parents spent time together on those activities that they felt were otherwise downplayed in a hectic everyday family life. Even though the activities could vary greatly between families, there was a common factor in children's and parents mutual appreciation of the togetherness (or 'cosiness' - in Danish 'hygge') found in activities such as playing a game, talking and cuddling or watching a video together.

The consideration constituted through this family care was to fulfil the ill child's wishes and needs, a consideration only limited by what the adult found possible or detrimental for their recovery. This was illustrated in parents' concern to encourage their children through offering favourite foods and special treats. Lena, mother of Billy, two-years-old, and Gitte, six-years-old, said:

*'They (Billy and Gitte) get whatever they want, when they are ill. If they want to choose empty calories, they get that. Chips, pancakes and so on.'*

In children's accounts, in addition to parental company and care, it was these sweets and presents that most children associated with illness and which they most cherished. Seven-year-old Catherine pointed humorously to this commonality of children's illness experiences when she contrasted it to her own experiences. She said:

*'Some (children) get sweets and some get presents. I don't get anything. The only thing, I get, is my temperature taken and I don't like that.'*

Nina, ten years old, said:

*'The best thing about being ill is getting ice cream. If you have a sore throat it can be quite cosy ('hyggeligt'), because then you can go about and eat liquorice.... The worst thing about being ill is throwing up and have a headache.'*

However, in their accounts Catherine and Nina also capture the ambiguous meaning of sickness for children: for most children the privileges of illness (like presents, sweets, togetherness and cosiness) never 'really' compensated for its disadvantages. Seven-year-old, Dorte underlined this:

*'It's nice to be ill if it's only for a few days, but if it's for several days it's boring.'*

And another seven-year-old, Michael, said:

*'I'm happy but never really happy when I am ill.'* (original emphasis).

When I asked children how they felt when they were ill only a very few children unambiguously or determinedly said that they felt unhappy. Bodily discomforts and parental restrictions that hindered their usual activities contrasted with the pleasure of experiencing special care, eating sweets and a sense of togetherness. However, the children also bemoaned the fact that illness meant that 'Then I cannot do anything', 'I cannot play', and 'I cannot do what I usually do'. Most children lived in areas of detached houses with gardens and peaceful streets around the school, which meant that they would usually spend most of their time after school (or after-school centre) and at weekends playing outside. Their perception of illness as deprivation was marked by regret at not

being allowed outside. In a conversation six-year-old Tom said with a dreamy, contented smile:

*Tom: When you are ill - mum cares mostly for the one who is ill.*

*Pia: What happens when one of your sisters gets ill, Tom?*

*Tom: It's the same, but then you (I) can be outside playing.'*

In such ways children's sickness episodes, like holidays, can be seen as spatially and temporarily bounded to the idea of the family and the home with the cultural performance of sickness working to confirm important aspects of children's status within the family. During sickness the child is a cherished and sociable centre but, at the same time, their dependence and its associated confinements are established.

### **Conclusion.**

In this chapter I have suggested that the cultural performance of everyday childhood sickness at home or in the family can be understood as a form of 'time-off' in which the bonds between parents and children are celebrated for a temporary period. This must be seen in the context of the fragmentation of modern family life and an ideology that, in response, creates notions such as 'quality time' and the 'nursing' of relationships. In this sense there are parallels between everyday child sickness and the family holiday. Both are forms of time-off, structural breaks as Turner and Turner (1978) call them, that prioritise recovery and recreation and are marked by departures from conventional patterns of behaviour. I do not suggest, however, that the family holiday is the dominant cultural form that shapes everyday child illness. Rather that the two activities shape each other and the



relationship is a two-way one in which, for example, the language of health ('nursing') can be used about holidays and vice versa.

My analysis has also noted two further features of the cultural performance of child sickness. The first is that its referents are polyvalent, not solely oriented to family holidays, but also to the future. I found that, especially as children grow older, sickness becomes thought about by parents in terms of their child's schooling, especially the demands this places on them to attend school and make attainments there for future employment. Second, I have suggested that the celebration of family togetherness has a paradoxical effect that is echoed in children's accounts about the ambiguities of the experience. Here, I suggest, we can see the elements of nostalgia, as child sickness becomes the focus for a celebration of a primary social bond between parents and children. Even this, however, is complex and ambiguous. On the one hand the creation of 'hygge' produces closeness, treats and special treatment; on the other hand it confirms and highlights children's position in the family as dependent and vulnerable.

### Notes

1. It should also be noted that I focus, as with my analysis throughout the thesis, on the everyday aspects of children's health and illness and do not include questions of chronic or serious illness in childhood, which I expect need a somewhat different interpretive framework.
2. It may be that this more varied and contradictory set of referents for childhood sickness found in my fieldwork material was due to the wider range of methods and

informants to which I had access. Whilst Frankenberg relied on essays by school children I used participant observation as well as informal and formal interviews with both adults and children. My fieldwork also often referred to contemporaneous episodes of sickness rather than to 'being ill' as a normative phenomenon.

3. Here I am making a direct translation of the formulation of such questions in Danish. The question in Danish is 'Har du rekreeret dig selv?' which literally means to re-create or rebuilding the body (mentally and physically), for example through rest. It finds its equivalent in the English usage of the phrases, 'Did you have a good rest?' which indicates ideas of recuperation and restoration.

4. In translation I used 'nurse' to capture its connotation of the ill health of relationships and actions that will recover them. I could also have used 'care for', which perhaps would have been just as appropriate but it puts more emphasis on emotional involvement and the expression of social bonds.

5. The following account is based on interviews and conversations with parents and professionals. Although apparently missing children's perspectives on these issues, this does not mean that we should understand children as passive or without any influence in family negotiations about time off. On the contrary (as later chapters will show) they are engaged and active in many other aspects of their lives. Their absence from my account here derives partly from two methodological problems: the first is that my actual observations of interfamilial relationships and interactions were few and far between; the second relates to the representation of children in the accounts of adults. In the conversations that I held with adults, it was emphasised that time off

from school and work is formally the responsibility of adults and institutions. These issues were primarily presented to me as being the concerns of parents, rather than seen as questions which involve negotiations with children. Other studies, for example Prout (1986), as well as my own fieldwork with children reported in later chapters of this thesis, show that school children are active in negotiating sickness absences. However, in adult accounts children's contributions were rendered invisible and they were seemingly excluded from familial negotiations and decision making.

6. That the importance of time during family holidays is linked with values such as 'freedom' and 'having control over one's own time' was exemplified to me in a discussion between a mother and her two daughters outside a supermarket during the summer vacation. They had obviously just begun their holidays and, while waiting, one of the girls suddenly wanted to make plans for the holidays. She asked questions such as: 'So, what are we going to do tomorrow?'. She also wanted to know about the more detailed planning, by asking 'And after that, what are we going to do then?' and 'Will we also have time to go to the beach then?' Her mother, on the other hand, seemed distracted. Her answers went like this: 'I don't know, yet', 'Maybe' and 'Of course'. From her answers it was obvious that she was less keen to give precise answers or, indeed, commit to any specific planning. After some exchanges between them, consisting of the daughter's persistent questions and the mother's reluctant answers, the mother exclaimed with great impatience and emphasis:

*'Now, you stop it!! We are on holidays and I am not going to make any plans. We will see, what we want to do. I am not making any plans and that's it.'*

In the mother's persistent reluctance to give any commitments and her final objection to the idea of planning their holidays, she emphasised that 'holiday time' means 'free time'. It seemed that, in her view, holidays meant trying to avoid any notions of routine or the sort of time pressure that may signify everyday work and family life. Their conversation illustrates that time in families is contested. In this respect the daughter, in her questioning, was seen to challenge the idea that holiday time is constituted as time 'outside the normal time' suggesting rather that it was 'free time' open for negotiations and plans.

7. I asked eighteen children to make a drawing of 'the last time you were ill yourself (or somebody you know was ill)'. The children were keen to claim authorship of their drawings and they all decided to put their name on it. Eleven children's drawings illustrated the time during illness and recovery. The last seven drawings were more varied. One drawing, by a six-year-old girl, was of a girl walking around in the lounge coughing with 'air that comes out of the mouth when you cough'. Two children pictured themselves becoming ill. A ten-year-old girl, explaining her drawing, described the circumstances of herself getting a headache and feeling unwell on a day she had painted a marshmallow machine with a friend. They had been painting in the playground in preparation for the harvest festival at the after school centre. A six-year-old boy made a drawing that showed how a family member had thrown a stone and he was hit by it. Friends and family had been on a picnic when the accident happened. The drawing showed all the persons involved in the accident on the beach. Two seven-year-old boys made two identical drawings of a traumatic incident that they had experienced separately. One of the boys started to copy another boy's drawing and then he told me his 'own' account of his experience afterwards. The two drawings showed a face with a big lump the size of the head on top of it. The head was 'throwing up', which was illustrated as a 'pond' of a similar size coming from

the mouth (see Chapter 6). A six-year-old girl made a drawing of her room and her bed in front of the window. A 'smiling sun' could be seen through the window but there were no people on the drawing. One seven-year-old girl and one seven-year-old boy made a drawing of their younger sibling being ill. The girl showed herself asking her younger brother whether he would like an ice cream, which she then had gone out to buy to him. The boy pictured his little sister crying: 'vraeh, vraeh, vraeh' (as text on the picture). Their granny was looking after her and she was drawn thinking (also put as text, which he asked me to help him to print on the drawing): 'Oh, if only Tim was here'. He explained to me that the grandmother became increasingly upset while his little sister was ill and crying. His granny was hoping, therefore, that he would come home from school soon and help her look after his sister. A six-year-old boy told me that he could not draw anything and sat watching a group of other children drawing. I asked him whether he would like to draw something else or whether he would prefer not to paint at all. After some consideration, he decided suddenly that he wanted to make a drawing of a tree. I was somewhat surprised and he explained that he liked to draw trees at home with his mum. Afterwards we had a conversation about being ill at home and at school. A ten-year-old girl said she couldn't think how to draw a picture of what I had suggested. When I suggested she could make a drawing about 'being healthy' she made a picture of people playing and jogging in a park.

## Chapter 5

### THE SOCIAL CONSTRUCTION OF HELP AMONG DANISH CHILDREN: HEALTH AND ILLNESS AT SCHOOL

#### Introduction

Whilst home and family were the focus of the last chapter, here I turn to Egeskoven School and the two after-school centres associated with it. These were also main sites for my fieldwork. Children spent a large proportion of their time there each week, arriving each weekday at about 8.00 a.m. for school, moving to the after-school centres after lunch or in the early afternoon and staying there, in some cases, until about 6.00 p.m. Children frequently experienced minor illnesses or accidents in school and after-school institutions and the actions and interactions around these form the topic of this chapter. I first focus on how, during such incidents, children give help to other children in the everyday life of these institutions and argue that, in order to understand children's evaluation of and communication about help, a cultural approach that distinguishes between the intention and the motive of an act is needed. Through this it becomes possible to recognise children's individual actions as embedded in a collective strategy and I discuss the relationship between this illness related action and children's broader cultural practices that are the other constitutive elements of their everyday life. The manner in which children give care to each other is understood in ways similar to those suggested by Corsaro (1992, 1997; see also Chapter 1 of this thesis). In this respect it is worth underlining a point made

in Chapter 1. It is that a focus on children's practices and constructions does not mean that the children's lifeworld can be understood as isolated from that of adults. On the contrary the children's practices take place in settings created and shaped by adults and in many respects parallel features of the adult ones. However, whilst the children's lifeworld is not an autonomous one, it, nevertheless, has its own characteristics. The meaning of help giving, which is the focus of this chapter, must, therefore, be seen as refracted through these specific childhood forms and practices.

Let me illustrate the importance of understanding children's help giving on such a basis by providing some of the background context to 'help' at school and in relation to schoolwork. The children were required to work and perform individually in specific subjects or when working on particular sub-themes. By contrast, in project work or in working on particular subjects, teachers put great emphasis on or even insisted that children should work collaboratively together. Help giving was thus, in general, but certainly during such project work, encouraged as a positive quality in children by teachers. Some types of help were, however, regarded by the teachers as children's attempt to cheat. It could be seen in this way when, for example, children copied from each other, gave each other too much help (such as telling another child the result of a calculation) or when help was given at an inappropriate time, i.e. when children were expected to work on their own. Children, having understood the generally well respected notion of 'helping each other', therefore used the notion of help to escape, sometimes successfully, boring individual tasks or to avoid their teacher's disapproval when 'messaging about' and not doing the work assigned by the teacher in a lesson. 'I was helping' could

thus be a useful reply, if they were challenged by a teacher who had discovered that that they were unoccupied, chatting or engaged in the work of a friend, rather than occupied with their own work which was left untouched. In sewing lessons, for example, the teacher emphasised the children's individual conduct but, in particular, some of the boys found these lessons 'boring'. They, therefore, found some satisfaction in doing the cutting, measuring and sewing on the sewing machines together in pairs or with a girl. This meant that they would, for example, try to pair up with a girl who liked to sew, so that she would happily take over doing it for them. In the same way the girls who enjoyed sewing would encourage the boys to let them do the task for them. However, the children were sharply monitored by the teacher. On one occasion the teacher was busily occupied with helping some children while, at the same time, trying to keep an eye on the children who did not complete their tasks independently. Thus, when the teacher would watchfully ask, for example, 'Peter what are you doing there?', the boy could gain some peace by saying 'I am just helping, Michael'. This reply was, in some respects, more effective in avoiding the teacher's disapproval than if he had answered: 'I was just looking'. In such situations children would be asked by the teacher to go promptly back to their own seat and work on to get on with their own sewing.

These preliminary observations suggest, therefore, that help-giving takes its meaning from the context in which it is embedded. In this respect I was able to observe help actions around everyday illness and minor accidents in different contexts. Specifically, I was able to observe the whole incident, such as children stumbling and hurting themselves, more or less from start to finish. This included periods when the children acted without adults



being present and those when adults had arrived on the scene. It was through these events that I began to notice the performative shape of the children's actions, the changes that the arrival of an adult brought and the different shape of events from thereon in. By talking to the children and adults concerned, and puzzling over their replies, I was able to see the very different perspectives from which they acted. In the last section of the chapter I focus in particular on 'the act of looking' and some temporal aspects of children's worlds and examine how these relate to understanding childhood sickness and the social negotiations between children and adults.

The theoretical approach of the analysis presented in this chapter thus continues the dual themes of children as social actors and sickness as a cultural performance which underpin the whole thesis. In general this is based on theoretical notions about social drama and communicative interaction utilised in critical medical anthropology (see Chapter 2). At this point, however, I also introduce Schechner's (1988, 1990) ideas about the performative aspects of social life into my discussion in order to show that the children's collective practices, made visible through my ethnographic study of children in the school and after school centre, can be seen to conform to the general pattern of performative action that he describes. In the first place, and as a step towards showing how children's individual acts of care-giving can be seen as having a cultural base, I will set up a theoretical difference between the 'intention' and the 'motive' of an act.

## Intention and Motive

In order to understand children's help giving as embedded in a collective culture it is necessary to make a distinction between the intention and motive of an action. It became clear, as my fieldwork in the school and the after-school centres developed, that children's help as an intentional act, could not be comprehended as being only concerned with the person as an agent. Rather, it was important to emphasise the perspective of the recipient or, more specifically, the person towards whom a help action (1) was directed and to place this in the context of social action. Through this approach important aspects of the total interplay in children's mutual construction of help become visible.

In examining help as an intentional act, I draw a distinction between the intention and the motive of a help action. This definition is inspired by Kirsten Hastrup, a Danish anthropologist, and her discussion of causal explanatory models in science. Hastrup (1990: 199) uses as an allegory for her ideas the philosopher Philip Pettit's (1976; Macdonald and Pettit, 1981) highly psychologically inspired everyday or orthodox conception of agents, and his distinction between the intention and the motive of an action.

The intention of an act relates to questions such as: what was the purpose of the action and what reasons does the actor give? However, this can be supplemented by a more indirect and unconscious explanation, that is the motive of an action, which relates to the implicit assumptions of the final causes. Systematic intentions are to be understood as a strategy, while the systematic motives constitute an individual character (Hastrup 1990; Macdonald and Pettit 1981), which I will argue points to a more general or complex level.

Hastrup argues that the distinction points to two different levels of abstraction: intention applies to an empirical level and motive applies to an analytical level. Hastrup's contribution concerns causal analysis, but her distinction corresponds to another similar distinction suggested by F. Allan Hanson (1975) that enables me to refine my arguments. Hanson argues for a differentiation between individual and institutional questions in the analysis of human phenomena. He distinguishes between intentional meaning, which relates to the level of individual acting, and implicational meaning which relates to institutions, that is to say it concerns concepts, forms of organisation, roles and patterns of behaviour. The implicational meaning concerns the thing in question, and the way in which this is linked by logical implication to other ideas, customs and patterns. Hanson further emphasises that neither level of abstraction can be seen as above the other, rather they operate from two different perspectives.

During my fieldwork many of the children talked about the help they got from other children. For example, six-year-old Gitte recalled the following in a conversation we had:

*'Pia: Have any of the other children helped you when you have been ill at school?*

*Gitte: Yes, Katrine, she has helped me. She gave me some sweets and things like that. She played with me and looked after me. And been considerate of me.'*

This can be contrasted to the more instrumental experience that she reported in relation to teachers giving help in the next question and answer:

*'Pia: Have the teachers helped you if you have been ill?*

*Gitte: They just said, 'Well, then we'd better fix it.'*

However, some of the accounts, and in particular the one given below, were less easy to understand. These prompted me to examine the children's actions by drawing on the related set of distinctions, between the intention and the motive of help actions. These allowed me to see and demonstrate another level at which the construction of help amongst the children was taking place. The following, seemingly contradictory, incident from my fieldwork in one of the after school centres illustrates its importance. I quote from my fieldwork diary:

*'Michael a seven-year-old suffered from headache and fever this afternoon. While he was waiting for one of his parents to take him home, he rested on a sofa in one of the playrooms.*

*Later he told me:*

*'A girl helped me in the after-school centre today.'*

*I asked: 'What did she do?'*

*Michael said: 'She turned down the music and told the other children to be quiet.'*

*Michael paused and then he said: 'But really, the music did not bother me!'*

In Michael's account there is an implicit contradiction. Michael perceives the action at issue as help, even though it might just as well be interpreted as being of no help at all: 'But really, the music did not bother me'.

In examining this incident a question of an intentional kind results in answers such as: 'the girl turned the music down, because she links the cause of the headache to loud noise and by reducing the noise she wanted to relieve Michael's pain and make him feel better.' If, however, we want to understand the other part of Michael's perception, which is that the girl 'helped' him, although what she did literally did not 'help', then we also need the concept of motive. This is because the action at issue derives its meaning from an understanding of implicit cultural ideas and beliefs of help. Michael perceives the act as a symbolic expression of help.

The symbolic approach in anthropological studies tends to see the conceptual framework supporting the social order as, at once, both more and less than purely rational. Many actions and practices are regarded as symbolic expressions of non-rational choices, and have tended to see the acquisition of ideas as 'communication' - whether these are tacit or explicit communication (Shweder 1984: 48). It has been suggested that socialisation may be seen as founded on 'tacit' communication, through actions defined as expressive symbolic actions, which are ways to express something about constructions of realities, that are not dictated by logic or science. This, I will argue in later chapters, underpins much of the difference in perspective between adults and children. Whilst adults make explicit aspects of care such as giving various treatments, focusing on the naming of body

parts (see Chapter 6) and the instrumental investigation of whether the child has a 'real' illness (see Chapter 7), children read the implicit or tacit social relations that are expressed within them.

Here, however, I want to highlight how, in their interactions with each other, children experience and communicate cultural ideas about help, in this case the motive of help-giving. This argument, however, suggests that children strongly evaluate help from the perspective of the motive, which they treat as prior to the intentional meaning of the action. I will elaborate this point further through an exploration of intention. Analysis of communication acts points to the interrelationship between the content, the form and the context of an act (Eco, 1979). I will now examine the construction of help from this perspective. The following event, which took place one day in school, is a useful starting point. My fieldwork diary recorded the following:

*'Carin, who is Anne's thirteen-year-old sister, had injured her knee in a basketball game. To comfort Carin, Anne offered her an ice cream but, as she had already taken a few bites herself, Carin refused rather sulkily to receive it.*

*A few days later the 4th graders celebrated a birthday. Anne and her best friend Linda saved some of the sweets that had been passed among the children. Leaving the classroom, Linda suggested: 'Anne, why don't you give Carin one of the sweets - maybe she will be happier with that.'*

*Later they explained to me why Carin had refused the ice cream.*

*Anne said: 'That's how it is between brothers and sisters... she is the eldest and she is also at a 'difficult age' (Anne refers to the transitional phase from childhood to adolescence). Linda added what she saw as the obvious reason: 'There were other children present', that is Carin would have felt humiliated accepting the ice cream in front of others.'*

Linda's suggestion that the action be repeated with another content implied that Carin would be able to receive Anne's gift, despite her personal prejudices and the public context. Like the first example about Michael, the action of help carried meaning beyond the actual content of the action. Furthermore, Anne and Linda's story shows that, by experimenting or juggling with repetition and changeability of form and content, children express the motives of their action. Linda recognised the possibility of repeating the form of support with a changed content in order to establish a mutual understanding of the motive of the action.

The two examples given so far in this chapter concern actions separated from their context and I have done this in order to clarify my point about intention and motive. However, my next example serves to contextualise episodes of sickness, minor accidents and help actions in children's culture. Furthermore, it suggests the importance of recognising children's individual actions as they combine in a collective strategy of help. In doing so it underlines, in a new way, Corsaro's insistence that seeing children's actions within the

context of the collective culture, which they produce through their interactions with each other, is crucial for an understanding of how children experience events. The incident (as recorded in my fieldnotes) went as follows:

*'Three six-year-old boys were playing in the sandpit at the after-school centre making tunnels and breaches in them with a water tube. The rhythms of the play were constituted by the constant shift between periods of eager digging and covering the water tube with sand and periods of waiting for the water to break through. Suddenly their playing was interrupted. Peter hit his bare foot with the shovel and started to scream and cry. Christian immediately ran into the building shouting repeatedly: 'Peter is crying'. Peter himself entered the nearest door so that the two boys arrived at almost the same time in the kitchen. One of the adults then took care of Peter and Christian returned to the sandbox, where he and Martin continued to play.*

*I arrived at the sandbox and asked: 'What are you doing?'. And without stopping they proclaimed: 'We are working'. While talking about the incident Martin showed me convincingly how Peter hit his foot. I asked: 'What did you do then?'*

*They told me in detail, how Christian ran inside to tell one of the adults. Then I repeated the question to Martin, who answered with surprise: 'I was looking after this', circling his arms around to show the imaginary boundaries of their playground in the sandpit.'*



What Martin draws attention to, first of all, is the physical conditions of play among larger groups of children. These mean that when a child leaves a play site or their playthings, other children will take over and maybe destroy what has been built. Children can, of course, fight for and claim their rights. However, by virtue of the power relations among children, it can be difficult for a younger child to succeed in this endeavour.

Martin's staying in the sandpit, while Christian made sure that one of the staff helped Peter, essentially ensured that Peter's accident did not affect them all. Christian and Martin could continue their particular 'game' immediately following the incident, which also allowed Peter to return. By taking this role Martin guarded not only the physical terrain, but also in a wider sense he protected the 'game' itself. Through contextualising Christian and Martin's practices, it is possible to acknowledge their individual actions as being interconnected and directed towards solving multiple aspects of the incident. This was carried out through the boys implicitly organised 'division of labour'.

By focusing on the individual actor it would have been theoretically possible to establish the systematic intentions of help which constitute the individual's strategy. This, however, would then emerge merely as a pattern aggregated from individual acts. My approach, however, is similar to Corsaro's, in that it argues for an understanding of children's individual actions in the context of a collective strategy of intentions of help. I also want to integrate this with the cultural performance approach to sickness outlined in Chapter 2 of this thesis. To develop this idea further I, therefore, now examine everyday episodes, wherein help may be performed, in terms of social drama.

## Events and Social Drama

During fieldwork I focused on three kinds of episodes which, as daily events, take on the character of social drama (Turner, 1974, Schechner, 1977). These were: acute, non-life threatening illness episodes and complaints of feeling unwell; sudden minor accidents in school or after-school centre; and conflicts among children. The examples in this chapter are drawn in particular from the first two types (but see Chapter 7 for a discussion of conflicts between children). By looking at events such as these as social dramas, I will suggest that it is possible to move from a focus on meaning, motive and communication, of and between individuals, to an understanding of collective interactions.

Sahlins suggests that any event can be seen as a relation between a happening and a certain cultural system. An event is the empirical form of the system, a happening of significance which is dependent on the structure for its being and outcome. Moreover, the meaning of a specific cultural form can be understood as the sum of all its possible uses in a community, but this meaning Sahlins argues, is comprehended only through events of speech and action (ibid). Hastrup supplements this observation as follows:

Events are (...) happenings of social meaning and that is why they separate out from the undistinguished mass of actions and noise that always surrounds us. It is through events that we experience the structure of the world, and social relations within it. (Hastrup, 1988:131) (my translation).

The analysis of such events as 'social dramas' derives from Goffman's thesis, that all social interactions in everyday life can be usefully theorised as staged and performed (1959); and from Turner's (1974) analysis of conflict or crisis. Turner uses theatrical terminology to describe how these inherently dramatic situations are dealt with, whereas Richard Schechner, a performance theorist, suggests that:

...participants not only do things, they show themselves and others what they are doing or have done; actions take on a reflexive and performed-for-an audience aspect. (Schechner, 1977:166) (original emphasis).

My fieldwork in Egeskoven school and the after school centres showed that almost every day there were incidents around which such dramas were enacted as children were, for example, involved in falls, bumps and collisions with each other. Although each of these may have lasted for only a few minutes, their repetition showed them to have a general pattern. Typically the children would be in the playground. Suddenly a child would stumble, fall on the ground and start to cry. Because the boy or girl did not make any attempt either to stop crying or to continue to play, one of his/her playmates would spontaneously take the role of messenger and run off to tell an adult. At the same time the other children present in the playground gathered around the injured child lying on the ground. Some of the children would comfort him and try to remove his clothes and shoes in order to see what had happened. They might support him under each arm or simply carry him if he attempted to walk up to the teacher. Other children would take the

position of spectators. All the children would express their support or participate passionately in the discussion about the accident and try to establish the roles of those involved, attempting to solve the question: 'Whose fault was it, anyway?'

When an adult arrived, one or more of the children would act as the spokesperson and take pains to explain what had happened while the sufferer continued to cry or just remained passive. From this moment on, however, the adult was in charge of the situation and also undertook the care and treatment of the child. The teacher or pedagogue would send the accompanying children away from the scene, whilst perhaps letting just one child, maybe a close friend of the sufferer, stay behind. This child would usually follow the treatment carefully - either through silent attention or by commenting on the incident or relating a similar experience. Some of the other children would perceive their task as completed and resume playing. However, most of the children would stay close by and perhaps actively prevent other children from interrupting the treatment. After the treatment had been completed they would comfort the child and ensure that he resumed playing.

In this ideal type description, constructed from the many examples observed during my fieldwork, the children's actions of help show the implicit and spontaneous division of labour previously mentioned in the example of Martin, Christian and Peter. However, an examination of the dramatic and performative aspects of the everyday incident shows the collective forms and strategy of help captured in the actions of gathering, performing and dispersing. Richard Schechner suggests that these three elements comprise the basic

performance structure that underlies and literally contains the dramatic structure of an event:

Conflict, in theater, but perhaps in society too, is supportable only inside a nest built from the agreement to gather at a specific time and place, to perform - to do something agreed on - and to disperse once the performance is over. (Schechner, 1977:168)

Once on the scene an adult would take charge of the situation and give any treatment thought necessary. Nevertheless, the scene had already been set by the children who collectively attended not only to the instrumental and expressive needs of the hurt child but also to the breach created in their activities.

I will now describe how the general pattern of this gathering was performed by children at school and the variations in it that I observed. Among the youngest children at school there was a very collective feel to such events - as all children gathered around the injured person. There was no gender difference - all children did it. There was, however, a clear distinction in that the children concerned were all from the same grade as that which the injured boy or girl belonged to. The children from other classes kept, in general, at a distance. The youngest children said they would not want to risk gathering together when an older child at school got hurt or was fighting. They felt the older ones would not want them to 'interfere'. Of course there was also a notable difference here as older children more rarely fell or stumbled in the schoolyard. When, however, it came to fights and

public conflicts, the younger children (apart from particular brave or curious ones) would keep out of the way.

The children also drew on another important general distinction, that of family, when discussing their actions and patterns of help and support. When the children had a sibling or another familial relation, such as a cousin at the school, they would, when told by the other children, always set out to find out if their relative needed help. Their manner of communication took place in ways of which I was sometimes completely unaware, but time after a time I would notice an older sister or brother defending a younger one, attending to them or accompanying the younger sister or brother to the teacher or school nurse for adult assistance. I was often surprised to see how well the children informed each other and how promptly they would come to help. This does not mean, however, that children gave and received help and support in all situations. Sometimes a sister or brother would refuse to intervene or would just come to look to see if the younger child was sorting a problem out for itself. In particular when attending fights the older children explained to me that 'it's better that s/he sorts it out her/himself' or the children might not want to receive a help offered because of embarrassment or fear of losing prestige, as I described above. It was important for children not to be regarded as weak. The children used the notion 'slap' (in English 'feeble or weak') to express their disapproval of someone who was not able to sort out their own problems.

Among the ten to eleven-year-olds in fourth grade, whilst there was still a collective interest in sharing, helping or looking out for each other, there was, however, now a very

clearly marked gender difference that could be observed. Children would also refer to friendship as an important marker for actions of help or even when attending an accident. In particular it was the older children who said they sometimes felt embarrassed when other children were looking at them when they had fallen or hurt themselves. Thus, there was a clearer notion of privacy and intimacy relating to feeling unwell in their accounts, similar to that noted in Chapter 4 as marking adult's accounts of their own illness. Among the fourth graders, for example, the girls described very clearly the form of the social relations in their class when somebody stumbled and fell in the playground. They confirmed my observations that girls often paired up or, more rarely, formed a smaller group of three or four girls together. By the fourth year at school the girls had more or less stabilised their friendships with one best friend. However, they would also fit in with a larger group of one to four other girls who also had established themselves in pairs. These girls would play together or gather together when discussing, talking and giggling at playtimes and in the afternoon. But the girls would generally do most things together in twos and more rarely seek the group. It was even more rare to see all girls together or joining in collective activities (except for football with the boys at playtime). These large group collective activities took often form as game playing such as 'rundbold' (a Danish variation of 'rounders') or when collective activities were initiated by teachers or staff.

This collective organisation was expressed in, but only partially shaped, the performance of sickness. The older girls told me that if a girl hurt herself in the playground they would always first wait to see if her best friend would come to help her (and they would also attempt to call her if she had not seen what had happened). Only if the best friend was not

around, or did not seem to help, would the other girls join to help the wounded girl. A few girls described how they would come to help a boy who got hurt, whereas it was generally more unlikely for boys to give help, comfort or other assistance to a girl. This only happened if the girls did not seem to be able to handle what had happened. Among the boys, who either all played together or formed friendship groups of four or five, they would all (whether playing in a smaller or larger group) gather to help when something had happened to a boy.

Among the oldest children, of fourteen or fifteen, both boys and girls would deal with most of their health problems on their own. They were more likely to see the school nurse privately or, more rarely, they would bring a supportive friend. The diary that the school nurse kept of children visiting her clearly showed this pattern. In discussion of this observation with her, the school nurse felt that children in this age group generally managed more health problems on their own but also that they attempted to keep even serious problems to themselves because of embarrassment, insecurity and shyness or sometimes out of stoicism.

This pattern among the oldest children at the school bears a marked similarity to the notions of individuality and privacy more widely associated with adult illness behaviour in Danish society. It is important, furthermore, that these different forms of cultural performances of sickness among the children were roughly synchronised. The children adopted the same pattern at approximately the same age. However, these shifts in style of behaviour suggests that it is, therefore, important to consider the trajectory of sickness



performances across the life course. My data indicate that these performances range from a very public and collective form in early childhood, followed by the forms reflecting the increasing personal privacy and confidentiality of friendship groupings, extending into the individualised independence and intimacy of later childhood. This is important in relation to the process of the cultural learning of sickness by children. In concluding that childhood sickness is not one thing, but that children have to engage with different forms and aspects of its performance, we have, therefore, to incorporate and recognise in the analytic framework of cultural performance of sickness, the importance of its spatial and temporal dimensions. The cultural learning of children is signified by moving from the very public character of children's collective approach to sickness to the private and intimate (including familial) sphere (see Chapter 4).

### **The Institutional Context of Children's Health**

The school's primary duty and obligation is to provide children's education and ensure that they acquire knowledge and skills. Nevertheless, the school did have a role in relation to children's health, that is in preventive care and, to some degree, in acute treatment through the school hygiene service, which comprised a school nurse, doctor and dentist who visited from time to time. This work was also supported by the obligation to teach children about health topics formulated in an unscheduled curriculum subject called 'Health and Sexual Education'. Nevertheless, children's illness episodes lie literally outside the school's work and areas of interest. Children must, by definition, be looked after in their home if they are ill, using other professional expertise such as the general practitioner rather than

that of the school (see Chapter 4).

However, to assist their (limited) work in relation to health, Danish schools can choose to have a 'Support Centre'. This is a place where, for example, an ill child can rest until he or she feels better or is collected by a parent and, depending on the school's judgement, the centre can be used for different categories of children. At Egeskoven the centre included three categories of children: particularly noisy and troublesome children, children with learning difficulties and children who were or felt ill. This had several important implications that were demonstrated to me in the accounts of some of the youngest children at the school. In our conversations they would, for example, refer to the number of times a boy had been sent to the support centre in order to demonstrate to me how badly he behaved in class. They also described how some of the teachers frequently used the centre as a disciplinary 'last resort' if children caused trouble in the classroom.

Another specific example was provided by a nine-year-old boy, who in his third year at school was offered help for dyslexia by the support centre. In responding to the school's proposition he said with firm pride: 'I have never been in the 'Support centre' and I am not going to now.' Due to lack of space, the reading group that he joined became located in an ordinary classroom in the school. Later I talked with him again, and he told me happily about the interactions with the other children in the reading group, their work and the support he received from the teacher. However, when in our conversation I asked him whether he liked the support centre now, he referred to the location of the reading group still insisting, 'I am not in the 'Support Centre'.

The purpose of separating the three groups of children from the rest of the children was, at one and the same time, to consider the individual child, the collectivity of children and the school's main purpose and work. However, it also contained, a moral categorisation and social exclusion of, what one might call, 'disturbing elements' in relation to daily work in the school and acceptable social relations. The effect of this was that among the children, especially the six to nine-year-olds, the support centre took its most important moral meaning from the social exclusion of troublesome children. Some children, therefore, expressed fear and severe resentment about having to go to the Support Centre if they were ill. Because illness has no institutional place within the school (and is, in this sense, a cause of 'obstruction') it was symbolically categorised and put together with other 'troublesome' behaviour. The Support Centre, therefore, took on a certain stigmatised character among the children. When, a teacher proposed to take a child who was unwell to be observed and to rest in the Support Centre, as a step towards moving them away from the school into the home space, this was from a staff point of view part of a positive move to 'care' for children. For the children, however, the Support Centre was most prominently associated with separation from their peers for bad behaviour and was thus negatively perceived.

At school children's illnesses and accidents were dealt with by the nurse on the days when she was at the school, or by the teachers working in the Support Centre, and also, sometimes, by teachers in the staff room. In the after school centres these episodes were dealt with by the staff in the kitchen of the institution. The staff called the kitchen 'the Emergency Ward' when they used it for this purpose. They used the name jokingly, to

refer to its repeated daily use to clean and bandage children. This gave it an association with the 'revolving door atmosphere' of a hospital emergency ward. When an injured child appeared they gently directed the wounded child towards the kitchen sink and alerted them to what was going to happen next. Sometimes a child was brought into the staff room but, in either case, the most important aspect of this practice was to bring the child to a quiet corner of the institution. This emphasised to children that illness and recovery best takes place in a cool and calm atmosphere attended to by one of the adults. This practice was in contrast to the sociable character of children's illnesses within the home (see Chapter 4) and can be seen as part of the process through which children learned culturally appropriate ways to perform sickness.

Cultural notions of individualisation, control and power marked the everyday handling of illness and minor accidents at school and after school centre. The process of individualisation, central to these events, was manifested in various ways. First, sickness was primarily seen as the concern of the family. Children observed that an ill classmate would be sent home and thus separated from the domain of school and the after school centre. This process was further emphasised through the dispersion of children's collective gathering and the removal of the ill or wounded child from the collectivity of their peers, that is from the public arena of the playground to the indoor 'privacy' of the institution. In this way adults wished to channel the collective interest and actions of children into a more focused and organised attention on only one classmate, usually the injured child's best friend (who was usually of the same gender). When children first enter school (aged five or six) staff would choose one child from the rest and ask them to accompany the injured

child. This child would always be one from the same grade and gender (unless an older sister or brother was present). Later in the children's school career the staff would ask the injured child to nominate someone. This child would then be called from the group to accompany the other into the school building. This process, highly visible in the public space of the playground, took place as a routine practice by which child collectivity was gradually dissolved and cultural notions of intimacy and privacy in relation to health matters implicitly introduced.

Second the process of individualisation was symbolised in the conventional positioning of children and adults during such events. I will now examine this in some detail. Above I noted children's passivity in the practical management of their health problems (once their collective help giving had been dispersed) and contrasted this with the active intervention and problem solving of adults, arguing that the adult protection and responsibility of children inevitably included the enactment of adult control and power. Said in another way, this meant that the 'everyday adult conduct' during illness events and minor accidents strikingly symbolised to children the power of the individual to solve and manage (health) problems. From an adult perspective, however, this was, in part, connected with ideas of professional autonomy among teachers and after school staff. The norm among the teachers and staff was to rely on one's own professional capacity, competence and skills to handle the everyday problems and conflicts with individual children and among the children at large. A teacher would, of course, at times seek the help and involvement of other staff in specific situations when dealing with children (or they would commonly discuss particular children and events during coffee breaks or at meetings). Nevertheless,

the general collegial rule among both after school staff and teachers was not to interfere in each other's work unless asked to do so. To do otherwise was seen as a transgression of a professional etiquette. This stated that it was wrong to undermine the authority of a staff member by interfering when a colleague was handling an accident or dealing with a conflict amongst the children. During fieldwork I did note a few examples when such interference was generally accepted among staff. For example, in the after school centre one of the 'older' (often a senior or more experienced) staff member would break in to support or directly take over the resolution of a problem when a 'younger' or less experienced colleague appeared to be having difficulties. This practice was also prone to happen between 'close colleagues', that is, for example, the two staff members working together in each 'stue', or 'lounge' (2). Thus, those who worked closely together would join in to terminate a heated discussion with the children or to execute a disciplinary rule. There would of course also sometimes be a particularly dramatic incident that, from the outset, required the involvement and collaboration of more than one of the adults. However, apart from such exceptions, a teacher or a staff member in the after school centre would wait to be asked by a colleague. For students or inexperienced staff it was stressed as important for their training at the institutions to empower them individually to handle difficult situations in order to state and enforce individual autonomy and authority in teaching and interacting with children.

These issues were particularly apparent in the social organisation of the school. Each class at the school was delegated a principal teacher who, ideally, would have the class from their start in first grade until they left school in tenth grade. The principal teacher would

teach a key subject, such as Danish language and literature or mathematics, and deal with most issues to do with the overall management and concerns of the class. These included the children's discipline, social conduct and work attitude. The subject teachers would, on the other hand, deal with the class based on how the children worked and progressed in their lessons. If, however, a subject teacher had continuous problems with a particular child or with the class in general, they may want to discuss these problems with the principal teacher, who would expect to be kept informed about the doings of 'their class'. Eventually, and if necessary, the principal teacher was expected to intervene. The principal teacher would also head the class during outings and in their participation on school trips, festive events and charitable activities etc. This delegated, in a very explicit way, power and authority to the principal teacher who through their involvement with one class gained a special place in children's eyes and would be someone in whom they could confide. Thus, the teachers were generally granted a large degree of professional autonomy in their everyday teaching work and within the classroom, a process of individualisation that became apparent, as discussed above, in childhood sickness episodes and accidents.

### **Time, Tempo and the 'Act of Looking'**

Adults and children, therefore, had different perspectives on illness and accidents at school, each being embedded in a different form of collective life. To extend the analysis of these differences the dimension of time and tempo is now added. Time is an important key to the construction of meaning in health and sickness. Frankenberg (1988) suggests that the cultural performance of sickness can be seen as an episode in not one, but several,

time sequences for the involved persons. Children's sickness episodes are, in general, evaluated from an adult perspective. As we have seen, the adults concerned in such incidents would generally not recognise the children's contribution and render it invisible by not seeing it as part of the help-giving process. I argue that this leaves out certain important aspects of children's culture that can be exemplified by looking at some of the temporal aspects of sickness. This leads to the suggestion that, in order to understand illness, cure and recovery in childhood, one must consider the context of children's time structure and time perception. This recognition further elaborates my argument about interpreting episodes of health and illness and children's practices in relation to the constitutive elements of children's culture.

In his now classic work the sociologist Pierre Bourdieu argues that cultural practices must be seen as fundamentally constituted by their tempo (1977:7,8). The rhythms and tempo of children's everyday life show that their movements, actions and play are structured by a particular pattern of time. An example is found in the activity during the lunch break in the school, where children's exchanges of food, fruit and drinks are carried out through speedy transactions. Children also rapidly shift from one game to the other within a few minutes, causing difficulty for an adult trying to follow a six-year-old during a day. This implies, as I discovered, a day of constant running.

The possibility that children come to experience time in this way was exemplified for me during a visit to Disneyland. There the display 'It's a Small World' led an eight-year-old enthusiastically to remark on the clocks with hands rushing around at high speed, that



'...even the watches are made for children, for they [the children] always find that the time passes so slowly'. This child's statement shows an awareness of the dominant time structure that children are subordinated to in everyday life. The example serves to introduce the relevance of recognising a different way of acting in, and perception of, time and tempo among children in general.

In particular I suggest that tempo can be seen as an important aspect in the understanding of children's expressions of being sick. Teachers and parents often say that children can present many and varied complaints, give rapidly changing and different reports on bodily changes, feeling pain in unspecific and shifting places, and paying excessive attention to diminutive cuts and bruises. These comments are added to observations about the speed with which the child recovers and overcomes or forgets his/her complaints. At one moment the child complains of having a headache and the next he or she is to be found playing happily. This constitutes a paradox for adults. On the one hand, children present what they see as a severe complaint but, on the other hand, they experience a 'recovery' within a time frame that from the adult's point of view, does not correspond to its presentation.

Time thus serves as an important factor for adults in the classification of a condition and its severity. A frequent adult response to a child's claim of being sick or feeling unwell is: 'Go and sit down for twenty minutes and let's see if you will feel better'. From the adult's point of view 'time' is an indicator which reveals whether the condition is a momentary expression of the child's undefined sensations and thus is supposed to prove whether the

child is 'really' sick. Time as a category is, therefore, part of social negotiation about sickness in which the differences between the child's perspective and the adult's perspective are clearly demonstrated (see also Chapter 7).

When a child complained of, for example, a bruise on a finger, teachers at Egeskoven and staff in the after-school centres immediately responded by inspecting the finger, recognising that it was 'looking bad', and then giving it proper treatment. On the other hand, if the adult thought that the child was exaggerating the complaint, they would tease the child or speak ironically, for example by saying: 'Well, that can't be so bad can it?' or 'Oh, yeah sure, that looks terrible, maybe you are just about to die!'. Teasing and understatement were also practised alongside an intervention or after a treatment had been successfully completed, with the effect of 'de-dramatising the episode'. The adult explanation of these attitudes was that they were concerned to give the child a more realistic view of daily incidents in order to make him/her recognise what symptoms to present to others, namely symptoms that require treatment. This, they believed, further teaches the child not to be too concerned with bodily ills and more fundamentally it is supposed to make the child 'tougher' and able 'to take things easy' (the Danish equivalent to the English trope 'don't make a fuss').

From the point of view of adults, a child's demand for attention to bodily changes or symptoms contains an implicit expectation of an active response. The adults feel that they are expected to do something, to diagnose, to evaluate or to treat the condition or to educate and support the development of the child. A few teachers put forward an

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alternative argument; namely that one should not pay attention to children's minor symptoms. One teacher at Egeskoven explained how, when she was newly trained, she had always paid attention to, or expressed feelings of pity, whenever the children presented their complaints. The effect was overwhelming in that more and more complaints were presented to her. In this view adult attention has an epidemic effect like an infection or virus. Either the child intensifies their own complaints or other children become 'infected' in order to get adult attention. This process exacerbates the widespread 'anxiety' amongst adults that if other children get involved, it will lead to situations that are potentially 'out of control'. The lesson they draw is not to pay attention to children's complaints unless other signs suggest that 'something is really wrong'.

The frequency of children's complaints was often explained by adults as a child's way of showing that 'children like to get attention', and need to be cared for. It was said, for example, that 'He just wants to be nuzzled behind the ears'. Adults also argued that the presentation of bodily symptoms and experiences serves as a sort of 'cover-up': the child presents a physical symptom of 'not feeling well' or of having a 'headache' instead of presenting 'the real problem or conflict' either of a personal or of a social kind: for instance, having trouble getting on with other children, trouble in their family or trouble through not doing well in school. In this way physical complaints were translated into a powerful psychosomatic or sociosomatic explanatory model embedding 'sickness' in a larger social field and making strategies of cure and intervention diffuse and complex.

This can be compared with children's own responses to another child's presentation of a

bodily complaint or experience. Children often brought forward an experience or complaint, phrased dramatically and initiated with the request:

*'Look!'*

'Look, I'm bleeding', the child would say presenting a drip of blood the size of a pinhead on his finger, or ' Oh Look! My toe is all blue and swollen' when, to me, it looked very slightly bruised.

The different significance of this within children's culture can be seen from the responses of other children who often, in fact, simply 'looked'. Only seldom did the child refer to what he or she actually saw. A claim about a swollen toe was not judged and supposedly corrected. If the observing child did make a comment, it would often be confirming, 'Yes, I can see' or 'What a pity'. Likewise, when a child told another child about how they hurt themselves, the response was: 'Can I have a look?'. I am not here asserting that children do not sometimes tease each other for 'being too soppy' or paying attention to 'nothing', but that was not the most frequent or characteristic reaction amongst children.

James (1993) has shown that children's interest in observation and judgements of the body must be understood as an expression of and a source of certain aspects of children's social identity. My concern is to add to this by seeing children's presentations as rooted in children's culture through their more performative aspects. Performing, repeating and spectating derive meaning in relation to the way they are expressed in children's practices

in sports, games and play. Inspired by James's observations from her research conducted in Britain, quite early in my own fieldwork I decided to respond to children's requests by doing what I was asked: to look. This probably became one of my most enjoyable experiences. I heard the children's demand for my attention: 'Pia, look!' and responded by being attentive whilst the condition was shown or an action performed. In making sense of this, it is important to note that children's requests to 'look' occur as probably one of the most frequent requests, both among children themselves and of adults: 'Look at me when I jump from the diving board into the swimming pool?!' 'Look when I climb up the tree!' and 'Look when I kick the ball like this!'. Through the 'act of looking' children symbolically exchange and share the experiences of the body, as if saying 'look with me' or 'see, what I see'. More than this, however, it also shows a concordance between the practice with which children respond to presentations of the body in both play and other activity, and their responses to symptoms and to minor scratches.

The adult perspective links children's presentations of body symptoms and the meaning of time to sickness or other problematic conditions in personal or social life. For adults the child's request for attention implies a demand for an active intervention from the adult. In more general terms it demonstrates the moral demands on adults as having the care and responsibility for the child. This is further based on cultural ideas of childhood as being a period of vulnerability, dependency and care (see Chapter 7). However the alternative perspective that children provide corresponds to the following statement about attention proposed by Yi Fu Tuan, a geographer and performance theorist:

To attend properly and over a period of time, one must make an effort - often an exhausting effort ... One must forget oneself and try to be actively receptive. This contradictory state of being both active and passive accounts for the difficulty of paying attention. (Tuan, 1990:243)

My argument thus acknowledges time and tempo and the 'act of looking' as important for an understanding of the spectrum of childhood sickness. The child's perspective contains a recognition of the relation between children's cultural practices, including 'looking', and its constitutive elements including 'tempo'. Finally it suggests a path to disentangle the paradox which is created by the transformation of children's perspectives into an adult meanings, structures and perceptions.

### **Conclusion**

This chapter has examined the actions and interactions of adults and children around illness and minor accidents in the school and after-school setting. At the core of the analysis are the different perspectives and actions of adults and children and the overlapping, but distinct, collective cultures in which these are embedded. Examining children's help acts as intentional suggests that they interpret and act on the basis of an implicit but firm recognition of the cultural idea or concept of help. They interpret acts of help through an implicit recognition of their motive (3). In their own practice children experiment with the elements of content, form and context of the action, attempting to bridge the split between tacit and explicit knowledge. Their practices of giving help (see note 1) simultaneously

attend to multiple aspects of the situation: the hurt of another child, getting adult help, protecting the flow of ongoing play and simply sharing in or attending to the experience of another.

Much of this remains invisible to the adults. Their intervention into the frequent accidents that occur in these institutional settings tends to disperse the children's collective efforts and refocuses attention on the objective well being of an individual child. The adults take charge and act instrumentally to discharge their adult and professional responsibilities, making sure that child is well, diagnosing the problem and giving the appropriate treatment. These events take the form of repetitive performances in the daily life of the school and after-school centres. Although each performance is of relatively short duration, their repetition builds into a pattern in the everyday experience of the children. It is this, I suggest, that accounts for the gradual individualisation of children's views and actions around illness.

Underlying and enacted within these events are the relationally produced and interdependent notions of 'adult' and 'child' discussed in Chapter 1: the responsible, powerful and competent adult that finds its counterpart in the child as vulnerable and incompetent. These themes will be explored in Chapters 7 and 8. It can also be seen that in their interventions adults deploy ideas about the importance of timing and tempo in the interpretation of bodily experiences that do not necessarily correspond with those of the children. It is to the topic of the body that the next chapter turns.



## Notes

1. I use the phrase 'help action' to mean an individual act of support and help by a child towards another child. I do this to avoid any traditional evaluation or moral connotations associated with 'helping action' or 'helpful action', and to emphasise the understanding of 'help' as a social and cultural construct. The study also raises wider questions that relate to the differences between adult's and children's approaches and how children's views become adults' views that are only partially within the scope of this thesis.

2. This term is used generally in day care institutions and can be translated into English 'lounge', although this does not convey exactly its sense in Danish. Often each 'stue' would work as a semi-independent unit within the institution by creating its own atmosphere and plan of activities. A particular number and selection of children were allocated each 'stue' and in the after school centres each 'stue' was allocated two members of staff.

3. Further studies might show that the social processes involved in 'growing up' tend to bring about a converse perspective i.e. an (adult) perspective more likely to emphasise the intentional meaning of an action as prior to its motive. Socialisation thus establishes what has been called the split between tacit and explicit knowledge (Shweder, 1984). This finding suggests perspectives for understanding the ways in which knowledge informs both cultural practices and the processes of socialisation in society. It also emphasises that

to acknowledge children's ideas, practices and the meaning of their constitutive elements deepens our understanding of sickness and help in childhood. In a wider sense it also contributes to our understanding of the interplay of the adult's perspective and the child's perspective on culture.

## Chapter 6

### CHILDREN'S CULTURAL LEARNING: THE SUBJECTIVE AND OBJECTIVE BODY

#### Introduction

The idea of sickness as a cultural performance allows for looking at how children amongst others are socialised into cultural understandings and practices of illness. In Chapter 1 and 2 I criticised socialisation as a dominant concept for the study of children because of its particular focus on the individual and its strong orientation towards the future. Instead I took up the notion of interpretive reproduction (Corsaro, 1992; 1997) as offering a way of looking at and detailing children's participation in society and their engagement in learning about their culture. In Chapter 5, I showed how children are involved in making sense of, and strive to, understand the contexts of their lives and contribute to it actively and collectively through their everyday interactions with other children and adults. Corsaro locates such collective action at the centre of interpretive reproduction. He distinguishes three types of action that comprises it: first is children's creative adoption of information and knowledge from the social world; second is children's production and participation in the social and cultural milieu of children; and third is children's contributions to cultural reproduction and change in their wider groups and communities. The progression implied in these processes might, at first, seem to mirror traditional notions about socialisation processes. In Corsaro's view, however, these types of action should not be seen as subsequent stages of a linear order where one step automatically follows and depends on

the other. Rather, he suggests that they take place simultaneously and in different combinations in both moment to moment interaction and over time.

Taking up Corsaro's point this chapter adds an important dimension to the literature on the cultural performance of sickness through exploring how children and adults interpret children's bodily experiences. I, thus, engage with an aspect of children's cultural learning central to their experiences of illness and minor accidents. This concerns their experiences and understandings of the body and, in particular, the experience of the subjective body in contrast to its objective representations. My starting point is some fieldwork observations about how the youngest children did not seem to classify their experiences of illness as an event distinct from the flow of other events in their everyday life. Unlike older children and adults, they did not mark out their illness experience as a distinct mentally or bodily occurrence. Through an exploration of this phenomenon, I argue that it is an important aspect of children's understanding of 'illness' that they come to learn how to distinguish between bodily discomforts and pains that are defined as culturally acceptable or 'normal' and those that are seen as 'illness' in their particular cultural environment.

In a synthesis of anthropological and sociological writings about the body Bryan Turner (1984, 1992) has suggested that it tends to follow two separate analytical approaches. The first, phenomenological work, focuses on the experience of a lived body that is assumed to be real and independent of its social and cultural context. The

other approach, which focuses on social and cultural representations of the body, suggests that it is a discursively constructed object. In Turner's view these two approaches are complementary but incompatible. His conclusion is resisted by Shilling (1993), who argues that the body is both biologically and socially 'unfinished' at birth. Shilling suggests that sociologists and anthropologists must look at the mutual interactions between the body and society, a process that involves the body as a material thing, its social representations and the experiences of it.

In this chapter I take up Shilling's theme through a discussion of Stern's (1985) ideas about the emergence of self-consciousness. He suggests that children's perception of the body, prior to language, merges with cultural classifications of the body and illness in a complex interplay between the child's expressive behaviour and adult interpretations of it. During fieldwork, the social interactions of children and adults, which took place around illness and minor accidents revealed that this process also entails the polarisation of difference in perspectives on the body. Using Frankenberg's (1990) distinction between the 'incarnate' and 'somatic' view of the body, which distinguishes the subjective experience of the body as unbounded and in motion from the objectified body as a series of classified parts, I suggest that adults tend to objectify the child's body, translating children's subjective experiences into somatic terms. An important aspect of 'being ill' or 'injured' is that children learn to classify and objectify the body according to culturally appropriate representations whilst, simultaneously, struggling to make sense of these in terms of their own subjective

experiences. This can be recognised in the different collective processes among the children themselves. Thus, just as Chapter 5 showed how children engage in processes of gathering together and giving help, so this chapter will show how children's exchanges of their experiences and ideas also took form through collective bricolage.

Another important aspect, as noted above, is that children learn to distinguish illness from the flow of everyday events. When children, in their accounts, paid less attention to the significance of different bodily sensations and conditions and their treatments than to the social processes of illness, it suggests that illness episodes for children are broad cultural events through which children engage with and come to understand the social relations and organisation of their world. As shown in Chapters 4 and 5, illness episodes and minor accidents accentuated, in different ways, children's relationships in the social settings of their everyday life. Children experienced this through the investments and constraints that were placed on them and the performance of social relations between adults and children and among children themselves. Children's experiences during illness and minor accidents emphasised to them the centrality of adult care, protection and responsibility and their own relative dependency. In this way illness becomes a window through which children come to understand aspects of child-adult relationships, including social hierarchies and the distribution of knowledge, competence and social status, of wider importance for their social position in society (see Chapter 8).

### Separating Illness Events from the Flow of Everyday Life

In the early months of my fieldwork I was struck by what seemed to be younger children's (those aged between six and seven) tacit 'acceptance' of illness. In the children's accounts illness appeared as almost indistinguishable from the flow of everyday life and they did not draw a strong boundary between it and the rest of the everyday events that they experienced. It appeared that, for the children, illness was just one experience alongside many others and it had no particular importance or significance for them. Indeed many other events, for example going on a visit, receiving a present or having a quarrel with a friend, were sometimes of far greater interest and concern. They also seemed relatively unconcerned with the significance of various bodily and mental sensations and how their body responded to receiving different treatments and cures.

It seemed, then, that, although illness was experienced in a direct bodily way, this experience was not one that the younger children objectified as an entity distinct from their person. Rather, in the accounts of six to seven-year-old children, 'to be ill' was associated in a quite literal sense with a state of subjective being. In more general discussions about 'being ill' children said, for example: 'It doesn't feel very nice', 'It usually hurts all over' or simply, 'It hurts'. In conversations focused on 'the last time you were ill' (see Chapter 3), they similarly described the illness episode as 'I didn't feel very well' or exclusively through stating a symptom; for example, by saying: 'I

had a fever' or 'I coughed' (in this respect they did not make a distinction between a symptom and an illness). Generally, the youngest children simply noted that they had been ill without offering much further detail. When I asked children further, however, they would tell me about illness through describing actions and practices. For example, Søren, one of the seven-year-olds explained: 'When you are ill you lie in a bed and vomit in a bucket'. Another boy, seven-year-old Frank, told me about a day one of his friends had got hurt. In telling me the story he emphasised in great detail the amount of blood from the injury. When he paused, I asked him why it bled like that. He said:

*'It bleeds because you fall and hurt yourself or because somebody beats you.'*

Frank's answer was typical of those from the younger children. Rather than providing me with an account based on physical bodily functions, such as 'because the skin was cut', he drew my attention to the body engaged in social interaction.

By far the most prominent aspect of the younger children's accounts of the experience of 'being ill' was the social (inter)actions and details of the social positions of themselves and other persons (parents, grandparents, friends, doctors) involved in the illness event (see Chapter 8). This was shown, for example, in what ten-year-old



Olivia revealed in a conversation. During which I asked her to tell me about when she was last ill:

*'Olivia: Not very long ago, I had something with my eyes. When I looked straight up it hurt and when I looked straight down I got a headache. And I had a fever, 39.6.*

*Pia: What was the matter with your eyes?*

*Olivia: I cannot remember what it was (pauses). First my mum looked after me to half past ten, then she was going to work. The first day my granny came and looked after me until Ellen (Olivia's older sister) came home at one o'clock. Then she looked after me. The second day I only had to be alone for three quarters of an hour, my mum went at half past nine and Ellen didn't come back before twelve o'clock so it was a bit longer in the end.'*

As illustrated in Olivia's account, children were less likely to dwell on how their well being was affected. Instead, they would emphasise the different procedures of the home, school and after school centre, which included reflections on how illness in this respect changed usual activities and practices. Children discussed illness in terms of alterations of everyday practices and routines and recovery was expressed in terms of one's re-enrolment in everyday social interaction. Mark, a seven-year-old boy summarised the general view of children, when he answered my question about what it meant to get better by firmly stating: 'To do as I usually do.'

The children's accounts also suggested that for them experiencing vulnerability in illness was related to losing their social position, activities and relationships and changes in their environment. For example, David, a ten-year-old boy, was unable to play in an important football match because of a knee injury. Although the injury was severe, tears first started to pour down his face only when he realised he could not participate in the match. When I talked with David he told me why he felt so upset. He felt he was letting his team down and he was generally disappointed that he could not play in the match, to which he had been looking forward. David was also worried that his coach would be cross with him and perhaps think he was weak. It was these aspects that upset David, rather than the injury itself or the pain associated with it.

Another characteristic of children's accounts was that they were less concerned about the usefulness of specific remedies or treatments. A conversation with seven-year-old Catherine about the last time she was ill illustrated this:

*Catherine: I had a sore throat. My ears still hurt a bit.*

*Pia: Do they?*

*Catherine: You know, it changed all the time. It would never hurt in both ears at the same time. First it was in one ear and then the other ear, and then the first and then the other. Never in both ears at the same time.*

*Pia: Did it hurt a lot?*

*Catherine: Yes, but never in both ears at the same time.*

*Pia: Can you tell me more about how it was when you were ill?*

*Catherine: It wasn't very nice (pauses and shrugs her shoulders)*

*Pia: So, what did you or your family do to make you feel better again? Did you get any treatments?*

*Catherine: I was lying on the settee and I read all these Donald Ducks. Ten files full (she giggles at the thought of the huge number of magazines she had read). Then suddenly, after a few days, I was well again and I could go back to school.*

*Pia: Did you do something else (to make you feel better)?*

*Catherine: Yes, then at night I had to go to bed. Then I slept.*

*Pia: Did you do anything else?*

*Catherine: No, not really I just had to stay in the bed all the time.*

Another aspect revealed in Catherine's account was her particular fascination with the character of the pain in her ears, that is with the way it changed and shifted from one ear to the other but never (as perhaps it might have been expected) in both ears at the same time. This perspective relates to what, I in Chapter 7, call children's engagement with the body as project. Rather than being engaged with the 'suffering body' children were occupied with the 'phenomenal body' exploring, for example, how the body may work and creating for themselves images of different bodily processes (1). For example a six-year-old girl making a drawing of the last time she was ill pictured

herself walking around in the lounge at home (Fig. 4). When describing the drawing to me she said: 'I was coughing and this is the air that comes out of the mouth when you cough'. Another example was provided by two seven-year-old boys who sat in the same group when they made their drawing. They copied each other making a picture showing only their head with a great big lump extending from the top of it and 'throwing up' (see Figs.5 and 6). When I asked them independently afterwards whether the lump had actually been so big. One of the boys chuckled and said: 'No, no that's just because it looks funny - a big one like that'. The other boy, however, who had got hit by a rafter replied by saying: 'No, it wasn't actually, but it just felt like it.'

The aspects of illness and therapy that the younger children gave only secondary or no attention to were, however, much more evident and pronounced among the older children. Even though the children aged ten and eleven still focused on illness as a social event, they paid more attention to bodily sensations, symptoms and their emotional states and would engage in discussions of the efficacy of different treatments. They made attempts to cluster symptoms together. For example, Nis explained: 'when you have a fever you usually also get headache'. They often gave a name to an illness (for example, by calling a condition by its specific name 'chicken pox', 'flu' or 'cold'). They identified an illness or an injury as a problem relating to a specific part of the body and would sometimes discuss in more detail whether a particular remedy seemed to work. It was as if they were far more ready to treat

MARIA

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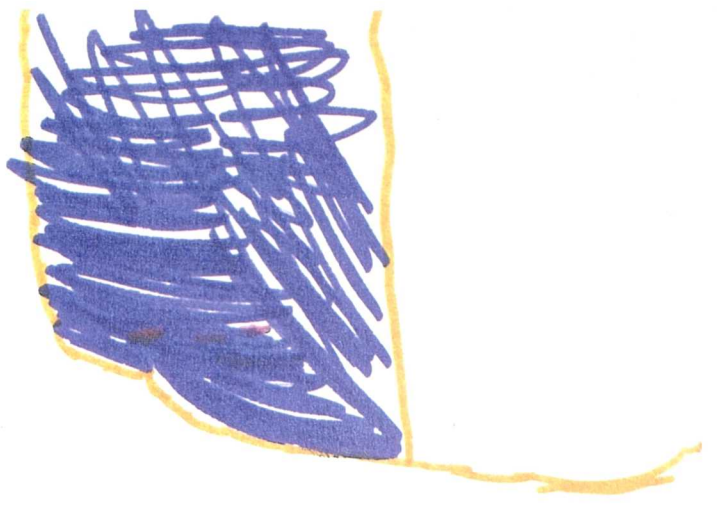
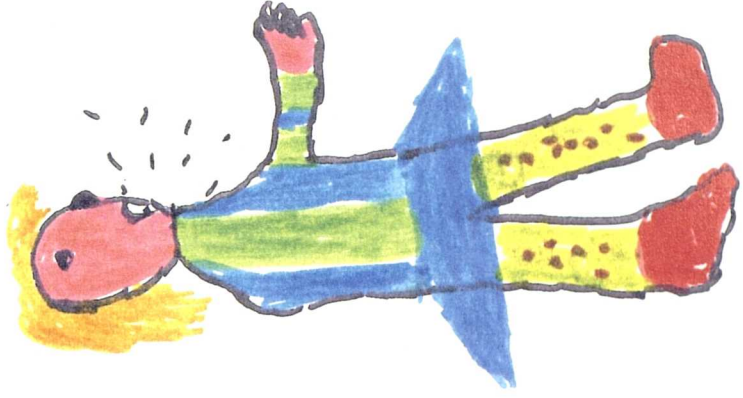


FIGURE 4



FIGURE 5

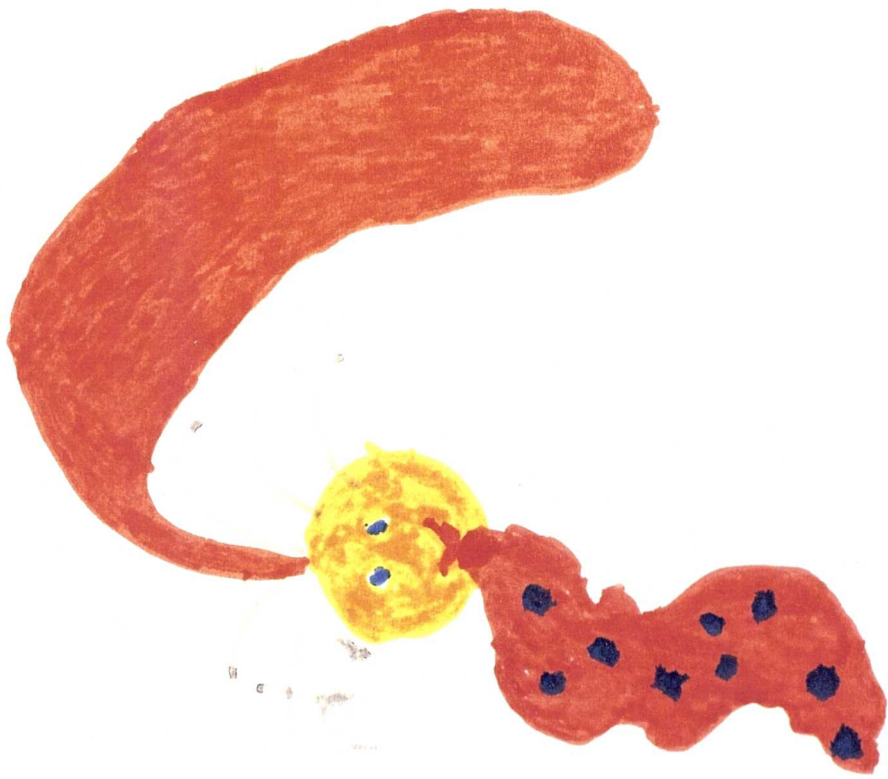


FIGURE 6

illness as a specific category of experience and as having a reality that could be shared, talked about and understood by others. It is notable that all the aspects discussed above, which concern the classification of illness and the effectiveness of therapies and have the effect of separating illness out as a particular mental, bodily and social event, are prominent in adult accounts of illness (2).

### **Illness and the Accentuation of Social Relations**

As noted at the outset of this chapter my analysis, although congruent with Frankenberg and Young's theoretical framework, also extends and develops it through its specific application to children. In part this arises from my effort to understand how illness, and its different aspects, are conceptualised and learned by children, starting from my concern with how illnesses become classified as events of particular social significance for children.

As noted above, it was the youngest children, who most distinctively represented bodily sensations of feeling unwell as acceptable experiences of everyday life. However, a significant aspect of their accounts was an ever-persistent complaint that illness, injuries or the associated parental (adult) care interfered with and sometimes even hindered their usual activities. Throughout my fieldwork, in the conversations I had with them, the children associated 'being ill' with 'then I cannot do, what I usually do'. Their annoyance with this, or even objections to it, paralleled how



children conventionally contested the different temporal and spatial restrictions placed on them by adults in their everyday activities at home, school or after-school centre: 'time for bed', 'meal time', 'watching television', 'playing the computer' or 'indoor versus outdoor playing'. However, it is important to note that the significance of the restrictions associated with being ill was the intensity and firmness through which children experienced the application of such governance by adults. During an illness episode parents strictly and routinely enforced the rule that 'a sick child has to stay indoors' and at school the children experienced that 'a sick child has to stay at home'. While children in many other situations were able to negotiate or in other ways influence their parents' decisions and administration of different rules, they found that the onset of 'illness' inevitably determined that they had to stay at home and to stay indoors. In this respect 'illness' would repeatedly be marked out as an event of special significance.

The onset of a child's illness at home or institutional setting, then, could be seen to accentuate social relations and interactions. This, however, was both a way through which 'illness' became an event distinguishable from the everyday flow of life and its reverse. Illness events, because they exaggerated or brought social relations into sharper focus, also provided a 'window' for children through which they gained crucial understanding of their social and cultural world and their place within it. Illness episodes (and minor accidents) were, as shown in Chapters 4 and 5, revealed as repetitive performances through which

children (and adults) explored, substantiated and confirmed their social relations and positions of every day life.

### **The Problem of Subjective Experience and the Objective Body**

I will now return to the question of how children learn to mark out 'illness' from everyday experience. This question became clear to me during fieldwork when my preliminary observations among the young children of their illness experiences as part of the flow of everyday life received a further twist. This happened when I talked with health and educational professionals. They drew my attention to what they saw as an intrinsic problem in child health. They expressed this as a concern about the way younger children sometimes responded to illness through what they called 'compliance strategies'. By this they meant that a young child may, in the course of their everyday activities, deal with the experience of pains or other dysfunctions of their body by adopting a number of compensatory bodily postures, manoeuvres and techniques. These often tacit alterations of a behaviour or subtle changes of 'normal' bodily movement thus enabled the child to ignore, even for a long period, any obstacles or inhibitions caused by an illness or an injury. Let me illustrate this with the story that nine-year-old Rebekka told me about when she first got glasses.

*'Pia: Tell me about when you got your glasses? How did you find out that you needed them?'*

*Rebekka: Well, I didn't at first, did I? First I had headache, just a little bit but then it became even more. Headache at school and headache at home. I didn't know why then I told my mum when it was really bad sometimes. First she said: Have a drink or have something to eat, or she would say: have a lie down you look tired probably you go too late to bed (Rebekka imitates the tone of her mother's voice, when she repeats her advice). After some weeks or so, she suddenly said: let's go and see the doctor maybe you need glasses. You have moved closer and closer to watch the television without me noticing it. And then we went to the doctor and then he tested my eyes and I got the glasses.*

*Pia: Had you not noticed that you couldn't see so well anymore?*

*Rebekka: No, I don't know. Perhaps I just thought things had to look like that - and then with television, I could still see it, if I just sat really close.'*

The subtle occurrence and progress of a child's poor health, such as that revealed in Rebekka's story, were the kind of thing that health professionals felt troubled by. It demonstrated to them how children acted, although unintentionally, contrary to their own health and well-being. Moreover, this conduct might render a health need invisible for adults; the child may develop a quite serious affliction before it came to the attention of a parent or a professional. This, I argue, contributed to adults' sense

of unpredictability in relation to children's illnesses and threatened their experience of acting responsibly in monitoring their child's health.

Tove, mother of seven-year-old Mattias, illustrated this in a conversation about how she, from one day to the other, discovered that Mattias had developed a severe limp and had to go into hospital. He had developed an inflammation of his left knee without her noticing that he needed quick treatment. Tove said:

*'For a couple of weeks or so he (Mattias) sometimes said it hurt when he walked. I thought he was just a bit lazy - didn't want to walk to school or go shopping or so. Because if I looked at his leg I couldn't see anything. Then he wouldn't mention anything for a while but then just over the weekend he seemed to limp when he walked. During that whole weekend I tried to look really carefully, but it seemed like it had passed again. Then right, on Sunday night we all went for a walk around the neighbourhood. Then Ole (Mattias's dad) and I said to each other that there is something wrong here. He does limp. When I asked Mattias does your leg hurt? He said that sometimes it does but then it goes away again. On Monday I took him to the doctor. He examined the leg and then he said: I am afraid, I need to take him into hospital he has got a bad inflammation of his knee and he needs some blood tests done and treatment quickly. I was totally shocked and upset. I felt I had neglected something, which*

*somehow seemed to be so obvious. The doctor calmed me down a bit. Because, he said not only can it be difficult to tell with young children when something is really wrong but in this case the knee is also just slightly swollen which makes it difficult to see for an untrained eye. He pointed to the difference between Mattias's legs and then I could see it, actually, what he meant. But I think it is this feeling that you think, you have insight into how your child is and you simply want to look after them well and then you feel you don't.'*

The contrast between children's experiences and practices and those of adults' (including my own) was such that it appeared almost as an inversion. For adults, illness was marked out as an event of significant social and cultural meaning, but children, especially the younger ones, did this more hesitantly, seeming to see it as merged into the flow of everyday events. Furthermore whilst adults focused on bodily and other discomforts and the effectiveness of therapies, younger children seemed to notice these less than the social interactions and changed everyday routines.

The observations discussed above suggest that the marking out of illness as an event focused on the body and marked out from the flow of ordinary life is something which has to be learned by children. This is a point of some interest in relation to the analysis of sickness as a cultural performance. As outlined in Chapter 2, Frankenberg (1980, 1986) and Young (1982) alerted attention within medical anthropology to sickness as a

processual concept. This located the experience of 'being ill' in its wider social and cultural context and the term 'sickness' was coined to name the interpretive process through which different worrisome biological or behavioral signs and changes are given a socially recognizable meaning as 'symptoms' which constitute a person's illness in a given culture. Their proposition drew attention to how disease and illness are socialised, the means by which social relations create, form and distribute sickness and allowed both the expressive symbolic aspects and the instrumental actions and practices of sickness to be explored. However, as my observations suggest, this account neglects to recognise that 'worrisome signs and changes' in the body cannot be apprehended as some kind of intrinsic knowledge that persons are born with. A new member of any particular culture will necessarily have to come to understand that some sensations are to be classified as 'illness' whilst others are not.

My study of younger Danish children suggests that due attention has to be paid to how this learning takes place and, in so doing, it reveals another, as yet unremarked, layer to the cultural performance of sickness. It is an unstated premise of the work within medical anthropology that actors are able to recognise an 'out of the ordinary' bodily sensation, a 'disturbance' that suggests that the normal sensations of the body are being disrupted. Medical anthropology's engagement has been with the cultural processes by which a bodily disturbance is classified. It thus largely takes for granted that actors within a field of recognise such disturbances. It has thus been concerned with how people (both lay and professionals), in a given context, engage in and with the discursive: the specific

conceptual, belief systems and sets of practices when illness or misfortune strikes. This has meant, for example, exploring how people engage with indigenous or biomedical conceptions and models, or sometimes how they employ pluralistic systems of health care, drawing on a number of different understandings and practices. While medical anthropologists were locked into studies of the different discursive systems that people make use of when they are ill, Frankenberg and Young's theoretical model was an attempt to search out the closer dynamics between illness experience, socioeconomic forces and social environments. However, within this, and despite their broader conception, they share with mainstream medical anthropology the assumption that people engage in the cultural performance of sickness as 'knowing' actors who are somehow able to recognise, define and enact illness in their specific social and cultural contexts in accordance with its cultural scripts and performances.

However, the cultural performance of sickness is a mediated one and studying children reveals some of the mediations that otherwise may be missed. My data suggest that, whilst Frankenberg and Young are correct to point out that social actors, in interaction with others in the performance of sickness, categorise their experiences and sensations as illness, they do not detail important parts of this process. Amongst the first steps is that persons recognise and single out their physical, mental or social experience from the ordinary, that is they understand it as an experience or happening of particular significance or, using the terminology of Frankenberg and Young, as 'worrisome'. My suggestion in this thesis, however, is that children, in growing up, come to learn and engage with a

complex interpretive and classificatory process, fundamental to which is the understanding that whilst some bodily or mental sensations involving discomfort, suffering or pain are culturally accepted as 'normal', others are not. Illness is thus culturally constituted as being both a part of and apart from everyday life.

Children in any cultural setting will learn the double-edged character of 'illness'. On the one hand some experiences and sensations are treated as 'illness', and are not to be accepted, integrated, or adapted to. On the other hand, and at the same time, such sensations form an inevitable part of almost all people's lived experience. In other words, they are part of the very condition of life. Nevertheless, such experiences are also to be seen as contrary to life because their effect is realised as unwanted, damaging or even life threatening. It was this cultural understanding that underlay the concerns of the health and educational professionals about children's 'compliance' with illness described above. It is through such understanding and recognition that the processes of sickness and its treatments become relevant and make sense to children. They have to learn to distinguish the experience of sickness from the rich and diverse muddle, which constitutes everyday experience, and they have to learn to distinguish illnesses as events of significance because of their (actual or potential) damaging effects. In this process they will have to distinguish these from sensations or changes that, although they may appear as having an unpleasant, uncertain or enigmatic character, are, nevertheless, regarded as part of acceptable everyday experience.



This step is, itself, a complex interpretive process and children's engagement with it was demonstrated throughout my fieldwork. As discussed in Chapter 5, children often expressed their experience of a bodily sensation or change in such a dramatic way that adults subsequently categorised them as children's exaggerated reactions and over sensitivity to 'normal' and 'acceptable' bodily experiences and changes. This phenomenon was exemplified, to quite the opposite effect, in the situations noted above. When children were observed too readily to accept and adapt to discomforts and hardship this disturbed their adult care takers (3). These themes will be taken up in more detail in Chapters 7 and 8. Both these chapters will discuss the ways in which children's understandings and competencies become contested by adults in everyday social interaction. For the moment, however, it should be noted that children's responses in these various, and from the point of view of adults, sometimes inappropriate ways, demonstrates that children's sickness categories display more plasticity and less stability than those of adults. This requires that children's interpretations are examined in relation to both their own more fluid understandings as well as in relation to the relatively more fixed cultural models held by adults.

### **The Intertwining of Biology, Culture and Society?**

As suggested above, in thinking about how children come to understand the bodily, emotional and social experiences of illness it is important to acknowledge the links between cultural learning and the child's biological nature - however imperfect our current

theoretical means for doing this are. Whilst sociologists of childhood have correctly highlighted the social and cultural dimensions of children's lives, this sometimes seems to go beyond being a corrective to biological and developmental perspectives. For example, Morss (1990) attempts to expel all biological, and even all developmental, aspects of childhood in the cause of seeing childhood as a social and cultural construct. However, the point of the critique of developmentalism (see Chapters 1 and 2), as writers such as Corsaro (1992, 1997) show, is not that children are cultural and social beings as opposed to biological ones. Rather, it is a question of thinking about how biological processes and social/cultural ones are intertwined. To understand child illness otherwise would be to make it an entirely social or cultural phenomenon rather than a biological one when, as I have indicated in the previous section, it necessarily brings together both these aspects. Although this thesis can only touch on this point, it is important to recognise that the relationship between the body and culture is a foundation stone for the anthropological study of child health even though it remains a relatively unexplored field and, therefore, a serious gap within sociological and anthropological studies of childhood studies (but see Prout, 1999).

However, for the purposes of this thesis, work within the literature on childhood development, which has begun to integrate the social and cultural context into its account of the processes of psychological growth, is suggestive of some new directions. A first contribution is found in the theories on infancy advanced by Stern (1985). Covering the ages between birth and three years old, these specifically address the importance of

locating the infant's self-perception in the context of interpersonal interaction, Stern makes at least two important assumptions that are shared by my study. The first is that some form of self-perception exists for the child prior to consciousness and language, where self-perception, or the experience of self, refers to the infant's non-reflexive attention to and knowledge about the immediate experiential or non-conceptual level. Second, that the development of self-perception is relationally constituted. Any development and change in the infant's self perception, Stern argues, arises from a complex interplay between their own expressive behaviour and how adults (in particular, the mother/parent) interact with the infant. He suggests that, on the basis of their interpretation, adults subsequently form new understandings of the infant in a self-propelling process. The compounding of the infant's behavioural pattern, and the adult's interpretation of it, engages them in continual interaction, through which they both progress and mutually influence each other. In the gradual experience of a self, the infant is able to organise his or her experiences into knowledge and understanding which then enables them to develop and sustain their relations to others.

We may here begin to see how the infant's biological competencies and capacities develop through engagement with the cultural knowledge produced in social interaction with others. In relation to the argument of this chapter, this point helps us to understand how the infant's ability to recognise and express crude distinctions such as 'pleasure' and 'pain', 'nice' and 'nasty' and 'pleasant' and 'unpleasant' might be gradually refined and take on conceptual complexity during such interactional processes. Thus it is that such

experiences and sensations may, over time, contribute (though only partially because children interact with many persons other than their mother figure) to the formation of a culturally specific category 'illness'. Very importantly this work suggests that children's embodied understandings of the significance and meaning of different situated sensations are accomplished in the social and cultural, that is their collective environment, a point paralleling that made by Corsaro (but see also Chapter 2).

### **A Methodological Aside**

However, only rarely is the literature on development in infancy brought into dialogue with discussions of children as social actors (where the focus tends to be on older children). An example that shows both the advantages and, to a certain extent, the problems of such a dialogue is found in Mayall's most recent work (1998a). She is also concerned to think about ways of including infants in the study of children's subjective experience of health and well being but recognizes the methodological difficulties of doing so. As a solution she suggests that, in the case of babies, who are still too young to act as verbal informants, researchers must turn to mothers. They, she argues, can provide valuable insights into their children's experience of health and the relations between the bodily and the social. As an illustration she draws on a comparative study conducted with mothers in Sweden and England (Lauritzen, 1996, 1997) to suggest how details about their subjective experience can be found in mothers' interpretations of their baby. This comparative study details how mothers focus on the babies' shifting moods and bodily

expressions of happiness and distress to gauge their health. Their concerns for their child's normality rest on his or her bodily activity, growth and development. Mothers define their baby's happiness in terms of his or her alertness and responsiveness to both physical activities (touching, tasting, smelling and looking at things) and to events in the social environment surrounding them (in particular, the parents' faces, actions and words). Drawing on this work Mayall (1993a) concludes that a baby's physical, emotional and social well being must be seen as inter-linked and interactive. She suggests that:

...the baby's feeling of well-being, discomfort or pain serves as a bridge or mediator between her embodied self and the social context, through the expression of emotion related to physical sensation the baby links into and participates in constructing the social relationships with her parents within which her health will be restored, maintained and promoted. (Mayall 1998a: 276)

Although Mayall's proposal corresponds, to some extent, with the work of Stern, outlined above, I disagree with Mayall's confident advocacy of mothers as articulating the infants well being and her reading of this as insight into the infant's subjective experiences. I am less ready, than Mayall, to rely so completely and one-sidedly on mothers' accounts and interpretations. The reliance on mothers' interpretations that Mayall advocates is, in fact, seriously challenged by studies such as Stern's. He, whilst enquiring into the possible interpersonal universes that infants create, agrees that understanding these must be a

central aim for developmental psychology. Nevertheless, he highlights the difficulties of doing so in a trenchant critique of previous attempts. First, he points out that observations of infant's responses (facial expressions, vocalisations etc) to people around them are not easily translatable into statements about their subjectivity. Because researchers can never 'be insiders' to the subjective experience of the child, there is, he argues, the ever present dangers of objectifying infant actions and subsequently turning working hypotheses into supposed facts about the development of the infant's experience of the self. Second, he points out that adult interpretations of infant interactions are always part of, and not separate from, the relationship between the infant and adult. They are part of the relational process through which self-perception is brought into being. Adult assumptions shape ideas about who the infant is and, beyond this, what infancy is and how it shares in our ideas of human nature. They steer how parents react towards their infant and form part of the context within which an infant develops its subjectivity and self-perception.

My reservations about Mayall's assumption that mothers are the best interpreters of infant subjectivity do not detract from the value of such detailed and careful studies as the one by Lauritsen. I do, however, share with Stern the view that attempts to understand infant subjectivity should be approached by using multiple methods in an inventive and explorative way, treating it as a complex, relational and interdependent phenomenon (see also Chapter 3). Through such careful studies we may then further our understanding of infants' and children's health and wellbeing as constituted relationally as they grow up.

## Conceptualising and Experiencing the Child's Body

I have argued that part of children's cultural learning about sickness entails coming to distinguish bodily experiences as outside the range of the normal and acceptable. Through examining how, in my fieldwork, I could observe that adults and children approached the understanding of children's injuries and illnesses in different ways. I shall now go on to demonstrate this as being based on their contrasting perceptions of the body.

Learning to distinguish and define their body forms part of children's enculturation. In infancy, for example, different professional techniques are used to assess children's acquisition of self-awareness. These assessments are mainly based on observing the child observing (showing signs of acknowledging) its own body exterior. In this context developmental psychological assessments attend to the child's experience of and mastery of their exterior body. An example of such an approach is the 'mirror image' experiments (Lewis and Brooks, 1978). These experiments show that not until children are about eighteen-months-old are they able to recognise that they are looking at their own face in a mirror. Thus, through such processes, the child's experience of their body exterior constitutes a measurable sign of the child's sense of self. Developmental psychologists theorise the formation of identity in this vein as illustrated in the following account:

The sense of self emerges gradually over the first two years. In the first month, infants have no awareness of their bodies as theirs. To them, for example, their hands are interesting objects that appear and disappear: two-months-olds, in effect, 'discover' their hands each time they catch sight of them, become fascinated with their movements, then 'lose' them as they slip out of view. Even eight-month-olds often don't seem to know where their bodies end and someone else's body begins, as can be seen when a child at this age grabs a toy in another child's hand and reacts with surprise when the toy 'resists'. By age one, however most infants would be quite aware that the other child is a distinct person, whom they might well hit if the coveted toy is not immediately forthcoming. (Berger, 1983:147)

Such professional discourses draw on the everyday convention that 'subjective states (for example, sensations, feelings and emotions) cannot be found, recognised or discovered in bodies but are attributed to them on the basis of certain observable manifestations that warrant such attribution' (Vendler, 1984:201). However, this approach neglects the child's subjective experience of self and body, which as concluded above cannot be reduced to its observable state.

During fieldwork parents, teachers and the other professionals working with children in the different settings of children's everyday life told me about their uncertainty as to



whether the meaning of a child's complaints or an unusual condition could easily be read off from the child's body. A child's cry or expression of pain would sometimes leave adults worried and puzzled about the 'invisible' nature of the child's illness experience. One problem experienced by parents and professionals concerned the complex notions associated with child vulnerability and adult responsibility that were evoked when a child got hurt. This, as I will show in Chapter 7, had implications for the negotiation of vulnerability and its distribution between children and adults. But the strong cultural connection between the protection of children and having to take action in their assumed status as responsible adults made them feel stressed. They dealt with the problem of comprehending children's experiences through investigations that aimed to establish the condition, and to define and classify the effect of an illness, or accident in order to establish its severity and its duration. In this sense illness had, preferably, to be specified as a set of distinct factors located in certain parts of the child's body so that its clear effects could be indicated and appropriate treatment applied. This interpretation would often be based on reading signs off the child's body. For adults, an obstacle in this process was the 'otherness' of children, which adults commonly encountered in their everyday social interactions with children. For example, children's unexpected behaviours, sudden movements, inarticulate screaming or other, sometimes, to all appearances random, reactions could prove difficult for adults to understand. This perhaps emphasised to adults the need to rely on more objective criteria in understanding children's experiences; for example, locating and naming the body parts affected by an illness or accident. The

approach taken by adults was, therefore, directed towards the child as a unity but paradoxically so - through the differentiation of the body into its parts. This was illustrated by Elsa, one of the senior members of staff in the after school centre. Elsa and I talked about how she would find out if a child was ill. Elsa said:

*'Well, if they don't get red spots or if it's not an eye infection - I mean if you cannot find out by looking - if they haven't got a broken arm or cut a finger or something. Then it is about knowing the children. For example, if it's a kid, who is usually lively, one who always races about, who suddenly sits in a corner, then of course you will go and ask them... or touch their forehead to see if they are very hot.'*

This emphasis on the objective signs of illness by professional adults was also supported by the accounts of parents. They described how changes in the child's appearance, moods or behaviour would alert their attention to the fact that something was wrong and the child might be ill. They also shared a reliance on objective parameters, such as time duration or the child's temperature, to classify illness and its severity (see Chapters 5 and 8). For example, IIselil, Mark's mother, said:

*'I tend to look out for signs like if he looks pale and tired or I'll feel whether he is hot, behind the neck. Our doctor once told me that's the best place. Then if I know it cannot be because he has done anything in*

*particular (sports, playing or other physical activities. I know he must be ill. If I'm in doubt I will usually tell him to go and have a rest and then check on him an hour later'.*

This approach of adults is, I suggest, analogous to what Frankenberg calls the 'somatic' view of the body, that is an objectification of the body beyond subjective experience. In this perspective the body is 'revealed at a particular diagnostic instant...(a)...partial, often technologically mediated, clinical view, restricted in time and space' (Frankenberg, 1990: 356). Working in this mode adults were concerned, for example, to validate the 'objective reality' of an illness or injury (more readily than exploring the meaning of the experience to the child) within this culturally dominant categorisation of the body.

Adults strive to introduce children to this classification. They do this, for example, through different games and songs. One popular variation of such a game, through which young children are supposed to experience and learn about their body, differentiates the child's (or the adult's) body through naming its parts. In the game, played by nursery staff or parents together with a child, the adult asks: 'Where are your knees? ... your tummy? ... your chest? and your nose? and where is mine?' The child replies by pointing to the appropriate body part. The game will be varied through reversals such as pointing to a body part and asking 'What is that' and the child answering by naming it. In this game both successful answers and corrected

mistakes will be appreciated with amusement by both adults and children. However, in addition to the pleasurable entertainment that is created during playing, the game has also the purpose of teaching the child, how the body appears, from an adult's point of view. During illness too, naming parts of the body exterior is an important tool in the communication between child and adult. The child is requested by adults specifically to localise their complaint by pointing to a particular place on the body.

Thus the naming of the body parts forms a path for adults who are attempting to understand how a child is affected by illness or an injury. At the same time, what Frankenberg (1990, 1994) calls the object body or the body somatic, becomes part of the cultural learning of children. Even though naming in this way was a mediating device, it was, as I will go on to show, also problematic in relation to understanding the body experiences and images of children. During the fieldwork one of the discussions I held with health professionals was with a doctor in Vanløse who recognised this problem. She told me, with amusement, how children under the age of seven years would, on being requested to localise their pain, point to their tummy and then, when asked to localise their pain further, they would inevitably point directly to their 'belly button', despite the fact that their pain might subsequently be designated by doctors to be in a completely different part of their body.

Another example will make the difficulties that sometimes underlay the communication between adults and children even clearer. During my fieldwork in the

school and after-school centre I often observed that when an adult was with a crying child they would ask the child 'Where have you hurt yourself?'. The youngest children would reply by saying 'On the swing' or 'In the sandbox' or 'On the chair', or by naming the child who had hit them. However, answers like these were surprising for adults because they wanted further guidance from the child to first locate the specific part of the body that was injured. The child's reply, however, referred to the experience of hitting the chair or falling in the sandpit or to the event of being hit by another child. Following this argument, from the child's point of view, she/he does not hurt their knee or elbow; the experience of pain is striking the sandbox. The experience integrates playing in the sandbox, striking it, the experience of its texture, the unexpected alteration of the situation and the body in motion and pain. The child's subjective experience of the body in (inter)action does not take the 'outsiders' view' of the body as an object. Rather this perspective may usefully be thought of as based in experiences of the body as unbounded and 'incarnate':

... a unity of past, present and future simultaneously experienced from inside and outside (...). The perspective of the incarnate body lacks boundaries in both time and space and is permeable to the world.

(Frankenberg, 1990:358)

In contrast, the adult approach, as described above, represents the 'outsiders' perspective, which tends to emphasise the child's body as object. This approach is, at

least in part, based on notions of adult care, including expectations of adults' active intervention, protection and responsibility and gives privilege to the view of the child as a subject acted upon by others. This means that adults would seek to determine how much the child is hurt and suffers (in order to decide what has to be done) through objective assessments of the 'extent' or 'amount' of an injury. Although this information is partly beyond objectification, adults sought to confirm how much the child was affected by observing and assessing the visible signs and manifestations on the exterior body of the child. Chapter 7 shows that adults' understandings of children as vulnerable are based on cultural ideas of the vulnerable inner nature of the person. They would therefore focus on the severity or extent to which the interior of the child's body is affected through observing how the body surfaces are transformed through damage, change and ageing.

That this was a particularly strong adult view was exemplified by parents and professionals in their understandings of adolescence (the transitional phase from childhood to adulthood). In their efforts to describe how this was a particularly problematic period, both in the experience of children themselves and of others, they pointed to the visible representations of the child's conflictual and fragile state. In adolescence, the perception is that severe inner and outer conflictual processes take place. These battles are perceived by others through visible manifestations on the child's exterior body, exposing troublesome transformations in their appearance and social behaviour. This signals what is seen by adults as the young person caught in the

tensions between an intruding complexity of adult life and status, and the immature competencies and understandings of the child. Whereas below I will argue that early childhood also takes on specific meaning from suffering displayed on the outside of the body, during adolescent growing up the reverse picture is presented. Suffering is understood in terms of concealed symptoms and interior illnesses. This is illustrated in the psychological emphasis on the effects in adult life of the effects of social constraint in childhood, as reflected in the number of psychological therapies (as well as popular understandings) that seek to offset the supposed effects of childhood experiences and childhood relations. In this perspective the developmental process constitutes a shift in the perception of illness. Being unhealthy is no longer concerned with the apparent concreteness and exterior reflection of childhood but with the concealed nature and subtle severity of the psychological and inner pathological organic processes of adulthood.

### **Children's Collective Bricolage of the Body**

I suggest that shifting the researcher's perspective from the child's body as object to the child's body as subjective, lived experience opens up a theoretical space for understanding the body as unbounded: the body as process and the experience of the body as constituted by continuous activity and (inter) action. During the fieldwork I found that the children, and in particular the oldest children (ten to eleven-year-olds), were engaged in creating conceptual linkages between the 'incarnate' body and the

'somatic' body. Let me illustrate this with an extract from a conversation I had with Thomas (eleven years old), Benjamin (eleven years old) and Dan (ten years old):

*Thomas: I know a boy called Michael from 7th (grade). He has such a strange disease of the liver. If he drinks a beer by accident, he will lose half a year of his life.*

*Pia: How do you mean, half a year?*

*Thomas: He won't live as long if he drinks beer. Anyway, he doesn't drink beer or anything.*

*Benjamin: Orh yes! If he drinks 100 beers then he looses 50 years just like that! (The boys burst into laughter)*

*Thomas: It's the liver, that collects all that alcohol-something. The liver cleans the blood, right - and alcohol in the blood it will first reach the liver, then it goes up to the kidneys.*

*Benjamin (points to the right side of his tummy and asks): The liver it's that one, isn't it?*

*Thomas: Yes, it looks like a sausage, it sits right here (he points to a particular point on his own tummy on the right, under his chest). That's the one that causes a stitch.*

*Pia: Where is it placed? In that side (I point out again the place that Thomas just marked)?*

*Thomas: I'm not quite sure....*



*Benjamin: It's placed here, right in the middle!*

*Dan: No, it's placed here on your side, here (Dan taps his finger on an exact point on the right side under his chest).*

*Thomas insistently: The liver is placed over here!*

*Dan: Yes, that's it!! The liver is placed on your side and then there is such a small green one, that sticks on it, and if you run too much and the little green one starts to shake, then you get a stitch.*

*Pia: The little green one - Do you know what it is called?*

*Bent: How do you do, so it doesn't shake?*

*Pia: It's the gallbladder.*

*Dan: No!! the gallbladder that's the one (you use) when you pee.*

*Pia: The gallbladder, that's the little green one.*

*Benjamin: How do you do then so it doesn't shake? What about people who run a marathon?*

*Dan: They are probably used to running.*

*Bent: Yes, but there is also something about, that you have to breathe in a particular way. You have to breath in through your nose and then blow out through the mouth, I think (Benjamin begins to practise according to his own instructions. Dan joins in with him and they practise for some time keeping in rhythm).*

This example can be used to summarise some of my most important arguments. The three boys are, I suggest, engaged in a collective bricolage of their social experiences, information and biological knowledge out of which they try to create a mutual understanding. They try, in particular, to create an understanding of their experience, that ‘when you run too much you get a stitch’ (the incarnate body) by combining this experience with their knowledge about the different separate parts of the body and, in particular, the function of organs such as ‘the liver’ and ‘the gallbladder’ (the somatic body). In their conversation the body is made central, partly through using it to localise, mark and unite their different understandings and partly in their final practical exercise of testing whether a particular way of breathing will work. Thus the body is in itself a project for investigation and a medium for deepened understanding.

### Conclusion

In observations of everyday illness episodes or minor accidents at school and the after-school centres, it became apparent that children’s concern was with the disruption of their body and its continuous connection with the social and material world. It was not, for example, focused on the penetration of the body skin or naming the body part that hurt. The important elements in children’s illness accounts were around items such as ‘Then you cannot play’ and ‘When you are ill you cannot be outside’. Children described themselves as part of the processes and events that they were involved in, thus conveying a sense of that they are their world not separate from it. These experiences of self and body sharply

contrast with adults' perceptions, forming what I term a perspective of 'the body as project'. Here I am not referring to what, in relation to adults, has been described as the modernistic strive for perfection, re-creation and control of the body (Turner 1992; Shilling 1993). On the contrary the children's engagement with the body is as a project in itself. This is about attempts to create understandings of the body and its capacity (see also James 1993). It covers the different ways in which children investigate, test and create control over their body through interactions with the surrounding world in their everyday life. As shown in this chapter, children were particularly engaged in gaining knowledge and understanding of the body as a base or medium for activity. They expressed this engagement in investigations of the body's appearance, capacity and functions, including its changes. In this endeavour, questions about vulnerability - for example the meaning of pains or other traumatic signs – sometimes had no or only minor importance. This meant that children's curiosity and thorough examination focused on the blood flow and colour from a wound or on clarifying the details an event. In other situations, however, the children would single out an aspect of a happening and relate it to their experience and understanding of vulnerability. In such situations they, so to speak, experienced and explored their capacity to be injured by expressing their pain, fear, fright or bereavement. In this way children spoke from the perspective of the body incarnate, the body as experience and as involved in (inter)actions with the social and material environment.

By focusing on children's social and cultural learning this chapter has prepared the ground for the next two chapters. I have suggested that adults' and children's perspectives on the

body are different and shown how adults attempt to objectify the child's body, dealing with the child's incarnate, subjective bodily experience by translating it into a somatic representation. In the process of sickness children not only learn culturally appropriate ways of transforming bodily sensations into illness and how to classify body parts but also, through the intensified social interactions that go on around sickness experience, they obtain a window on the social world. In the following chapters I explore vulnerability and competence, two different facets of the social relations between adults and children that illness accentuates and brings to the fore.

### Notes

1. I am highlighting the importance of the body as 'phenomenal' for children and argue that this, as such, constitutes a fascinating investigation. Christine Battersby points to a twofold dimension of 'phenomenal', which captures well the understanding I am pleading for. First, the meaning of 'phenomenal' is given as: 'Extraordinary, exceptional, prodigious, unnatural, marvelous, amazing; often used hyperbolically in reference to some object or person of extraordinary power, gifts or other quality which excites wonder'. Second 'phenomenal' can be defined as: 'in philosophy, that which has the nature of a 'phenomenon' (pl.'phenomena') and is the object of sense experience; applied to that which only seems to exist but which is a mere illusion of the senses; often opposed to that which is 'real', 'objective' or 'noumenal'.'(Battersby, 1998: 1)

2. See for example the volume called 'The Illness Narratives. Suffering, Healing and the Human Condition' (Kleinman 1988) which thoroughly examines the illness experiences of adults. Similarly, in a medical anthropological study I conducted in the late 1980s with stroke patients and their families (Christensen and Rasmussen, 1990) the subject of therapies and their effectiveness was a dominant feature of the adults' accounts of the experience of stroke, its associated illness process and was also important in their concerns about other minor conditions they encountered.

3. In a documentary film about street children in Brazil a social worker was interviewed about her work among the children. She told about her experiences and how what had shocked her most was the often hopeless efforts to save the children from the extreme poverty and inhumane conditions of their lives. She expressed deep worries and anxieties about the children, pointing to what she saw as the main obstacles to the success of her work. She said: 'Many children may not live to next week - because of assassination. When someone beats up a street child, the children don't think they can do anything about it. They just think it's life'. (BBC, 5th February 1995).

## Chapter 7

### VULNERABLE BODIES: CULTURAL MEANINGS OF THE CHILD, THE BODY AND ILLNESS

Adults like children when they behave and help with cleaning or tidying up  
and do what they are told but not if they cry and shout and hit the adults -  
but sometimes also if they (children) say something funny.

Peter, a nine-year-old boy

The only universal language in the world is a child's cry.

Save the Children Fund Campaign

#### Introduction

This chapter is concerned with one of the key aspects of child health identified in Chapter 1 and revisited in the report of my fieldwork in Chapters 4 and 5: the cultural meanings of vulnerability in childhood. The implicit assumption of much research into childhood, and the everyday practices around it, is that children are vulnerable and that, during illness, the child is particularly vulnerable and in need of adult care and therapy. Adults are, therefore, viewed as being in charge of, and having responsibility for the child, and the child is positioned as the dependent and passive object. Whilst not wishing to make a general challenge to the idea that children may be vulnerable, or to the idea that this vulnerability has a biological dimension (see Chapter 6), I suggest that the construction of children as essentially vulnerable tends to exclude consideration of the cultural and social context in

which vulnerability is constituted (see also Archard, 1993). This view also renders children's own understandings of themselves and their bodily experiences invisible. In contrast, I will show that a child's vulnerability is associated with the way in which a person is perceived by himself or herself and by others.

Understood in this way vulnerability is seen as a constructed status, in this instance embedded in cultural understandings of the child as a social person, of the child's body and conceptions of health and illness in childhood. In this chapter I will show how the public imagery of childhood vulnerability refers to the 'child as type' (Bühler Niederburger 1997; Jenks 1996b), that is to essentialist or stereotypical cultural representations of children. Therefore, I investigate three different, but related, aspects of the wider cultural representation of children that shape responses to the ill child. First, I suggest how the powerful theme of children as victims calls forth acts of care and help but, at the same time, confirms adult power and superiority. Second, I suggest that images of children as vulnerable coexist with ones that represent children as the 'spirit of life', a notion that simultaneously symbolises both a challenge to adulthood and a means of ensuring continuity. Third, I link these to the part that childhood plays in modern conceptions of human authenticity and interiority. These representations are then employed to examine the understandings and practices around children's bodies during illness that I observed during my fieldwork (some of which have already been described above, especially in Chapters 4 and 5). These focus on the approaches of adults to children's everyday accidents and illnesses and show how adults were involved in making interpretations about the (vulnerable) interior of the child by reading signs from their exterior surface, especially the skin. These adult interpretations were, however, not necessarily shared by the children. Rather, these contrasted with and questioned the adult's views. The vulnerabilities actually

experienced by children were not necessarily those attributed to them by the adult reading.

During these interactions the hierarchy between children and adults was starkly revealed. In the everyday life of both school and after school, adults generally expected that children should be engaged in more or less genuinely active ways. Teachers and staff in the after school centres encouraged children to take an outgoing and active part in, for example, collaborative manual work projects and in competitive playing. In football matches they were urged to be tireless and take risks. In a similar vein adults would express their disapproval if children seemed generally disengaged or lacked what they called a 'fighting spirit'. Whilst girls were not pushed to participate or cheered for their actions to the same degree as boys, and they were not expected to display the same physical effort or strength, this was a difference of degree rather than kind (see also Prendergast (1992, 1995). The overall expectation was that children, girls as well as boys, should be active and participatory. This general picture was, however, in marked contrast to the anticipated passive role of a child when illness or accidents occurred. Such situations expressed adult ideas about a child's vulnerability and positioned the adult as active, protecting and responsible in relation to a passive and unprotected child.

### **Images of Vulnerability in Childhood**

The social positioning of child and adult during episodes of childhood illness can be seen as a particular reflection of more ubiquitous images of children and childhood in Western cultural thinking. Anthropological studies have suggested the specificity of these by documenting how in different cultures children are thought of in terms of their vulnerability (Mead, 1955, 1962; Briggs, 1971, 1986; Stafford, 1995). Briggs's classic



study of Canadian Inuit families, for example, paid particular attention to the cultural practices and social interactions between children and adults. She suggested that it was crucial for children to develop an understanding of the ambiguous, but interlinked, conceptual framework of vulnerability, caring and protection, on the one hand, and of strength, power and killing, on the other. This combination not only helped to secure their personal survival but also helped to sustain the existence of the community in a harsh environmental context. It formed a central part of child rearing practices. Adults engaged in purposeful playing with the boundaries of weakness, danger and risk and engaged in the almost brutal teasing of their children in order to motivate articulated and independent understandings, abilities and strategic actions in them.

In most discussions within a European and North American cultural perspective, particularly those using a psychological approach (see below), the focus is on understanding of the child as dependent on others because the concern is that children develop independence (see discussion in Chapter 1). In such studies 'vulnerability' is viewed as a basic quality of children or childhood, it has been a taken-for-granted feature and its analysis has been neglected or excluded from the core of theoretical discussions. The major concern has been with the dependence and independence of children, an emphasis motivated, I would suggest, by the dominant European and North American cultural ideal of the individual as autonomous, responsible and mature (see Chapter 1).

Unlike child vulnerability, however, child dependency has been subject to a certain amount of critical cultural analysis. Hockey and James (1993), for example, examine notions of dependency, providing an important account of the powerful influence of social and cultural ideas and practices in constructing dependence and independence in childhood and

old age, suggesting how these processes are reflected and maintained at both extremes of the life course. In these processes, they argue, different forms of infantilisation constitute disabled and old people as marginal social groups in relation to the normative central position of adults. Similarly, in establishing the norm of the adult as an independent, competent and responsible person, the child is constituted as the cultural other. The child is, as the adult's opposite and complement, seen as vulnerable, dependent and incompetent.

Within certain areas of sociological and psychological research and within social policy, however, the vulnerability of children has been employed as a general notion. This has been in relation to 'special needs' or preventive health programmes for psychologically, physically or socially disadvantaged children (Anthony et al, 1978; Palmer et al, 1988). The aim of such initiatives is to detect the sociocultural settings or particular factors in children's physical environments that put 'children at risk' and may cause pathological conditions or developmental problems. In this chapter, however, rather than taking the vulnerability of the child as given or as a particular feature of disadvantaged children, I shall begin to unravel some of the ways in which childhood is constituted as essentially 'vulnerable', suggesting that vulnerability acts almost as a key signifier of children.

In many cultural discourses of childhood, children are constituted as essentially vulnerable beings, who can only survive and develop successfully if nurtured and cared for by adults. That contemporary childhood is and should be a 'nice', protected world in which problematic external forces from the environment, or perhaps from malevolent adults, only sometimes intervene, is an important component of such discourses (Ennew, 1986). However, as Ennew also notes, it is in seeing children as essentially vulnerable beings that

they become constituted as a target for adult power and exploitation (Ennew, 1986, 1994; Boyden, 1990; Holland, 1992). This conception of vulnerability in modern childhood finds expression in particular sets of ideas about children, the family and work. As discussed in Chapter 1, these ideas are fundamental to prevalent views of children in European and North American societies and to the form and structuration of childhood (Giddens, 1991:20).

Popular images and public pictures provide another set of sources for the cultural understandings of children's vulnerability. This can be seen particularly in fund raising campaigns addressed at protecting and saving children. The United States child survival programs, which have great international influence, represent young children as only worth saving because they are seemingly innocent and need to be protected. As such these campaigns have been criticised for separating out the health and wellbeing of the young child from that of their household and family (Nichter and Cartwright, 1991). Similarly, adolescents' and adults' perceptions and use of alcohol, cigarettes and medicines are by implication considered as irredeemable, for these groups have grown up and thus lost their child-like innocence.

Another example of the emphasis being placed on the protection of children is provided by campaigns that urge us to 'Adopt (or support) a Child' in a developing country. These campaigns assert that the health of the local community will be improved through the sponsorship of a particular (and identifiable) child. The images of these campaigns are similar to those of the 'Adopt a Whale' (or Dolphin) ones, which aim to safeguard the environmental health of the ocean. The fellowship between children and animals is expressed in the use of visual displays and vocabulary that reinforce the symbolic analogy,

thus further supporting understandings of children as 'endangered species'. However, there is also an ambiguity constituted by images of children suffering, children as victims of wars or children as victims of natural disasters. Patricia Holland's analysis suggests a paradoxical tension, which she argues underlies the relationship between children's and adults interests:

Children are seen as archetypal victims: childhood is seen as weakness itself. As the children in the image reveal their vulnerability, we long to protect them and provide for their needs. Paradoxically, while we are moved by the image of a sorrowful child, we also welcome it, for it can arouse pleasurable emotions of tenderness, which in themselves confirm adult power.(Holland, 1992: 148)

Patricia Holland's analysis demonstrates that representations of children's suffering and frailty is closely related to the symbolic value of children for adults, which further reinforces a power-dependency relationship between them.

### **The Child as 'the Spirit of Life'**

One important aspect of the pictures in campaigns to protect children is that the child is constituted as an agent or a catalyst by which the future survival of the whole community is secured. In this sense, however, the child may not be constituted as being the central concern. Rather their image as the personified and vulnerable being is what attracts the attention of the (primarily) adult public. The campaigns attempt to provoke immediate emotional empathy with the suffering child in order to forward a central purpose and to

justify 'rationally' based arguments (such as the importance of sustaining the basic needs of people). The images almost stereotype a 'universal truth' in their portrayal of children as essentially vulnerable, suffering and in need of help. Thus the campaigns imply that the value of financially contributing to them is not achieved in actually 'saving a child' – an argument that further substantiates the point that the instrumental value of children for adults has been largely replaced by their symbolic value (Scheper-Hughes, 1989).

However, the messages also point to another set of cultural ideas: the 'charm of children' that positions children as embodying the 'spirit of life' and attributes to them the particular gift of 'bringing life, warmth and happiness' to people, to their hearts and to places. This view was, for example, illustrated in a film version of 'The Secret Garden' based on Francis Hodgson Burnett's classic book (1911). The story is about Mary, an orphan girl who is brought from India to live with her relatives in a lonely Manor house in Yorkshire, England. In the context of bereavement and loss and apparent bleakness, Mary comes to act as the spirit of life. One day, while exploring the grounds surrounding the big house, she discovers a neglected walled garden imbued with natural fertility. Mary tends the garden with the help of a local boy and, like a magic spell, everything starts to revive. Not only the old garden and Mary herself, but also warmth, happiness and health is generally restored in the lives of all the people around them. In thus forming an almost integral part of nature Mary is pictured as bringing the spirit of life to her reclusive uncle, as well as his physically weak and grieving son. In the final sequences of the film the uncle having realised her important contribution says warm-heartedly to her: 'You have brought life back to us, Mary ... Thank you!!'. The girl Mary thus becomes associated with more the general symbol of 'life-giving', pictured as representing the authentic value of nature, vitality and purity.

Together these different views constitute children as symbolising not only the continuity and future but also the fragility of human life and are images played out in representations of the child's body and in perceived notions of its fragility, as well as in the images of its natural vitality. Strength and the capacity for survival are depicted, for example, in the image of a new-born infant's forceful and eager suckling that demonstrates a determination to live but also characterises children's (rapid) growth, development and activity.

The child represents continuity in their similarity to adults just as their difference represents their uniqueness and the hope of another and better future. The notion of continuity, and further that children are expected to survive adults, forms at the same time a challenge to adult control and power. This was illustrated in the following conversation, recorded in my fieldnotes, which I observed in my fieldwork:

*'A staff member of the after-school centre and a twelve-year-old boy teased each other one afternoon. The adult said: 'You are a 'silly-child'' and the child replied 'Yes and you are a 'silly adult'.' After some banter back and forth the adult wanted to conclude saying triumphantly 'OK, then but I don't mind being a 'silly-adult' because I am the one who makes the decisions. What do you want to be then?' The child concluded their conversation saying: 'I want to be a 'silly-child' because I will live longer than you.'*

### **Authenticity and Interiority**

A further set of values is expressed in the infant's purity and innocence; the child is constituted as a 'living symbol of the forever lost' values of adulthood. In Denmark the

infant is praised for representing that which, in a sense, every one of us loses in growing up, that is 'the innocence of childhood'. This view is reflected through the idea that children, with their increasingly complex nature, are perceived to 'lose' their charm. The ambiguity of this relationship between the child and the adult has been described by Jenks (1982: 9) in his encapsulation of it in the notions of 'difference' and 'sameness' (see Chapter 1 and Chapter 8). The implication of this is that childhood has to be understood as a relational category: the child cannot be imagined without considering the idea of 'adult' just as it is impossible to picture the 'adult' and 'society' without positing 'the child'.

In this respect, Carolyn Steedman (1995) disputes her own earlier proposition that the powerfulness of the idea of the child is, 'that it is the first metaphor of all people. But now, I think that what I sought to describe is not best discussed as a process of metaphor, but as one of personification.' (Steedman, 1995:18). My work can be seen as being in precise agreement with Steedman on this point (although what she calls the process of personification I choose to call the work of making difference as well as sameness, see Chapter 8). However, Steedman suggests that:

The insight of various late nineteenth-century theorists of childhood, that children gained their enormous affective power because there became available more and more ways of seeing their similarity with adults and of apprehending them as part and as extension of the adult self. (Steedman 1995: 18)

Thus in the perception of children's otherness, that is in their innocence and as symbols of new life, but also in their sameness as being the continuation of oneself, the child

symbolically defends and purifies the 'dark sides' of adulthood. A child's naive, open and curious investigation of and interactions with the world represents a charm that fascinates the adult, who may recognise the imagination and fantasy that (as with romantic love) acknowledges the unboundedness of the world; a world imagined to represent the simple, spontaneous unconditional and infinite dimensions of social relations, unconstrained by conventional restrictions and limitations. Hence, the symbolic value of the child incorporates notions of originality and 'not being spoilt' that are only rarely associated with modern adult life.

Modern life has been described as a social and cultural world constituted by a multiplicity of unsolved paradoxes, contradictions and experiences, where fragmentation and inconsistency are central traits (Giddens, 1991; Isern, 1993). In order to create sufficient degrees of integration and affinity to life and personal experience, people devote themselves to a number of cultural practices in order to produce meaning. One example of such a practice is striving for the 'authentic' as a means of bridging the gaps and contradictions of the modern experience. I suggest that the contemporary symbolic value of children for adults reflects such attempts at re-establishing originality and authenticity in modern adult life. Steedman (1995) describes in a similar way the search for the self, which has dominated the last century, as a search for a past that is lost and gone. This lost essence or vision of the self has, she suggests, assumed the shape and form of the child. She argues that:

The idea of the child was the figure that provided the largest number of people living in the recent past of Western societies with the means for thinking about and creating a self as something grasped and understood: a



shape, moving in the body ... something inside: an interiority. (Steedman, 1995: 20)

This view corresponds with Foucault's (1983) argumentation in the last volume of 'The History of Sexuality'. He says that it is not the sense of self that is a development of the modern world; rather it is the location of the self that is new. The modern self is imagined as being inside. Interiority seeks to describe the self as created by the laying down and accretion of a person's childhood experiences and personal history, in a place inside the body. This, perhaps, is what we may call an embodied self - an interiorised subjectivity that constitutes a sense of the self within.

### **The Body: Somatic and Incarnate: Bounded and Unbounded**

From addressing notions of vulnerability in childhood represented in the collective imagery of children this section will now turn to investigating the understandings of these questions in relation to the child as body and self. In the process I draw specific attention to a view of the child's body that distinguishes between the exterior (or surface) of the body and the interior body and in which the transformed surface of the child is seen as a sign of vulnerability. Different perspectives on the child's body are examined in order to indicate how they relate to adult's and children's understandings of vulnerability.

The quote which opens this chapter illustrates how a nine-year-old boy acknowledged the importance of the (outer) appearance and the (inner) qualities of a child for adults: 'behaving', 'doing what they are told', 'crying', 'shouting', 'hitting' and so on. Below I show how specific ideas about children's exterior bodies, their interior bodies and the

relationship between them shaped adult approaches to children's everyday illness episodes and minor accidents (1). In particular children's vulnerability was understood and acted upon through the distinction between the 'somatic' and 'incarnate' aspects of the body previously explored in Chapter 6. The somatic perspective on the body objectifies it (Frankenberg, 1990: 356) so that when working in this mode adults were concerned, for example, to validate the 'objective reality' of an illness or injury (rather than investigate its meaning for the child) and localise it within a culturally dominant categorisation of body and its parts. This contrasted with the incarnate body that children experienced themselves when they suffered accidents or felt unwell. As suggested in Chapter 6, experiences of the permeability, fluidity and extensibility of the body are transformed for children when adults attempt to translate the body incarnate into the somatic body, a process that routinely occurs during minor illnesses or everyday accidents. These translations objectify the body, fragment and classify its parts and constitute the exterior body as a shield - that is to say a boundary between the child and the world.

The transformation of the child's bodily experience and conception is an important aspect of cultural learning in European and North American societies because it relates to notions of the person as a unity (see also Chapter 1). Clifford Geertz has given the following description of the unity they are said to learn:

The Western conception of the person as a bounded, unique, more or less integrated motivational and cognitive universe, a dynamic centre of awareness, emotion, judgement, and action organised into a distinctive whole and set contrastively both against other such wholes and against its social and natural background. (Geertz, 1983:59)

In popular understandings and everyday language this has come to mean that a healthy and mature person embodies psychological strength and independence, social assertiveness and physical boundedness. This is, in part, achieved through notions of the toughening of the body surface, expressed, for example, as the importance of being able 'to make oneself hard' whilst, at the same time, retaining an openness to one's surroundings so that one does not appear 'insensitive'. The exterior of the person must not harden so much that the person and his or her vitality suffocates and that, as commonly expressed in Danish, 'overfladen krakelerer' (which translate into English as 'the surface cracks'). Ideas of the consistency of personhood are reflected in understandings of a balance between the inner and the outer nature of the person, established in a responsive, but well-defined and coherent outer appearance.

In this context the skin or the surface of the body works as a metaphor for personal experiences and social relations. For example, to express that something or someone is problematic and constantly annoying, Danish people say 'Jeg får knopper af det', (literally 'It gives me the hives', but perhaps more idiomatically rendered in English as 'It gives me the creeps'). If a person feels overworked or battered by the hardships of everyday life and thus fragile and hypersensitive they may be described as or feel 'tyndhudet' (in English 'thin skinned').

The cultural theme that I identify here is often found in literary accounts of childhood and youth experiences. For example, Doris Lessing, calls the first volume of her autobiography 'Under My Skin' (1994). In Danish literature, Troels Kløvedal's book, 'Den tynde hud' ('The Thin Skin'), is a stark account of his difficult and complex childhood (1994).

Another example is found in the novel 'Borderliners', by Peter Høeg (1993, English edition, 1995). This novel is a portrait of the relationship between children, adults and time. The main character of the book, as an adult, visits the school of his childhood and finds the old school clock. This awakes a chaotic stream of memories about the tensions between himself as a child and the adults that are expressed in terms of the body and its skin:

The deputy head, the engineer, the secretaries in the office, the teacher who had worked at Frederikssundsvejen's School - all of them have forgotten me within no time of having met me. But, while we were standing together, they thought they were dealing with an adult.

Wrong. They had been speaking to a child.

Confronted by them I had no skin, nothing to shield me. I noted their every change in tone, every shift of the eye; I sensed their need to be getting on, their politeness and distraction and indifference. They forgot me five minutes after I was gone, I will remember them always. (.....) They were protected. Time had wrapped a membrane around them. They were jovial and pressed for time and totally unaffected by our meeting. (...)

Time has wrapped itself around the adults - with its haste, its dread, its ambition, its bitterness and its long-term goals. They no longer see us properly and what they do see they have forgotten five minutes later.

While we, we have no skin. And we remember them always. (....) Things adult. Precise, accurate things. Of those there is no shortage. In fact, everything else around us is comprised of them. (Høeg, 1995: 143-144)

In Høeg's symbol-laden description the skin, the body surface, represents the child's virtual protection.

Such views of the skin as a protective barrier form an important part of the discussion in this chapter by being linked to the idea of the permeability or unboundedness of the body raised by Battersby (1993). She encourages the examination of the female body through notions of its 'unboundedness' in order to bridge the contrast between the body as object (the somatic body) and the body as lived subjectivity (the body incarnate). She proposes that in order to understand gender differences (see below) one has to see that cultural notions of the body as bounded, almost in the image of a 'container', are derived from a male-centred approach to the body and then used in a wider sense to express personhood in general. Battersby's important observations in relation to women resonate with parts of my own fieldwork data, where children expressed their experience of self and body as inseparable. As suggested in Chapter 6, they emphasised an understanding of the body in process, in continuous action and connection with other features of the social and natural world. Adults, however, tended to emphasise the ill or injured child's body as somatic and, therefore, as a bounded entity distinct from the rest of the world.

### **The Exterior and Interior Body**

Cultural notions about the relationship between the interior and exterior of the body, I suggest, shape social interactions during children's everyday accidents and illnesses. An important part of this process concerned the adult readings of the child's outer surface, especially the skin. A Norwegian dermatologist, Ole Fryand, (1996, Danish edition 1997)) has written an impressive piece of work about the skin from a biological, cultural and

historical perspective, including examples of how it is represented in art. The body, he points out, is constantly exposed to attack from the surroundings and, therefore, the skin has an important function in providing a good protection. At the same time, the skin is the body's biggest sensory organ as well as a communicative system. He focuses on the skin's role as a communicative medium in everyday social interaction emphasising that (everyday) life takes place in both a biological and a social space. For example, he writes:

Something happens with us when we meet other people. Already at a distance we acknowledge how the other is - through the movements of the body, rhythms and posture, by the skins colour and quality and by the form and volume of the hair. We judge also the character, cut and colours of the clothes. Gradually while the distance shortens we get even more information from the details of the appearance and the smells of the body. And by the handshake, the direct skin contact provides information about how the other reacts to us. A dry and warm hand signals control, while a cold and damp hand discloses other emotions behind an apparent relaxed social mask. The skin tells its own story, both about us and about the other - and that can be quite a different message than that which words and learned gestures communicate. (Fryand, 1997: 13, my translation)

Terence Turner (1980) has also suggested that the surface of the body may be conceptualised as 'the social skin', a surface upon which the drama of socialisation is inscribed. Bodily adornment, like body paint and clothing, becomes the language through which the social actor and cultural subject is constructed and expressed (Turner, 1980:112). Here I take up this idea by suggesting that the surface of the child's body in

European and North American cultural contexts presents a medium from which can be read not only cultural understandings of the child's well-being but also the relational, mutually constituting, position of child and adult. In particular, the transformation of the exterior body of the child exposes the opposing but still complementary values of vulnerability and protection. I will argue that, from an adult point of view, the transformed body surface of the injured child represents the child's vulnerability and the moral demands on adults to protect, be responsible for and to care for children (2).

Underlying the 'adult' perspective, I will suggest, is an embedded cultural understanding of the child that designates an implicit distinction between the exterior and the interior body of the child, and a consequent compartmentalisation of children's nature into two parts. The first is a visible, exposed and specific outer nature of a child, and the second is the idea of a hidden, wild and vulnerable inner nature. The adult approach to the child mirrors this division and also takes two forms. One attends to the exterior health of the body through observing, cleaning, clothing, grooming, touching and so on. The aim of the other is to nurture the interior body with food and knowledge. However, that the adult focus tends to be on the health of the child's exterior body may be, as I will return to below, because it provides a possible route to conceptualising the wellbeing of the 'inner' child. In this view the child's body surface is particularly significant because while adults engage in attending to the child's body – in sickness and injury - it is this that becomes the most concrete aspect for them. It constitutes the child's physical presence and existence and, at the same time, the object of their love, affection or rejection. Adult emphasis on and constant engagement in discovering and understanding the child through the perspective of the exterior child is further exemplified in other areas of their interaction beyond illness episodes. It is found, for example, in parental instructions about and

monitoring of children's comportment, in the stories adults exchange about children's appearance, behaviour, and talk, and in adult's requests that younger children perform, sing, dance or repeat funny words in front of an audience.

There is, however, a complementary notion of the child's inner body when this is seen as a source of hidden information, emotions and bodily processes. It is understood as the motivated agent in the body and becomes the subject of adult control. The child is thought to develop from what are seen as primitive inarticulate, functions to a socialised complexity that follows acceptable cultural norms. Thus the child is acknowledged to be elusive and flexible but also capable of being modulated by the influence of adults. Attending to the surface of the child, that is to the child's exterior body, is first a means of expressing love and adoration of the child. Second, however, it serves as a means of formation and social control (Turner, 1992). However the surface of the body is not in itself the ultimate target of control. Interventions, restrictions and modulations directed at the exterior body have a more subtle concern to discipline the inner body.

Thus the child's body as it visibly appears, is acted upon by others to establish an appropriate and acceptable surface, but it is distinguished from the interior processes of the body or the 'inner' child. The child who is cleaned and dressed exhibits the social status of its carers. In this sense the child becomes a symbol of adult creation and a moral statement of adult achievements. Children are seen as picturing their family. They present the image of their family in their person. For example, one school nurse told me that she could always spot children who lived alone with their father because of the way they were dressed. She said:



*'The colours don't match and the clothes don't quite fit'*

Taken further, this meant that the pathology of a child could be established by professionals working with the children through their observations of his/her appearance and behaviour. The child reflected the pathology of the family and, in a circular argument, the pathology of the family could be established through the child's appearance and behaviour. Instances of the 'passive child', for example, could be detected by their exterior bodily presentation: pale, inactive and unresponsive, described by professionals in a Danish idiom 'falde i et med tapetet', which can be translated as 'just part of the wallpaper', an extreme form of which communicates a shallow person, one who merely exists.

**The Protective Shield**

In adult estimations a child's skin is appreciated as the 'perfect' skin. Its softness and fine character represents values of purity and innocence. However, ideas of the openness and transcendence of the child's body are reflected in the assumption that, through growing up, the child develops a unified hardness of the body surface. Susan Whyte (1986) has described European and North American ideas about personhood as specifically directed towards inner conditions and processes, an occupation which both underlines and is made possible by the physical barriers of the body: that is in conceptions of its boundedness. In this perspective the external body surface serves as the protective shield of the vulnerable interior of the child, a notion that has been repeatedly emphasised in the work of researchers in child health (see, for example, Wilkinson 1988; Scheper Hughes and Lock, 1987, 1995; Kakar, 1982). They have shown how the use of metaphors such as 'castle' and 'fence' underlines a dualistic perception of the body, which nevertheless prioritises a

cultural occupation with the body's inner processes. Thus an intact exterior body is indicative of the well being of the child.

In their everyday life the children in my study continually displayed their vulnerability as they stumbled or were hurt in other ways, such as in childhood diseases like measles or chicken pox. But it was a vulnerability understood differently by children and adults. Such events reinforce for adults the importance of the child developing a hard surface through their constant observation that 'the inside leaks out'. The diffuseness of the inner body is reflected and established on the surface through blood, crying and screaming. It may also be indicated by fever. Adults explained that 'children often get a high temperature without being ill'. They believed that children, in infancy and early childhood, may be more affected by a virus, developing a high fever but for a relatively short period in comparison with older children and adults. Biologically (that is from the point of view of the somatic body) this can be explained in terms of the immaturity of their immune defence system and temperature regulation centre (3). However the experience of this situation for a child, that is understood from the point of view of the body incarnate, is still one of major illness that seriously affects their lives for a time. For adults, on the other hand, the length of time a child was affected by a high temperature was the crucial factor in indicating its severity.

During the fieldwork I was struck by such differences, and sometimes even discrepancies, between adults' and children's perceptions of vulnerability. These divergent perspectives were illustrated by the approaches taken to a minor accident of a child in school. As described in Chapter 5, in these situations teachers generally reacted immediately. They were alarmed and greatly concerned especially when a child was bleeding. In contrast the injured child (and also sometimes other children attending) were often deeply engaged

with quite other matters - for example, in investigating the blood and establishing the amount of it. Often this was done without showing any signs of fright or repulsion. In other situations, by contrast, children appeared to exaggerate and magnify the scale of their injury. Maria, a ten-year-old, dramatically said 'Look, I'm bleeding!' whilst presenting a drip of blood the size of a pin head on the finger. And in a football match Hannah jumped about, pointing to a foot which looked quite normal declared 'Oh look! My toe is all blue and swollen'. As I also showed in Chapter 5 (see also Christensen, 1993), the most frequent and characteristic reaction to such claims amongst other children was precisely 'to look'. A child's claim of 'a swollen toe' was not met with judgement or correction from other children. This response was in marked contrast to adults who would meet such dramatic expressions of children with disapproval of such reactions. They would correct them by pointing out that the toe looked absolutely normal and would humorously minimise the importance of the cut by suggesting there was only little or no bleeding.

This suggests that even though different but very visible signs are displayed on the surface of the child's body they take their meaning, for adults, from the complexity of the child's inner nature. Whilst the inside of the body spreading to the exterior of the body signals severity, the manifestations may be instrumentally and symbolically 'wiped off'. An adult would wash blood from a wound, drying tears at the same time as calming the child, saying: 'Shh, shh, Stop crying' or 'Stop now! Don't make a fuss'. The severity of what has happened is investigated through re-examining the damaged surface and the event may be re-established as 'innocent'. In my fieldwork I frequently observed that after everyday accidents, adults cleaned wounds and covered them with a plaster or bandage to sustain the healing process. The adults acted to produce a protective shield by applying the plaster

that as substitute skin would protect the broken surface and thus aimed at re-establishing, toughening and hardening the surface of the body. That a plaster does not necessarily have that meaning for children is seen illustrated in the frequent observation made by adults that younger children may insist that a plaster is placed so that it is visible, perhaps on skin that is perfectly undamaged, rather than hidden under the clothes.

In some ways the adult approach to vulnerability may also hinder them in attributing the experience of 'real' suffering to children. This may be illustrated by the following two statements of childhood illness contrasted in the Open University text 'Birth to Old Age' (1985). The first example is from a medical textbook:

'Chicken pox is a common and highly infectious disease but it is usually mild in childhood.'

This statement made by a paediatrician is contrasted to a child's account of their illness experience. The child explained:

My last illness was chicken pox and it was dreadful. The first two days were the worst. I did not just have chicken pox but was ill as well. I felt very lazy and was asleep all day and I would not eat. I think chicken pox is the worst illness I have ever had ... it was dreadful and I hope I never have it again.

(Open University Press, 1985: 165)

In my own study the issue of how adults' attributed suffering to children can be illustrated in the following account of the school nurse. Her viewpoint was widely shared among staff

at the after school centre. She said:

*'I want children to know that I help them. Because if they know that I am able to help with a small problem (for example a wound on the knee) then they know that they can always come to me for help when they get bigger problems, for example more complex psychological or social problems.'*

Thus the younger children's everyday problems were in general thought of in terms of being simple, straightforward, concrete and visible to adults. The problems of an older child or adult, however, were associated with an enveloped and complex nature. The older child was seen as in and between more diverse social interactions and contexts. This was taken as implying experiences of a more complex nature, which were also considered as problems of the inner body, that is symptomatic of emotional distress or other psychological tensions.

### **The Child's Gendered Body**

That ideas and experiences of vulnerability in childhood are developed in terms of the gendered body may seem self evidently an important point. Generally my fieldwork material revealed that it was more acceptable for girls to be vulnerable. Indeed, this was sometimes even acknowledged as a positive personal attribute of a girl; she was someone who could become the focus of adults' protection. This perception is furthered, I will argue, by the attention that is given to the child's body surface and the qualities linked to it, values traditionally perceived as specifically female or feminine: those associated with appearance, passivity and caring. These are qualities that girls and women are often represented as possessing and, perhaps, even being imprisoned by (4).

In Egeskoven school the girls in 1st grade, those six or seven-years-old, often adopted the role of carer. They were seen by the teachers as more mature than boys were and encouraged to take the role of being 'little adults' to the boys in the classroom. The girls were perceived to be more organised in relation to their schoolwork and would sometimes be encouraged to take on a role as 'assistant teacher' in relation to boys. What was being offered to a girl appeared to be the role of a responsible and protective adult. During the spring term the classroom in 1st grade was reorganised. Since the beginning of the school year the tables had formed a horseshoe so that all children were facing each other as well as the teacher. Now the tables were positioned in three rows with two children at each table facing the teacher. The class was seen as generally noisy and the teachers were beginning to experience problems in keeping the attention of the class during lessons. The situation had gradually intensified because three, or sometimes four, of the boys acted so disruptively that they would draw in other children. To encourage an improved behaviour among the boys, the principal teacher decided to place each boy on a table next to a girl. At the same time, the teacher told the girls collectively to admonish the boys if they bothered them and she stressed to them the importance of the girls encouraging the boys to behave well in class and in the playground.

It was characteristic that the girls in the playground were unlikely to engage in play through which their body might be covered in dirt or mud. The few girls who did engage in such play were noticed and commented on in boys' discussions but, in general, their expectation of the girls conformed to the comment of one nine-year-old boy who said:

*'They (the girls) cannot take it but we boys can.'*

The boys' conflicts often took a physical form. They fought, hit, kicked, shouted and abused each other. That their conflicts were often conducted openly, or publicly, often attracted the attention of others and, thus, were more likely to receive intervention by adults. For example, at school when two or three boys fought they would be physically separated by an adult, and the problem was often dealt with in an 'open trial' attended by the other children in the playground. Severe conflicts, or conflicts that appeared to be getting out of the control of adults, were solved by isolating the boy(s) concerned from the rest of the children. During this process the adult addressed the causes and conduct of the fight and the roles of the boys involved. This was done in a particular way. Adults insisted that fighting was not allowed in the institution. At the same time, however, the boys were also reminded of the 'set of rules' for hitting another person. These were that only specific areas of the body should be hit and that care should be taken with the severity of a blow or the strength of a punch. They would be told that it was prohibited to hit 'above the chest and below the belt' or that it was dangerous to kick someone's back. These were rules that could be established quite clearly and firmly by adults.

Such conflicts among boys were often perceived by adults as easier to intervene in and to solve than those of the girls, which were seen as generally more problematic and vicious. Girls were rarely seen fighting or hitting each other to any great extent. Instead their conflicts were of a kind different from those of the boys. The girls did not tend to get involved in trials of physical strength such as those entered into by the boys. However, the girls did tend to engage in trials of psychological and verbal power in their social interactions. This can be seen as not only related to the lower level of physical acting out of their relationships but as also echoing 'trials' of strength and weakness in adult

relationships, especially those based in subtlety of verbal and psychological power. Moreover, since physical punishment and control of children has been legally abandoned in Denmark, an emphasis has been put on the psychological element in the interactions between adult and child. Girls could be seen as generally more adept and skilled in these terms.

Conflicts among the boys were seen to take place within a pattern of equality because the boys often shifted their hierarchical positions in the group according to different activities. In contrast, girls often constituted themselves in peer groups with a more stable hierarchy and their conflicts involved testing these positions and the liberties they implied. Girls would verbally abuse each other and these conflicts were enacted using techniques that served to humiliate and frighten. Furthermore, girls constantly used different strategies and social sanctions which, for long periods every day, might be based on deciding who could play with whom and who was excluded from playing with the group. Sometimes one girl had the decisive power to choose a 'best friend' from amongst her playmates. At other times a group of girls might shift their loyalties by excluding one girl from their play. A conflict in a group of girls, or between boys and girls, not only addressed the persons involved but often extended to involve threatening and humiliating other emotional bonds of the child, such as those with their family. For example two six-year-old girls threatened a boy (also six) saying: 'We will put our clogs on and kick your little sister'.

However, unlike the boys', the girls' conflicts were often invisible to adults. A parent may be aware that conflicts had taken place, or be cognisant of a girl's distress, but the conflicts could take place for long periods of time before they were discovered or acknowledged by adults. This was seen, by adults, as adding to the interior suffering and vulnerability of girls



and to the refinement of their methods of isolation and to their ability to put pressure on each other. Another problem for adults intervening in girls' conflicts was that their rules, based on psychological and social fighting, seemed to be much more subtle and diffuse. As is the case in such conflicts among adults, it was regarded as difficult to establish a set of clear-cut rules for moral conduct that calibrated the degree of psychological or social distress that might properly be directed to another person. In such conflicts the external body could not be examined or addressed to clarify where 'a psychological punch' might have been given or to determine its force.

Drawing on the earlier perspectives of the interior and exterior body, adults' intervention in the boys' physical fighting and violence could be seen as accomplished through declaring, pointing to and classifying zones of the exterior body and defining its fragile parts. The meaning of interventions in the girls' psychosocial conflicts, in contrast, reflected the diffuseness of the inner body. Even though some general moral code of conduct may be established, the enactment of psychological power is more invisible because only in its extremes (for example, in severe bullying) does it attract public attention or sanctions. Furthermore, it is important to see this process in relation to adult sociocultural norms. Adults are supposed to achieve control and power over children (in conflicts or as a means of punishment) by using verbal and psychological weapons and using social sanctions such as the expulsion of children from the classroom (or school), the withdrawal of privileges, or isolation from the company of others.

Finally in this comparison of the boys and girls, it was clear that the boys engaged in activities that took up more space, had larger territories in the playground, took over many rooms within the institutions and their activities were more noisy. Girls, in contrast, were

expected to be more restricted in their body actions and they were often engaged in activities such as playing in the 'dolls corner' of the institution. Girls tended, at an earlier age than boys, to seek to play and be involved in interactions on the fringe of the playground. Girls were considered to have a more passive approach to their body and were offered much earlier an 'acceptable' adult role.

Girls' conflicts thus mirrored adult domains of psychological power, social sanction and hierarchical positioning. Adult perceptions of the problematic severity of girls' conflicts may refer to the fact that girls' actions directly targeted the vulnerable inner body and, furthermore, that they carried meanings that were diffuse and invisible. In contrast, because they were expressed through the vehicle of the exterior body, conflicts between boys carried more explicit meaning in terms of adults' active interventions. Their conflicts were open and clear and the severity of a physical fight could be established through damage visible on the exterior body, damage that could be readily translated into judgements of damage to the inner body.

### **Conclusion**

The examination of vulnerability, I suggest, is useful for understanding not only illness in childhood, or other episodes where children may be injured, but also for understanding some basic conceptions of modern childhood itself. Children's vulnerability may be partly associated with their biological being but it is also a construction of the way in which children perceive themselves and are perceived by others. It is embedded in cultural understandings of the child as a social person, of the child's body and conceptions of health and illness. The cultural performance of (child) vulnerability and (adult) protection

is accentuated when children's body surfaces are transformed. I do not wish to argue that this perspective forms any exclusive stance in adults' understanding of children. On the contrary, it exists alongside other perspectives on children and their bodies held by adults and by children themselves (including, for example, gender differences). In this chapter, however, I have outlined how it forms an element of the broader cultural performance of childhood health and illness and I suggest, further, that this perspective may usefully be employed to further understandings of how the lifecourse is culturally constituted in terms of frailty and strength.

The dissonance revealed in the communication between children and adults was an important element in the differences I observed in their approaches to the every day episodes I have been discussing. I have analysed these by drawing a distinction between the somatic body seen by adults and the incarnate body experienced by children and by suggesting the culturally constituted processes by which the inner and outer bodies of children are translated. Vendlar has suggested that in order to bridge the gap in understanding between a person's subjective states and exterior manifestations a solution must be found in the interpreter's own experiences (1984: 201). In a recent paper, Hastrup addressed this point further adding that:

Solidarity is not achieved by inquiry but by imagination, the imaginative ability to see strange people as fellow sufferers. (Hastrup, 1993: 735).

In this chapter I have suggested that adults attempt to understand children's experiences by translating them into those of adults themselves and that it, thus, creates particular problems in the interpretation of childhood illness. These problems may not be constituted

from the adult's own experiences, but could be seen as arising from, in Hastrup's terms, the limitations of adults' imaginative abilities. However, this may be too easy. An anthropological understanding of children must also be achieved by replacing adults' images of children as social persons and of their essential vulnerability and by firmly contextualising children in their own social worlds.

A statement by the founder of the international charity Save the Children Fund, used in a recent campaign, is that 'The only universal language in the world is a child's cry'. This quotation addresses the issue of children's suffering as an unarguable and easily recognised global truth. Yet, as Putnam has pointed out, 'for a particular proposition to be 'true', that is generally acceptable to others, it must display a degree of coherence with experience' (Putnam 1981:49 cited in Hastrup, 1993). The child's cry, as any other behaviour, is given meaning within its particular social and cultural context. The understanding of vulnerability seen in a child's cry or through another expressive process, poses a problem when it is interpreted through the knowledge and images of adults. Anthropological understanding of vulnerability must be achieved within the context of children's relations and social interactions, those between children and adults and it must be related to the child's position in the social structures and cultural frameworks that mediate their experiences.

### Notes

1. A recent study has addressed the powerful role of images of the exterior body for children. This study conducted in England showed that younger school children constituted understanding of social identity as being reflected in the body appearance, shape, size and behaviour of another person (James, 1993).

2. Elsewhere I have shown how the moral demands of adults to take care of and be responsible for children implied that they (adults) would actively intervene and claim control during the everyday episodes of illness and minor accidents of children (Christensen, 1993).

3. During infancy and early childhood the child may be more affected by a virus, developing a high fever but for a relatively short period in comparison with older children and adults. Biologically this can be explained in terms of the immaturity of their immune defence system and temperature regulation centre. However the length of time a child was affected by a high temperature was the crucial factor in indicating its severity.

4. Conversely women may indeed be criticised for taking on a more passive role in contrast to that of boys and men. Indeed it is this distinction which underpins the argument that 'Men act and women appear' (Berger, 1972:47). A study of English primary school children showed similarly that girls were expected to take a more passive role in physical activities and were seen as being of a more fragile constitution than boys by teachers and mothers. These distinctions were discussed by adults in terms of a child's 'wetness' (Prout, 1986).

## Chapter 8

### CHILDREN'S COMPETENCE AND ITS CONSTITUTION IN ILLNESS AND TREATMENT

#### Introduction

Throughout this thesis I have emphasised, both theoretically and in the analysis of my fieldwork material, that notions of children and adults are culturally constituted in relation to each other. My starting point for this view (discussed in Chapter 1) was Jenks's (1982) observation of the paradox that children are simultaneously constituted as both familiar to us, that is recognised as the same, and as different or 'other'. In this chapter this theme is explored through an examination of the various sickness practices through which children's and adults' competence are made similar or different during illness and therapy.

As a preliminary to this it is necessary to examine different notions of competence. Mortier (1997) distinguishes between the legal and psychological versions. The former describes the granting to individuals of a decisional right in a certain domain, typically the right to accept or reject proposed medical care (see also Appelbaum and Grisso, 1988, Alderson, 1993). The legal approach constitutes competence as a threshold concept in which a person is judged either to have the capacity or not to have it - even though it may be acknowledged that there is a great deal of variation in the underlying skills and knowledge required. In this situation an adult may be deemed competent even though

nothing or little is known about their capacity and abilities. Children, on the other hand, may be deemed incompetent even when they can demonstrate knowledge and skills. As Jaffe and Wicky (1997) point out, the consequence of this is that legal norms about competence often appear to be extremely arbitrary.

Underpinning the legal conception of competence is a very particular notion of 'rationality' that Mortier traces back to both Lockean and Kantian ideas of the free or autonomous individual (see also my discussion in Chapters 1). Children are assumed not to '...have the kind of rationality that enables them to take a conscious stand against their own preferences and to work out a valid personal conception of the good' (Mortier,1997: 101). This, however, leads directly to a double standard between children and adults. When adults are seen not have the means to make an informed and reasoned choice, it is assumed that others have the duty to correct this. Compensatory mechanisms are put into place to ensure that, as far as possible, they are given the means to exercise choice. For example, doctors in many societies are expected to inform their (adult) patients, who are not generally experts in medicine, about a condition or therapy. Furthermore, they are enjoined to explain the situation in terms that are understandable to the patient. In relation to children, however, their presumed incompetence is assumed to be the natural or normal state of affairs about which nothing can or needs to be done. In this Mortier suggests that:

...a double standard has come to reign. Irrationality in adults is mostly (but not always) compensated for by institutional and legal arrangements, while irrationality in children is simply assumed to be what distinguishes

them from adults and is taken to justify the exclusion of children from opportunities of self-government.’ (Mortier, 1997: 102)

The psychological version of competence is less concerned with such judgements about categories of person and is more focussed on discovering what sorts of competencies different individuals are in possession of. For this purpose psychologists have created extensive taxonomies of competence which, whilst detailed, are almost always exclusively cognitive in orientation and give little attention to emotions and affect. They have also devised various methods for testing individuals for reasoning skills and their application to practical situations (see, for example, Ennis, 1987) Whilst this literature is a large and complex one (and its details lie beyond the scope of this thesis) its main trends are clear: adults are generally poor reasoners in relation to both formal and practical contexts; in both cases children are better reasoners than is often assumed; and, in consequence, the difference between children and adults has often been exaggerated. Mortier writes:

‘.. I am certainly not going to argue that whereas adults are poor reasoners and behave rather irrationally, children are excellent thinkers and little Aristotle’s (sic). They are not. But they are better thinkers than is mostly assumed.’ (Mortier, 1997: 105)

Although psychological investigation is a useful counter-balance to the rigidities and arbitrariness of legal definitions (and medical and other professional assumptions), they both share a conception of competence that constitutes it as an attribute of an individual. I



suggest, however, that from an anthropological perspective competence can be seen as an effect created within social relationships (Christensen, 1998). Hutchby and Moran-Ellis take up this suggestion by arguing that competence is something:

‘... established in situ, for this particular here-and-now occasion ... something that children themselves negotiate, argue about and struggle about in local occasions of activity rather than being a function of the attainment of some specific stage of development.’ (Hutchby and Moran-Ellis, 1998: 16)

It follows from this that competence is a contextual matter not separable from the sets of social relations within which it is negotiated or displayed. From this perspective it becomes possible to examine how children might achieve the recognition of competence, or fail to do so, in their interactions with other actors (whether other children or adults). Nevertheless, and whilst agreeing that it should not be understood as a psychological property of an individual, my perspective extends beyond this in order to emphasise that competence needs to be apprehended as a phenomenon that is relationally constituted. This means that competence and incompetence are created at the same time; adults, in particular, create their own competence through the constitution of children as incompetent. This is not entirely a matter of negotiation in a local, individual context but also involves how social groups are represented. The importance of these social representations of children, such as the legal ones discussed by Mortier, is that, in part, they determine how children are perceived by others. I suggested in Chapter 1 that the

neglect of children's experience has meant that children may have little influence over their own social representation and, therefore, although children can, as I will show below, act in ways that are competent they, nevertheless, fail to overcome this representational deficit.

### **Similarity and Difference**

In the previous chapter I suggested that powerful images of children as vulnerable shape how adults respond to children's illnesses and accidents in such a way that children's own experiences of vulnerability are excluded or underplayed. Here I will examine how in everyday child illness, especially in therapy and the use of pharmaceuticals, children's incompetence is constituted. Through these practices children learn not only the instrumental and other contingencies of how to perform sickness in a particular Danish context but also how to enter into those broader social relations concerned with age hierarchies. This engagement is, however, not constituted as a simple hierarchy in which children are always and to the same scale in a subordinated position. Rather child-adult relations are constituted in more varied and mobile ways on a continuum of difference and similarity. This is partly because there is a divergence between cultural categories and real actors' everyday experience and practice. Children and adults do not belong to a fixed category of 'child' or 'adult'. In part, this is because eventually children are going to grow into the category of adult, a transition which is not completely fixed in time or place. Furthermore, in everyday interactions both children and adults observe situations and contexts where adults exhibit incompetence and children act competently and skilfully.

This again leaves scope for interactions and negotiations that may obliterate or demarcate the accepted categorical positions, even though it might in the end simply confirm the relative positions of children and adults.

I have argued above (and in Chapter 1) that the child cannot be imagined in the absence of an idea about what an adult is, just as it is impossible to picture an adult and his or her society without positing the child. The ambiguity in the relationship between the child and the adult is encapsulated in the notion of 'difference'. This perception of 'difference', as Jenks (1982) suggests, may be attributed to a focus on the social processes of overcoming it - that is socialisation. Thus at the same time as child and adult are seen to form a continuum, a 'sameness', there is an implication of a socially and culturally constituted opposition, an opposition which designates not only difference but also hierarchy. To establish the norm of the 'adult' in terms of an independent, responsible and competent person necessarily constitutes its opposite, which at the same time is its complement, through notions of the vulnerability, dependency and incompetence of children.

But, as is implied in the notion of 'becoming', the relationship between the categories of child and adult, whilst depending on the construction of difference, cannot be simply characterised by this alone. For difference is only one side of the processes through which social and cultural relations are made, maintained, reproduced and transformed. As Douglas, in a large body of work on cultural theory, has persistently argued (see, for example, 1975), cultures can be understood by what they do and do not allow to be brought together. There is always, therefore, the possibility that cultural categories are

enmeshed in relations of sameness as well as difference. This point can be taken further with the possibility that social relations might be constituted precisely through 'partial connections' - a formulation (Strathern, 1992) that allows for more fluid, mobile and heterogeneous sets of difference and similarity than Douglas's more static conceptualisation. In this sense social and cultural relations might be thought to involve both bringing items in their repertoire together and keeping them separate. The contradiction is only apparent. Sameness and difference (i.e. the work of making connection and disconnection) might go on in different times and spaces, at different points in a process - or, as also seems likely, held in tension through moment by moment interaction.

It might be noted that in the above discussion, an implicit shift has been made from the notion of culture as the moving force (that does something) towards a notion of culture as a less solid phenomenon that is constructed through situated activities, practices (both discursive and non-discursive) of connection and disconnection. Latour (1993) refers to one side of this equation as the work of purification, by which he means the work that goes into keeping things apart, for it is not reified culture that does this but social actors. On the other side we might speak of the labour of connection by which things or persons (such as children and adults) are brought into proximity, made to interact and through which, it might be suggested, they are made to be more similar (or at least less different). Children's and adult's competence to deal with illness and injury can, therefore, be seen as something continuously made in a tension between similarity and difference.

### Children as the Incompetent 'Speakers of Fact'.

In children's accounts of sickness, therapies had central importance for their understanding of illness and illness processes. Cohen's analytic conception of symbolic boundary markers (Cohen, 1985), although deployed by him in the analysis of community and its construction, can also be used to suggest that practices such as specific medical examinations and therapies act as symbolic boundary markers in illness for children. In particular, my fieldwork showed how they helped children identify graduations of illness and stages in the process of becoming ill and recovering. Children's accounts were full of boundaries, transitions and their markers. Particular therapies or care actions signified the possibility of transition from one state to the next, thus facilitating subsequent steps and stages of the sickness performance. For example, one ten-year-old boy wrote the following story about a recent experience of illness:

*'One morning I feel ill. I call my mummy and I say. I have a tummy ache, mummy. Yes I'm on my way. Mummy I have a tummy ache. My mother went to my bed and touches my forehead. What a warm forehead you have. We walked down into the lounge. My mother brings the duvet. And my dad has left for work a long time ago. My mother takes my fever. It is very high. My mother calls the doctor. Ten minutes later the doctor arrives. He says that I have got a fever. The doctor leaves again and my mum says you must have some medicine. I get sick. My mother runs to get a cloth. When she has wiped up she said that she would go to the pharmacy. She would be*

*back home in ten minutes. I got some tea and some medicine and we read some books, then we made some drawings. Then it was lunchtime. Dad came home and discovered that I was ill. The time went past. At one o'clock my dad and I talked together and watched a cartoon. I got medicine, I slept a bit. It was evening. I watched a children's programme and got soup. I was going to sleep now. ... The next morning I was well again. I was happy and also my dad and my mum. The end.'*

Therapies acted as boundary markers for children in distinguishing transitional stages in illness, whilst simultaneously enabling them to classify therapies and gain ideas about hierarchies of medicine. In general, the start of a therapy marked the child's shift from health to illness and its cessation marks the move from illness to being well. Particular therapies, such as the use of pharmaceuticals, mark different degrees of illness. The giving and receiving of therapies can, therefore, be seen as important in the process, discussed in Chapter 6, through which children learn to mark out illness from the flow of everyday life. As such it also is an event of particular social significance for their project of the body.

However, apart from their role in communicating the phases and severity of an illness event to children, therapies, therapeutic actions and medical examinations during illness also constitute a field that engages both children and adults in producing difference and similarity of competence. In general, adults constitute themselves as competent by drawing on 'rational' knowledges and mediating devices (such as a thermometer) to classify children's mental and bodily experiences as 'real' illness. This simultaneously

entails that children's competence becomes suspended; their subjective experiences of their own bodies do not qualify them as 'speakers of fact'. Adults accomplish this disqualification in a number of ways. First, is the significance of temporal aspects such as 'duration' in adults' definition and classification of a condition and its severity. As discussed in Chapter 7, the accounts of mothers, teachers and staff in the after school centres, and in my own observations of child-adult interactions, 'duration' was an important, if not central, reference point for adults in deciding whether a child was 'really ill' and whether his or her complaints were to be taken seriously. Second, the process involved was generally similar to the counterposition of the body incarnate and the body somatic that I have identified in relation to the constitution of children's vulnerability (see Chapters 6 and 7). In this case, however, the result was to deny children's competence, through adult actions that implied their view of the child's body as somatic (that is as an objectified entity similar to that found in biomedicine)

As I have shown, a general theme in adults' accounts revealed, for example, that children might have a high temperature, 39C or 40C, without being thought to be 'really ill'. This normalisation of children's symptoms related to what the adults perceived as rapid bodily changes in children. Duration thus acted as an important boundary marker between a well and an ill child. Similarly a common adult' response, (both at home and in the institutional settings) when a child said they were ill or felt unwell was: 'Go and sit down for twenty minutes and let's see if you'll feel better'. From adults' point of view time would reveal whether the child's claim was dependable and the child was 'really ill'. Duration of symptoms thus constituted a point of comparison with adults' illness. If the child's

symptoms endured over a period it validated, for adults, that the child was ill. However, if symptoms did not endure the child's claim was proven wrong and consequently they were not ill. From adults' perspectives the child's claim signified the unreliable and contestable aspects of children's illnesses and ultimately of children's competence itself.

Adults understood this unreliability to be the result of one or a combination of the following reasons. First, it was thought that, in order to gain adult attention or be let off a demand, children may deliberately fake illness. However, the expectation was that children were not able to persevere such pretended performances for a long time, The passage of time and passive waiting, therefore, seemed to them to be an appropriate test of the child. Second, was a psychosomatic explanation of children. If children felt neglected or lacked adult attention and care they would, it was thought, tend to express their psychological and social needs through claiming illness. This can be seen as an instance of children's outer bodies being read as a signifier of their inner vulnerability (see Chapter 7). Third, children were thought to forward false claims of illness because of their inexperience and incompetence in the interpretation and classification of mental and bodily experiences. In this situation it was thought that the child expressed momentary bodily sensation because they could not, yet, distinguish between common experiences of healthy bodily processes and illness. Accordingly, temporal contradictions in the subjective experiences of the 'natural course' of child illness epitomised the differences between children and adults in illness transitions and in social negotiations between them (Christensen, 1993). Children's expression of subjective experiences, such as them saying 'I don't feel well', was translated by adults into the task of answering the question 'Is there



a disease?'. This was a question for which they sought objective evidence in the child's body, rather than engaging with the child's expressive statement in itself. In this way, the performance of the hierarchical child-adult relationship mirrored, what Kirmayer (1988) has identified as an important values of biomedical practice, that is to keep rational control over and distance to bodily and emotional experiences.

Another important symbolic marker in the classification of an illness was temperature taking. A general understanding among the six to seven and ten to eleven-year-old children whom I interviewed was that they were the first person to know when they were ill. The children felt that their experience of their own body was a useful guide to their state of health. However, as I outlined in Chapter 6, there were also differences between the accounts of the children in the two different age groups. The younger children (six to seven years old) would generally describe being ill in rather unspecific ways. Frequently used phrases included 'It does not feel very nice' and 'I did not feel well'. The youngest children would rarely attempt to label their condition specifically and the illness process would appear as almost indistinguishable from the flow of everyday life.

Even though none of the children in either age group expressed doubt in their ability to recognise that they were ill, ten to eleven-year-olds acknowledged that having a fever was a determining factor in being accepted as ill by parents or teachers. Anna, a ten-year-old, told this story about her last illness. She said:

*'I felt ill. Then my dad took my temperature. He said, 'Yes you are ill'.'*

In this example Anna's father confirmed and validated Anna's own experience by an objective measure. The children also recognised that practices such as having one's temperature checked acted as the explicit confirmation of being well again. For example as Charlotte, also ten years old, wrote in an essay:

*'I yawned and got out of bed. I took a glass of water because I was thirsty. Mummy shouted to me that I should go back to bed, but I said, I feel well now. Mummy looked at me and said, 'We must take your temperature'. It showed 37.2 C. Mummy exclaimed: 'But, you are well!! Run out and play with the others, but wrap up well. ''*

Accounts such as these suggest that while, on the one hand, children recognise that they have to go through the 'tests' to be accepted as ill by adults, on the other hand, they express no doubt in their own judgement. However, children also learn that their own views are less 'true' until confirmed by higher status adult action. A child cannot make the judgement that they are ill on their own and their claim is not *a priori* evidence of illness. It is not even necessary evidence - and certainly not sufficient.

The above examples demonstrate that the examination of the child's body temperature was an important marker of illness and well being for children and for adults. When, however, illness or health was established to adult satisfaction, and the children had passed the various tests employed, this facilitated taking other steps in the process of illness or recovery. In the above instance of Charlotte, for example, her mother's recognition that

Charlotte was well again meant that she was allowed to play outside. It seems that adults subject their own views and judgements to 'rational' measures that objectify children's condition.

The following example, from Prout's (1986) ethnography of illness in an English primary school, suggests that this is not only of significance in parental practice at home but can also be important in the interactions and negotiations of children's every day illness at school. Prout highlights the powerful role of the school secretary as gatekeeper in children's illness episodes. When confronted with a child's complaints of illness the school secretary took their temperature to conclude whether they were 'really' ill and consequently unable to stay at school - a procedure she conducted more or less detached from the accounts of their own illness given by the children. Thus, the school secretary established what she perceived as a reliable diagnosis. A child's vague bodily sensations were given a name - 'fever'. The typical practice of taking the child's temperature in the course of illness thus revealed itself as, not only an instrumental act accomplishing a practical objective, but, at the same time, as an expressive symbol of the location of competence in adults (parents or professionals) rather than children.

Situations such as the ones described above communicate important elements of difference in the social relationships between child and adult. Illness classification indicates the position of the child as incompetent (as well as vulnerable and therefore dependent, passive and subordinate) while the adult is seen as competent, active and in charge. These typifications are embodied and encoded in practices of surveillance and regulation. When

a mother, staff at school or after school institution check a child's temperature, there is an underlying notion that the adult acts as a competent and responsible carer. This is a serious matter for adults because if a professional does not discover that a child is ill they may, in the eyes of parents and even eventually from an official or organisational perspective, appear irresponsible and neglectful. Likewise, if a mother/parent does not carry out tasks such as taking the child's temperature (especially at the doctor's request) or giving a child their medication it questions the adult's ability and competencies and, ultimately, their status as a 'good mother' or 'good parent'. As I demonstrated in Chapter 4, parents take this into account when making decisions about keeping a child off from school with a sickness.

The successful handling of the means and practices that serve to determine children's health and illness continually demonstrate and support adult skills and competencies as being over and above those of the child. Through persistence and authority adults carry out procedures that inevitably exhibit particular competencies: keeping time, taking the temperature and reading the thermometer, opening the bottle of medicine (indeed, the specially secured screwcap lids for 'child protection' means it cannot be opened by a child), determining the dose of medicine and making the child comply in taking the medicine (even when it tastes disgusting).

Many of these procedures, however, may also be acknowledged as practices that cannot be carried out by the adult single-handedly. They may involve a number of persons. At the very least, they involve the co-operation of the child for their successful completion.

This was recognised by children in their accounts of their own active participation in taking medicines. Most children emphasised that they took medicines by themselves when they referred to sickness events. As described by seven-year-old Lasse:

*'First my mum pours the medicine into a small glass and then I drink it'.*

The emphasised 'I' here signals Lasse's awareness of his own role in the process.

Children would often stress the unpleasant taste of medicine but they were, at the same time, able to describe how they explored different food items (for example, sweets, fruit juice and milk) as a technique that could be used to cover the taste of medicine and make it easier to swallow. These accounts, therefore, emphasise the interactional aspect of therapy and the importance of children's active participation in the therapies being given to them by adults.

However, in adult's accounts, children's co-operation often appears as a taken-for-granted. It was children's different attempts to control or their objections to adults' practices that, although regarded as common experiences, were acknowledged for their significant, even provocative, challenge of adult's sole competence and authority. An infant or a young child might scream, cry or fight to avoid an unexpected, unpleasant or even possibly painful procedure such as temperature taking, which in Denmark is still generally measured rectally. As Catherine, seven years old, said giggling:

*'I don't like to have my temperature taken. I scream.'*

Parents, who wish to persist in conducting such a test or in giving a medication, therefore have to hold the young child firmly while giving it, or they may try to persuade the child or negotiate with him/her in order to obtain his/her collaboration. In and through these potentially conflictual situations, that may occur in the home or at Egeskoven school (for example, in the chaotic turmoil following an accident in the playground), adults endeavour to exhibit their competence in keeping control and order and taking calm, strategic action. Thus, a child's illness episode acts as a medium for adults to express and confirm their competence and position in relation to children.

On the other hand, any doubt about a child's health and welfare could potentially challenge the status and position of the adults charged with protecting and being responsible for them. Of course the adults did genuinely want to safeguard the health and well being of children. But, in the institutional settings, adults also had to protect their own competence through their everyday routine advice to children. This was:

*'If you need help remember to go and find an adult'.*

Although teachers and other staff expressed the plea in general terms they meant specifically those situations when a child got involved in a conflict, a fight or an accident (that is situations where children were seen as particularly vulnerable). However, despite its open and helpful tone this advice communicated to children a view of their own

incompetence in personally handling these sort of situations and undermined the idea that, as children, they may be able to help each other without adult intervention. This was underlined for children when they had managed a situation independently and failed to call an adult. In such situations adults would usually rebuke the children whether or not the children's own actions had led to a successful management of the situation - a fact which was easily dismissed as incidental by the adults (see Chapter 5). In such ways illness and accidents became strong symbolic events for the display and confirmation of the hierarchical nature of the child-adult relationship. One important element of this relationship was that similarity between adults and children was intertwined in the constitution of the very difference between them.

The disqualification of children from self-care that is implied in the adult view can be contrasted with the many accounts I gathered from children when they described the actions they had taken after an accident. These were very specific about what the children did when they had an accident or hurt themselves in some other way. For example, Gitte told me that:

*'Gitte: Well, you, I had got a wasp sting. Then I bite it and then it is as if it does not hurt as much.'*

*Pia: Have you figured that out for yourself?*

*Gitte: Yes. And when I have hit myself, then I move the legs back and forth on the floor, because when you move, move the body, then it is as if it does not hurt as much where you hit yourself.'*

Although the children were aware that they might need help from others when they had hurt themselves or felt unwell, this did not mean that they were not also engaged in finding how they could help themselves.

### The Competent 'Affectionate Child'

The above examples show that children were generally constituted by adults as incompetent in speaking 'the facts' of their own body - that is of translating a bodily experience into an illness state or condition. I have also shown how the processes of every day life emphasised the importance, for adults, in constituting their competencies in opposition to or through children's constitution as incompetent and dependent. It would, however, be a mistake, however, to interpret this as meaning that children were constituted as incompetent in all respects. The incapacity of children to understand or judge the facticity of illness can be contrasted to the special capacity children were seen to have in the sphere of emotions, especially the giving and receiving of affection.

Let me first return to the situation where the meaning of therapeutic and similar practices is not shared by children and adults. This is powerfully exhibited in the 'battle' between the parents' (and by implication the doctor's) perspective and children's views, which may lead to a child being 'forced' into compliance; for example, making the child take an unpleasant but necessary medicine or pursuing an examination by holding him or her firmly. Such incidents would, however, most likely be resolved through the parent's gentle comfort of the child after the event, thus constituting this care as another part of



children's experiences of illness. Nevertheless, the love, affection and care, which forms part of adults' interactions with children, does not alter the basic hierarchy of the relationship.

The reason for this is that, as Kirmayer (1988) notes, in the western worldview rationality has precedence over affect. Both children and their parents emphasised that children's illness episodes and time off from school represented an opportunity for child and parent to spend time together (see Chapter 4). This aspect was, as I have suggested, regarded by adults as having increased in importance because of the large proportion of mothers in the labour market in Denmark. In the context of a hectic and pressurised every day work life, a child's illness episode may thus provide families with an opportunity to express and maintain the affective bonds between children and adults.

The importance of this affective dimension was reflected in the type of therapies used in children's illness episodes. The families used a wide range of home remedies and other means of self care as well as pharmaceuticals. Home remedies and therapeutic practices, such as special clothing, baths, specific drinks or food, temperature regulation therapies, massage and relaxation, usually involved several persons. Parents and staff in the after school centres related this use of home remedies to their knowledge of traditional self-care practices and to their personal and familial experiences. Although parents, teachers and other staff may sometimes be recommended to use a simple home remedy by the school nurse or their general practitioner, these remedies were generally used independently of any involvement by health professionals. Home remedies were seen as time consuming for

the families both in preparation and conduct and their effect may be slow or diffuse. However, their appeal was in concordance with the general (perhaps especially Danish) principle of using non-invasive therapies for children. According to this view, intrusive medical practices such as medicines, injections and radiotherapy are to be avoided, or at least monitored carefully, with children to prevent inflicting unnecessary harm or pain. An ideal image of child health is characterised by elements such as purity, naturalness and simplicity. Basic essentials such as food, drink, sleep and activity, further supported by adults sensitivity to the psycho-social aspects of child health, fed in to the very same model of the importance of adult attention and care. Most importantly, these therapeutic practices offer ways of expressing the affective bonds between child and adult that together with their engagement in sociable activities such as playing games, reading aloud and watching television, emphasised reciprocity in their relationship.

However, the emotional expressiveness of children has a double-edged quality. In my conversations with children and their parents I asked what children did when somebody was ill in the family. The children's replies pointed, very specifically, to some exclusive action or they would more generally list the various activities they engaged in to help and comfort a parent or a sibling (see also Chapter 4). These included, for example, fetching things for the ill person, making tea, getting sweets or ice creams, picking flowers, comforting them and playing or reading loud for a sibling. But they also included going shopping, helping with domestic work and assisting parents in looking after a younger sister or brother. Gitte, a six-year-old, told me, for example, how she had helped her mum by staying at home and looking after her two-year-old brother when he was ill while her

mother 'nipped out' to do some shopping.

In contrast to the precision of children's replies, the most frequent response from their parents to this question was hesitation eventually followed by a statement about the child's affectionate personality or character. Lene, mother to six-year-old Gitte, said:

*'Gitte, she is a very caring and helpful child.'*

Most parents found it difficult to pinpoint the actual actions the child engaged in to help and comfort a family member. In this way, the competence of children to give and receive affection rendered invisible their capacity to give practical therapy and help. This was underpinned by cultural representations of children as essentially vulnerable, as solely recipients rather than givers of help and care. This, in part, constitutes everyday childhood illness as an occasion through which to express key parental values such as affection, protection, care and responsibility that, ultimately, leave children at the passive and receiving end.

### **The Negotiability of Children's Competence through Pharmaceutical Practices.**

That these understandings are associated with cultural conceptions of children as particularly vulnerable beings (see Chapter 7), supports the idea that children should be kept apart from pharmaceutical use. In the final section of this chapter I will suggest that pharmaceuticals are embedded in a biomedical hierarchy which, when they are used in the

household, is 'imported' in a way that delegates authority in medicine use to parents and, thereby, constitutes children as less competent. At the same time, however, the grounds are, nonetheless, created for children to negotiate access to medicine use that may shift ideas of their competence and status.

From a societal viewpoint, pharmaceutical use is subject to both market structures, such as the range of available pharmaceutical products, and to official regulations about their distribution and cost (Dukes, 1993). The pharmaceutical market is also a domain of powerful societal gate keeping. It is the doctor's prescription that forms the essential access to a pharmaceutical, thus detaching it from any subjective experience and judgement on the part of the patient. The decision that allows medicine to be bought over the counter is conditioned by ministerial legislation but pharmaceuticals are further supervised by, or may even be subjected to the control of a pharmacist. In the family and household, the use of pharmaceuticals again forms part of a set of social relations and interactions including parental gate keeping.

In their encounters with medicines, children came to understand their special character. Children from six to eleven years old could map, in more or less detail, the quest for pharmaceuticals. Their accounts emphasised the social organisation in which pharmaceuticals are embedded. They told me about how the doctor was consulted to prescribe the medicine, about the pharmacy where they subsequently bought the medicine, and about the persons involved in the transactions. They explained where pharmaceuticals were kept in the house and who, how and when they were used by family members. They

also acknowledged how medicines, in particular, were kept away from children in the household.

However, the children did not sharply distinguish between a therapy and the social interaction surrounding its use. In particular, children described therapies as inseparable from the person who provided care; for example, their mother, a general practitioner or a teacher. They described different therapeutic actions by simultaneously identifying the roles and positions of the persons involved in the illness episode. A general practitioner was most commonly referred to by saying:

*'The doctor prescribes medicine.'* (my emphasis)

Mothers, on the other hand, were identified with home remedies. Many children's descriptions were similar to that of Marian (seven years old):

*'When I am ill, my mother always puts a cloth with cold water on my forehead.'* (my emphasis)

In this way children sketched out the social organisation of everyday illness through an understanding that a therapeutic action defines the status of the person involved.

That children were not systematically told about the use of pharmaceuticals did not hinder the way that their use implicitly communicated cultural conceptions of hierarchy to

children. In dispensing pharmaceuticals, both the formal hierarchy of competence and the negotiation of status were made possible. This was illustrated by Linda, a ten-year-old girl, who explained:

*'Usually I get those headache pills for adults - it says do not take under 16 (years-old), but I only get a half. Then once I was ill, my mum went to buy some for children. I could not swallow one, then I got sick. Oh, it was disgusting.'*

Most ten-year-old children described Panodil (a brand of paracetamol) as 'adult pills', adding 'You know, prohibited for children under twelve' (years old) or 'under sixteen' (years old). However, in their everyday experience, children found that tablets restricted to adults were divided and given to them in a smaller dose. Through dividing a tablet into smaller pieces, the once 'prohibited' was made accessible and, thus, children were shown the idea that therapy is negotiable. At the same time, the division of the tablet confirmed the child's position in relation to adults through its symbolic portrayal of the child as, metaphorically, half the size of an adult.

Access to medicine and the ability to use it independently is suggested as one of the 'charms' of pharmaceuticals (Van der Geest and Whyte, 1988). The flexibility of pharmaceuticals makes it possible to act privately or to engage socially in different exchanges within families and other social relations. This contributes to the process of deconstructing and distributing medical power and status from the doctor and pharmacy to

the level of family and peers. The use of pharmaceuticals is thus embedded in a set of hierarchical relationships that may, for children, indicate some means for the achievement of independence and personal control. Most importantly, pharmaceutical use may represent to children the scope for independent action within or towards the constraints of different social relationships.

These elements of control, privacy and independence, here exemplified in the use of pharmaceutical therapy, have been suggested as cultural values at the core of European and American understandings of personal health (Crawford 1985, 1994). If an important aspect of growing up for children is to achieve competencies and to be recognised as having the controls of adult life, then pharmaceutical use may symbolise important relations of power and hierarchy in children's everyday life. My data suggest that, as well as communicating their general position as subordinate to parental and professional adults, for children, getting access to medicine or using medicines independently could also contribute to their sense of an improvement of social status. For example, a mother related this story to me about her two sons. David, who is a fourteen-year-old, had been suffering from asthma since he was very young and had to use an asthma inhaler daily. However, when Thomas, who is nine years old, recently was ill he was given a nasal spray to relieve his cold. During his illness he said to her:

*'I am just as big as David now'.*

She was bewildered and had asked him what he meant. Thomas explained that now he

used an inhaler just like his older brother, David.

Parents, teachers and staff in the after school centres saw themselves as competent and in charge of care and treatment. Responsibility and protection of the child was seen as an adult domain but even though this approach emphasised the dependent and more passive role of the child, there were in fact differences in the degree to which they permitted the child's active involvement. Adults tended to take responsibility and to take action over acute conditions. This limited in some ways the scope for children's competence. However, a child suffering from a chronic condition or one who was in need of a treatment for a longer period was often taught how to conduct the treatment (more) independently. Thus, control and responsibility were sometimes actually delegated from the adult to the child. In regard to long-term conditions such as eczema, warts or blisters, children said that they would apply the cream themselves. This was also the case of children with asthma. They kept their asthma inhaler in their school bags and used it without consulting an adult. Linda, ten years old explained:

*'When I have a big attack (asthma) I have difficulties in getting my breath, that is mostly, when I get breathless. Then I am not going to school, then I am at the doctor's. But if I take the 'turbohaler' over here (at school) then I just continue to play.'*

Linda used the turbohaler when she felt it was necessary and at the same time she was able to continue her activities without any unwanted interruption.



However, the actual competence and control that children with chronic illness achieved would, I suggest, confirm their status as different from other children rather than exemplifying the potential capacity of all children to administer and use pharmaceuticals with a greater degree of independence. For example, in talking to teachers, I found that they approved of the way that Linda and other children with asthma were able to control and use their inhaler. When, however, I asked them if they would allow children independently to decide on and take everyday medicines, such as Panodil or other over-the-counter medicines, they vehemently opposed this suggestion. One teacher said:

*'No! They are only children and should not be allowed to that on their own.'*

In this way adults would 'bracket off' children with chronic conditions, seeing them as different from other children. Their competence was, thus, discounted as being part of childhood itself (see also Bluebond-Langner, 1978, 1991).

### **Conclusion**

This chapter has suggested that, in every day child illness, the idea of children as incompetent is relationally constituted. It cannot be separated from the ways in which adults render themselves as competent. This depends not only upon general cultural assumptions of adult 'competence' and child 'incompetence' but is accomplished in everyday social interactions such as those specifically dealing with children's every day

illness. Here we see the points at which actual difference and similarity between children and adults are made more or less visible and stable. Everyday child illness interactions between adults and children, at home and school, draw on the traditional hierarchies and values of biomedicine in various ways: parents and teachers are delegated the responsibility, competence and intervention; 'rational' methods are employed in preference to children's subjective experiences; children's ability in giving and receiving affection (as part of health care) is both valued as part of the reciprocity of human relationships but remains subordinate to other competencies and children's actual contribution to practical care is often rendered invisible to adults. In relation to pharmaceutical use, which children saw as embedded in societal hierarchies, I have showed how, within these rigid relationships, children found scope for negotiating independent social status and competence. However, I finally suggest that even in the case of chronic illness, where children are often seen as capable of medicine use, their competence becomes constituted not only as different from adults but also as different from their peers.

## Chapter 9

### CONCLUSION

In the introduction to this thesis I located my work within the growing field of studies that, in recent years, have addressed the particular problem of children's 'lack of visibility' within academic disciplines. One of the main purposes of these studies is to contest traditional perspectives on children and childhood, which tend to leave children no, or only a limited, influence over their own social representation. In the thesis I have demonstrated how the task of creating a voice for children in their own representation can be theoretically and methodologically undertaken through an empirical focus on health and illness. I have used everyday illness and minor accidents to suggest how the particular images, discourses and symbolic meanings of childhood in contemporary Danish society influence the ways in which children are seen and the interactions that take place with and around them. In the process I have shown how adults' understandings and treatment of children are shaped and limited when such representations dominate adults' perceptions at the expense of children's own views and experiences.

In emphasising the importance of giving children conceptual autonomy, I have suggested that the anthropological project entails tracing the links between interactions in the milieu of children's everyday lives (what, Nader, 1981 calls the 'horizontal slice') and the institutional contexts of the family, schools and after-school centres and their place in the broader hierarchical patterns of Danish society (the 'vertical slice'). Using this perspective, I have

presented a way of thinking about childhood that parallels the analytical framework coming from critical medical anthropology, the second main theoretical influence on my work. This treats 'sickness' as a cultural performance and the interactions around illness as part of a total set of social relations and broader societal structures. By employing and developing this analytical framework in the thesis, I have explored what this approach can tell us about children's health and illness in Danish society. In doing so, everyday illnesses and minor accidents have become a lens through which contemporary understandings and practices by and in relation to children can be seen and examined.

The approach I have adopted involves an analytical shift away from traditional perspectives of childhood, for example socialisation and child development theories, which see the relationships between children and adults, the epitome of which is the child-mother relationship, as necessarily the most important ones. The theoretical framework that forms the basis of this shift, discussed in Chapter 1, is a reformed anthropology of childhood that focuses on children as social persons in their own right and treats children's interrelationships and their interactions with others (children as well as adults) as of equal importance. To support this perspective I have suggested seeing the child as 'the other'. This does not, however, indicate that children's social worlds are to be seen as isolated or exotic ones. Rather, it presents a way to acknowledge, theoretically, methodologically and empirically, the interplay between adults' and children's perspectives on culture. The research practices flowing from this pay close attention to children's perceptions, experiences and actions in their social world. They include exploring children's position in the social relations and interactions that make up the cultural framework that mediates their experiences.

In this concluding chapter I will first review my methodological experience and summarise the main observations and findings. I will then discuss these in terms of my concern, central to the approach I have taken, to challenge the dominant view of children as ‘becomings’. This, I have suggested, locates the importance of children and childhood in the future, or sometimes the past, but in either case powerfully obscures an understanding of children as ‘beings’, social persons who share present time and space with adults. This theme, of how children become thought of primarily in terms of the future or the past, has been explored in the chapters of this thesis that discuss how children are culturally constituted as vulnerable and incompetent. I have shown how these perceptions enter into interactions around children’s health and illness.

### **Doing an Ethnography of Children’s Everyday Lives**

During the study I used traditional anthropological fieldwork methods, ethnographic interviews and participant observation, supplemented with other data production methods. At the core of my study was an effort to advance the understanding of children's perceptions, actions and social relations during illness and minor accidents, the interplay of different perspectives and the complex social and cultural processes that shape these. With this agenda, ethnographic methods appeared to be particularly suitable because they would allow children to have a more direct voice and part in data production. The participation of children in the research highlighted the dialogical and reflexive qualities and potential of ethnography. Looking back at my fieldwork experience, I am convinced that if children are to be actively involved in research then this has to be integral to the process and cannot be added on as an

extra or optional element. When, for example, I introduced the research to the children and explained my interests, my approach and its purposes, I would at first gain the consent of children to participate in the research. However, I had also to be continually prepared to renegotiate it. During the fieldwork at school and after school centres I, together with the children, had sometimes to ensure their privacy during interviewing in these particularly public settings. Throughout the research I would feed my interpretations of fieldwork material into discussions with the children and review my methodological approach in light of their 'commentary' on how useful or not they found it. Thus, through such discussions with children (and adults) I attempted to maintain a constant reflexive and dialogical approach throughout the fieldwork.

In retrospect, the flavour of research with children can be encapsulated in notions of 'attention'. A most important requirement of the ethnographer, I suggest, is a preparedness to 'retrain' one's attention in social interactions with children. I learnt a significant lesson about this by observing the children's practices in conducting their social relationships with one another. Among the children the essence of this was a form of attention, that required 'looking' (that is, watching and observing) before joining in an activity or interaction. By coming to understand the children's own culture of communication I found ways to be with the children and to form productive relationships with them. During the fieldwork my practice of persistent attention differentiated me from other adults' emphasis on active intervention and a less focused, or only momentary attention, to what children were doing and saying.

I did not, however, deliberately set out to be different from other adults in this respect. Rather, I adopted this approach in my communication with the children because, in it, I found concordance with children's way of relating to each other. It proved, therefore, a most successful way of interacting with the children. I only later gradually discovered how different it was from the way that other adults usually interacted with the children. The children alerted my attention to this, and I began to see how my approach contrasted with my own prior conduct, even, for example, in relation to my own children.

Doing an ethnography of children is, therefore, not like reworking an already well-tested recipe. More than applying some already existing methods, making amendments to them or supplementing them with some new ones, it highlights the need to break the research process into smaller units and to pay close attention to the dynamics of the different elements that make up the overall process. For example, it requires critical attention to conventional assumptions that give adult priority in verbal interaction. Conventional adult practice tends to undermine awareness of children's own communicative practices and obscures the need to engage with them in ways that acknowledge them as serious participants. To some extent children's accounts are easy for adults to dismiss because their formulation sometimes seems diffuse and confused, or cute and naive. Although often received with humour, these accounts often become discounted. At other times children views or expressions are difficult to understand or their accounts seem contradictory, a feature that is often used to confirm children's incompetence. I worked persistently to understand what the children meant and tried to communicate using their words and actions.

During this process it was necessary to investigate the topics that emerged in the fieldwork from several different angles, and to reflect on and interpret what the children said and did within the context of their whole lives. In this respect the notion of imagination has been suggested as an important prerequisite of the anthropologist. She needs a humane, empathetic understanding of other people and a capacity to search for resonance in her own experiences.

Whilst this is true, it is not sufficient. For me the most productive and enlightening approach was to relate my findings and interpretations to the children themselves, to discuss with them, to ask them about their views, and to explore how they understood, recognised and empathised (or otherwise) with them. Patience and care in the research process, together with a reflexive examination of whether her practises are based on adult-centred assumptions also seem to be necessary basic requirements for the anthropologist.

Such examinations may include questions such as 'How can adults study children?' and 'How can the work be seen to be based on a more 'genuine' understanding of children?' In addressing these questions a central feature of my practice was a continuous effort to achieve and maintain the position of a 'different kind of adult'. Some adult researchers (for example, Mandell, 1991) feel tempted to try to pass as a child but my experience is that children are well aware that this is a ploy. It masks the fact that the researcher is, nevertheless, interacting, interpreting and using the data on the basis of their academic and adult knowledge. Children are sensitive to and well aware of the adult-child differences performed in their everyday lives. To build serious and genuine research relationships means to accept the 'other's' experiences and understandings and to respect one's own. There is, however, scope in being a 'different adult', who, whilst not pretending to be a child, intends to respect their views and wishes.



This includes retreating from the position of being the more competent, patronising, guiding, caring and authoritative adult in relation to children. Such an approach, I found, also required close attention to the practices of other adults in order to conduct oneself in a way that was different from, but still sensitive to, the spoken and unspoken rules and expectations of adult conduct. One practical example of this was that, in the same way as teachers, I refrained from playing physical games such as football or chasing games in the playgrounds of the school.

In this manner my role in the field inevitably involved a delicate balance between acting as a 'responsible adult' and maintaining my special relationship with the children. One implication of this sometimes precarious position was to be 'let in' on secrets, particular games or children's 'dubious' practices from which other adults were usually excluded. This required that I had a readiness and ability to respond to the provocative insights and surprises that this sometimes produced. In the everyday routines at school and the after-school centres this was not too difficult to accomplish but sometimes it could be extremely testing. In the thesis I have exemplified this with a key moment in the fieldwork, where my experience of a highly dramatised event tested my commitment to not take on the customary responsibility and authority of the adult and intervene in children's activities. This incident, which left me for weeks on end in intense reflection, was ultimately another challenge to my assumptions about and expectations of children (in this case a group of boys) and of myself. However, what, at first, gave me a 'shocking' glimpse into the world of boys, eventually facilitated a close investigation of some significant aspects of child-adult relationships: the conflict between the demands of research and the conventionally appropriate ways for an adult to respond; the ambiguities of adults' everyday, protective interventions in children's activities; children's

potential and actual harm to each other; and, most importantly, the exploration of cultural understandings of children's vulnerability. As demonstrated in the thesis, these are at the core of, and therefore present in, mundane and interactions around childhood health and illness.

### **The Cultural Performance of Childhood Sickness at Home and in School**

The core of my fieldwork has been concerned with the cultural performance of sickness in two main settings of children's everyday life: the home and family, and the institutional context of the local school (Egeskoven) and its associated after-school centres. In each of these settings I have identified different, but overlapping, cultural performances around children's everyday illness and minor accidents. In Chapter 4 I focused on the family and home setting of the children participating in the study. This revealed a close relationship between the performance of childhood sickness and work/leisure, particularly the form and characteristics of the family holiday. In Denmark, I suggested, modern family life has been characterised by fragmentation and an accelerated tempo of everyday family and work life. This has produced an inward-looking family ethos centred on values such as parents spending 'quality time' with their children, the importance of creating togetherness and happiness (expressed through the particular Danish notion of 'hygge') and the maintenance of primary social bonds. These aspects highlight the parallels between the symbolic meanings and practices of everyday childhood sickness and the family holiday. Both are structural breaks that take important shape from each other. Both have, at their heart, notions of 'wellbeing', 'recovery' and 'recuperation'. I have shown how everyday language used about holidays illustrates this by commonly featuring a health terminology of 'recreation', 'rest' and

'nursing' ones close personal relationships. Similarly, for the families in my study, entertainment and 'hygge' were central aspects of both children's sickness episodes and their family holidays. These encapsulated a familial sociability, a sense of togetherness that included spending time together, having special foods, drinks, treats and other expenditure. The celebration of familial bonds (especially that between parents and children) or 'belonging' and the restoration of the self for the future were strong themes in accounts of both children's illness episodes and the family holiday.

Through this exploration I was able to suggest a theoretical modification (or clarification) of the concept of the cultural performance of sickness (Frankenberg, 1986 Young, 1982). My analysis rejects the implication of a hierarchical order that sees sickness as shaped by a dominant overarching primary cultural form. In its place, I propose that the relationship between sickness and other social practices or cultural forms be theoretically treated as symmetrical. In the first place, this means that one form is not necessarily assumed always to be dominant over the other; rather, they should be examined for the reciprocal play between them. Second, the referents of the cultural performance of child sickness must be seen as fluid and polyvalent and not, for example, solely defined in relation to family holidays. The childhood sickness performances that I identified were more complex than this. They drew on conflicting spheres and sets of referents, including, for example, those relating to education and work as well as 'hygge' and holidays.

Therefore, although the cultural performance of child sickness drew on and enacted ideas about children as in need of close familial care and protection, it was also an event around

which conflicting ideas about what is 'good' for children were performed. For most parents child illness entailed a difficult balancing act between their own engagement on the labour market as breadwinners of the family, concerns for their child's personal health and wellbeing and the need to ensure children's education and preparedness for the labour market. One set of ideas places children at the centre of (adult) attention in the families. Children's illness events were times to give emotional and practical care to children and, in a wider sense, they provided families with an opportunity to invest in the social bonds between parents and children. However, these activities were in tension with the everyday work patterns and routines of labour market organisation. Thus, in parents' view, illness created 'a space for children to be children', freed from the pressures of everyday life. At the same time such concerns had to be weighed up against the different obligations and constraints placed on parents in employment when they had to take 'time off' in order to attend to an ill child. In the same vein, parents believed that children must learn not to take 'time off' unnecessarily and to take their schoolwork seriously. This perspective was especially dominant among parents with older children (those over ten years old). Parents saw the demands of school and the discipline of the work ethic as reflecting their parental aspirations for their children's wellbeing and anticipating their children's future place in the labour market. Illness episodes were in this respect thought about in terms of the children's schooling and, in particular, the demands it places on children to attend school, to keep up with the pace of work and to make academic attainments there. Therefore, a child's illness episode could be an ambiguous experience for parents: it evoked a nostalgia for a time when families did not have to contend with contemporary pressures and could devote themselves to each other; at the same time,

they had to struggle with the opposite, that is with the pressures of everyday life and their efforts to prepare and secure their child's future.

Similar tensions were also expressed in children's ambiguous experiences of illness. On the one hand, the children adored the creation of 'hygge' for producing familial closeness (in particular to parents), treats, special care and treatment. On the other hand, most children were well aware of the clash of loyalties that parents experienced between 'work time' and 'time off' when children were ill. For a small number of the children it meant that, in their own words, they 'looked after' themselves (that is spend some time alone at home) when ill. For other children, with both parents working, it meant that in some situations they may attempt to 'fake a good health', so that their parents did not have to take 'time off' from work, in order to collect them from school or after school centre, or did not have to stay at home to look after them.

Illness also highlights children's position in the family as dependent and vulnerable. Although parental concern was to affirm family bonds and to assure children's well-being, the various practices through which ill children became the objects of care and attention in the families rendered them quite passive. Children recognised this in the restrictions placed on their usual activities, for example not having visits from their friends during illness. That the adult view positioned children as 'cared for' rather than giving care became apparent when talking with parents and children about children's contribution to self and familial care. For example, although parents readily attributed qualities to their children such as having a caring and attentive personality, most parents found it difficult to recognise their children as providing

significant practical or emotional help. Most children, however, describing the same processes, provided examples, or even a list, of practical help giving and support which they individually remembered carrying out in relation to their own personal well being or in relation to helping family members when they were ill.

When, in Chapter 5, I examined the second main setting, the school and after school centres, the importance of the collective dimension of children's help giving was revealed. This took the form of a 'focused gathering'. During it children gave help and support, organised adult involvement, safeguarded their collective play and made ready to re-involve a child who had temporarily been away from the playing field or from the group of children because of an accident or through feeling unwell.

This highly collective form of help was particularly prominent among the youngest children but seemed to change, or diminish, as the children became older. Among the ten-year-olds and over, it gradually became replaced by more individualised and intimate forms of helping relationships based, for example, on friendship and siblingship. It seemed that, in growing up, the children came to understand that health and illness are matters of individual concern and privacy. How this shift from the collective to individual forms of help actions takes place among children, I have argued, becomes apparent when looking at how the active engagement of the youngest children was under the scrutiny of, and sharply conditioned by, adults. The teachers and after school staff would continually, but unknowingly, intervene in ways which dissipated children's own collective help-giving actions. The common adult response to accidents and illness was to 'take charge'. This meant, initially, dispersing the

group of children who had encircled the injured child and, in this way, effectively ending the collective gathering, which from the adult's point of view could become uncontrollable. The unwell or injured child was moved away from the other children, alone or accompanied by a friend, to be further examined, cared for and treated indoors by an adult before returning to the group. In my analysis I use the metaphor of social drama to show how such everyday illnesses and minor accidents are particularly important instances of cultural learning for children because of their repetitive character and because of their culturally performative qualities. At school and after school centre these events happened at least once a day and often more frequently. In their public form, repetitive temporal pattern and their routine handling by concerned adults they emerge as ritualised cultural events.

In this discussion I make an important theoretical point by examining children's individual helping acts for their intentional meanings. I argue that children interpret and act on the basis of an implicit recognition of some cultural ideas and conceptions of help. This suggests perspectives for understanding the processes of socialisation and, in particular, the ways in which knowledge informs cultural practices, and is produced and takes form through them. I demonstrate this by focusing on children as the recipients of help action. Thereby, it was revealed that children interpret actions of help by recognising the underlying motive of an action. For this reason, I suggest, a child will more readily define an action as 'help' even when he or she, at the same time, identifies the action as in practice as being of 'no actual' help. In their interpretations and practices of help-giving children juggled with the content, form and context of an action. This suggests a way to understand how children bridge the split that is conventionally conceived between tacit and explicit cultural knowledges.

## **Cultural Learning about the Body, Health and Illness**

Throughout the thesis I have looked at children as active in the process of learning about health and illness rather than seeing cultural learning as a process in which children are the passive receivers of the knowledge and values transmitted by adults. I have explored this at the most basic level by enquiring into how children engage with the culturally appropriate ways of transforming their bodily sensations into illness. My starting point was an overlooked phenomenon in medical anthropology, even in that concerned with the cultural performance of sickness: that notions of 'worrisome' or 'troublesome' bodily experience cannot be taken-for-granted and must, instead, be seen as something that children learn to interpret in culturally appropriate ways. In particular, children learn the classificatory distinctiveness of illness from other bodily experiences and everyday events that may have more or less significance for them. Attention, therefore, has to be paid to the ways in which illness becomes punctuated as a special event, separated from the flow of everyday life. Through this process children also learn to classify the body in culturally given ways. This involves them in a form of collective bricolage through which they together explore the relationship between their subjective experience of the (incarnate) body in motion and action and the (somatic) objectified, but culturally specific, classification of the body and its separate parts. This exploration is so intense, and so central to children's understanding and practices, that I am able to point to it as a 'project of the body' of special importance in childhood.

The collective nature of children's active exploration of the body is an important point on which I am in agreement with Corsaro (1992, 1997). From this perspective it is paradoxical



that looking at children as active participants in society reveals how they seem to learn that health care requires their passivity. The everyday routines at school and the after-school centres described above rendered children as passive: their subjective experience of the body was generally subordinated to a set of objectifying techniques and practices. Furthermore, I have shown that children's active and collective participation in help and care giving was discouraged. A pattern was observed in which the youngest children were most collective in their actions but this became narrower and more individualised as the children became older. Among the ten and eleven-year-olds helping acts were only focused on close friends and siblings and the eldest children expressed the strongest ideas about independence and privacy.

It is widely accepted in Danish schools that an important part in children's social development concerns learning to be considerate, to solve conflicts in a non-aggressive manner, to find ways of being together, to show mutual regard and to understand and respect each other's vulnerabilities. From this point of view it is puzzling that children are not expected to improve their practical skills and knowledge of everyday self-care and health care towards others. In the institutional settings children were generally discouraged from tending to their own cuts, scratches and bruises. This contrasts with the extent to which such activities do go on in the family; children often would, for example, have access to scissors and plasters and, as they grew older, sometimes to pharmaceuticals.

Finally, I have suggested how, through the social relations and interactions during illness, a window is opened that children use to view and increase their understanding of the social world. In my analysis I have aimed to show, not only how children are exposed to the small-

scale interactions of their immediate circumstances, but also how children come to learn about much wider aspects of social institutions, hierarchies and social organisation and about their own place in them as children.

### **Childhood, Vulnerability and Competence**

Underlying the performances described in families and in the institutional settings are sets of cultural ideas through which children are characteristically conceptualised in European and North American societies. In Chapter 1 I suggested how children are constituted as particularly vulnerable, incompetent and in need of adult care. Chapter 7 set out to investigate notions of child vulnerability more closely. Vulnerability is traditionally seen as a natural, essential and universal characteristic of children and childhood. This, I have argued, is a significant feature of the social representation of children and needs to be taken into account when attempting to understand their lived experience. In doing so it is important to establish that vulnerability is one of the fundamentals of human experience. It, therefore, needs to be freed from being seen as a signifying mark or essence of any particular group. It is for this reason that I have insisted that the concept needs to be problematised in relation to children rather than simply taken-for-granted, as much research seems to do. In this respect, children's dependency can be seen as one particular cultural translation of vulnerability. I propose that, in being taken-for-granted, the translation of vulnerability into cultural understandings of children as dependent has restricted the unravelling of children's own experiences and active engagement with such notions.

In removing vulnerability of its universal wrapping it becomes possible to see how it is given meaning within its local social and cultural context. Thus, in the case of this thesis, vulnerability is a quality or a status that is seen as distributed and negotiated in everyday social interactions between children and adults and among children themselves. These interactions are, I argue, based on cultural representations of the child as a social person, understandings of the child's body and practices around childhood health and illness. All of these have importance for the social position of children and adults when a child is hurt or feels ill. The assumed vulnerability of the child has its counterpart in the adult impulse to protect the child and take responsibility for actions necessary to relieve suffering. An ill child is, accordingly, positioned as a passive and dependent recipient of adult care. The adult on the other hand is positioned as active, protective and responsible.

Although this positions the adult as responsible for the humane treatment of a child, the assumption of a child's vulnerability becomes problematic when it is interpreted through the understandings and images of adults rather than being contextualised in children's own understandings of their social world. My observation of, and conversations with, children in the playground suggest that there is significant dissonance between adult's and children's interpretations of their day to day bodily injuries. These differences centre around situations when children are experiencing their bodies as incarnate, that is in motion, flow and connection that is not separated from the social and physical environment in which it takes place. Adults rarely enquire into and address this experience but rather focus their attention on the somatic body. This process involved an important interpretative shift as the adult focus moves from the hurt child's subjective experiences to an objectified view of the injury

achieved through making a set of instrumental judgements based on the use of the thermometer, time, the identification and classification of body parts and observations of bodily appearance. In their concern to identify the affected body parts, to name them and assess the severity of the damage (all of which, of course, are necessary) they objectify the experience of the child and neglect those aspects of the situation that may also be causing suffering. These tendencies are accentuated when the outer body, the skin, of a child is damaged, for it is through this outer appearance that the inner state of the child is read. For me this was vividly illustrated when an eleven-year-old boy revealed that what hurt most about an accident in which he damaged his arm, which was consequently put in a plaster cast, was not the injury to his body but the way that it prevented him from taking part in the football team of which he so desperately wanted to be a member. It was this and not his bodily injury that caused him to cry.

As noted above, a child's assumed vulnerability and dependence is powerfully connected with discourses of child incompetence. Chapter 8 addressed this topic in more detail through a critical discussion of legal, psychological and sociological understandings of competence. It was argued that understandings of children's competence are another important aspect of the cultural constitution of childhood that becomes visible through the part it plays in health care interactions. In everyday child illness ideas of children's competence cannot be separated from the ways in which adults render their own competence. This depends not only upon general cultural assumptions of adult competence and child incompetence but was shown to be accomplished relationally in the everyday social interactions, such as those taking place during children's illnesses. Everyday child illness interactions between adults and children, at home

and school, draw on the traditional hierarchies and values of biomedicine in various ways: parents and teachers are delegated the responsibility and competence to intervene. The rational methods that adults employ to give some objective measurement of children's wellbeing or the severity of illness constitute children's subjective experiences as inferior. Children's ability to give and receive affection (as part of health care) is valued as an important property of the reciprocal character of human relationships. However, like biomedicine, in comparison with the rational and objectifying expertise that are drawn on by adults in responding to child illness, it remains subordinate. Children's capacity to be affectionate tends to render children's other contributions to practical care, which they can readily enumerate, invisible to adults. Affection is seen as another characteristic capacity of children and, although sometimes recognised as an important aspect of any health care, children's contributions tend to be discounted because of the higher status of the practical and rational aspects of care work undertaken by adults in their pursuit of responsibility for protection. Where there could be both similarity and difference between children and adults, this process tends, therefore, towards the polarisation of difference, rather than the convergence of similarity.

### **Futurity and Nostalgia**

I will now relate these observations to a central theme in my discussion raised at the outset of this thesis: that children are constituted in European and North American societies as becomings not beings. In Chapter 1 I noted Jenks (1996a) suggestion that modernity's constitution of children through futurity may be being superseded by a new image of the child

that acts as a repository for nostalgic longings for stability and certainty. The child, he suggests, is the source of the last remaining primary relationship.

The contrasting images of childhood that Jenks presents have strong echoes with the analysis of this thesis. The 'futura' of children is seen in the concerns of parents that children, especially as they grow older, do not miss too much schooling, that they return to school reasonably quickly and do not dwell on illness. It is evident in the practices of school teachers and after school staff in making objective assessments of children's injuries, of applying appropriate remedies, of taking quick and efficient professional responsibility to make children fit again and inculcating children with a sense of individual capability for health and autonomy in their personal care. A future orientation is, as I argued in Chapters 1 and 7, at the heart of cultural notions about children as vulnerable and adults as responsible for their protection. Similarly, the hierarchy of competence, which I described in Chapter 8, constitutes children as becomings whose present abilities and capacities are often almost routinely discounted.

Nevertheless, futurity does not entirely encompass the practices of child health that I have described in this thesis. Child illness episodes, especially those of younger children, take on the forms of 'time off' that to celebrate family togetherness, elements of 'nostalgia' for the primary social bond can be seen at work. This is especially so in Danish culture, which so strongly values 'hygge' as a form of sociality that it even has a special word to describe it, a term that in its broad resonance is almost untranslatable into English. There is, however, a sense in which these family practices can be seen as a way that child illness (at least of the

non-life threatening type I have studied) is transformed into a moment when the pressures of the contemporary world are temporarily set aside and resisted.

It is significant, however, that my fieldwork suggests the predominance of futurity over nostalgia in children's experience of health and sickness practices. Nostalgia was prominent only in the family - and even there it was entangled with parental concerns about schoolwork, discipline and fitness for the future labour market. This suggests that Jenks is overestimating the degree to which the vision of childhood has moved away from a concern with the future and towards nostalgia for the past. Rather, it is more likely a matter of these two images coexisting in various proportions and configurations. In this respect, it is important to look at the settings in which these two images of childhood find expression. As noted above, only in the family was sickness systematically and routinely performed as an expression of primary social bonds. In school this was so rare that I did not encounter it. There the routine practices ran in the contrary direction.

The likely explanation of this difference between home and school (in which I include the after school centre) has several different facets. As I argued in Chapter 4, although home and school have a mutually shaping influence on each other, they are distinctly different settings. In the family, parents focus on a particular child, more or less in the totality of his or her activities, hopes, feelings, problems and intimate relations – and this is the case, even when a child has siblings. One of the problems parents describe is balancing different aspects of a child's life and reconciling the needs and interests of different family members. It is exactly this process that characterised their accounts of illness. Educational institutions, on the other

hand, deal with a mass of children and, however concerned to treat children as unique individuals, emphasise that their problem is keeping order and control. It was partially for this reason that teachers were so ready to break up the collective gathering of children around an accident or ill child. At the same time, it might be said that schooling as an institution has a strong bias towards thinking of children as 'becomings' because it is focused on education (1). This leads teachers not to see children as 'competent' but only as 'becoming competent', under the educational guidance and efforts of the school. Although teachers, and especially after school staff, would acknowledge the importance of children's feelings, in the process of schooling and learning more generally, their efforts were primarily directed towards transmitting rational and instrumental knowledge. This was reflected in their rational control over and distance from emotional experiences when they encountered children's expressions of vulnerability or affection, a process that required an important interpretive shift as the adult focus moved from the hurt child's subjective experiences to an objectified view of the injury. This shift was achieved through the separation of the injured or ill child from the group and the accomplishment of a set of instrumental judgements based on the use of the thermometer, the duration of symptoms and observations of the body's outer appearance. I encountered only one member of staff who had a different vision. She had noticed that children spend time looking after and caring for each other and saw something valuable in it. Nevertheless, she too followed the practice of dispersing groups of children because, when she had refrained from doing so, she had encountered the disapproval of the other teachers. She was, thus, the exception that also proved the rule.



## **Children as Social Actors: The Challenge of the Present**

Throughout the thesis my focus has been on children as complex beings actively engaged in social life rather than as simple becomings. I learned a great deal about this from the children that I met through my ethnographic work and, perhaps, most enduring for me was the experience of their insistent engagement with the world. The children had zest, humour, happiness and a vibrant involvement in everyday life. The children told me about their experiences, lives, conflicts, constraints, expectations and aspirations and they involved me actively in their interactions, games and other activities. This conveyed to me the centrality of values such as care and generosity in children's social relationships. At other times, however, it also revealed to me how animosity and destruction would, for a period, mark their relationships in and experiences of their collective life. Despite this, the children could be seen as focused on learning about society and social relationships and they were actively engaged in creating their own and other's wellbeing.

It could well be argued that all members of society, adults and children, should be conceived of as both being and becoming. This would seem just. However, my fundamental argument for pressing the importance of a focus on the present value of childhood is that we are not able to know the future that children will grow into. By investing in the present lives of children we have to define and evaluate the factors that contribute to children's health and wellbeing and this would compel the inclusion of their subjective experiences and perspectives. This would be to work with a more humane perspective that, at any one point in

time, would require asking questions about how to maintain and improve the health of children, working with them gradually towards and into the future.

Like all social beings they live within a network of social and biological interdependencies that produce particular vulnerabilities and asymmetries of competence. I am not, therefore, arguing that children are invulnerable and fully competent. I am suggesting, however, that dominant representations of childhood, embedded in the social and historical circumstances of Danish society (and shared more or less by many European and North American ones), tend to overstate children's own experience of vulnerability and underestimate or discount their competencies. Consequently, although childhood is conventionally seen as a phase in the lifecourse of unique importance, one when the child is surrounded by care, love and protection, this does not necessarily entail that childhood achieves independent, present value. This, I have suggested, comes about because of the adult emphasis on seeing childhood as representing both a past that is lost and gone and as a hope for the future. These cultural perceptions of children and childhood, therefore, constitute a paradox that may account for the experience of childhood as a sometimes ambiguous affair.

If my ethnographic experience has brought me to look critically at the way in which children's lives are dominated by the notion that they are particularly and essentially vulnerable and incompetent beings, this does not imply that I believe children should be left to care for themselves. Rather, my critique is based on a close observation of children's actions and attention to their perspective on the world. This showed me that there is a gap between how adults apprehend children's experiences and capacities and those that my research indicated.

Children, I conclude, have a greater capacity for health care actions, towards themselves and others, than is often appreciated. At the same time their experience of vulnerability often contrasts with that assumed by adults. From this point of view there is a contradiction between the oft-proclaimed rights of children to have a voice and to participate in society and the emphasis on their (potential) vulnerability and incompetence. These are often cited by parents and professionals as an automatic and unquestionable reason for adults to protect, guide and even constrain (2) their activities without any enquiry into their experience or point of view. It is, therefore, important that researchers of children and childhood begin to ask how much this practice can reasonably be derived from children's own experiences of their vulnerabilities and from an accurate understanding of their competencies to deal with problems of their life. Or is it that much of this protection and monitoring can be seen as part of an ideology of modern childhood that constructs and justifies their exclusion from social participation? My suggestion is that only if adults are prepared to take a more open-minded attitude to children, to explore and determine their actual limits, to listen seriously to children's own perspectives on vulnerability and be sensitive to their competencies will adults, whether professionals or parents, be able to do children greater justice.

## Notes

1. In recent fieldwork in Northern England I noticed that teachers hardly use the term 'children'. Rather, they talk about 'the pupils' or refer to a whole year group (for example 'Year 5 are doing a nativity play'). In this sense, from the point of view of teachers, schools do not contain children per se but groups of coevals in age groups.

2. However, although the study produced a rich set of data that confirmed children as social actors, it also left a strong sense of children's experience of everyday constraints. These experiences were brought about not so much by strict rules and regimentation as by the problems children had in dealing with adults. In this thesis I exemplify this by contrasting the views of adults with those of children themselves. However, another problem was that adults in school and after-school present themselves as willing to help, give guidance and support to children (and to a greater or lesser extent they do so) but the institutional practice of dealing with children 'en masse' seemed to discard children's individual and collective views and actions. Sometimes this led to an overwhelming sense of defeat in children, who repeatedly experienced their inability to alter or even influence the views and actions of adults. An example of this has been detailed in the general disregard of children's collective help giving but it is also illustrated by other aspects of their everyday school and after-school life. When, for example, children complained about the noise level at school during lessons they found that the adults did not take much notice when asked to try and stop it. Children also found it difficult to persuade adults that something needed to be done to keep their personal belongings safe and private. Their efforts to share and work together in lessons, and to draw

on the insights and competencies of each other, would not always be directly undercut by teachers but there were no attempts to draw on the skills of children in this respect across the class and the school.

## REFERENCES

- Alanen, L. (1988) 'Rethinking Childhood', *Acta Sociologica*, 31, 1: 53-67.
- Alderson, P. (1993) *Children's Consent to Surgery*, Milton Keynes: Open University Press.
- Alderson, P. (1995) *Listening to Children: Children, Ethics and Social Research*, London: Barnardos.
- Anthony, E.J. et al. (eds) (1978) *The Child in His Family: Vulnerable Children*, New York: John Wiley and Sons
- Appelbaum, P.S. and Grisso, T. (1988) 'Assessing Patient's Capacities to Consent to Treatment', *New England Journal of Medicine*, 319: 1635-8.
- Archard, D (1993) *Children: Rights and Childhood*, London: Routledge.
- Ardener, E. (1975a) 'Belief and the Problem of Women', In S. Ardener (ed.) *Perceiving Women*, London: J. M. Dent.
- Ardener, E. (1975b) 'The 'Problem' Revisited', In S. Ardener (ed.) *Perceiving Women*, London: J. M. Dent.
- Aries, P. (1962) *Centuries of Childhood: A Social History of Family Life*, London: Jonathan Cape.
- Aronsson, K. (1991) 'Facework and Control in Multi-Party Talk: a Paediatric Case Study', In Markova, I. and Foppa, K. (eds) *Asymmetries in Dialogue*, Hemel Hempstead: Harvester Wheatsheaf.
- Backer, G. and Christensen, P. (1992) 'Selvhjælpsgrupper - hvordan? Erfaringer med apopleksiramte familier', *Ugeskrift for Læger* (Journal of the Danish Medical Association), 13: 858-864.
- Backett, K. (1990) 'Studying Health in Families', In Cunningham-Burley, S. and McKeganey, N.P. (eds) *Readings in Medical Sociology*, London: Routledge.
- Bakhtin, M. (1968) *Rabelais and His World*, Cambridge, Mass.:MIT Press.
- Battersby, C. (1993) 'Her Body/Her Boundaries: Gender and the Metaphysics of Containment', In Benjamin, A.E. (ed) *The Body: Journal of Philosophy and the Visual Arts*, 4:31-39, Academy Editions: Ernst and Sohn.

Battersby, C. (1998) *The Phenomenal Woman: Feminist Metaphysics and the Patterns of Identity*, Cambridge: Polity Press.

Beck, U. (1992) *Risk Society: Towards a New Modernity*, London: Sage.

Benedict, R. (1946) *The Chrysanthemum and the Sword: Patterns of Japanese Culture*, USA: Houghton Mifflin Company

Berger, J. (1972) *Ways of Seeing*. London: Penguin Books

Berger, K.S.(1983) *The Developing Person Through the Life Span*. New York: Worth Publishers, Inc.

Bibace, R. and Walsh, M.E. (1979) 'Developmental Stages in Children's Conceptions of Illness', In Stone, G.C. et al (eds) *Health Psychology*, San Francisco: Josey and Bass

Bluebond-Langner, M. et al (1991) 'Paediatric Cancer Patients' Peer Relationships: The Impact of an Oncology Camp Experience', *Journal of Psychosocial Oncology*, 19, 2:67-80

Bluebond-Langner, M. (1978) *The Private Worlds of Dying Children*. Princeton: Princeton University Press.

Bourdieu, P. (1977) *Outline of a Theory of Practice*. Cambridge: Cambridge University Press.

Boyden, J. (1990) 'Childhood and the Policy Makers: A Comparative Perspective on the Globalisation of Childhood', In James, A. and Prout, A. (eds) *Constructing and Reconstructing Childhood. Contemporary Issues in the Sociological Study of Childhood*, London: Falmer Press.

Bradley, B. (1986) *Visions of Infancy*, Cambridge: Polity Press.

Brannen, J. and O'Brien, M. (eds) (1996) *Children in Families: Research and Policy*, London: Falmer Press.

Briggs, J. L.(1971) *Never in Anger: Portrait of an Eskimo Family*, Cambridge, Massachusetts: Harvard University Press.

Briggs, J. L.(1982) 'Living Dangerously: the Contradictory Foundations of Value in Canadian Inuit Society', In Leacock, E. and Lee, R. (eds) *Politics and History in Band Societies*, Cambridge: Cambridge University Press.

Burbach, D.J. and Peterson, L. (1986) 'Children's Concepts of Physical Illness: A

Review and Critique of the Cognitive Development Literature', *Health Psychology*, 5, 3, 307-25.

Burman, E. (1994) *Deconstructing Developmental Psychology*, London:Routledge.

Burnett, F. H.(1911) *The Secret Garden*, London: Thames and Hudson.

Bury, M. (1991) 'The Sociology of Chronic Illness: A Review of Research and Prospects', *Sociology of Health and Illness*, 13, 4: 451-68.

Bush, P.J. and Iannotti, R.J. (1985) 'The Development of Children's Health Orientations and Behaviors: Lessons for Substance Abuse Prevention', In Jones, C.L. and Battjes, R.J. (eds), *Etiology of Drug Abuse*, National Institute on Drug Abuse Monograph Number 56: 45-54.

Bush, P.J. and Iannotti, R.J. (1988) 'Origins and Stability of Children's Health Beliefs Relative to Medicine Use', *Social Science and Medicine*, 4: 345-352.

Bush, P.J. and Iannotti, R.J. (1990) 'A Children's Health Belief Model', *Medical Care*, 28: 69-86.

Bühler-Niederberger, D. and Hungerland, B.(1997) 'The Social Value of Children - and the Sociology of the Assessment Process', Paper presented at the International Conference 'Childhood and Children's Culture', Esbjerg, Denmark.

Campbell J D. (1975) 'Illness is a Point of View: the Development of Children's Concepts of Illness', *Child Development* 46, 1975: 92-100.

Campbell J D (1978) 'The Child in the Sick Role: The Contributions of Age, Sex, Parental Status and Parental Values', *Journal of Health and Social Behaviour* 19, 1978: 35-51.

Chrisman, N. J. (1977) 'The Health Seeking Process: An Approach to the Natural History of Illness', *Culture, Medicine and Psychiatry*, 1: 351-77.

Christensen, P. (1993) 'The Social Construction of Help among Danish Children', *Sociology of Health and Illness*, 15, 4: 488-502.

Christensen, P. (1994) 'The Child as the Cultural Other', *KEA: Zeitschrift für Kulturwissenschaften*, Tema: Kinderwelten, 6: 1-16.

Christensen, P. (1996) 'The Danish Participation in the COMAC Medicines and Childhood Project', In Trakas, D and E, Sanz, (eds) *Childhood and Medicine Use in a Cross Cultural Perspective: A European Concerted Action*, Luxembourg: Report



EUR 16646 EN, European Commission.

Christensen, P. (1998) 'Difference and Similarity: How Children's Competence is Constituted in Illness and its Treatment', In Hutchby, I. and Moran-Ellis, J. (eds) (1998) *Children and Social Competence: Arenas of Action*, London: Falmer Press.

Christensen, P. (1999, forthcoming) 'Vulnerable Bodies: Cultural Meanings of Child, Body and Illness' In Prout, A. (ed): *The Body, Childhood and Society*, London: Macmillan.

Christensen, P. and James, A. (forthcoming, 1999) *Conducting Research with Children*, London: Falmer Press.

Christensen, P. and Rasmussen, L.E. (1990) *Forandring i Fællesskab: En medicinsk antropologisk undersøgelse blandt apopleksiramte familier i Danmark*. Specialerække nr. 30. Magister Dissertation, Institute of Anthropology, Copenhagen.

Cohen, A. (1985) *The Symbolic Construction of Community*, London: Routledge.

Cohen, E. (1988) 'Traditions in the Qualitative Sociology of Tourism', *Annals of Tourism Research*, Special Issue, 15:29-46.

Copenhagen Statistics Office (1992) *Your District - Your Health*, Vanløse: Healthy Cities Project 10.

Corsaro, W. (1992) 'Interpretive Reproduction in Children's Peer Cultures', *Social Psychology Quarterly*, 55: 160-177.

Corsaro, W. (1997) *The Sociology of Childhood*. California: Pine Forge Press.

Cook-Cumperz, J., Corsaro, W. and Streek, J. (eds) (1986) *Children's Worlds and Children's Languages*, Berlin: Mouton de Gruyter.

Crawford, R. (1985) 'A Cultural Account of 'Health': Control, Release, and the Social Body', In McKinlay, J. (ed) *Issues in the Political Economy of Health Care*, London and New York: Tavistock.

Crawford, R. (1994) 'The Boundaries of the Self and the Unhealthy Other: Reflections on Health, Culture and AIDS', *Social Science and Medicine*, 38,10:1347-65.

Csordas, T.J. (1994) *Embodiment and Experience: the Existential Ground of Culture and Self*, Cambridge: Cambridge University Press.

- Davis, A. (1982) *Children in Clinics*, London:Tavistock.
- Davis, A. and Strong, P. (1976) 'The Management of the Therapeutic Encounter', In Wadsworth, M. and Robinson, D. (eds) *Studies in Everyday Medical Life*, London: Martin Robertson.
- Denzin, N. (1977) *Childhood Socialization*, San Francisco:Jossey-Bass.
- DeMause, F. (1974) *The History of Childhood*, New York: Psychohistory Press.
- Ditch, J., Barns, H. and Bradshaw, J. (1998) *Developments in National Family Policies in 1996*, Brussels: European Observatory on National Family Policies.
- Donaldson, M. (1978) *Children's Minds*, London: Fontana.
- Douglas, M. (1975) *Implicit Meanings: Essays in Anthropology*, London: Routledge.
- Dukes, M.N.G (ed) (1993) *Drug Utilisation Studies: Methods and Uses*, WHO Regional Publications, European Series, Number 45.
- Durkheim, E. (1950(1903)) *The Rules of Sociological Method*, Chicago: Free Press.
- Dyer, R (1993) *The Matter of Images: Essays on Representations*, London:Routledge.
- Eco, U. (1979) *A Theory of Semiotics*, Bloomington: Indiana University Press.
- Elkin, F. (1960) *The Child and Society*, New York: Random House.
- Ennew, J. (1986) *The Sexual Exploitation of Children*, Cambridge: Polity Press.
- Ennew, J. (1994) The Environmental Health of Working Children (unpubl. paper). Paper presented at 'Sociology of Childhood', Seminar at Brunel, The University of West London.
- Ennis, R.H. (1987) 'A Taxonomy of Critical Thinking, Dispositions and Abilities', in Baron, J.B. and Sternberg, R.J. (eds) *Teaching Thinking Skills: Theory and Practice*, New York: Freeman.
- Fabian, J. (1983) *Time and the Other: How Anthropology Makes its Object*, New York: Columbia University Press.
- Fallon, K. (1990) 'An Involuntary Workforce', *Community Care*, 4, (January).
- Farmer, P. (1992) *AIDS and Accusations: Haiti and the Geography of Blame*,

Berkeley: University of California Press.

Feifer, M. (1985) *Going Places*, London: Macmillan.

Fine, G.A. (1987) *With the Boys*, Chicago: Chicago University Press.

Fine, G. A. and Sandstrom K.L. (1988) *Knowing Children. Participant Observation with Minors*, Qualitative Methods Series, Newbury Park: Sage.

Foucault, M. (1984) *The Care of the Self, Volume 3, The History of Sexuality*, Harmondsworth: Penguin.

Frankenberg, R. (1980) 'Medical Anthropology and Development: A Theoretical Perspective', *Social Science and Medicine*, 14B: 197-207.

Frankenberg, R. (1985) 'Malattia come Festa: Sickness as Celebration and Socialisation: Children's Accounts of Sickness Episodes in a Tuscan Community', Paper presented at The Annual Meeting of the American Anthropological Association, Washington.

Frankenberg, R. (1986) 'Sickness as Cultural Performance', *International Journal of Health Services*, 16,4: 603-26.

Frankenberg, R. (1988) 'Your Time or Mine? An Anthropological View of the Tragic Temporal Contradictions of Biomedicine Practice', *International Journal of Health Services*, 18,1: 11-34

Frankenberg, R. (1990) 'Review Article: Disease, Literature and the Body in the Era of AIDS - A Preliminary Exploration', *Sociology of Health and Illness*, 12, 3: 351-360.

Frankenberg, R. (1992) 'The Other Who is Also the Same: The Relevance of Epidemics in Space and Time for Prevention of HIV Infection', *International Journal of Health Services*, 22, 1:73-88.

Frankenberg, R. (1994a) Personal Communication, letter in the possession of the author.

Frankenberg, R. (1994b) 'What is Power? How is Decision? The Heart has its Reasons', In Robinson, I. (ed), *Life and Death under High Technology Medicine*, Manchester: Manchester University Press.

Fryand, O. (1996/97) *Det gådefulde sprog. Om hudens kommunikation*, Copenhagen: Gyldendal.

- Geertz, C. (1973/93) *The Interpretation of Cultures*, London: Fontana Press.
- Geertz, C. (1983) *Local Knowledge: Further Essays in Interpretive Anthropology*, New York: Basic Books.
- Gellert, E. (1962) 'Children's Conceptions of the Content and Functioning of the Human Body', *Genetic Psychology Monograph* 65:293-405.
- Giddens, A. (1979) *The Central Problems of Social Theory*. London: Macmillan.
- Giddens, A. (1991) *Modernity and Self-Identity. Self and Society in the Late Modern Age*, Oxford: Polity Press.
- Giødesen, L. (1976) *Jeg har været på hospitalet*, Copenhagen: Gyldendal.
- Giødesen, L. (1979) *Vort barn skal på sygehus*, Copenhagen: Nordisk Forlag.
- Glaser, B. and Strauss, A. (1967) *The Discovery of Grounded Theory*, Chicago: Aldine.
- Good, B. and Good, M. (1992) 'The Comparative Study of Greco-Islamic Medicine: The Integration of Medical Knowledge into Local Symbolic Contexts', In Leslie, C. and Young, A. (eds.), *Paths to Asian Medical Knowledge*, Berkeley: University of California Press.
- Goffman, E. (1959) *The Presentation of Self in Everyday Life*, Harmondsworth: Penguin Books.
- Goffman, E. (1968) *Asylums*, Harmondsworth: Penguin.
- Goffman, E. (1971) *Relations in Public*, New York: Harper.
- Graham, H. (1984) *Women, Health and the Family*, Brighton: Wheatsheaf.
- Gregory, P.R., Allebon, J. and Gregory, N.M. (1984) 'The Effectiveness of Home Visits by an Educational Welfare Officer in Treating School Attendance Problems', *Research in Education*, 32: 51-65.
- Grillo, R. and Rew, A. (eds) (1985) *Social Anthropology and Development Policy*, London: Tavistock.
- Gudeman, S. and Rivera, A. (1990) *Conversations in Colombia. The Domestic Economy in Life and Text*, Cambridge: Cambridge University Press.
- Hanson, F. A. (1975) *Meaning in Culture*, International Library of Anthropology,

London: Routledge and Kegan Paul

Hardman, C. (1973) 'Can There be an Anthropology of Children?' *Journal of the Anthropology Society Oxford*, 4, 1: 85-99.

Hastrup, K. (1988) 'Kultur som analytisk begreb', In Hauge, H. and Horstbøll, H (eds) *Kulturbegrebets kulturhistorie*. Kulturstudier 1. Aarhus: Aarhus Universitetsforlag.

Hastrup, K. (1990) 'Videnskaberne Magi. En antropologisk diskussion af årsag og virkning i verden', In Fink, H. and Hastrup, K. (eds) *Tanken om enhed i videnskaberne*. Kulturstudier 9. Aarhus: Aarhus Universitetsforlag.

Hastrup, K. (1993) 'Hunger and the Hardness of Facts', *Man: The Journal of the Royal Anthropological Institute*, 28, 4: 727-739.

Helman, C.G. (1978) 'Feed a Cold, Starve a Fever: Folk Models of Infection in an English Suburban Community and their Relationship to Treatment', *Culture, Medicine and Psychiatry*, 2, 107-137.

Helman, C.G. (1990) *Culture, Health and Illness*, Oxford: Butterworth Heineman.

HMSO (1976) *Fit for the Future: The Report of the Committee on Child Health Services (Vol 2)*, London: HMSO.

Hockey, J. and James, A. (1993) *Growing Up and Growing Old: Ageing and Dependency in the Life Course*, London: Sage Publications.

Holland, P. (1992) *What is a Child? Popular Images of Childhood*. London: Virago Press.

Holstein, B. and Ito, H. (1987a) 'Selvrapporteret helbred og lægemiddelforbrug blandt skoleelever', *Ugeskrift for Læger* (Journal of the Danish Medical Association), 149/5: 311-314.

Holstein, B. and Ito, H. (1987b) 'Livsstil og helbred blandt skoleelever', *Ugeskrift for Læger* (Journal of the Danish Medical Association), 149/5: 315-317.

Hunt, P. and Frankenberg, R. (1990/97) 'It's a Small World: Disneyland, the Family and the Multiple Re-representations of American Childhood', In James, A. and Prout, A. (eds) *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*. London: Falmer Press.

Hutchby, I. and Moran-Ellis, J. (eds) (1998) *Children and Social Competence: Arenas of Action*, London: Falmer Press.

- Høeg, P. (1994) *Borderliners*, London: The Harvill Press (Danish Edition 1993)
- Ingelby, D. (1986) 'Development in a Social Context', In Richards, M. and Light, P. (eds), *Children of Social Worlds*, Cambridge: Polity Press.
- Isern, P. (1993) 'Levi's og det autentiske: Jagten på en moderne erfaring', *Samtiden*, 5:45-53
- Jackson, A. (1987) *Anthropology at Home*, Tavistock: London.
- Jaffe, P.D. and Wicky, H.R. (1997) 'Competence? Now Really!', In Verhellen, E. (ed) *Understanding Children's Rights*, Ghent: University of Ghent Children's Rights Center.
- James, A. (1990) 'Body Types, Stereotypes, Ideal Types during Childhood', Paper presented to the BSA Medical Sociology Conference.
- James, A. (1993) *Childhood Identities: Self and Social Relationships in the Experience of the Child*, Edinburgh: Edinburgh University Press.
- James, A. and Jenks, C. (1996) 'Public Perceptions of Childhood Criminality', *British Journal of Sociology*, 47, 2: 315-31.
- James, A., Jenks, C. and Prout, A. (1998) *Theorizing Childhood*, Cambridge: Polity Press.
- James, A. and Prout, A. (1990/97) *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*, London: Falmer Press
- James, A. and Prout, A. (eds) (1990/97) 'Introduction: Constructing and Reconstructing Childhood', James, A. and Prout, A. (eds) *In Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*. London: Falmer Press
- Janzen, J.M. (1987) 'Therapy Management: Concept, Reality, Process', *Medical Anthropology Quarterly*, 1, 1: 68-84.
- Janzen, J.M. and Arkininstall, D. (1978) *The Quest for Therapy: Medical Pluralism in Lower Zaire*, Berkeley: University of California Press.
- Jenks, C. (1982) *The Sociology of Childhood. Essential Reading*, London: Batsford.
- Jenks, C. (1996a) 'The Postmodern Child', In Brannen, J. and O'Brien, M. (Eds) (1996) *Children in Families: Research and Policy*, London: Falmer Press.

- Jenks, C. (1996b) *Childhood*, London: Routledge.
- Johnson, M. and Sargent, C. (1990) *Medical Anthropology: Contemporary Theory and Method*, New York: Praeger.
- Johnson, V., Hill, J. and Ivan-Smith, E., (1995) *Listening to Smaller Voices: Children in an Environment of Change*, London: Action Aid.
- Kagan, J. (1980) 'Perspectives on Continuity', In Brim, O.G. and Kagan, J. (eds) *Constancy and Change in Human Development*, Cambridge (Mass): Harvard University Press.
- Kelstrup, A. (1983) 'Galskab, Psykiatri i Galebevægelsen - en skitse af galskabens historie', *Amalie*, Temanummer, March.
- Kleinman, A. (1980) *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine and Psychiatry*, California: Berkeley University Press.
- Kleinman, A. (1988) *The Illness Narratives. Suffering, Healing and the Human Condition*, New York: Basic Books Publishers.
- Kirmayer, L (1988) 'Mind and Body as Metaphors: Hidden Values in Biomedicine', In Lock, M. and Gordon, D. (Eds) *Biomedicine Examined*, Dodrecht: Kluwer Academic Publishers.
- Kløvedal, T. (1994) *Den tynde hud - erindringer om en barndom og opvækst*, Copenhagen: Gyldendal.
- Langsted, O. and Sommer, D. (1988) *Småbørns vilkår i Danmark*, Copenhagen: Hans Reitzels Forlag.
- Latour, B. (1993) *We Have Never Been Modern*, Hemel Hempstead: Harvester/Wheatsheaf.
- Lauritzen, S.O. (1996) 'Mother's Accounts of Health in their Babies', In Mayall, B. (ed) *Children, Health and the Body*. Papers from a Conference held at the Department of Child Studies, Linköping University, Sweden.
- Lauritzen, S.O. (1997) 'Notions of Child Health: Mothers' Accounts of Health in their Young Babies', *Sociology of Health and Illness*, 19, 4:436-456
- Lee, N. (1998) 'Towards an Immature Sociology', *Sociological Review*, 46, 2: 459-82.

- Leslie, C. and Young, A. (eds) (1992), *Paths to Asian Medical Knowledge*, Berkeley: University of California Press.
- Lessing, D. (1994) *Under My Skin, Vol 1. of my Autobiography*, London: Harper Collins.
- Levine, R. et al (1994) *Child Care and Culture: Lessons from Africa*, Cambridge: Cambridge University Press.
- Lewis, M. and Brooks, J.(1978) 'Self-knowledge and Emotional Development', In Lewis, M. and Rosenblum, L.A. (eds), *The Development of Affect*. New York: Plenum.
- Light, P. (1986) 'Context, Conservation and Conversation', in Richards, M. and Light, P. (eds) *Children of Social Worlds*, Cambridge: Polity Press.
- Lock, M. and Gordon, D. (eds) (1988) *Biomedicine Examined*, Dordrecht: Kluwer Academic Publishers.
- Lærke, A.(1998) 'By Means of Re-membering: Notes on a Fieldwork with English Children', *Anthropology Today*, 14, 1:15-19
- Macdonald, G. and Pettit, P. H. (1981) *Semantics and Social Science*, London: Routledge and Kegan Paul.
- Mackay, R. (1973) 'Conceptions of Children and Models of Socialisation', In H.P.Dreizel (ed) *Childhood and Socialisation*, London: Macmillan.
- Madsen, M. et al (1991) *Børns sundhed ved skolestart 1988 89*, Copenhagen: Dike.
- Mandell, N (1991) 'The Least Adult Role in Studying Children', In Waksler, F. (ed) *Studying the Social Worlds of Children*, London: Falmer Press.
- Marcus, G.E. and Fischer, M.M.J. (eds) (1986) *Anthropology as Cultural Critique: An Experimental Moment in the Human Sciences*, Chicago: University of Chicago Press.
- Mauthner, M. (1997) Methodological Aspects of Collecting Data from Children: Lessons from Three Research Projects, *Children and Society*, 11, 1: 16-28.
- Mayall, B. (1993) 'Keeping Healthy at Home and School: It's My Body So It's My Job', *Sociology of Health and Illness*, 15, 4: 464-487.
- Mayall, B. (1995) 'Children as a Minority Group: Issues and Prospects', Paper presented to the Seminar Childhood and Society, Institute of Education, London: Mimeo.



- Mayall, B. (1996) *Children, Health and the Social Order*, Buckingham: Open University Press.
- Mayall, B. (1998) 'Researching Children', Seminar Paper at the Centre for the Social Study of Childhood, University of Hull, May.
- Mayall, B. (1998a) 'Towards a Sociology of Child Health', *Sociology of Health and Illness*, 20, 3: 269-288
- McKinlay, J. (ed) (1985) *Issues in the Political Economy of Health Care*, London: Tavistock.
- Mead, M. (1930/68) *Growing up in New Guinea*, Harmondsworth: Penguin.
- Mead, M. (1955) 'Theoretical Setting', In Mead, M. and Wolfstein, M. (eds) *Childhood in Contemporary Culture*, USA: University of Chicago Press.
- Mead, M. (1962) *Male and Female*, London: Pelican.
- Mechanic, D. (1964) 'The Influence of Mothers on their Children's Health Attitudes and Behavior', *Pediatrics* (March): 444-453.
- Moore, H. (1988) *Feminism and Anthropology*, Cambridge: Polity Press.
- Morrow, V. (1996) 'Rethinking Childhood Dependency: Children's Contributions to the Domestic Economy', *Sociological Review*, 44, 1: 58-77.
- Morrow, V. and Richards, M. (1996) 'The Ethics of Social Research with Children: An Overview' *Children and Society*, 10, 2: 90-105.
- Morss, J. (1990) *The Biologising of Childhood: Developmental Psychology and the Darwinian Myth*, London: Lawrence Erlbaum.
- Mortier, F. (1997) 'Competence in Children: a Philosophical Perspective', In Verhellen, E. (ed) *Understanding Children's Rights*, Ghent: University of Ghent Children's Rights Center.
- Nader, L. (1981) 'The Vertical Slice: Hierarchies and Children', In Britain, G. M. and Cohen, R. (eds) *Hierarchy and Society: Anthropological Perspectives on Bureaucracy*, Philadelphia: Ishi.
- Nagy, M (1953) 'Children's Conceptions of Some Body Functions', *Journal of Genetic Psychology* 83: 199-216.

- Nichter, M. (1987) 'Kyasaur Forest Disease: An Ethnography of a Disease of Development', *Medical Anthropology Quarterly*, New Series 1, 4: 406-23.
- Nichter, M. and Cartwright, E. (1991) 'Saving the Children for the Tobacco Industry', *Medical Anthropology Quarterly*, 5, 3: 236-56.
- Okeley, J. (1992) 'Anthropology and Autobiography: Participatory Experience and Embodied Knowledge', In Okeley, J. and Callaway, H. (eds) *Anthropology and Autobiography*, London: Routledge
- Okeley, J. (1996) *Own and Other Culture*, London and New York: Routledge.
- Open University (1985) *Birth to Old Age: Health in Transition*. Health and Disease U205 Book V. Milton Keynes: The Open University Press.
- Palmer, B. B. and Lewin, C. E. (1975) 'Development of Health Attitudes and Behaviour', Paper to the Annual Conference of the American Health Association, Denver, Colorado.
- Pettit, P. H. (1976) 'Making Actions Intelligible', In Harre, R (ed) *Life Sentences: Aspects of the Social Role of Language*, London: John Wiley and Sons.
- Pollard, A. (1985) *The Social World of the Primary School*, London: Holt, Rhinehart and Winston.
- Pollard, A. (1987) *Children and their Primary Schools*, London: Falmer Press.
- Poole, R. (1994) *Dialogue and the Interpretation of Illness: Conversations in a Cameroon Village*, Cambridge: Berg Publishers.
- Prendergast, S. (1992) *'This is the Time to Grow Up': Girls' Experiences of Menstruation in School*, Cambridge: The Health Promotion Trust.
- Prendergast, S. (1995) 'The Spaces of Childhood: Psyche, Soma and the Social Existence. Menstruation and Embodiment at Adolescence', In Brannen, J. and O'Brien, M. (eds) *Childhood and Parenthood*, London: Institute of Education.
- Prout, A. (1986) 'Wet Children and Little Actresses: Going Sick in Primary School', *Sociology of Health and Illness*, 8, 2: 111-36.
- Prout, A. (1988) 'Off School Sick: Mothers Accounts of School Sickness Absence', *Sociological Review*, 36, 4: 765-789.
- Prout, A. (1989) 'Sickness as a Dominant Symbol in Life Course Transitions: an Illustrated Theoretical Framework', *Sociology of Health and Illness*, 11, 4: 336-59.

Prout, A. (1996) 'Getting Symmetrical about Children and Childhood'. Paper presented at the International Conference 'Childhood and Children's Culture', Esbjerg, Denmark.

Prout, A. (ed) (1999) *The Body, Childhood and Society*, London: Macmillan.

Prout, A. and James, A. (1990/1997) 'Introduction: Constructing and Reconstructing Childhood', In James, A and Prout, A (eds) *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*. London: Falmer Press.

Prout, A. and Christensen, P. (1996) 'Hierarchies, Boundaries and Symbols: Medicine Use and the Cultural Performance of Childhood Sickness', In Bush, P. et al (eds), *Children, Medicines and Culture*, New York: Haworth Press.

Qvortrup, J. (1995a) 'From Useful to Useful: the Historical Continuity of Children's Constructive Participation' In Ambert, A. *Sociological Studies of Children*, Vol 17, Greenwich, Conn: JAI Press.

Qvortrup, J. (1995b) 'Childhood and Modern Society: A Paradoxical Relationship', In Brannen, J. and O'Brien, M. (eds) *Childhood and Parenthood*, London: Institute of Education.

Qvortrup, J. (1991) *Childhood as a Social Phenomenon: An Introduction to a Series of National Reports*, Eurosocial Reports vol 36, Vienna: European Centre.

Qvortrup, J. (1996) 'En barndom med fast arbejdstid' In *Weekendavisen* 3-11. April, Copenhagen.

Rasmussen, N. et al (1988) *Sundhed og Sygelighed 1986/87*, Copenhagen: Dike.

Reynolds, P. (1996) *Traditional Healers and Childhood in Zimbabwe*, Ohio: Ohio University Press.

Richards, M. and Light, P. (1986) (eds) *Children of Social Worlds*, Cambridge: Polity Press.

Riesman, P. (1983) 'On the Irrelevance of Child Rearing Practices for the Formation of Personality: An Analysis of Childhood, Personality and Values in Two African Communities', *Culture, Medicine and Psychiatry*, 7, 2: 103-129.

Riesman, P. (1990) 'The Formation of Personality in Fulani Ethnopsychology', In Jackson, M and Karp, I (eds) *Personhood and Agency: The Experience of Self and Other in African Cultures*, Uppsala Studies in Cultural Anthropology 14, Stockholm:

Almquist and Wiksell International.

Riesman, P. (1992) *First Find Your Child a Good Mother: The Construction of Self in Two African Societies*, New Jersey: Rutgers University Press.

Rodgers, G. and Standing, G. (eds) (1981) *Child Work, Poverty and Underdevelopment*, Geneva: International Labour Organisation.

Sahlins, M. (1985) *Islands of Histories*, Chicago: The University of Chicago Press.

Schechner, R. (1990) 'Magnitudes of Performance', In Schechner, R. and Appel, W. (eds) *By Means of Performance - Intercultural Studies of Theatre and Ritual*, Cambridge: Cambridge University Press.

Schechner, R. (1988) *Performance Theory*, New York: Routledge.

Scheper-Hughes, N. (ed) (1987) *Child Survival: Anthropological Perspectives on the Treatment and Maltreatment of Children*, Dordrecht: Reidel.

Scheper-Hughes, N. and Lock, M. (1987) 'The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology', *Medical Anthropology Quarterly*, 1, 1: 16-41.

Shaw, J. (1981) 'In Loco Parentis: A Relationship between Parent, Child and State', *The Journal of Moral Education* 6, 3: 181-190.

Shildkrout, E. (1978) 'Roles of Children in Urban Kano', In La Fontaine, J.S. *Sex and Age as Principles of Social Differentiation*, London: Academic Press.

Shilling, C. (1993) *The Body and Social Theory*, London: Sage.

Shweder, R.A. (1984) 'Anthropology's Romantic Rebellion against the Enlightenment, or There's More to Thinking than Reason and Evidence', In Shweder, R.A. and LeVine, R.A. (eds) *Culture Theory: Essays on Mind, Self and Emotion*, Cambridge: Cambridge University Press.

Shweder, R.A. (1979) 'Rethinking Culture and Personality Theory. Part 1: A Critical Examination of Two Classical Postulates', *Ethos*, 7, 3: 255-278.

Shweder, R.A. and E.J. Bourne (1982) 'Does the Concept of the Person vary Crossculturally?', In Marsella, A.J. and White, G.M. (eds) *Cultural Conceptions of Mental Health and Therapy*, Holland: Reidel/Dordrecht.

Silverman, D. (1987) *Communication and Medical Practice: Social Relations in the Clinic*, London: Sage.

- Solberg, A. (1990/1997) 'Negotiating Childhood: Changing Constructions of Age for Norwegian Children', In James, A. and Prout, A. (eds) *Constructing and Reconstructing Childhood: Contemporary Issues in the Sociological Study of Childhood*, Lewes: Falmer Press.
- Sommer, D.(1998) *Barndomspsykologi. Udvikling i en forandret verden*, Copenhagen: Hans Reitzels Forlag.
- Stacey, M (1988) *The Sociology of Health and Healing*, London: Unwin Hyman.
- Stafford, C. (1995) *Learning and the Process of Childhood in China*, Cambridge: Cambridge University Press.
- Steedman, C. (1995) *Strange Dislocations: Childhood and the Idea of Human Interiority 1780-1930*, London: Virago.
- Stenbak, E. (1979) *Børns vilkår på hospitalet*, Copenhagen: Dansk Sygeplejeråd.
- Stenbak, E. (1981) 'Barnets angst kan lettes ved forberedelse', In Dietl, U. (ed.) *Born og børns forhold*, Copenhagen: Dansk Sygeplejeråd.
- Stenhouse, L. (1975) *An Introduction to Curriculum Research and Development*. London: Heinemann.
- Stern, D.N. (1985) *The Interpersonal World of the Infant: A View from Psychoanalysis and Developmental Psychology*, New York: Basic Books.
- Steward, M. and Regabulto, B. (1975) 'Do Doctors Know What Children Know?', *American Journal of Orthopsychiatry* 45: 146-149.
- Strathern, M. (1992) *Partial Connections*, Savage, Maryland: Rowman and Littlefield.
- Strong, P. (1979) *The Ceremonial Order of the Clinic*, London: Routledge and Kegan Paul.
- Tedlock, D. (1979) 'The Analogical Tradition and the Emergence of a Dialogical Anthropology', *Journal of Anthropological Research*, 35: 387-400.
- Tedlock, D. and Mannheim, B. (eds) (1995) *The Dialogical Emergence of Culture*, Chicago: University of Illinois Press.
- Thomas, C. (1993) De-Constructing Concepts of Care, *Sociology* 27,4: 649-669.

- Thorne, B. (1993) *Gender Play: Girls and Boys in School*, New Jersey: Rutgers
- Tuan, Y.F. (1990) 'Space and Context', In Schechner, R. and Appel, W. (eds) *By Means of Performance - Intercultural Studies of Theatre and Ritual*, Cambridge: Cambridge University Press.
- Turner, B. S. (1984) *The Body and Society: Explorations in Social Theory*, Oxford: Blackwell.
- Turner, B. S. (1992) *Regulating Bodies: Essays in Medical Sociology*, London: Routledge.
- Turner, L. and Ash, J. (1975) *The Golden Hordes*, London: Constable.
- Turner, T. S. (1980) 'The Social Skin', In Cherfas, I. and Lewin, R. (eds) *Not Work Alone: A Cross Cultural View of Activities Superfluous to Survival*, London: Temple Smith.
- Turner, V. (1974) *Dramas, Fields and Metaphors*. Ithaca: Cornell University Press.
- Turner, V. (1968) *The Drums of Affliction: A Study of Religious Processes among the Ndembu of Zambia*, London: International African Institute, Hutchinson.
- Turner, V and Turner, E (1978) *Image and Pilgrimage in Christian Culture*, Oxford: Basil Blackwell.
- Uldall, P. (1987) *Spæd-og småbørns almindelige sygelighed - forekomst og sociale konsekvenser*, Copenhagen: Fagl's Forlag.
- Urry, J. (1990) *The Tourist Gaze. Leisure and Travel in Contemporary Societies*, London: Sage.
- Van der Geest, S. (1996) 'Grasping the Child's Point of View? An Anthropological Reflection', In Bush, P. et al (eds.), *Children, Medicines and Culture*, New York: Haworth Press.
- Van der Geest, S. and Whyte, S. (1989) 'The Charm of Medicines: Metaphors and Metonyms', *Medical Anthropology Quarterly*, 3,4: 345-366.
- Vendler, Z. (1984) 'Understanding People', In Sweder, R. A. and LeVine, R. A. (eds) *Culture Theory: Essays on Mind, Self and Emotion*, Cambridge: Cambridge University Press.
- Whiting, J.W.M. and Child, I. (1953) *Child Training and Personality: a Cross-cultural Study*, New Haven: Yale University Press.

Whyte, S. (1986) 'Dialog og Diagnose: Sandsigelse om sygdom i Østafrika', In  
Elsass, P. and Hastrup, K. (eds) *Sygdomsbilleder*, Copenhagen: Gyldendal.

Whyte, S. (1992) 'Pharmaceuticals as Folk Medicine: Transformations in the Social  
Relations of Health Care in Uganda', *Culture, Medicine and Psychiatry* 16: 163-186.

Wilkinson, S.R. (1988) *The Child's World of Illness*, Cambridge: Cambridge  
University Press.

Young, A. (1982) 'The Anthropologies of Illness and Sickness', *Annual Review of  
Anthropology* 11: 257-285.