The Life History of a Social Norm

Introduction

In what are now theoretically ancient times, Herbert Blumer gave a deceptively appealing characterisation of symbolic interaction: Social meanings are neither situated 'out there' in the real world nor inside individual minds. If they need to be metaphysically 'placed,' they must be placed within human interaction where they are created and sustained. One of sociology's distinctive problems is to understand the processes through which interaction creates meanings which, in their turn, affect interaction.

One of the things that entitles a complex of meaning to the label 'social' is that it has normative properties which remain invariant across individuals, situations and time frames. An enormous amount of research focuses on the operation of norms, once they are already in place. But there has been much less research on how they are created to begin with.

This study is an example of the latter. It traces the life history of a phenomenon that starts its life as a deviant, illegitimate action. The action undergoes a history of change and use, and finally becomes integrated into the activities of a group of people. It becomes a normative action with a stable, standardised meaning. In studying this action, I use a heterogeneous combination of conversation analytic, ethnographic, and interviewing methods. It is not a thoughtless combination, but one designed to get at a basic question in a practical way. The study looks in great detail at how interactional dynamics provide a crucible within which social norms are forged.

The Setting

The action to be traced had a life and existence within a set of conversations. They formed a natural series, in that they involved the same set of participants, occurred with regular frequency in real time, and were regarded by participants as items-in-a-series, in terms of collective purposes, contexts, setting, and so on. The people in question were in-patients on a psychiatric ward at a San Francisco medical facility. The major thing that made them a group in their own eyes was precisely that they regularly had these conversations.

Two separate groups met regularly on the ward. Both were observed and one was used as an informal control. The other met twice a week for about two hours and consisted of approximately ten patients, a resident psychiatrist, one or more psychiatric social workers, and several members of a research staff (which included the author) who were there as non-participating observers. Patients and staff sat in chairs arranged in a circle, and the research people sat outside this circle.

Conversation as a Professional Service

We are so familiar with this scene, that we may be blind to its specialness. Patients were scheduled for therapy at regular intervals, for fixed periods of time, much as they might be put on a regimen of exercise or medication. In these and other ways (for example, economic) these exchanges had the sociological status of treatments. Counselling and psychotherapy may be unique professions, in that talking and listening, *in and of itself,* constitutes a primary service provided by the

professional.[1] It thus became important to discover how the talking and listening in this scene differed from ordinary conversation.

In a sense, what I discovered was that it did not. A therapy session for this group was basically an ordinary, informal conversation which had been modified. It was not a distinctive mode of communication in its own right. Other researchers have made the same observation for other types of therapy (Turner, 1972).[2]

Ordinary conversation can be considered an activity; an activity that can and does go on in almost every domain of social life. It can occur between anyone and everyone, for a few seconds and many hours. Any topic or no particular topic can be discussed through its use, and amazingly wide differences in individual purposes, knowledge, competence, and style can be accommodated within its formatting requirements. To accomplish this the conversational from must be self organising and self correcting in a variety of ways. Research on conversation has unveiled many kinds of organisation, but we will be most interested in the following three (Sacks *et al*, 1974):

1. A turn-taking system which determines who talks next, and when to talk next.
2. A recursive organisation through which previous utterances indicate how to listen to, and produce current utterances.
3. An overall structural organisation through which a conversation unravels itself into bounded sections such as beginnings, beginnings of beginnings, endings, first topics, and so on.

Therapy, on the other hand, is a formal activity which, in certain obvious ways, is structured quite differently. For example, like many other semi-formal exchanges it has many aspects fixed in advance:

1. The number, identity and roles of its participants.
2. The time and place of its occurrence.
3. Its duration.
4. Its relationship to a series of other exchanges.
5. Certain aspects of its content.

These are fixed, moreover, by criteria that are external to the dynamics of the conversations themselves. These facts may seem simple, even mechanical. But they rob therapy of many of the self-altering capabilities built into conversation. The attempt to combine informal, personal communication with requirements like these leads to a variety of conflicts, some of which will now be explored.

Participation as a Turn Taking Problem

If the kinds of conversations called psychotherapy are to be somehow medicinal, then the degree to which one is helped should depend on the extent to which one participates in them. This should be true somewhat independently of the particular problem involved. But the types of participation that occur depend in important ways on the parent conversational form.

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[1] Legal or financial counsellors, for example, do not regard their conversations with clients, in and of themselves, as capable of improving the client's legal or financial situation.

[2] This observation has firm roots in the nature of therapy itself. Most therapists attempt to achieve a relationship with clients which is simultaneously personal and professional. The conversational form, for a number of reasons, has close ties to the informal, personal spheres of life. It is thus not surprising that therapists try to achieve a dual relationship with clients by adapting a personal form of communication and modifying it to meet professional requirements.

For example, talking and listening might seem equally important in therapy. But getting a turn to talk is quite a different thing to getting a turn to listen. Unwillingness or inability to talk makes one less of a participant in an essential sense.

It turned out that this group had a way of internally manufacturing just these kinds of non-participants. After a while, a session would resolve itself into a small set of people who did most of the talking and a larger set who did most of the listening. The two sets tended to remain stable throughout the rest of the session. This provided particular sessions with a characteristic flavour—making them 'types' of sessions. By quantifying individual patterns across sessions individuals were also typed as participants or non-participants.

Styles of talking and listening within sessions were used to infer personality traits. If someone never spoke unless spoken to, or stopped talking immediately when interrupted, they might be seen as withdrawn or a 'number one doormat.' If one obtained turns at talk or held the floor by techniques of interactional force, he might be seen as aggressive or 'acting out.'

As these examples show, different senses of participation and participants can be created by 'amounts' of talking and listening—independent of their content or quality. 'Amounts,' however, were not defined by clock time or word counts, but by layers of conversational rules. In fact, 'amounts' in this sense provided a general model for the roles of patient and therapist. To be crass, good therapists listened a lot and talked a little, and good patients did roughly the reverse.

To be less crass, conversational rules implicitly define the role of 'good listener.' Good listeners do such things as minimising the length of their utterances in ways that are visible to others or using their own opportunities to speak to ask questions which give others extended opportunities to speak. The latter device is, in fact, a traditional therapeutic technique:

> Begin by a general question which can not be answered by yes or no. Avoid leading questions which suggest the answer. Use such questions as, 'How are things going?', 'How do you feel?', 'What's been happening?', 'What are you thinking about?'… (Finesinger, 1948).

If the good listener provides a model for therapists, it also provides a reciprocal model for clients. For one can hardly be a good listener alone. To facilitate patients talking, a number of conversational practices are modified in therapy (Blum, 1970: 52 – 56). For example, How-are-yous are ordinarily part of greeting sequences. A therapist's 'How are you?', however, is an invitation to engage in the kinds of extended monologues that make good listening possible. In this context, to reply with a mere 'Fine' would be ignorant, sarcastic or downright subversive.

Insofar as the previous models for talking and listening were accepted by our group (and they were), the group contained bad patients and the leader was a bad leader. For he talked very much indeed. He made speeches, he blustered, and otherwise conducted himself more like a classroom lecturer than a good listener. He interpreted this as a problem with his personality.

However, there were reasons for the speaking patterns in this group that were independent of anyone's character traits or desires. They were tied, instead, to interactional features of the encounter. Conversational turn-taking rules operate *turn by turn* making the distribution of speaking opportunities dependent on a variety of complex contingencies (Sacks *et*

al, 1974). There are ordinarily four ways for smoothing out any lopsided results of these contingencies (Schegloff and Sacks, 1973):

1. The option of non-participants to leave.
2. The splitting up of one large exchange into several smaller ones.
3. Adjusting the length of a conversation in light of who has thus far had a chance to say what.
4. Placing unfinished business within ending sections which are, in part, designed for this purpose.

However, in the therapy situation there is no leave-taking ritual, nor can the group divide itself into subgroups. With a fixed time for each session, length is not malleable and endings can not be used to do what they otherwise might do.

There were also pressures acting on those who happened to become non-participants to remain non-participants. If such a person spoke, it became visible, not just that he said what he said, but that he said anything at all. The next question was why he came 'back to life' at that point. Given the high visibility of such a remark and the possible inferences that could be drawn from it, speaking after a long silence became something that progressively required better and better reasons.

Finally, if some people were pressured into silence, others actively welcomed it. The topic at hand was frequently different from what some individuals saw as their pressing, personal problems. Given their primary reason for being in the group, they could find themselves emotionally invested in their own topic, and disinterested in others. For such people the silent majority was a place to interactionally hide. Without its protection their silence would be visible as an individual's silence, with its own motives, reasons and implications.

We have lamented the absence of some of the conversational devices which could ordinarily deal with problems like these. It would therefore be no surprise to find therapists trying to compensate with sensitivities and skills of their own. Both therapists in both groups on this ward did, indeed, have ways of 'directing traffic' when turn taking seemed to go awry. A typical such problem was provided by new patients who often employed the communication patterns they were accustomed to in other service relationships, for example with a doctor or lawyer. For such people, getting helped was synonymous with obtaining expert advice and evaluation. They displayed a preference for addressing the expert or, even when addressing other patients, constructing their remarks to be heard by the expert. Thus, if asked a question by another patient, a new patient might attempt to give her answer to the therapist, not the asker of the question:

Bill: What didju anticipate? Whatje think this place was about?
Joan: (to therapist) Well I thought I w'z going to U.C. to get some tests fuh find out what—was making my uh—that if I had a nervous disorder—I mean if it were a disease, or something within my nerves. Then perhaps they would—be able to, uh, find it,—reason. And give me the proper medication, so that I would no longer have these—this—um,—. Well if it was a nervous disorder then I would no longer have it. I mean if they would find the proper medication to treat me,—. And that's all I//
Therapist: Yer-yer answering <u>me</u> en I think <u>he</u> asked you the question—
Joan: Well he's not a doctor, I don't want to talk to someone who doesn't know any//more about then I do

This was not the main turn taking problem our group faced. Instead, it was a problem

that is well known to any classroom lecturer. What happens when a fair number of people, for one reason or another, do not respond when they are invited in on the topic at hand? There are those awkward silences after general questions and invitations pull in, either nothing at all, or minimal replies. One can let the silences prevail, risking a mutually embarrassing feeling of a gathering that, in some deep sense, is simply not working; or one can end the silences by answering one's own questions and making speeches. The length of the latter depends to some extent on what help one's audience is willing to provide. If that help comes predominantly from the patient equivalents to 'teacher's pet,' the temptation is strong to share one's topical load with such people. In that event, those who talk less than they should have reflexively created a set of people who talk more than they should—a set that might very well not have been there on its own.

Again, this problem may seem mechanical, even superficial. But it had deeper roots and implications which we must now look at from several sides and excavate still further. In speaking of good and bad patients and patients who speak more or less than they 'should' we imply that they are subject to some kind of moral/social code of responsibility. We must now look into what such a code could be, how it could be, and the nature of a therapist's power (or lack of same) to enforce it.

The Moral Responsibilities of Mental Patients

As Scheff (1966), Goffman (1961), and others have documented, the basic problem experienced by the 'mentally ill' is the disruption of normal social life. Most people are admitted to mental hospitals like this one because they have been causing certain kinds of interactional trouble (Whitmer and Conover, 1959).

When we speak of disruption we are not just alluding to a problem faced by friends and neighbours, but a serious one for the mentally ill as well. If they act out socially troublesome behaviour or speak freely of their experiences or belief, they encounter strained problematic relations with others. If they become afraid of this and try to anticipate, manage, or inhibit problem behaviour, they experience a painful gap between themselves and their fellow creatures. In either case they get cut off from meaningful relations with others (e.g. Jacobs, 1967). This problem may be secondary to a psychological one, but its effects can be devastating. It defines for therapists and mental hospitals one of their critical functions—to provide a place for certain kinds of behaviour and experience to interactionally breathe. It thus becomes virtually part of a therapist's job to suspend or relax many of the social conventions that subdue individual differences. On the other hand, any organised form of interaction has minimal formatting requirements.

It is hard to envision how helping and being helped could take place, were patients to be permitted to come and go as they please, or speak in wildly varying amounts and intelligibility. In short, mental patients are people who, by definition, will make interaction difficult or impossible in many different ways in the process of being themselves.

What then could a competent, well-behaved patient possibly look like? Some standards of conduct and competence are required, but what standards? They can not be independent of individual circumstances, since it was a divergence between individual circumstances and standards of conduct that made people patients to begin with.

Secondly, whatever standards are decided upon and expected, there is the question of

what to do when they are violated. Is there, for instance, some equivalent to the 'following doctor's orders' of the physician? How could there be, since psychological troubles are not consistently differentiable from the capacities and willingnesses needed to enact any standard regimen of conduct? One can hardly require as a condition for working on a problem that one behave as if the problem did not exist. Further, how might patients feel free to express unacceptable behaviour or belief in the face of the usual vocabulary connected to social norms, *i.e.*, praise and blame, right and wrong, rules and punishments? These are all difficult and thorny issues and, to some extent, they were simply muddled through in actual practice.

The Personalisation of Social Interaction

However, a more general solution to this problem did exist. I discovered it fortuitously in connection with the ward's programme in movement therapy. I was told that many patients were alienated from their bodies because of excessive taboos on movement and touch present in their life-worlds. To help free them from these internalised structures they were introduced to creative movement. Creative movement, it turned out, was something one did in the creative movement room, at three o'clock, for one hour, as taught by the movement therapist, and it did not include ballet or social dance steps because this was restricted, rule-governed movement! Similarly, in therapy, patients were encouraged to express what was on their minds freely, openly and honestly without regard to rules of appropriateness. However, this meant talking about feelings, motives and relationships, not football or cars which were superficial, safe topics (which could conceal real feelings and concerns).

In short, the spontaneous, the free, and the real were tamed in the most remarkable way. They were given institutional definitions. Such a way of being oneself can indeed be harmonious with a social role like 'patient' and can, in fact, be synonymous with fulfilling it. However, it gets defined as 'this' and not 'that.' Whether one is doing it, is getting better or worse at doing it, or is trying or not trying to do it become matters for public recognition, public discussion and public debate.

In a similar vein, the whole world of the personal was annexed by the institution through a paradigm of ways to look, speak and reason. It was a distinctive topical pastime, for instance, to inspect virtually any action or communication for general aspects of self which it revealed. Those aspects would then become discussion topics. Thus a pastime that needed no explanation in the author's world—discussing intellectual discoveries—was consistently greeted here with, 'Why are you telling me this?' His customary, 'Because it's interesting' did not constitute a personal motive or an answer, since what a motive was, and what one's own motives could be, were things learned and decided on the ward.

More generally, almost all action could legitimately be interpreted as an enactment or performance of the personal self. But to see and do this in a concrete way, one had to learn or know a particular vocabulary of motives (Mills, 1940). One also had to know 'who everybody was.' This was accomplished through the assignment of personal traits to each individual. Others would discover the traits operating in what one did and said, and feed the information back to you. As relationships between people stabilised, these traits became relatively public knowledge instead of something selectively transmitted in one-to-one situations.

On a communicative level, many of these results were achieved by the use of a device which ethnomethodologists call a 'formulation' (Garfinkel and Sacks, 1970). Its existence depends on a peculiar fact about the syntax of conversation. One can think of the utterances of each speaker as 'words' in a grand, collaborative conversational 'sentence.' In that case, a current 'word' must be selected to fit those that have already occurred, if it to be sensible and appropriate. However, in contrast to the syntax of the sentence, a current utterance, for the most part, needs to fit only the one just before it—not the whole structure created by things said before (e.g. Sacks *et al,* 1974: 44 – 47).

One way to do this is to reply topically, speaking to the things talked *about* in a current remark. However, because of the previous syntactical fact, there is another way to respond to almost any remark, independent of its content. One can treat the *remark* as the topic, and construct a reply that describes or 'formulates' the remark itself rather than the things it talks about. One can describe the motives for saying it, the way it is said, its emotional tone, or the kind of insult or defence that it consists of. Instead of answering a question directly, for instance, the question can be described as doing-things-with-words:

Patient: Um, I like tuh see what we c'd do tuh help out—Stan.—C'z he—I feel that he needs—help—help, en stuff like that, buh we have nevuh given it to 'im. I like tuh know how we would go about—helpin'im.
Therapist: D'you need my approval?

Through devices like this, mundane remarks can be redescribed as personal actions. Because the device can be used on virtually anything, patients come by a new and important concern, 'What are they going to do with what I say?'

The next question becomes which remarks are more likely to solicit this kind of a response. If one examines concepts like 'motive,' 'feeling' or 'defence' with this question in mind he will notice something disconcerting. Their semantic potential is enormous. They too have the potential to be applied to almost anything a person does or says. This should really be no surprise. Any group that construes itself as dealing with something basic to human life inherits what must seem like a moral duty: to take the semantic space they use to describe that something, and make it 'gobble up' the rest of the world.

Conceptions of the personal, in fact, 'gobbled up' many of the things that are ordinarily interpreted as social. The vocabulary of social control, for instance, is usually one of morality and propriety, loyalty to and sanctity of, the gathering, or conformity and deviance. As we have seen, this vocabulary is troublesome in therapeutic situations and was not used here. Socialising, judging, and sanctioning still took place, but they were personalised so that, while performing their social functions, they simultaneously appeared to be something else. Thus, instead of directly criticising the violation of some rule, the violation was first characterised as an instance of a personal trait. It was then the trait, not the violation, that was criticised:

Bill: The thing is I felt alot of anger towards Jill and it came out sooner. I mean we had a little matching of horns there for a little while and it came out sooner, and this to me sounds like a terrific barrage against someone who isn't particularly fighting it and so—I don't know—it seems like a terrific waste of time everybody sit here and//
Therapist: Hey that's you same old shit again—that the group is a waste. You got to sneak that in at least once an hour.
Betty: (to Bill) It's a waste for you maybe. What would you like to talk about?

Bill: But she's not responding.

As this excerpt makes clear, the world of the personal was hardly a neutral, empirical realm. It had its own kind of morality, its own notions of better and worse, real and false, central and peripheral. How, for instance, might one decide whether Bill is, in fact, sneaking in his 'same old shit again?' Truth is an awkward criteria: it takes time and tentativeness to gather the materials it demands. Personal characteristics like feelings and motives do better, at least in the sense that they become available immediately. And there were strong ways in which 'feelings and motives made it so' in these conversations (e.g. Schwartz, 1976). For instance, claims whose motives were identifiably suspect could be treated as sociologically equivalent to false claims. And if I made an uncomplimentary claim about your motives and you cried, we could both see that there was truth in what I said. Finally, of the various feelings, motives, and traits it was possible to have, some were better than others. In fact, personal traits of all kinds functioned as status characteristics: There were serious senses in which happy, loving people were superior to depressive, defensive ones. Given the various kinds of evaluations personal traits made possible, they provided a way to punish deviance, reward conformity, and accomplish other social tasks, through an idiom that did not have the same experiential 'feel' as moral right and wrong, or good and bad.

Unfortunately, they did more than that. They extended the domain of evaluations to include all kinds of behaviour that is normally assessment free. The most innocent facial expression could be characterised as an expression of personal feeling. Feelings like that are expressed for certain reasons and motives, and these can be evaluated. From there it is a small step to evaluating the person who has such motives. In short, what was potentially at stake when one did or said something like this, was no less than one's identity, one's worth, and the status of one's relations with others:

Bill: I think she's trying to stereotype everything——
(to Jill) now you're looking at me like you're very angry at me.
Jill: No I'm just listening to you.
Bill: You don't resent being cut down?
Jill: No.
Bill: Just goes off like water on a duck——
Jill: No I wouldn't say that either. I really listened because I don't——you or your opinion or for expressing it

The Emotional Tone of the Gathering

Given this dramatic fact, certain equally dramatic changes in group behaviour appeared to flow from it. We have been repeatedly comparing therapy to informal conversation. There were two differences between the former and the latter that struck me immediately, but evaded understanding until I happened upon the status functions of personal traits. Our gathering tended to occur in the temporal phases differentiated by Turner (1972). He distinguished pre-therapy, therapy, and post-therapy talk as qualitatively different kinds of interaction, each with its own boundary markers and transition devices.

If one can escape one's cultural heritage for a moment, the transition from pre-therapy to therapy proper was quite dramatic: from a variety of movements and locomotion options to a highly stylised and controlled use of eye contact, head motion, facial expression, and movement of the upper trunk—where locomotion, for the most part, was entirely avoided. Along with this, and partially through this, was a characteristic emotional tone to the gathering. It could only be described as suffocatingly serious. The fact that mundane actions could be monitored for

personal motives and traits, and these traits could be used to evaluate its doer in a personal way, turned many otherwise mundane actions into serious matters indeed. Therapy became deadly serious business, and seriousness was created and displayed through a variety of verbal and nonverbal modes of expression.

We can summarise many of these observations by reference to our opening problem. The problem of conflicts between the social requirements of interaction and the personal requirements of therapeutic relationships was solved by collapsing the social into the personal and simultaneously using the personal to accomplish social functions.

The Ownership of Therapeutic Knowledge and Intent

However, this solution was not total. There was an interesting, if predictable, exception to it in the person of the therapist. The fact that he was there to help with your problems and not the reverse, turned out to be a role structure that was hard to make symmetric. It meant, among other things, that therapist's actions were accounted for by formulating them as rational, whereas accounts of patient actions formulated them as personal. In effect, he was 'doing therapy' while you were simply being yourself. This structure was made visible in several ways. Three of them are illustrated in the exchange below. If asked about his own personal life, the therapist would avoid answering such questions to the point of stony silence:

Soc. Wkr.: What do you want to know about him—Betty?
Betty: I don't know, just—I know your story, like we all have our stories of how we got here. I heard that you did something great, you went three years over in Asia or something
(LONG PAUSE)
Betty: Oh, okay (laughs)
Sam: He's not talking
Dan: That's classified information, we're not supposed to talk about that.
Therapist: It was three years, one year was in Asia//but what'uh difference does it make what I was doing before?
Betty: Oh

A patient who asked such personal questions might swiftly find herself in possession of negative personal motives for doing so:

Betty: That's why I liked to talk to Joe, you know. I found out about his past and what he did and what he wants to do, kind of?
Soc. Wkr.: Sometimes though Betty, I think you use this as a way of avoiding talking about your problems.
Betty: Oh yeah
Soc. Wkr.: Yeah, y'remember we talked about that—that's one thing I think you're kind of out of now—at least with me but it seems like you're back into it with him.

Finally, sometimes the role structure would be explicitly described with versions of the maxim, 'We're here to deal with your personal life, not mine.'

Betty: I never got into it with him
Therapist: I think we got into a lot of things—I think, my bias is, it has a lot to do with my personality, but my bias is we got into it more easily by my—you not getting into a lot of personal stuff with me—. This is a different game here than out here.
Bob: You feel you have to maintain a certain amount of objectivity?
Therapist: Yeah
Bob: Not get too personally involved?
Therapist: I think I have to get personally involved but in a different way that you want perhaps (long pause) like it really doesn't matter you know whether I was overseas one year or four years, what matters is for you, is who,

> whatever's in your head at the moment.

It might be thought that if therapists could account for their actions in terms of therapy, helping patients 'get into it,' and so on, then patients might attempt the same thing. Like the proverbial child who plays mommie by copying what she sees in the kitchen, patients did occasionally try to mimic the therapist's interactional style and its accompanying rationale. Such attempts failed because therapeutic knowledge and intent were morally 'owned' by categories of people. It either was or was not believable that one knew what some action or remark would do to/for another person. This believability had nothing to do with what one really knew, but with whether one was entitled to know such things. This, in turn, depended on which of various relevant categories one fit into, categories such as patient, medical student, psychiatric social worker, or secretary.

An interesting side consequence of this, was that unknowledgeable people, in the previous sense, were held responsible for the things they 'did' to patients—things like making them feel fearful, suspicious, agitated, and so on. Patients could do such things, but since they had licence to be themselves, they had another evaluative format available in such situations. On the other hand, non-clinical personnel like the researcher had no such alternative, and the mistakes they made in dealing with patients could be counted up item by item, leading to a cumulative total of patient harm. Remarkably, for those who were entitled to know what they were doing, single negative incidents with patients were not even noticed as such, much less counted up. Only broader trends became noteworthy.

Equitable Distribution of 'Topic'

If for convenience we think of each patient and/or the problems he owns as a potential topic, then for ten people there are at least ten topics to discuss. Moreover, conversation is structurally organised so that the maxim, 'One person talks at a time,' is broadly mirrored by the maxim, 'One topic is discussed at a time' (neglecting many technical qualifications and considerations—Speier, 1973: 91 – 94). Again in one-on-one therapy this fact is inconsequential, but in a group, another selection problem is created. How does one adequately deal with ten such topics within the space of two hours?

The reader might object that one need not discuss a problem as a topic in order to deal with it. But if someone's troubles *are* being directly discussed, this certainly constitutes a reasonable sense of dealing with it. And while it is being dealt with in this way there may be nine other paying customers whose troubles are not being dealt with in a similar way. Secondly, it is certainly true that many conversational sequences and sections are not topical in nature. But if those that are form a more or less linear order, and with ending time determined by the clock, certain patients are almost assured of unequal attention, both within a particular session, and over a series of sessions.

The problem may be highlighted by comparing therapy to analogous service situations. Imagine a group law or economic consultation where many people come together with one lawyer or certified public accountant and some people have their economic or legal problems discussed while others do not.

How then might one provide clients with some (possibly new) way to recognise that therapeutic resources are being distributed equitably? One can employ a form of group therapy like the Synanon game

where each person takes turns at being the topical focus of the whole group, and a fair count is kept. One can populate a group with people possessing similar or identical problems such as is done for alcoholics, smokers, and so on. Finally one can devise ways of working on problems that are relatively independent of the content of what is being talked about.

It was this third approach that was employed in our group. It is an interesting one, in that it attempts to disengage psychological problems from conversational topics, a task which requires a fairly unique conception of what a problem is. To be sure, standard names and categories are used in this hospital to initially define a person's illness or problem. But they are perhaps more perfunctory, more 'merely administrative' than in any other profession. The therapist and group exercise extraordinary liberty in discovering and revising what the trouble(s) is throughout the course of administering its remedy. Along with this, any participation of a patient in the group process becomes, potentially , a part of dealing with his/her problems. To turn the term, 'potential' into 'actual,' we need only add the devices which personalise interaction, since they literally convert any exchange into a dynamic personal enactment replete with feelings, motivations and relationships.

If this diffuses what a trouble and its remedy are somewhat, it also removes the strong veto power which clients enjoy in other service relationships, concerning what it is they want remedied. Their complaints and self-diagnoses can be treated, either as descriptions of their problems, or as living examples of their problems. Thus, whether or when one is talking about a problem, exemplifying a problem, or working on one all become ambiguous and negotiable. This creates a series of pitfalls and uncertainties for patients concerning how to describe problems. What should be brought up as a discussion topic, when and how should this be done, and what will be the fate of such a topic, once initiated?

For instance, we earlier witnessed the fate of a woman who tried to ask the therapist about his stay in Asia. Her question, as she explained, was intimately connected to an interpersonal problem:

Betty: I just thought you might know about meditation a little bit 'cause it kinda interested me (pause) 'cause I'm going to start trying to go back into it again…I'm sorta worried about that cause my husband's into it so strongly, and he says I don't haveta be but, you know, it helps if we're doing some of the same things…

However, when she tried to ask him about Asia, she was told she was doing this as a way to avoid talking about her problems! We also saw another patient attempt to talk about the possible futility of the group's attacking one of its members, only to be told he was doing 'that same old shit again.' Finally, witness this attempt of a patient in physical pain to bring up his fears about what drugs may be doing to his body. The therapist had focussed the session on the sexual problems of a teenage girl:

Bob: I keep getting these funny twitches.
Girl: Jesus, Bob, every time something real comes up in the group you try to change the subject.

In sum, the power/status structure we have discussed largely determined who had the power to safely talk about what. Therapist's actions, normatively speaking, were rational with therapeutic functions. Single consequences of his actions were either not noticeable at all, or could not be brought to account in the same way. On the other hand, patients had personal and psychological motives for actions like changing the topic. These motives could be

evaluated as could the effects of their actions on others—effects which were both noticeable, case by case, and could be treated morally.

Tentative Deviance

However, there were two patients assigned to this group whose actions were dramatically exempt from the kinds of controls we have just described. The latter, to be fair, are rather fancy affairs—concerned as they are with one's identity, esteem, and how one is seen by others. It was entirely unclear that these people were capable of the kind of high level, cognitive processing necessary to be concerned with something like a good self image. They were known to be virtually sleepwalking due to an unknown combination of psychosis, large doses of tranquillising drugs, and electro-shock treatments. Both could hardly speak coherently and seemed unable to control their physical movements. In therapy they would and did sit, stand, remain stationary, lie on the floor, or wander around in ways that were blatantly inappropriate. The proper interpretation of their behaviour was a difficult problem for therapists, *i.e.*, what actions were motivated, deliberate, and which were inabilities, drug related, etc.

New Pt.: What's the matter? I mean—is this what the medicine does to a person—that thorazine or whatever it is?

Therapist: I——, I think uh,—people t-uh often tenduh blame the medicine on uh,—things which really aren't due t'the medicine. —But yes the medicine can make you drowsy. Uhm:—d'z it make Stan like he is overall, probably not.

If their actions constituted deviance, it was deviance of an interesting sort. For the very thing that qualified them a legitimate members of the group—their psychosis—was also the thing that was responsible for their deviant behaviour. Social control was difficult with them for two reasons. First, it is difficult to define the moral responsibilities of a psychotic patient. Second, punishments, admonitions, attacks on their self esteem and the like simply did not work. Such actions were likely to evoke responses that were just as strange as the ones they were trying to prevent.

Given this situation, the treatment of these patients was extremely interesting. In theory, their behaviour could have been treated as deviance. In fact, it was not. It was treated as incompetence in a very unique way. Since what could be expected of them was chronically in doubt, problem behaviour was first responded to as 'tentatively deviant' to see what would happen. If this produced unsatisfactory results, the working interpretative mode was to 'ineptitude.' In effect this meant that the patients were alternately socialised and ignored. Someone might attempt to instruct, correct or chastise them, carry the sequence through a few comments, and then abandon the whole task as untenable:

Don: Bill?
Bill: Hm
Don: How yuh <u>feel</u>?
Bill: (mumbles incoherently)
Don: C'n you talk clear?
Bill: G'nna try to (still hard to understand his speech).
Sue: But you <u>can</u> talk clearly Bill, c'z I've <u>seen</u> you talk clearly
Sam: He's on heavy medicine (pause)
Jill: He <u>is</u>.
(The group go on to other matters and no one addresses Bill again for the duration of the session)

Leaving-the-Room

Thus, many of the things other patients would have liked to do but could not, became more possible to do and safer to do for these patients. For example, one of the

things they did with some frequency was to leave the room. More specifically this kind of leaving-the-room was done during the therapy proper and required doing by a single incumbent who had the right to be there at that time, and was both a patient on the ward, and a qualified participant in this group. Exits by members of the research staff, or exits during pre- or post-therapy periods were, for instance, quite different kinds of leaving-the-room.

Within this context, such an action acquires a variety of potential horizons of meaning. Like telephoning a stranger, it becomes an accountable action—something that stands as deviant unless done for good reasons, reasons that are either visible, or given in the doing. Such reasons are, of course, standard parts of the leave taking rituals that accompany ordinary interaction. However, with no legitimate ritual of this type available in therapy, leaving the room became more analogous to leaving class with or without permission, than to retiring from a conversation.

Leaving without permission was thus, in principle, a violation. However, if it was done by these two incompetent patients it was permitted, allowed for, and sometimes talked about. To treat it as 'tentatively deviant' was, in effect, to make it quasi-legitimate for them.

Such a course of action would have been a solution, of sorts, to a particular version of the general problem we have so painstakingly explored. Patients would often come to this group with some problem or event that was intensely bothering them and which they had planned to talk about, in advance. If the session got started on some other topic or person, and especially if the therapist directed a focus to that topic/person, a depressing situation was in the making. This matter could be taken up for long periods of time, perhaps the whole time, and this was known. One could not actively change the topic, nor leave, without risking consequential evaluations. One thus had to just sit there with something she was dying to say, knowing or thinking there was no safe way to say it. This created a motivational and emotional situation that could predispose such a person to join the ranks of those who said nothing at all—creating a double sense of isolation.

Patients reported extreme anxiety when they saw themselves faced with this problem. On a few occasions persons in this situation were seen to spontaneously burst into tears. This was another solution to their problem, in that tears were noticeable and could be asked about. But tears had the disadvantage of not being something most people could deliberately produce.

What was needed was an action that would not be treated as changing the topic, but which solicited responses from others that changed it for one. This is exactly what happened when, on one occasion, a woman who was clearly disturbed about something abruptly left the room.

Before discussing what happened next let us consider why and how she might have come to do what she did. For the 'why?' we can tentatively entertain certain theories and evidence from psychologists of emotion (e.g. Tomkins, 1978). They speak of problems which evoke constellations of negative feeling often described by members with phrases like 'I can't stand it,' 'I can't let it pass,' or 'It gets to me.' As such a problem recurs, and if coping strategies fail to alter or reduce these feelings, a feedback process is initiated between feelings, coping strategies, and thoughts which results in the mutual escalation of all three. This is no place to detail such theories. However, there is some evidence on the question of whether our problem evoked such feelings,

and whether the strategy of remaining silent, reduced them. In addition to the crying episodes, patients independently reported extreme anxiety in the face of this problem, even while remaining silent.

Assume then, that this woman and others like her have built up a clear conception of their strategic problem, and a backlog of bad feelings about it. They would thus be predisposed to a line of interactional action that promised a solution—or at least one that allowed one to actively respond to the problem. Traditionally, we would pit this predisposition against rules and the fears of breaking rules. But there is another stong way in which social norms constrain. Most of us never violate such norms because most kinds of violation simply never come to mind. The sets of options, responses and possibilities that are likely to occur to a person within the tight time constraints of ongoing action are strongly controlled by her knowledge of normal social structure (Garfinkel, 1967).

In light of this issue, our two incompetent patients appear to have performed a service. They created psychologically 'new' forms of deviance and conformity. For example, before they walked out, there was no direct sense in which patients saw themselves as either 'leaving or not leaving the room' during therapy. After they did this, this action had the aura of the normative and generic hovering about it. It became a generalised possibility which violated a newly appreciated norm. thus, it may never have occurred to this woman to walk out, especially given her agitated state, had she not seen this done by the incompetent patients in potentially similar circumstances.

Since this woman was considered relatively competent, her action was interpreted as deliberate, sensible, and therefore motivated. What was done was to choose a friend of hers to retrieve her, and then she was asked why she left. Imagine that—they were asking *her* to tell them what she had wanted to talk about all along. At this point, both the personalisation of patient's actions, and the sequential organisation of conversation started to work for her rather than against her. Insofar as she came to therapy in possession of a bona fide trauma, and she 'just could not sit there' in the face of the feelings accompanying it, she had a superb psychological reason/justification for leaving. Since patients were not directly faulted for breaking rules and there was no obvious way to translate this action into a personal/psychological fault, she was protected from any obvious, heavy lines of criticism. There were also interactional considerations that insulated her against the direct charge of 'topic changer.'

Sequentially, her action worked like questions such as, 'Guess what?' It created an open ended puzzle, getting others to ask an open ended question to which the answer is what you want to say. This is why children, who also have restricted rights to talk, use such questions 'on' adults to bring up their topics (Speier, 1973: 148 – 149). However, leaving had the additional advantage that it was not (yet) an utterance and thus not a standard move in the conversational 'game.' It did not visibly start a new conversational sequence or interrupt an old one, in the same way as an utterance might. Their question to her, on the other hand, *was* a remark and did start a new topical sequence. Within this sequence, she was placed in second speaker position, answering this question. She was therefore not visible as someone who changed the topic, at the point the topic was actually changed.

The sequential properties of this procedure did not go unnoticed by the others present. Having seen it done once, it was not long until others with 'important' things to say, who were having difficulty getting the floor, started to walk out as well. With

enough cases of walking out, retrieval and subsequent explanation (and there were enough cases) this action came to be a standardised event.

As one of my colleagues pointed out, these events can be considered as a successful patient revolt against the structures imposed on them by therapist and/or institution.[3] They found themselves with topical needs which, intuitively, should have been addressed as part of psychotherapy. Within the structures they learned, there was no way to articulate or defend these needs. But when an interactional road opened up which accommodated these needs, it was travelled forcefully and happily.

Walking Out

Walking out thus came to be interpreted as a walking out 'about' something—that something being some unknown trouble possessed by the walker. However, this trouble had its own history, starting out as a trouble-in-hand possessed prior to, and independent of, the session, and progressing to things which would actually happen in the session itself which bothered, irritated or depressed a given patient. The point at which one left was seen as arbitrary, in that immediately prior events were not seen as causing it or intrinsically related to it. This aspect of its meaning turned out to be both valuable to patients and, in a sense, a carry over from the walking out done by the incompetents. In contrast to a verbal complaint about a remark that irritated or offended, there was no pressing need to walk out about something immediately. There were thus all kinds of sequential, strategic and psychological differences and advantages to the leaving response as compared to ordinary verbal ones.

What would happen, however, if someone left the room immediately after an event occurred which clearly provided that person with a trouble? Such an event is supplied by, for example, an insulting remark directed to this person by another patient. In this context, this person would undoubtedly be seen as *walking out about that*. Evidence for this contention was provided by what actually occurred in such situations. The prior utterance and its speaker were marked off as the action's target. When the exitee was retrieved, it was the just prior speaker who talked next, saying such things as 'What's wrong?'

Leaving-the-Room as a Nonverbal Turn at Talk

In this context, leaving the room becomes a standardised action that acquires many of the characteristics of verbal utterances. Its point of initiation is no longer arbitrary. It is executed at the completion point of a prior utterance—at the same point where a next remark would have been started. It is often done by just that person who would have uttered the next remark, had a verbal reply been forthcoming. It is not merely a 'next' thing done, but is fitted to the prior utterance as a response, and is intersubjectively seen as such. In fact, it acquires a categorical meaning which depends on the meaning of the prior utterance and its placement with respect to it. The prior utterance, in its turn, has its meaning reflexively highlighted or altered by this kind of response. For instance, it was not always obvious that a remark said some negative thing about, or did something to, another person—until that person walked out after it was said. Finally, if we think of the work of retrieving the exitee as something akin to a side sequence (Jefferson, 1972), then walking out performs a standard conversational function of single utterances: it selects the next speaker. In

[3] My thanks to Jay Meehan of Boston University for this interpretation of the patient's actions.

particular, it selects prior speaker as next speaker, preserving a prevalent type of conversational turn taking order (Sacks *et al*, 1974: 17).

An important question now presents itself. Once created, our social action has taken on a life of its own and detached itself from the original need that created it. For it was this third version of leaving-the-room that stabilised in the group, gathering social norms about it so as to become a 'sequential structure' in most sense of the term, as used in conversational analysis. Why was this distinction bestowed upon the third, rather than the first or second version, and why were there not fourth or fifth ways to leave the room showing up in future sessions?

I have nothing resembling an empirically based answer, but I do have a speculation. The issue may involve how this action is sequentially organised. By 'sequential organisation' I refer to such matters as the connection between this action and prior events, the nature of this connection, how prior events and such connections determine when the action is done, what should be done next and who should do it so as to achieve sensible continuities between the action, what happens after it, and what went before. What, then, is required for a new action to become part of an already existing normative, social activity? It may be that information about its sequential organisation must be readily available to the general public (*i.e. bona fide* participants of the activity). There may well be phenomena such as emotion which, if not interfered with by culture, would have intensities, colours, timing, durations, and relationships to worldly events which are understandable to the individual actor, but systematically indecipherable to those who do not know the individual. If so, the fact that emotional expression seems subject to almost universal, normative, cultural control is explained by my postulated condition (Tomkins, 1962). For uncultured emotional expressiveness would have a sequential structure which was subversive to interaction. It would always function somewhat like a crying baby in the middle of adult conversation. It is not merely that the occurrence of such an event is determined by individual, rather than group dynamics. These individual dynamics—the information that would answer 'Why that now?'—are not readily available to others. Such an action becomes difficult to make part of 'what we have been doing with each other' and is much more likely to routinely subvert it.

Summary: A Theory of Precarious Functionalism

In the previous analysis of a social action in transit, patients were seen as having to sustain two normative orders simultaneously, one associated with ordinary, informal conversation and the other associated with therapy, respectively. Different systems of relevance and background assumptions within these two orders created conflicts between social requirements and individual needs. These were not individual needs in the usual sense understood by micro-sociologists, *i.e.* phenomena which get labelled, orientated to, recognised or treated as such during interaction. They were psychologically felt constellations of feeling, purpose and thinking—existing within the individual—which could be silently harboured, whether or not they found their way into an interaction or conversation.

In thinking about the interactional fate of such needs I employ a perspective which I have come to think of as 'precarious functionalism.' For they are needs which I postulate as establishing inarticulated lines of interactional direction. If a direction opens up which promises to meet such a need, and the individual recognises this

direction as such, (s)he will follow it. However, there is no guarantee that such a direction will arise, or that it will be directed when it does. All of this depends on group dynamics. Finally, once travelled, the chances of such a road becoming a 'standard route' depends not only on the places it takes an individual, but on if and how it fits together with already standardised modes of interactional travel.

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