CONVERSATIONAL RESOURCES OF TWO-PERSON PSYCHOTHERAPY

by

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ABSTRACT

The research reported here takes as its data tape-recordings and transcripts of a number of two-person psychiatric interviews, , conducted by two psychiatrists with a number of patients of both sexes. The transcripts are analysed by reference to speech acts as units, and the emphasis is on properties common to all speech in natural language. An attempt is made to show (a) that by reference to such unit acts, psychiatric events can be made intelligible, and (b) that an analysis along these lines is in principle capable of "explaining" the interactional mechanisms of the psychiatric interview, without recourse to psychiatric theory as part of the analytic apparatus.

Among issues given special attention are (1) the opening of the psychiatric interview and its consequentiality for further developments, (2) the negotiated character of topics and the availability of interactional devices for controlling topical development, and (3) the accomplishment of "treatment" through "talk".

Findings are reported with respect to each of these issues, but the report should be read chiefly as an exercise in the application of a method of socio-linguistic analysis to a type of data usually reserved for substantive treatment in the area of social psychiatry.

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I would like to take this opportunity to thank Roy Turner for introducing me to this method of investigation and for providing me with helpful criticism during the research and writing of this report.

In addition I would like to thank the doctors and patients who provided the data for this thesis. In order to maintain their anonymity all names and places have been changed.

CHAPTER I

INTRODUCTION

The data presented in this thesis comes from tape recorded psychiatric interviews. Tape recordings were obtained from psychiatrists who recorded their interviews with the patient's consent.[1] Once the tape recordings were in the possession of the researcher a transcript of each interview was made.[2] The transcripts constitute as near a verbatim account of what was said as is technically possible to produce, i.e. no paraphrasing of the talk took place, nor were any coding procedures used to construct the transcript. To quote Speier, "There is an object analysts construct called a transcript. It is a written record of some conversational encounter that is produced from a tape of the event."[3] Such transcripts constitute the body of data used.

Now it is a major contention of this thesis that by studying such transcripts of the "natural interaction", i.e. the talk that took place during some conversational encounter, that as analysts it is possible to learn something about the social organization of such settings and encounters. Furthermore by studying such pieces of "natural interaction" it is possible to discover some general and invariant features of the conversational resources members use when talking to one another. Let me elaborate.

I have emphasized the point of the data being the "natural interaction" between the participants rather than some transformation of that data, e.g. content analysis. Recent developments in philosophy, particularly that branch known as ordinary language philosophy,[4] have been concerned with the structure of natural language and the "speech-acts" produced by the participants. Consider the following remark by Searle:

> In a typical speech situation involving a speaker, a hearer, and an utterance by the speaker, there are many kinds of acts associated with the speaker's utterance. The speaker will characteristically have moved his jaw and tongue and made noises. In addition, he will characteristically have performed some acts within the class which included informing or irritating or boring his hearers; he will further characteristically have performed acts within the class which include referring to Kennedy or Krushchev or the North Pole; and he will also have performed acts within the class which included making statements, asking questions, issuing commands, giving reports, greeting and warning. The members of this last class are what Austin called illocutionary acts and it is with this class that I shall be concerned in this paper, so the paper might have been called "What is an Illocutionary Act?" (Emphasis mine)[5]

With respect to the study of interaction some sociologists have found it desirable to adopt the philosophers' concept of the performative character of language.[6] That is, members of the society accomplish certain activities through talk and that as analysts much can be learned by treating the talk produced by members of the society as members' methods, i.e. methods-in-use for accomplishing certain interactional activities.[7] This concern

by sociologists with speech and the methods members of the society use when talking to one another is nicely stated by Speier:

> Unlike past researchers who have only noticed in passing the most general significance of language (as in symbolic interactionism) this new direction in studying speech as the living performance of language has emphasized the methods participants use when building talk and practical activity around each other. By methods is meant what others in this volume have often alluded to as the procedural basis for everyday interactions, or as Turner puts it, our enterprise consists of "the uncovering of members' procedures for doing activities", talking, or "doing things with words" being a major component of those activities. (Emphasis in the original).[8]

The analytical utility of talk, i.e. the "natural interaction" that takes place between participants, as primary data for the study of the social organization of settings and encounters, cannot be overemphasized. What in effect is being advocated is a revolutionary[9] idea concerning the nature of sociology. Consider the following statement by Turner:

> It is increasingly recognised as an issue for sociology that the equipment which enables the "ordinary" member of the society to make his daily way through the world is the equipment available for those who would wish to do a "science" of that world....A science of society that fails to treat speech as both topic and resource is doomed to failure. And yet, although speech informs the daily world and is the sociologist's basic resource, its properties continue by and large to go unexamined. Linguistic models have had some recent influence on the development of sociolinguistics, but it is still not at all clear that any specifically linguistic properties of talk can be related to central sociological concerns. If we take sociology to be, in effect, "a natural history of the social world", then sociologists are committed to a study of the activities such a world provides for, and the methodical achievement of those activities by socialized members. (Emphasis in the original).[10]

This thesis is a study of the conversational resources employed by the members of a particular setting (the psychiatric interview) as a way of organizing that setting. It is advocated that:

> In exactly the ways that a setting is organized, it consists of members' methods for making evident that setting's ways as clear, coherent, planful, consistent, chosen, knowable, uniform, reproduceable connections, i.e. rational connections. In exactly the way that persons are members to organized affairs, they are engaged in serious and practical work of detecting, demonstrating, and persuading through displays in the ordinary occasions of their interactions the appearance of consistent, coherent, clear, chosen, planful arrangement. In exactly the ways in which a setting is organized, it consists of methods whereby its members are provided with accounts of the setting as countable, storyable, proverbial, comparable, picturable, representable -- i.e., accountable events.[11]

By studying such conversational resources it is hoped to learn something about the social organization of the psychiatric interview and furthermore that such an analysis may yield findings that are generalizable to interactional exchanges between participants regardless of the setting being one of a psychiatric interview.

While I have attempted to provide the reader with some background information concerning the perspective of this thesis I admit that this attempt has been brief. The most important point I feel is to present the analysis and in this context I share Speier's views as expressed in a passage introductory to his analysis of children's talk:

> No attempt will be made to justify the topic of inquiry as an elaboration upon current sociological fact and theories. It does not seem to be a case of elaborating current facts and theories. Nor will any attempt be made to supply the reader with materials that could be organized into intellectual antecedents to the topic. The reader is advised to consult the available works in structural linguistics, psycholinguistics, transformational grammar, anthropological linguistics, componential analysis, socio-linguistics, and philosophy of language and ordinary language. While such materials offer suggestive clues to the sorts of problems encountered in investigating talk they are entirely dispensable to a preliminary consideration such as this....It is assumed an unquestionable and unassailable fact of social life that talk exists. Given the fact the next step is to directly confront the phenomenon in whatever form it can be taken as empirical data.[12]

In short the conversational analyst is presented with the following dilemma: either to attempt to provide a lengthy and elaborated set of arguments, justifying the analysis to those to whom it is unfamiliar; or to plunge directly into the empirical work itself. While my preference is for the latter, in these few pages I have tried to meet a minimal obligation to the reader who is assumed to be already interested in work of this character. Any other working assumption would have required a "theoretical" monograph rather than a preface to an empirical investigation.

FOOTNOTES

1. To those who would offer as an argument that by the psychiatrist taping the interview an "artificial" situation has been created I suggest a reference to Roy Turner, "The Ethnography of Experiment", The American Behavioral Scientist, April 1967.

2. For a discussion of the construction of a transcript and the complexities involved see Matthew Speier, "Procedures for Speaking and Hearing: The Interactional Display of Social Organization" in David Sudnow (ed.), Papers in Interaction (forthcoming).

3. Ibid.

4. For works representative of those philosophers engaged in ordinary language philosophy the reader should consult Anthony Flew (ed.), Logic and Language, Oxford, Basil Blackwell, 1966.

5. John Searle, "What is a Speech Act?" in Philosophy in America by Max Black (ed.), George Allen and Unwin Ltd., London, p. 230.

6. I am particularly thinking of the recent works by Matthew Speier, Roy Turner, and the study of conversation by Harvey Sacks.

7. For a discussion of members' methods see Harold Garfinkel, Studies in Ethnomethodology, Prentice-Hall, Englewood Cliffs, New Jersey, 1967. In the area of childhood "socialization" see Matthew Speier, "The Organization of Talk and Socialization Practices in Family Household Interaction", unpublished Ph.D. dissertation, University of California, Berkeley, 1969. Chapters 4 and 5 aptly demonstrate members' methods (in this case children's methods) for accomplishing interactional activities.

8. Matthew Speier, "The Everyday World of the Child", prepared for Jack Douglas (ed.), Understanding Everyday Life, Aldine Press, 1970.

9. What is meant by a "revolutionary idea" in the development of a science is aptly discussed by Thomas S. Kuhn in The Structure of Scientific Revolutions. University of Chicago Press, Chicago, 1962.

10. Roy Turner, "Words, Utterances and Activities" prepared for Jack Douglas (ed.), Understanding Everyday Life, Aldine Press, 1970.

11. Harold Garfinkel, Studies in Ethnomethodology. Prentice Hall, Engelwood Cliffs, New Jersey, 1967, p. 34.

12. Matthew Speier, "Some Conversational Sequencing Problems for Interactional Analysis: Findings on the Child's Methods for Opening and Carrying on Conversational Interaction." Paper presented at John Gumperz's Summer Workshop Group IV of "Language, Society, and The Child", University of California, Berkeley, Summer Quarter, June 19-September 7, 1968.

CHAPTER II

SPEECH AND PSYCHIATRIC PRACTICE

It is the purpose of this thesis to examine some features of the social organization of two-person psychiatric interviews. Unlike other works in this area, I will not be concerned with providing a psychiatric analysis of the interview nor will I be concerned with providing some explanatory scheme that will "instruct" therapists in the proper ways of conducting such interviews. I will deal with an analysis of the "natural" interaction, i.e. the talk that occurs during psychiatric interviews, with the hope of discovering some organizational features of such occasions.

Contrasting therapy situations with the prototype doctor-patient relationship, one of the features of such a relationship is that 'talk' facilitates or accompanies "treatment", but unlike therapy situations does not consitutute the treatment. Freud dealt with this when he stated:

> To all appearances nothing takes place between patient and psychiatrist except that they talk to each other. The psychiatrist does not take recourse to any instrument, nor does he write out prescriptions. If it can be arranged he will not even take the patient out of his usual surroundings or upset his daily routine in any way while treating him.[1]

Turner, in a recent paper on "Some Formal Properties of Therapy Talk" makes reference to a similar point:

> 'Talk' with the practitioner may be acceptable to the client as a necessary prelude for the institution of appropriate treatment routines. With respect to some domains of expertise, however, it seems to be the case that 'talk' is also the chief medium of help and not merely the prediagnostic work whereby the practitioner gathers the facts and symptoms.[2]

Much of the psychiatric literature is concerned with this basic feature of the psychiatric interview, i.e. that what occurs between patient and therapist is 'talk'. While I am not concerned with psychiatric theory, an examination of the way this 'talk' is characterized in the literature is useful for subsequent sections of this thesis.

In The First Five Minutes, the authors make an interesting comment concerning the special character of the talk that occurs in therapy situations.

> The patient cannot leave his problems at home, even if he wants to or thinks he has, since they are himself, or something about himself, and go where he goes. He may not be able to describe his problems very accurately (compare the engineer, who has a very precise terminology for what ails the bridge), but there is an excellent chance that sooner or later he will demonstrate them in the way he comports himself vis-à-vis the therapist. Similarly, the therapist cannot leave his instruments elsewhere, as a plumber can forget his tools or a family physician his black bag, since they reside within him. At the outset there is no simple dichotomy, as in the bridge conference, between some "primary concern" and the "incidental by-play"; the discovery of the basic trouble is part of the work to be done, and until it has been discovered nothing that transpires can safely be disregarded.[3]

Consider also the following statement by Sullivan:

> It simply means (referring to the participant character of the psychiatric interview), as I said earlier, that the psychiatrist listens to all statements with a certain critical interest, asking, "Could that mean anything except what first occurs to me?" He questions (at least to himself) much of what he hears, not on the assumption that the patient is a liar, or doesn't know how to express himself, or anything like that, but always with the simple query in mind, "Now could this mean something that would not immediately occur to me? Do I know what he means by that?"[4]

In terms of the talk which occurs between therapist and patient during the psychiatric interview and regardless of the psychiatric theory supported by the particular therapist, psychiatrists are entitled to treat talk generated by the patient as being "more than what is just said", i.e. as "demonstrating" the patient's problems. For example, consider the following remarks produced by a patient and the subsequent analysis of those remarks by competent clinicians:

> P8d I need to get away from them. (Referring to the patient's husband and children).
>
> P8e I can't stay closeted up in the house all the time.
>
> The phrase closet up is somewhat unusual. *Shut-up or *cooped up, or *closeted (without the up) would be commoner. We suspect that to be closeted is a natural idiom in P's more elevated vocabulary, in the meaning of confinement and constraint, physical and emotional; perhaps it is reinforced by memory or knowledge of confinement in a closet as a punishment in childhood. The

> addition of up might then be a blend with, say, *cooped up or might merely be an intensive (compare *used up, *drink one's milk all up, where up has no directional reference).
>
> At a deeper level, closet might conceivably be a symbol for the uterus, and up retain slight overtones of its primarily directional meaning. Also, in the light of earlier possibly anal references (P8a, relief duty), closeted might carry connotation of the water closet, and up may have associations with various extremely common expressions referring aggressively to the anus and to the insertion of various objects therein. P is complaining here of being too confined; we should perhaps think of earlier experiences in her life for which the bathroom was the secluded place for indulgence in assorted viceral pleasures which, in addition to pleasure, would have generated a certain amount of guilt and of desire to "escape" into the controlling context of being with other people.[5]

While the above analysis may represent a psychiatric account of the patient's remarks, to assume that such an account is a reflection of the way those remarks were actually 'heard' in the therapy situation is, I suggest, to make an error. The above analysis is a socially produced account of the patient's remarks, the production of which took place "outside" of the interview and perhaps hours, days, etc. after the interview, and not by the therapist conducting the interview. Such an account tells us very little about how the participants interacted within that situation, i.e. that therapists are entitled to make such an analysis does not tell us how they 'hear' such remarks by the patient as "demonstrating his problems". Furthermore to say that psychiatrists 'hear' or "listen to all statements with a certain critical interest", using some

psychiatric theory, seems to bypass the main issue of what constitutes psychiatric data for the therapist and how that data becomes recognized.

In considering the 'talk' that occurs in the psychiatric interview I am suggesting that whatever psychiatric theory a therapist subscribes to, such theory does not explicitly enable a therapist to recognize patients' remarks as psychiatric data nor does such a theory forecast what the therapist will or should say in terms of the on-going interaction between patient and therapist. I am not arguing that therapists do not treat patients' 'talk' from some psychiatric perspective, but only that such 'treatment' occurs after the therapist has recognized a piece of interaction as being data.

Data in psychiatric practice, I suggest, is gathered the same way other competent members of the society would 'hear' patients' remarks. Therapists use interactional skills which they share with other members, and which relate to everyday common-sense knowledge of the world, to gather their data. They recognize patients' remarks as <u>first</u> being, e.g., insults, questions, greetings, etc., and then engage in some transformational work on these everyday remarks to produce instances required by psychiatric theory or a set of psychiatric categories. For example, a patient "insults" the therapist by referring to him in a derogatory manner. The

therapist treats this "insult" in terms of some psychiatric perspective, e.g., reflecting the patient's problems with aggression. In order for this piece of interaction to be recognized the psychiatrist uses his everyday common-sense knowledge about the world, i.e. it is first 'heard' as an "insult" and then equated with a psychiatric category provided by a theory. Furthermore, such a psychiatric theory does not determine how the therapist will handle the patient interactionally, i.e. what the therapist will say to the patient. Data for psychiatrists consists of recognisable forms of natural language, or speech acts, and the way the benefits of his therapeutic skill are administered is similarly through forms of natural language.

In the remaining sections of this thesis I will be examining actual pieces of natural interaction that occurred during psychiatric interviews. While the data consists of the talk between patient and therapist it is important to remember that the analysis is predicated on being able to explicate the everyday common-sense features of the world and not some prior acceptance of a particular psychiatric theory. I am not concerned with providing clinical accounts of "what is happening" between patient and therapist (I take this to be the job of competent clinicians), but rather in providing an analysis of the interactional development of the interview. The concern is with the actual progress of the psychiatric interview as developing sequences of interaction.

FOOTNOTES

1. Merton Gill, Richard Newman, and Fredrick C. Redlich. The Initial Interview in Psychiatric Practice. International Universities Press Inc., New York, 1954, p. 24.

2. Roy Turner. "Some Formal Properties of Therapy Talk". Prepared for David Sudnow, (ed.), Papers in Interaction (forthcoming).

3. Robert E. Pittenger, Charles F. Hockett, and John J. Danehy. The First Five Minutes. Ithaca, New York: Paul Martineau, 1960, p. 2.

4. Harry Stack Sullivan. The Psychiatric Interview. W.W. Norton and Company, Inc., New York, 1954, p. 20.

5. Pittenger, Hockett, and Danehy. The First Five Minutes, p. 71A.

CHAPTER III

OPENING THE PSYCHIATRIC INTERVIEW

The data used in this chapter comes from the beginnings of psychiatric interviews. It is my purpose to examine how topics become interactionally constituted, i.e. what is interactionally required in order for an utterance to gain the status of being regarded as a topic for discussion. The importance of this issue for an analysis of psychiatric interviews lies in its relation to the problem of topic control, as I shall show.

That talk contributes to the social organization of settings and occasions is a major contention of this thesis. That social settings and occasions can provide for the accomplishment of certain activities and that such activities are accomplished via talk can pose problems with respect to topicality.[1]

It is possible to view settings as constraining topical talk. Thus when purchasing a newspaper talk usually concerns the buying of the newspaper and not, e.g., one's problems at home. Such a notion, however, can lead one to assume that the topics available to participants of certain settings can be listed, i.e. a list of topics that can occur in social situations could be produced. Such an assumption seems to be empirically false since I suggest it is a feature of daily life that while settings may

constrain topical talk it seems not possible to describe those constraints by way of producing a list of topics.

Despite this, however, there seems to be something intuitively correct in wishing to say that settings constrain topicality. For example, when entering a butcher shop one gets categorized as a "customer". In order for this category to be maintained one must engage in some talk about the buying of meat. This is not to say that many items will not be discussed but only that sometime during the interaction one must act like a customer. Thus while no list of the topics that would occur in, e.g., a butcher shop can be constructed, one of the constraining features of the setting is that once categorized as a customer one cannot engage in talk without the topic sometime being concerned with the purchase of meat. While certain settings and occasions provide for the accomplishment of "core activities" this is not to say that the talk that occurs in such settings must only be about the core activity, but only that such talk cannot be absent without some form of re-evaluation of the participants. That is, while talk contributes to the social organization of settings it can also contribute to the disruption of settings and one way of disruption is not to talk about the core activity the setting provides for. However, it is not only the case that core activities provide topics whose absence would be noticeable, but that whatever "side topics" get constructed must be placed, proportioned, etc., with

an orienation to the structure of the core activity, e.g., when purchased articles are being wrapped there may be a slot for small talk.

While therapy sessions are "methodically initiated encounters" (MIE)[2] and are often regulated by some system of appointments it seems to be the case that (1) talk is supposed to occur between patient and therapist, even when patients complain of having nothing to talk about, and (2) what can constitute a topic is something that is not necessarily pre-arranged between patient and therapist. Rather it seems to be the case that therapy sessions are settings in which although the participants encounter each other on a methodically initiated basis the setting is one in which the "core activity" is not obvious. While patients know that talk is supposed to occur they do not know what constitutes "therapy talk" in the same way they know, e.g., what constitutes butcher shop talk. Such a feature is not only applicable to therapy sessions but also to many sociable occasions, e.g., a cocktail party. (Although it is not being advocated that useable topics are interchangeable from setting to setting).

It seems to be empirically the case that therapy situations do not require their participants to speak on any specific topic.[3] As such, a variety of topics can be discussed during a psychiatric interview and furthermore any topic can be seen as

occasion relevant, i.e. used as the basis for a discussion between the therapist and patient. Given the empirical condition that the parameters of what can become a topic in the psychiatric interview are quite large, one of the interactional problems faced by the participants is how an utterance can gain the status of a topic. What we are dealing with then is the notion of <u>making a topic</u>, i.e. topics are interactionally negotiated between the participants.

I will now present data from psychiatric interviews, the analysis of which will hopefully allow the reader to follow how initiating a topic is interactionally accomplished.

1. T. (Come on in) [Therapist inviting patient into his office from waiting room.]

2. P. (It's getting cold) [Patient seems to be taking off coat; also, there is a pause] So how are you?

3. T. Okay. How about yourself?

4. P. I'm fine. Great.

5. T. What's so great?

6. P. Nothing. Just great. [pause] Nothing's great though, everything's the same. [pause] I'm feeling okay. I don't really have too much to talk about.

7. T. Well I haven't seen you since you telephoned to let me know that Clint had not passed.

8. P. Yeah.

9. T. What's been the repercussion from that?

10. P. For about two weeks he was very depressed...

I have presented this data to engage in an analysis of topic construction. Before analysing the data in terms of topic construction I would like to pursue a discussion of greeting exchanges. My reason for doing so is that such a diversion will clarify my discussion of topic construction. The reader should note, however, that the real issue under consideration is the negotiation of a topic between the participants.

I will be concerned with U's 2-5. One way of characterizing the specified exchange is to say that it is an exchange of greetings between a patient and a therapist. Harvey Sacks has done considerable work on greetings and has referred to "How are you?" as being a greeting substitute, and as such properly occurring at the beginning of conversation or at least following a pair of greetings.[4] Consider Sacks' examples:

1. a. How are you?
   b. Okay. How are you?
   a. Okay.

(end)

2. a. Hi
   b. Hi
   a. How are you?
   b. Fine. How are you?

Another property of the greeting substitute "How are you?" is that an exchange of such greetings between two people can constitute a "minimal proper conversation".[5] By this is meant that two

people can pass each other and only exchange "how are you" without feeling that something has been "left out" or "not done" in the conversation. It is not an uncommon experience to say "How are you?" to a person you know and for him not to say "How are you?" back, e.g., you pass a friend on the way to the library and say "How are you?" and he replies "fine" and continues on his way. I suggest that this is one way of forestalling a conversation from developing without being seen as rude, impolite, etc.[6]

To understand what is meant by "forestalling a conversation" one has to consider the complexity of the utterances involved and the particular nature of the encounter. "How are you?", although a greeting substitute is also a question, and one of the constraining properties of questions is that they usually receive answers. By saying "How are you?" in the above example the greeted person is interactionally bound to give an answer. To continue with the example, by the speaker just giving an answer in the affirmative "Fine" he has satisfied the questioner and may move quickly on his way since after all it was by accident that the encounter took place. If however, he replied with not only an answer but also "How are you?" he would be required to await an answer and thus increase the chance that a conversation might develop.

While it seems to be true that the exchange of "How are you?" can constitute a minimal proper conversation, a qualifier must

be added. It appears to be empirically the case that a negative answer to the question "How are you?" is an invitation for the asker of the question to undertake some investigative procedures to determine, e.g. what is wrong. Given these observations Sacks notes that it is often the case that members in order to forestall a conversation from developing about, e.g., why one is feeling miserable, etc., often answer the question "How are you?" in a positive manner.[7] Such an answer tends to close the greeting phase of a conversation and can either constitute a minimal proper conversation or allow the participants to proceed to a topic rather than make the negative answer to a greeting substitute the first topic for discussion.

A full grasp of the import of greeting exchanges for the analysis of topic negotiation requires us to address some explicit remarks to the categorial relationship between the questioner and questioned.[8] That is to say that members of the society have at their disposal various and hence competing ways of categorizing each other and that social situations provide for the employment of some categories and exclusion of others. Depending on the categorial identifications assigned and hence the relational claims between the participants it would appear, in our society at least, that there are some people entitled to know "how you are" and there are other people not entitled to know "how you are". To quote Sacks, "That is to say people belong to many categories. Some of them

provide that in general if you see this person you greet them and no more."[9] Etiquette manuals state this relationship between questioned and questioner rather nicely, and while not a sociological analysis should not be dismissed:

> The trait of character which more than any other produces good manners is tact. To one who is a chronic invalid or in great sorrow or anxiety, a gay-toned greeting: "Hello Mrs. Jones, how are you, you look fine!", while kindly meant is really tactless. Since to answer truthfully would make the situation emotional. In such a case she can only reply "Alright, thank you". She may be feeling that everything is all wrong but to 'let go' and tell the truth would open the floodgates disastrously. "Alright, thank you" is an impersonal, and therefore strong bulwark against further comment or explanation. As a matter of fact, "Alright, thank you" is always the correct and conventional answer to "How are you", unless there is some reason to believe that the person asking really wants to know the state of one's health.[10]

To further illustrate the importance of the relationship between questioned and questioner consider the following situation of hospital patients reported by David Sudnow:

> An additional way of describing the difference between doctor -- lay medical interaction and the special quasi-sociable character it takes here is by observing the use of ceremonial type exchanges. In the hallway of the hospital I observed doctors greet their patients with "How are you today Mrs. Smith?" to which frequently the return "fine thanks, doctor" was given, even when the patient was obviously not fine.
>
> The remark "How are you?" can be heard as a ceremonial piece, to which there is a proper ceremonial return and can be so treated. Or it can be heard "constructively", i.e. <u>how are you</u> today, as a question, an

> answer to which would entail enumeration, perhaps of one's feelings.[11]

Returning to our data from the psychiatric interview, the patient has offered the therapist a standard greeting, "So how are you?", and the therapist replies with what Sacks would call a ceremonial answer plus a ceremonial greeting in return. The patient does not inquire into what is "OK" with the therapist, but rather accepts the therapist's answer at "face value" so to speak. The therapist, however, does not treat the patient's ceremonial answer, "I'm fine. Great" in the same manner. The therapist in U5 requests the patient to provide an account of "What's so great?", i.e. he does not honor the patient's positive answer to his greeting as being "good enough".

Interactionally U5 accomplishes a redefinition of the initial greeting exchange. While in U3 the therapist asks the patient a ceremonial "How about yourself?", by so treating the patient's positive reply as the basis for further investigation I suggest the therapist has redefined his initial ceremonial greeting into a constructive, i.e. to be heard by the patient "constructively". Furthermore, I suggest that therapists have the option of treating patients' talk in such a manner and these entitlements are not symmetrical between patient and therapist. For the patient to perform the same operation on the therapist's utterance by saying, e.g., "I'm fine. Great. How come you're feeling Okay?" I suggest would be seen as being strange, odd, or inappropriate.

In addition to redefining a greeting substitute from a ceremonial to a constructive U5 is accomplishing other work interactionally. Consider for a moment the consequentiality of a negative answer to the therapist's question "How about yourself?".

Sacks has stated that if one answers with a negative term such as 'lousy' then the asker of the question is entitled to ask, e.g., "What's wrong?". Furthermore, a negative answer to the question "How are you?" not only allows the asker to inquire into one's personal state of health, but also provides a slot allowing the questioned party's personal state to become a topic for conversation. One way to get topical control of a conversation is to offer a negative answer to a greeting substitute. This not only allows (or requires) the asker to inquire into the reason for your "trouble" but also gives one the floor to explicate the reason for his feeling "lousy", "rotten", "terrible", etc. It is for this reason that our previous quotation from Emily Post lacks a certain qualification, i.e. that a person wishing to engage another in a conversation and "talk about one's problems" merely has to answer the question "How are you?" in the negative to provide the asker with a sanctionable requirement to make one's personal state a topic.

In the data U5 is treating the patient's ceremonial answer as a constructive in that it transforms what might have been the completion of a greeting sequence into a possible first topic.

However, that topics are negotiable is to be seen by U6 which while after all does recognize the constraint of U5, considered as a topical directive, nevertheless seems to insist upon the ceremonial character of U4 and to disallow what the therapist wishes to make of it as a first topic.

I speculate that one of the demand characteristics of psychotherapy is that therapists must generate talk on the part of their patients.[12] That is, while it is possible for the patient to remain silent such silences are not welcomed by the therapist. One of the problems of such encounters is what shall "get talked about" and this is something that gets negotiated interactionally as the interview progresses. U6 is problematic in that no topic as of yet has developed.

In U7 the therapist engages in the use of what I will call a "selection device". By this I mean that U7 can constitute a topic for discussion, i.e. it is relevant for this session. The patient has been having emotional problems with her boyfriend and recently phoned the therapist to inform him that her boyfriend had not passed his school exams (or at least during the telephone conversation such information became known to the therapist). By proposing this as a possible candidate for a topic its relevance is seen by the patient. Interactionally, however, the patient does not "pick up" on the therapist's utterance but merely confirms the

therapist's comment, U8 "Yeah". U9 is therefore very important in that it is a question less easily dismissed than U5 and is asking for specific information concerning a past occurrence that is relevant for the therapist and the patient. I suggest, however, that it is not until the patient treats the utterance as grounds for a discussion concerning the fate of her boyfriend that we can say a topic has been negotiated.

We have been concerned with how participants negotiate a topic. Consider the following data from another psychiatric interview.

1. T. So what's happened since I talked to you, yesterday?

2. P. Was it yesterday? It was on the phone yesterday. Well (( )) I went up to my brother's for dinner and I was tired I came home, washed, and went to bed. Got up this morning and went to work. [pause]

3. T. Uh, at the downtown store?

4. P. Yeah. That's where I came from just a few minutes ago.

5. T. Did anyone say anything to you about uh, giving up your other job.

6. P. No. A few did but I just steered it off. You know. I just said. Well anyway, I just said I wasn't feeling well or something and came back to Middle City. I don't go into all the details. I don't think that necessary.

Notice the generative character of U1, i.e. it is an utterance that generates talk on the part of the patient, and also constitutes a search for a topic by requiring the patient to provide an answer. I would like to offer for consideration that while many things may have happened to the patient since he called the therapist (and we do not know the specific reason for the call) the therapist does not expect the patient to come forth with a list of "everything" that has happened since the phone call. As in Sudnow's analysis, the question carries with it the assumption that the patient will see the parameters of the question, i.e. what has happened that is relevant for the therapy session.

The patient's answer in U2 comes close to being a list, but it is a special list comprising a set of what might be called "mundane activities". The consequentiality in terms of answering the therapist's first question might be summed up by saying "nothing much has happened". We are still faced with a problem in terms of the co-presence of the interactants. It seems to be a feature of psychiatric interviews that although nothing much may have happened since the last encounter with the therapist, the present session is not cancelled because "nothing has happened". This is what I have referred to as a demand characteristic of therapy.

The therapist must continue the interview and in so doing a topic on which to continue the interview must be negotiated

between the participants. The first problem is solved by U3 since by tying to the patient's previous utterance the conversation is interactionally sustained one more turn. I speculate that the therapist could have asked the patient, e.g., "How are things with you and your brother?" in which case the substantive character of the talk that followed would be different but its consequentiality the same as that produced by U3. Notice in U5 that out of all the possible items that could occur to the patient at work, the therapist selects an item relevant for the patient and the occasion, "Did anyone say anything to you about uh, giving up your other job?" The consequentiality of the utterance is that being a question it requires an answer, and once that answer is given allows the therapist to ask another question, thereby providing not only the interactional construction of the conversation but also for such talk to be seen as topical.

While what can constitute a topic in the opening of a psychiatric interview is something that has to be negotiated it should not be assumed that it is always the therapist who provides the proposed topic. Consider the following data:

1. T. How are you?
2. P. Hey, if I've got an hour, could I have a coffee? Please.
3. T. Hmhum.

4. S. What do you take in it. [U1-5 take place in the presence of the therapist's secretary (S)]

5. P. Three and milk. [pause]

6. T. [Patient and therapist are now in therapist's office] You got an hour's worth to talk about?

7. P. I don't know. It depends. [pause] You're never there when I really need you.

8. T. What did you need me for?

9. P. Oh (I wanted to see) Jesus [patient attempting to light a cigarette] Ray and I have some pretty bad fights some times. Where I want to walk out and never come back...

The analysis of the above will be restricted to U's 6-8. Similar to a previous example in which the therapist treated a patient's answer to a greeting exchange as the basis of inquiry, U6 makes reference to the patient's earlier utterance as the basis on which to start inquiry for this session. U6 seems to be a "topic searching device" in that while it does not provide a topic it somehow places a certain constraint on the patient's talk that follows, i.e. it generates talk on the part of the patient, talk which might allow for a topic to become negotiated.

While I have suggested that therapists are entitled to treat patients' talk in such a manner, to assume that patients must always address such questions is misleading. In U7, while answering the therapist's question the patient does not take the therapist's utterance much further, i.e. she does not interactionally

make much of the question: "I don't know. It depends". Instead, the patient proposes a very interesting statement, "You're never there when I really need you."

The last portion of U7 presents a problem in that one way of handling this comment by the patient is to suggest that patients "need" their therapist since they are unable to successfully conduct their everyday affairs. Patients "need" assistance since they are "sick". Another possible contention is that there exists some relationship between the patient and the therapist such that the claim "You're never there when I really need you" would be a legitimate one, the speech-act character of which would be open to analysis.

I suggest that there are some relationships, e.g., husband-wife, such that the members can have certain claims on each other. In such a case the proposition of "You're never there when I really need you" carries with it an evaluative 'should' be there by virtue of your/our relationship. Is there any reason to expect that the therapist would be "there" or should be "there" just because the patient felt a "need" for his presence, i.e. would one think that the therapist is sanctionable for not being there?

Rather than examine U7 in terms of some pathology of the patient or some system of "obligatory rights" between the patient

and the therapist, the question of interest is what is happening interactionally. Consider for a moment a hypothetical situation between two members where member A says "you should have been at the party, (at work, home, etc.) today." Member A is accomplishing several things interactionally. First he is suggesting to member B that "something happened", e.g. at work, at the party, etc., that he is aware of, and that member B would also like to know. Second, by saying that "you should have been there", member A is inviting member B to inquire 'why' he should have been there. This allows member A to tell his story and thereby to select what will be the first topic of the conversation.

In our data "You're never there when I really need you" is an invitational device that we might think of as achieving the strategy of preparing the hearer for talk by getting the hearer to ask the 'why' of the speaker's remark. Interactionally this is what happens in U9 when the therapist asks "What did you need me for?" The patient is now in a position of being able to "present her case", i.e. provide the first topic for discussion in the interview.

This chapter has attempted to examine a common place occurrence: the development of a topic in a conversation between two participants. Such topic development need not be a problem for the participants but by treating the notion of topic construction as "problematic" I have attempted to explicate what is interactionally required for a topic to occur in a conversation.

It has been suggested that a therapist is always able to treat patients' talk as the basis on which to conduct further inquiry, i.e. as "occasion relevant". While the encounter between patient and therapist is methodically generated the participants need not have a pre-arranged agenda of topics for discussion. Indeed it has been a major contention of this chapter that the participants jointly arrive at a topic, i.e. topics are interactionally constructed between the participants. What can be discussed during a psychiatric interview, however, is not something that can be delimited by attempting to provide a list of topics suitable for psychotherapy. Rather it is important to remember the categorial identifications of the participants and to realize that those items mentioned by the patient are heard by the therapist as occurring in utterances produced by a patient and hence as relevant for the occasion of the psychiatric interview. It is for this reason that I suggest that the topics discussed during a psychiatric interview can vary from, e.g., talk about meeting people on the elevator to the patient's family problems. The point being made is that if the therapist is able to treat a comment by the patient as the basis for further psychiatric investigation he will do so.

Through an examination of greeting exchanges it was shown that therapists are able to give non-ceremonial treatment to the ceremonial utterances of the patient. Therapists, then, have at

their disposal the interactional technique of "undercutting" the normative practices of ordinary conversation, e.g., they can question the ceremonial return of a greeting.

In addition to the above a more general feature of topicality was discovered. One way of gaining control of a conversation and being able to introduce the first topic is to answer a greeting substitute with a negative term such as, e.g., "lousy", "terrible", etc. Such an answer tends to invite questions concerning one's personal state and thereby allow one the first slot in the conversation for the initiation of a topic. Finally it has been shown that members have at their disposal a variety of interactional techniques such as "topic searchers", "selection devices" and "invitation devices" whereby the negotiation of a topic is interactionally accomplished.

FOOTNOTES

1. I would like to thank Dr. Roy Turner and Dr. Matthew Speier for their comments regarding topicality and topical constraints. Whatever faults occur in the subsequent analysis naturally are mine.

2. Emanuel A. Schegloff. "Sequencing In Conversational Openings". American Anthropologist, Vol. 70, No. 6, December, 1968.

3. Contrast this with such encounters as, e.g., if a student should call his professor with whom he is currently engaged in a student-professor relationship then the onus will be on the student to do some legitimating work if the call cannot be seen as generated by that relationship. Also consider the psychiatric literature dealing with "free association" and the fact that therapists often tell their patients that they can say "whatever comes to mind".

4. Harvey Sacks. Unpublished lectures. Lecture 8, April 21, 1967, Spring Quarter, U.C.L.A.

5. Harvey Sacks, unpublished lectures.

6. An exchange of greetings can constitute a minimal proper conversation. Using this feature of interaction it is possible for members to exchange greetings and no more, and that such an exchange need not be seen as improper, inappropriate, etc. Because such an exchange of greetings constitutes a minimal proper conversation members can get off the "hook" of further talk quite easily and properly by such a return. This is not to say that such an exchange of greetings always forestalls further topical talk between the participants but only that it is available for such use.

7. Harvey Sacks, unpublished lectures.

8. For a detailed discussion of the devices that members have available to assign categorial identifications to one another the reader should consult Harvey Sacks, "The Search for Help", unpublished Ph.D. dissertation, Department of Sociology, University of California, Berkeley, 1966.

9. Harvey Sacks, Lecture 9, April 24, Spring Quarter, 1967, U.C.L.A.

10. Although incorporated in Sacks' analysis the quotation comes from Emily Post. Etiquette, 1955, pp. 16-17.

11. David Sudnow. Passing On: The Social Organization of Dying. Prentice-Hall, Englewood Cliffs, New Jersey, p. 151.

12. By "demand characteristics" I follow Turner's formulation of "those situational and contextual features which persons engaged in everyday routines orient to as governing and organizing their activities..." See Roy Turner, "Occupational Routines: Some Demand Characteristics of Police Work", paper presented to the C.S.A.A., Toronto, June, 1969. See also Egon Bittner, "The Police on Skid Row: A Study of Peace Keeping", American Sociological Review, Vol. 32, No. 5, October, 1967, pp. 699-715; and Martin T. Orne's paper "On the Social Psychology of the Psychological Experiment", American Psychologist, November, 1962, pp. 776-783.

CHAPTER IV

CONTINUITY OVER CONVERSATIONAL ENCOUNTERS: PERSONAL BIOGRAPHY AND MEDICAL HISTORY

In this chapter I will introduce some of the ideas and concepts previously discussed with respect to topicality. While this chapter may appear to be restating earlier arguments I suggest their development will lead us to a set of new issues. For the moment we will be concerned with the following pieces of interaction from two different psychiatric interviews:

1. T. So what's happened since I talked to you yesterday.

2. P. Was it yesterday? It was on the phone yesterday. Well I went up to my brother's for dinner and I was tired. I came home, washed, and went to bed. Got up this morning and went to work.

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13. T. What else has happened that's been eventful?

14. P. Nothing too much. I'm certainly getting an interesting look at all the people in the office...

We may say that the above exchanges are the result of what Schegloff has called "methodically initiated encounters" (MIE).[1] Persons in need of psychiatric help seek out those persons so qualified to offer such help, i.e. the encounter is not one resulting from chance. This seems like a fairly obvious and trite bit of

information, but perhaps may give us some insight into the social organization of psychotherapy.

Turner in a recent paper dealing with group therapy discusses the omni-relevance of the question "Why are you/we here?", i.e. it is a question that can always be asked by the group members.[2] I would like to suggest that the question "Why are you/we here?" is not only an omni-relevant question for group psychotherapy but also a question which for many social situations is self evident and need not be asked. By this I mean that the relevance for your being 'here' is implicitly implied in the context of the interaction. Turner discusses this in terms of "transaction bound talk":

> In establishments the initiation of stretches of talk is frequently accomplished by, e.g., a sales person approaching any member of the public and asking, e.g., "May I help you?" But of course by so stating it, I have already presupposed a feature of the social organization that in fact is equally a matter for analysis, namely the categorial identification of a person as one credentialed by the establishment to handle its business with prospective customers (I owe this notion of credentialing to Harvey Sacks). Similarly, the formulaic utterances produced on such occasions do the work of providing that the addressed member of the public is or is to be treated as a "customer" and not, e.g., as one who has entered to escape the rain or to shoplift. (Emphasis mine).[3]

The consequentiality of the above fact for the interaction is that often both parties are aware of the parameters of the 'talk' that will occur and the 'topics' available for discussion.

The encounter between patient and therapist is not only "methodically initiated" but it would seem that there would not be an "information gap" as reported by Schegloff with respect to telephone conversations.[4] In some sense less work has to be done to discover why the encounter was initiated. Consider the following statement by Sullivan:

> In finding out in what areas the interviewee has trouble in functioning the interviewer would do well to remember that no matter how vastly superior a person may be, there is enough in the culture to justify his having some trouble. I have rarely experienced the embarrassment, or the privilege, of being consulted by a person who had no troubles, and I may say that when this did appear to be the case it rapidly proved to be an artifact. Thus we may safely assume that everybody has some trouble in living; I think this is ordained by our social order itself that none of us can find or maintain a way of life with perfect contentment, proper self respect and so on.[5]

From the above it appears that members once categorized as 'patients' are seen as having some 'problems' regardless of the specific nature of such problems, i.e., patients come to the therapist to talk about their problems. Unlike other social situations, e.g., sales person-customer, where the parameters of 'talk' are often known by the participants, therapy sessions, even though prearranged and often scheduled on an appointment basis, do not provide the participants with any agenda of "what will be discussed today."

In our data, U's 1 and 13, we may common-sensically say that therapists are concerned with what has occurred or happened to their patients since the last session. The therapist and patient are acquaintances and U's 1 and 13 seem to be questions relating to events that occurred since the last encounter. Thus, some 'resuming behavior' is appropriate or allowed to take place between the participants.[6] I speculate, however, that the resuming that occurs in psychiatric sessions is rather one-sided, i.e. entitlements with respect to inquiring into "what has happened since the last session" are not symmetrical between therapist and patient. As stated by Turner:

> The situation rapidly becomes more complex, however, when we recognize that such matters as the duration and occasion of the absence are germane to how persons ought to 'resume' and the informational rights with respect to sharing news of 'what has happened' in the interim -- however brief -- however long -- are apparently observed.[7]

The 'resuming' that takes place in psychiatric interviews is more than merely an asymmetrical sharing of news, but it is precisely this sharing of news that constitutes a large proportion of the 'talk' that occurs during the interview. Furthermore, while the therapist may be concerned with "what has happened" since the last encounter with the patient, such a concern can be contrasted with that of, e.g., a medical physician.

A general practitioner may very well be concerned with "what has happened" to his patient since their last encounter, but the parameters of what can constitute an appropriate answer to such a question usually refer to the patient's illness and not to his thoughts, feelings, dreams or personal problems. The psychiatric interview appears to be quite different in that (1) there is little continuity between sessions, i.e. therapists do not usually "pick up" where the last session "left off" and (2) because of this what will be discussed between therapist and patient is something that has to be negotiated between them.

The important point to note is that talk between participants who have not seen each other constitutes what has been referred to as "resuming behavior". For the psychiatric interview, however, the "resuming behavior" exhibited by the participants is of a rather special character. The interactional consequences of such talk not only reaffirm 'relationship claims' but also generate talk on the part of the patient which in turn allows the negotiation of a topic to occur. The rather asymmetrical character of the "resuming talk" between therapist and patient is especially important since when a topic does emerge such topical talk concerns the affairs of the patient. For example, if a patient should inquire into the affairs of the therapist such talk can be treated by the therapist not as a question to be answered but as the grounds for inquiring, e.g., why the patient wants to know about his life. The asymmetrical

sharing of news allows the therapist to treat patients' "curiosity" as the basis of discussion and such discussion revolves around the patient and not, e.g., what has been happening with the therapist since the last encounter.

The therapist is not just concerned with what has happened to his patient in the interval between sessions, in the same way that two friends might be concerned with what has occurred to each other since their last encounter, but is rather concerned with generating talk and conducting the psychiatric interview. Talk is necessary between the therapist and patient. "Resuming talk" tends to generate talk between patient and therapist and often allows for the negotiation of a topic to occur.

During the course of a psychiatric interview patients often share news about persons and events in their lives. The therapist is often "brought up to date" with the affairs of his patient. Consider the following data:

1. "Jennifer's got a boyfriend."
2. "I got a letter from Bob yesterday, Jones."
3. "Clive's awful crabby."
4. "Oh I saw Harry and Arnold up there. Just briefly said Hi. I see Arnold at school all the time."

The patient shares his biography with the therapist. To use a phrase from Schutz,[8] therapist and patient "grow old together". For the therapist, however, the patient's personal biography also constitutes his "medical history" and by inquiring into what has happened since their last encounter the therapist is also gathering data from which to do his work.

That patients have histories and therapists are 'knowledgeable' or at least in the process of becoming 'knowledgeable' of their patients' history allows us to speculate on the consequentiality of this feature for the therapy situation. As a way to "cut into" this area I would like to consider the following exchange between two friends:

A. I got a letter from Bob.

B. Bob who?

I speculate that speaker A assumed that speaker B would see the relevance of his utterance, i.e. while only providing a first name it was assumed that speaker B would be able to engage in some selection procedure whereby 'Bob' would be transformed into, e.g., 'Bob Smith'. It appears that while A assumes B knows 'Bob' and that receiving a letter from 'Bob' is an announceable event to B, speaker B does not know 'Bob' or at least he is uncertain as between alternatives. Speaker B's reply, "Bob who?", allows

speaker A to re-evaluate his appraisal of B's knowledge of his activities, friends, relationships, etc. Speaker A is entitled to make some inference concerning speaker B.

With the above comments in mind let us now examine some data which occurs in psychotherapy.

50. P. It was really cute. I think my taste in men is improving. So uh I got a letter from Bob yesterday, Jones.

51. T. Oh yeah.

I wish to examine the last part of U50, "So uh I got a letter from Bob yesterday, Jones"(emphasis mine). A noticeable feature of the utterance is that it does not contain a categorial identifier but only a first name (FN) and a last name (LN) and that the FN is not immediately followed by the LN. As naive readers of the data we have very little idea of who the patient is referring to, e.g., he may be a boyfriend, lover, employer, ex-husband, etc. Furthermore, although the therapist might be aware of the categorial relationship of 'Bob Jones' to the patient there is no reason for us to immediately assume that this is the case.

What we are dealing with is "reference to third parties". I suggest it is often the case that when people refer to persons for the first time that not only is a name provided but also some category term, e.g., "My roommate Jennifer". Naturally there are

times when the category term is not used but is implicitly implied by other circumstances. For example, saying "Julie and I went to the show last night" to a person who knows you are married but has not met your wife allows the warrantable inference that "Julie" is your wife. Also a name plus some category term may be used at times other than the first mentioned, e.g., when it is assumed that the person addressed will not remember.

In our data, I assume that 'Bob Jones' has been previously mentioned in an earlier session. If this was the first time such a person was mentioned, I speculate that the therapist's following utterance would not attend to the patient's remark. The therapist would be entitled to inquire "Who is Bob Jones?" Thus the data seems to indicate that the therapist recognizes the significance of the patient's remark by way of a name recognition.

Prior to the last part of U50, "I got a letter from Bob yesterday, Jones" the patient has been discussing a person she met while at work. One noticeable consequence of this last utterance is that it introduces a new topic and I plan to discuss the issue of 'topic changers' at a later date. The interesting feature of the construction of the patient's utterance is that she "tacks on" the person's LN. While I assume the patient expects the therapist to see the relevance of her utterance, i.e. know who "Bob Jones" is and assign a categorial identification to him, she is also attending

to a normal feature of interactions, namely people can forget. I suggest that the patient in adding the person's LN is attempting to provide sufficient information for the therapist to see the relevance of her remark. The patient is methodically assessing the interactional situation of her fellow interlocutor and is providing what she assumes is adequate information for him to supply the necessary categorial identifier to the person being discussed. This I suggest is a common feature of conversation where speaker A mentions another person to speaker B by using only a FN and then adds the person's LN to enable speaker B to perform the necessary reference work.

An interesting question that might now be raised is given the fact that therapists are expected to remember each patient's history and that an individual therapist might be seeing several patients who each have a whole set and cast of characters, how does the therapist manage? One possible answer is that a therapist possesses a fantastic memory. I suggest, however, that it might very well be the case that therapists forget names and relationships of persons mentioned by their patients during the psychiatric interview, but rely on certain interactional conventions to "pull them through" so to speak.

I presume it is not an uncommon practice for clinicians to engage in some categorization of their patients, e.g., having

problems with men, unable to adjust to work, domestic problems, etc. Given this categorization process such problems often allow for appropriate slots to be filled by persons mentioned during the psychiatric interview even if the therapist should "forget" the person mentioned. For example, by knowing that a patient is a single male and is having difficulties with female relationships any reference to a female such as, e.g., "Susan really gave me a bad time last night" can allow the therapist to infer that "Susan" is a girlfriend even though the patient may have mentioned "Susan" at an earlier session and the therapist has forgotten. Furthermore I suggest that such an inference is not made using any special knowledge obtained through psychiatric training but is made using the same conventions that you or I would use. That is, I assume we could also infer that she was a girlfriend of the patient.

A related issue is that often patients will make third person references in relation to some category bound activity, e.g., "I was typing at work when Mr. Smith started bugging me again". Again, "Mr. Smith" has been mentioned in a previous session by the patient, but it is possible that the psychiatrist has forgotten who Mr. Smith is. By virtue of the utterance, however, I suggest it is possible to make the inference that Mr. Smith is the patient's employer, supervisor, etc. The point to notice is that certain activities allow for the appropriate categorial identifications to be assigned.

Returning now to our data U51, it becomes a bit more interesting to examine the consequentiality of the utterance for the interaction. Earlier I suggested that it appears that the therapist recognizes the significance of the patient's previous remark, but it should be added that this need not be the case. I find the therapist's utterance interesting in that it (1) attends to the patient's previous utterance and (2) suggests to the patient that the therapist "remembers" 'Bob Jones' (which indeed might not be the case) and (3) generates further talk on the part of the patient, in the course of which the therapist may be provided with further information concerning the mentioned person. Thus psychiatrists, like other conversational partners, may wait for later remarks to clarify the import of an utterance or the categorial identification of a mentioned third party.

In our data from psychiatric interviews, patients seem to suppose that names can be used where it is crucial for understanding the relevance of the patient's utterance that the therapist be able to supply the necessary category term to the mentioned person. That patients use personal names when referring to persons mentioned on earlier occasions is not a particular feature of psychotherapy but a general feature of conversation, i.e. conversationalists tend to drop the category term after it has been mentioned. For example, consider the construction of jokes where "There was

this policeman named Al" becomes "and Al picked up this drunk" as the joke progresses.

That conversationalists tend to use names when referring to third parties previously mentioned on earlier occasions, and thereby assume that the necessary category term will be supplied, seems to be a rather unnoticed feature of daily life. By this I mean that the ability to remember who, e.g., 'Bob' is, is not seen as any great accomplishment.

While pursuing psychiatric care I suggest that patients are aware that the therapist they see is also seeing several other patients and that each patient has his own history, which he expects the therapist to remember. From the perspective of each individual patient I speculate that there is a general concern with whether the therapist "remembers who I am", "what are my problems", etc. Compare this situation with that of a general practitioner and his patients.

While such a relationship would not be concerned with the personal problems of the patient nor would patients tell their doctor, e.g., "I got a letter from Bob yesterday", nevertheless the consequentiality of "not remembering" certain aspects about the patient is very great. A patient who sees a doctor on a regular basis does not expect each subsequent visit to be "like the first" but rather expects the doctor to become "familiar" with his medical

problem. I speculate that one of the reasons persons go to private physicians as opposed to public clinics, where each visit might get you a different doctor, is on the grounds that the doctor will become familiar with your case and your history.

In the psychiatric interview, as stated earlier, a patient's "medical history" also is his "personal biography".[9] In some sense the therapist has much to remember and furthermore his remembering is seen by the patient as demonstrating that he is "tuned in" to the problems of the patient. Once the therapist acquires information concerning, e.g., 'Bob Jones' he is not entitled to forget that information for to do so carries with it inferential value much in the same way that, e.g., a general practitioner treating you as a new patient on your tenth visit might.

Consider the following piece of data in which a third party reference is made and the way the therapist demonstrates that he understands the significance of the patient's remark.

29. P. ...Oh I saw Harry and Arnold up there. Just briefly said Hi. I see Arnold at school all the time.

30. T. Harry does not shake you up any more hey?

I am interested in how U30 gets constructed. By this I mean that in U29 the patient has reported that she has seen someone called Harry and someone called Arnold; how is it that the therapist

produces U30 and what is interactionally being accomplished by such an utterance? Again we must assume that the patient takes it that the therapist can properly assign categorial relationships to the persons mentioned. The therapist in producing U30 is demonstrating to the patient that (1) he knows who Harry is and (2) this is interactionally accomplished by providing a possible question concerning 'Harry' that could be seen by the patient as a "possible question" the therapist might ask given the history of the patient, i.e. a question that could only be asked by one familiar with the patient's shared biography with Harry.

This chapter has presented some data and discussion on three related issues: topicality, "resuming", and references to third parties. It was demonstrated that the "resuming behavior" engaged in by the therapist was primarily a device to facilitate the negotiation of a 'topic'. Furthermore the asymmetrical character of the "resuming" between therapist and patient prohibited "topical talk" about the affairs of the therapist and consequently always generated talk about the patient.

It was illustrated that much of the talk that occurs in psychotherapy constitutes this asymmetrical sharing of news, i.e., a patient's personal biography also constitutes his medical history. Often such sharing of news involves references to third parties with the patient assuming the therapist is able to provide the

necessary categorial identification of the person mentioned. It was suggested that therapists might often forget the relationship of persons mentioned by the patient, but rely on the same interactional techniques of everyday members of the society to assign category identifications when only a FN or FN + LN is used by the patient.

Finally it was shown that one of the concerns of the patient is "whether the therapist remembers me" and it was demonstrated how the therapist interactionally attends to this problem.

FOOTNOTES

1. Emanuel A. Schegloff. "Sequencing in Conversational Openings". American Anthropologist, Vol. 70, No. 6, December, 1968, p. 1076.

2. Roy Turner. "Some Formal Properties of Therapy Talk", prepared for David Sudnow (ed.), Papers in Interaction (forthcoming).

3. Roy Turner. "Some Features of the Construction of Conversation". Paper presented to the A.S.A. meetings, San Francisco, 1969, p. 6.

4. Schegloff. "Sequencing in Conversational Openings", p. 1076.

5. Harry Stack Sullivan. The Psychiatric Interview. W.W. Norton and Company Inc., New York, 1954, p. 18.

6. For a discussion of 'Resuming' see Roy Turner, "Talk and Troubles: Contact Problems of Former Mental Patients". Unpublished Ph.D. dissertation, Department of Sociology, University of California, Berkeley, 1968. Especially chapters 4 and 5.

7. Ibid.

8. Alfred Schutz. Collected Papers I: The Problem of Social Reality. Martinus Nijhoff, The Hague, 1967, p. 17.

9. For a discussion of the importance of being among one's "knowing biographical others" and a general discussion of biography see Erving Goffman, Stigma. Prentice-Hall Inc., Englewood Cliffs, New Jersey, 1963. Particularly chapter 2.

CHAPTER V

TREATMENT PROCEDURES

It is the purpose of this chapter to examine some features of the 'talk and troubles' of the patient and the way such 'talk' is interactionally handled by the therapist. Since my concern is with developing sequences of interaction rather than psychiatric theory, no attempt will be made to provide a general description of how therapists 'treat' patients' problems. Our concern is with 'treatment' as an on-going accomplishment between therapist and patient.

In an earlier chapter we examined a piece of data in which the patient told the therapist "You're never there when I really need you". The analysis disclaimed the notion that such a comment was demonstrating the patient's pathology, e.g., she could not manage without the assistance of her therapist. Rather, it was demonstrated that such a comment interactionally enabled the patient to introduce the first 'topic' of the interview. The comment nevertheless is interesting when examined in terms of the administration of treatment in psychotherapy. Since the therapist does not usually engage in any procedures other than talking to the patient, and such talk usually takes place in the doctor's office, whatever 'help' or 'benefit' results from psychotherapy is accomplished during the psychiatric interview. Consider the following exchange between therapist and patient:

71. T. Where else would you meet the kind of men that you're being exposed to?

72. P. In another hotel. I like hotel work still. That place is terrible. You just wouldn't believe it. The assistant manager. She's the most hysterical woman I've ever seen...

In U72 the patient starts the initiation of a complaint about the assistant manager. While the patient may complain about her "working conditions", for present purposes I wish to note that the therapist is not able to remedy the working conditions of the patient, e.g., the therapist is not going to call up the assistant manager and tell her to stop causing trouble for his patient. Whatever help the therapist may be able to offer is accomplished by him in the psychiatric setting and not by, e.g., the therapist going to the hotel where the patient works and engaging in some corrective procedures. To use a common-sense phrase, therapists are not "troubleshooters" for their patients.

Before confronting the data we will be examining I would like to relate a joke told to me about a patient and his psychiatrist. The patient seems to be suffering from feelings of depression and inferiority and during an interview makes some statement to the effect that he feels "inferior". The therapist's reply to this is, "Mr. Jones, you know, you don't have an inferiority complex, you really are inferior".

Now I suggest that it is quite obvious the above constitutes a joke and I feel an examination of how the above 'joke' is constructed will prove beneficial for the remaining data to be analyzed. First, it is nothing unusual in psychiatric practice for patients to complain about feeling depressed or inferior. Indeed, to be categorized as a psychiatric patient often allows such a description of a patient to be used. Second, I assume it is a rather common-sense notion that psychiatrists, being competent clinicians, are concerned with 'helping' their patients out of their difficulties and not, e.g., reinforcing patients' feelings of inadequacy, inferiority, etc. The powerful nature of the 'joke' then is evident by the therapist's reply since it is something that we (I mean by this ordinary members of the society) would not typically expect a doctor to say to his patient, since by admitting the patient is inferior one is in effect admitting "nothing can be done" to remedy the situation. The power of the 'joke' comes from our everyday common-sense knowledge of what constitutes doctor-patient relationships and the rights and obligations of the respective category members. Keeping these comments in mind I would now like to consider the following exchange between a patient and his therapist.

The patient in the following piece of data has been recently transferred from a managerial position of a small bookstore

to another bookstore in which he is merely "another employee", i.e. there is some loss of prestige involved in the change of jobs.

60. P. Well. My opportunities here are good. [patient referring to his new job] I've still got my job and carry on. [pause] But I'm not very happy these days over the whole thing.

61. T. You're feeling you've let Mr. Smith Down? [Mr. Smith being the owner of the bookstore]

62. P. Well I felt that, I let my own self down. The goals I had in mind you know.

63. T. In other words you thought you had everything beat.

In U61 the therapist proposes that he can understand the patient's reason for being "not very happy these days over the whole thing". The proposal, however, is of a special kind in that the therapist in U61 offers a reason for the patient feeling "not very happy" that the patient himself might offer. This phenomenon is not necessarily peculiar to psychotherapy but I suggest is a feature of interactions between members who either possess knowledge of each other, or of each other's relevant category memberships, that would allow such formulations to be seen as appropriate, proper, etc.

In the above interaction the therapist is well aware of the patient's history. Such awareness allows the therapist to propose that he 'knows' the reason for the patient being "unhappy"

and that it is a reason the patient might use if asked "What's wrong?". Using Sacks' terms, the patient has described his personal state as being 'negative': "I'm not very happy these days over the whole thing".[1] Such a proposal allows the 'hearer' to inquire into the reason for feeling this way. Instead of inquiring "why are you feeling unhappy" the therapist is proposing that he "knows" the answer the patient would give if asked the question "Why are you not happy these days?"

Before proceeding further it should be noted that while the above data occurs during a psychiatric interview, the proposal of an account in terms of what the 'other' would say is not unique to psychotherapy. It is not an uncommon occurrence that two people, e.g., husband-wife, could produce a similar type of exchange. For example, the husband comes home from work and says "I feel lousy" and his wife replies "Bad day at the office" where she is proposing the reason for feeling 'lousy' her husband would offer if questioned.[2] She has selected out of those possible reasons her husband would give for 'feeling lousy' a satisfactory proposal and one that from her husband's viewpoint is 'acceptable' even though it might not be the reason for his 'feeling lousy'.

Before continuing with an analysis of U's 61-63 I would like to restate the patient's situation. The patient has been "demoted" from his job and is "not very happy these days over the

whole thing". The therapist, being aware of the patient's history, offers a possible reason for the patient's attitude. I suggest that the exchanges between therapist and patient in U's 61-63 are very complex and their analysis will reveal some interesting features of treatment procedures in psychotherapy.

U61, "You're feeling you've let Mr. Smith down?" constitutes a question. It is a special type of question referred to by Sacks as a 'correction invitation device'.[3] By this is meant that the questioned party can either (1) assent to the formulation proposed by the questioner or (2) **provide** a correction to the formulation.

For the patient to assent to the therapist's formulation constitutes what we might common-sensically describe as 'self debasement', i.e. the patient was given the responsibility of managing a bookstore and "failed", "Let Mr. Smith down". Such debasement, however, I suggest would tend to be discounted by the therapist. As suggested earlier, therapists are not concerned with making their patients feel any worse. While speculative, I propose that had the patient answered in the affirmative the therapist would engage in some work to discount the patient's feelings of "letting Mr. Smith down". For example, the therapist could have suggested to the patient "Did you ever think that maybe Mr. Smith let you down". The important point to note about U61 is that it not only

proposes a possible reason for the patient's feelings but allows the patient to either accept or correct the proposed reason. This in turn allows the therapist to engage in some procedure to engage in a discussion with the patient about the patient's problem.

In U62 the patient provides an account which tends to discount the therapist's previous formulation, i.e. the patient offers a 'correction' to U61. Notice, however, that the patient's formulation is also one of 'self debasement' and furthermore seems to carry a certain finality and sense of failure, e.g., "Well, I felt that, I let my own self down...." For the therapist to accept this formulation would again be assenting to the patient's negative account of himself.

Prior to U63 I suggest that what we have is the statement of a problem by the patient and some type of investigative work by the therapist to determine what is 'troubling' the patient. The therapist has offered one possible 'reason' which the patient has rejected and replaced by another, e.g., "I let my own self down".

U63, "In other words you thought you had everything beat", constitutes what I consider a very complex utterance in terms of treatment procedure in psychotherapy. First I suggest it is a "criticism" of the patient much in the same way that the patient's U62 is self critical. That is, both U62 and U63 are

critical comments concerning the patient. The important point to note is that the patient's utterance entails some definite moral tones to it. Indeed from listening to the actual tape recorded interview the patient sounds completely in "despair". The therapist's utterance is quite different. While a criticism of the patient, it is a criticism that does not carry any moral overtones. Let me elaborate.

I hear the first part of U63 as constituting something that might be likened to a "summation device", i.e. both patient and therapist have been engaging in an exchange of utterances and I suggest that the therapist's use of "In other words" acts as a "summation device" in terms of what has been previously said. The remainder of the utterance, "You thought you had everything beat", I have suggested is also a criticism of the patient but a criticism quite different from the patient's critical account of himself in U62.

First it should be noted that it is the type of remark which is exceptionally hard to assent to, i.e. few people, if any, can have "everything" beat. Second, in proposing such a comment to the patient the therapist is being critical of the patient but not critical on moral grounds, as the patient was in U62, but critical in that the patient should have even thought that "everything" was solved.

In the above data the therapist's utterance suggests that the patient's formulations are unfounded or not warranted. The patient has in some sense made an 'error in judgement' concerning his progress or state of health. Furthermore while the patient initially proposed his critical comments of himself in terms of some "moral degradation" the therapist's utterance seems to indicate that the patient has made an error in judgement concerning his progress. Interactionally, the therapist has managed to exchange the patient's moral problems for 'technical ones' and the latter are rectifiable through discussion with the therapist. The culmination of the exchange between patient and therapist from U60-63 seems to have provided the patient with an acceptable "excuse" for "things not working out".

I would now like to examine several utterances from a psychiatric interview to further illustrate how 'treatment' occurs during the on-going process of interaction.

1. T. Took me a few minutes to figure out how it worked. [reference to tape recorder.]

2. P. Oh [laughs] [pause]

   Oh I met somebody that was a real doll on the elevator in the elevator rather.

3. T. Yeah?

4. P. Yeah. Somebody who I hadn't seen in a long time. I went to school with him and I sort of looked at him and said to myself, "Gosh

what a doll". He had a mustache which, um, he didn't have before so he looks somewhat better than he did before. [pause] So we talked for a few minutes. I did most of the talking [laughs] Gosh it was funny (When I saw him) It sort of struck up something new (emphasis mine) That's what I was thinking about when I came back into (the office).

But I thought to myself, "Wouldn't it be nice if maybe I heard from him?" I doubt that very much. [pause] Why don't you talk? [laughs]

5. T. What, do you think you might hear from him?

6. P. Who knows. Well I mean it's like everybody else that I went to school with. I don't hear from any of them, so. Why should I expect to hear from him? He was a little surprised though you know. All of a sudden he noticed me like well I was trying to get his attention because he wasn't looking my way and then all of a sudden we caught each other's attention and [laughs] he sort of came over and talked for a few minutes.

7. T. Well he might, suddenly liven up or something, by calling you.

8. P. It would be nice. [laughs]

9. T. You said you were surprised that you could experience a good feeling about him? (emphasis mine).

Although the above is quite lengthy I have particular interest in utterance 9, "You said you were surprised that you could experience a good feeling about him?" In carefully rereading the patient's utterances I cannot find any instance where she had a "good feeling" about meeting this former acquaintance. U4 is per-

haps the closest the patient comes to approximating what the therapist proposes she said. In some interesting way the therapist has 'transformed' the patient's description of what occurred in the elevator into a therapeutically relevant occurrence for the patient. I suggest that one of the features of the 'talk' that occurs between a patient and his therapist is that whatever 'talk' is produced by the patient, such talk can always be treated as "clinically relevant" by the therapist. In some sense all talk produced by the patient is "good enough" for the therapist to do his job. Continuing with the same interview:

10. P. Yeah. It's sort of funny you know. It's almost the same like I felt with Tom. [patient's boyfriend] All of a sudden I felt a closeness to him. But I think what what uh, I found attractive about him most of all was his looks, you know. When I saw him, I thought "Wow!" I'd better watch myself because looks could deceive you.

11. T. We will have to schedule daily meetings so that you'll run into more people on the elevator.

12. P. [laughs] Yeah.

The patient's reply in U10 does not discount the therapist's handling of her account, i.e. if the therapist was wrong in his 'transformation' of the patient's account the patient could have corrected him. I suggest that in U10 by the patient saying "Yeah" she is assenting to the therapist's handling of her account and thereby affirming the expertise of the therapist.

Continuing with the data we might common-sensically call the therapist's utterance, U11, a 'joke'. Since I am assuming that a therapist generates talk not merely to be funny but also to 'help' his patient an examination of the above utterance might prove rewarding.

The first task is establishing how the above is a 'joke', i.e. once recognizable as a 'joke' to explicate how the utterance is constructed so as to constitute a 'joke'. The first part of the utterance is important in that the therapist is proposing a state of affairs that does not presently exist between him and the patient, "We will have to schedule daily meetings...". Having more frequent visits to the therapist is not to be seen by itself as anything unusual, i.e. therapy sessions <u>can</u> be scheduled 'daily'. The above utterance constitutes a 'joke' not by some criterion of frequency of visits between patient and therapist but by virtue of the grounds given for increasing the frequency of visits, "so that you'll run into more people on the elevators". Having more frequent visits to the therapist is not unusual (indeed such scheduling often implies that the patient needs more 'help' from the therapist than could be accomplished once a week), but the scheduling of such meetings to enable the patient to "meet more people in the elevators" does seem to negate the first portion of the utterance. The grounds for having daily meetings are not warranted grounds.

The second point I would like to consider involves the therapist's 'transformation' of the patient's account, the patient's case history, and the 'joking' comment by the therapist. The therapist has implied that the patient had a "pleasant experience" on meeting a former school friend. The patient has been suffering from extreme states of depression, such that having a "pleasant experience" is something important for this particular patient. In U11, although jokingly, the therapist allows the patient to reflect on this pleasant experience. In therapy situations even 'jokes' made by the therapist are not said "just to be funny".

As mentioned earlier much of the 'talk' that occurs between a patient and a therapist concerns the friends, events, places, etc., related to the patient. In some sense much of the 'talk' is concerned with 'others'. Consider the following data:

38. P. She thinks she'll be happy [reference being made to the patient's roommate] I said to her the other day, you're crazy because she insists that it's not <u>blind</u> (emphasis mine) love thing but of course she insists sitting there telling me how wonderful he is. She hasn't got a bad word to say about him and the only thing the only time she's ever mad at him is when she gets upset about him not marrying her. You know, I said to her the other day what do you want to do go through the rest of your life supporting this guy? Find out what's going on first. Cool it. But she's just so anxious, she's just as anxious as he is to get into bed with him and she's not going to do it until she gets a ring on her finger. [laughs]

39. T. Speaking of blind (emphasis mine) You two giving advice to each other is like the blind leading the blind.

In the above piece of data the patient has been discussing the problems of her roommate, i.e. the problems are not those of the patient but constitute the problems of 'others'. It has been suggested that this is a feature of two-person psychotherapy, i.e. patients engage in talk about, e.g., their friends, relatives, etc. While such talk does occur I speculate that eventually such 'talk' must be related to the patient, i.e. it should be seen to have significance for the patient.

The reader undoubtedly noticed that the therapist in U39 has 'tied' his utterance to a remark made by the patient during her previous turn at talking. Interactionally, 'tying' is not a particular feature of psychotherapy but rather a general feature of conversation, i.e. members when taking turns at talking can link their utterance to the last speaker's. Furthermore such 'tying' can but need not coincide with the previous speaker's last statement, but may refer to any utterance produced during the speaker's turn at talking.

For the moment I would like to concentrate on the first portion of U39 namely "Speaking of blind". Now I suggest that this utterance is very complicated but its examination will reveal some

interesting features of interaction. First we notice that it is 'tying' to the patient's previous utterance: "...she insists that it's not blind love", and we are able to see this as a 'tying' utterance by reference being made to some 'word' used previously by the patient. Thus in some sense the therapist could have initiated a 'tying' remark by say, e.g., "Speaking of being anxious..." where the use of 'anxious' would allow us to see the 'tie' between his and the patient's previous utterance. I suggest that the more interesting feature of this tying utterance is the use of the phrase 'Speaking of' which is then followed by a 'word' which allows us to see the 'tie' between utterances.

Interactionally I suggest that one way of being able to introduce a new 'topic' or 'idea' into a conversation is to use a 'tying' utterance employing the following formula: "Speaking of X" where 'X' can be any 'word' or 'phrase' from the previous speaker's turn at talking. The use of "Speaking of" allows the 'hearer' to see that a 'change' in the conversation is about to occur, e.g., a new piece of information is going to be added, a new topic is going to be proposed, etc. By supplying the tying word or phrase the speaker is accomplishing two things. First he is showing that the previous speaker's remarks have been 'heard' and second he is introducing a new 'topic' or 'idea'.

What we are dealing with is a speaker A, speaker B situation where speaker B ties his utterance to speaker A's using the

formula "Speaking of X". While I suggest that such a formula tends to interactionally constitute a chance for a 'new topic', the use of such a formula also allows speaker A to make some inference concerning the attentiveness of speaker B to his comments. Consider the following hypothetical examples:

1. A. "Boy, it was a rotten day today."

   B. "Speaking of rotten, where did you get that rotten suit you're wearing?"

2. A. "Boy, it was a rotten day today."

   B. "Speaking of rotten days, did I tell you what happened to me yesterday?"

In both examples I suggest that the formula for introducing a new 'topic' or 'idea' into the conversation is adequately demonstrated. Also, I suggest the reader is quite readily able to see the difference in character between the two 'tying' utterances. The point I wish to make is that "how the tying is done" carried with it the consequence that speaker A is able to make some inferential judgment concerning speaker B. In example one, we might wish to describe speaker B's comment as being rude, and one way of being able to substantiate such a claim is to note that while 'tying' to the previous speaker's utterance such an utterance does not have any corresponding relevance to the first speaker's utterance. Example two is quite different. While introducing a new 'topic' I suggest speaker A is able to see by the construction of

speaker B's utterance that he not only 'heard' what he said but has adequately attended to it. That is, speaker B honors the significance of speaker A's utterance by "sharing" his own trouble with the previous speaker and thereby demonstrating that what he now has to say is "relevant" also.

Returning to our data, U39, consider the rather compact nature of the therapist's utterance. By this I mean that the patient has given an elaborate account of her friend's problems, and the therapist's only treatment of this account is to 'tie' to something from the patient's utterance. In some sense this 'tying' does not even attend to most of the patient's comments and tends to discount much of the patient's utterance. Put quite crudely, the therapist, "cuts the patient short" and does not engage in any discussion concerning the affairs of the patient's friend. Rather, I suggest, that the second portion of U39 tends to reinforce the category of 'patient' on the patient. I hear this second portion of U39 as constituting what we might wish to call a "put down". By this I mean that the patient has been telling the therapist how 'foolish' her roommate is and how she had been giving advice to her roommate. The patient, however, is herself having difficulty with her own relationships. By the use of the personal pronoun 'you' the therapist co-memberships the patient in the same way the patient has been talking about her roommate and I suggest 'maps' the patient into the category 'patient' and not advice giver, i.e. as not one

in any position to give advice. Furthermore the therapist in U39 has interactionally redirected the 'talk about the patient's roommate to 'talk' about the patient.

In another psychiatric interview a patient has been discussing her husband's problems and the fact that he is in a "good mood" when he is performing on "stage". Consider the data:

47. P. Well I really think this music business is good for him. I mean I know he needs this [pause] That's when he's happy. Yeah that's when he's happy when everybody's making a fuss over him on the stage. (emphasis mine) He needs that.

48. T. Hmm. [pause] Speaking of being on stage (emphasis mine) How did you do on your assignment. [The patient plays in the same band as her husband and from the continuation of the interview it seems that the therapist had asked the patient to look at the people in the audience when she performs.]

Again we have an instance of the therapist 'tying' to the patient's previous utterance. The consequentiality of the therapist's comments is that the patient's 'talk' concerning her husband is interactionally handled by the therapist in such a way to make it relevant for the patient. While "the music business" may be good for the patient's husband, the patient's husband is not the concern of the therapist in that he is not the person getting 'treatment'. The patient's comments concerning her husband in some sense are 'dismissed' by the therapist and the 'talk' which follows is related to the patient, "How did you do on your assignment?"

Relating the above discussion to psychiatric theory I would like to offer the following quotation from Sullivan:

> The interviewer is also entitled to exercise his skill in discouraging trivia, irrelevancies, graceful gestures for his amusement, and repetition of things he has heard. It is perhaps harder for the younger interviewer to demonstrate his expertness in this respect than it is for him to insist on the data he must have. But if you are not an expert in interpersonal relations, you are likely, for good reason, to doubt that you have too much life-time ahead of you, and therefore you want to utilize it as well as you can. It is also profoundly impressive to people, in the lucid interval after they leave you, to realize that you have kept them to something that made sense, and that when they started telling you things all over again, you said "Yes, yes. Now we want to inquire into so-and-so." In other words, the expert does not permit people to tell him things so beside the point that only God could guess how they happened to get into the account. And so from his first meeting with the patient until the end or interruption of an interview or series of interviews the psychiatrist handles himself like an expert in interpersonal relations who is genuinely interested in the problems of the patient. He is careful to get all the details necessary to avoid misunderstandings and to clarify erroneous impressions unintentionally given by the patient, yet he is chary of encouragement toward any repetitive, circumstantial, or inconsequential detail in the report and comment of the patient. There is not time to spare in a psychiatric interview. If he sees that the patient is repeating himself, going into circumstances which are in no sense illuminating, or wandering into inconsequentialities about some fourth, fifth, or sixth removed person, he may, without unkindness, discourage such moves, tolerating only a minimum of wasted time, since he knows that there is plenty to do. Actually this is a kindness to the patient for it communicates to him that the psychiatrist seems to know what he is doing, and with such hope in mind he will put up very nicely with what the psychiatrist does.[4]

The data we have been examining seems to constitute what might be called 'discouraging' the patient from discussing, e.g., her roommate's problems, husband's situation, etc. Unfortunately Sullivan does not explicate how such 'discouraging procedures' are instituted interactionally and whether they are successful. Consider the patient's reply to U39:

> 40. P. Right. [laughs] Well that's what's scaring her of course you know is listening to me for over the last two years over Tom. And she keeps thinking about everytime she thinks well dammit I'm going to then she thinks about me, and she backs out [pause] It's funny. And Tom is telling me what I should tell her....

The patient obviously recognizes the character of the therapist's previous utterance, but at the same time she continues to discuss her roommate's difficulties. Perhaps this is some indication of why therapy is often such a long process compared to other types of medical help. Psychiatrists, I presume, assume that patients contemplate what occurred in therapy sessions after the session is over, i.e. much of the work of the therapist is accomplished in what Sullivan could call "the lucid interval after they leave you". As such, 'treatment' in the psychiatric situation may be similar to "making points" in which the patient tallies such points perhaps several hours, days, etc., after the interview and does not immediately see their significance. As such there is no

full scale diagnosis presented to the patient with the appropriate prescription as occurs in other types of medical situations.

It has been the purpose of this chapter to demonstrate how 'treatment' is interactionally administered within the psychiatric interview. While much of the psychiatric literature is concerned with "giving advice" to clinicians on how to successfully manage the psychiatric interview such works fail to 'translate' such advice into interactional procedures for the therapist.

I have attempted to examine some instances of 'treatment procedures' and describe the interactional techniques used by therapists in conducting psychiatric interviews. Again the major contention of the thesis is underlined, that while we are dealing with a psychiatric setting the interactional devices available to the psychiatrist are not the result of his possessing any 'special' knowledge by virtue of psychiatric training, but that his expertise lies in his ability to use common-place interactional devices in the service of treatment during the psychiatric interview.

FOOTNOTES

1. See the discussion of personal states in Chapter II: Opening the Psychiatric Interview. Also Harvey Sacks, Lectures 8, 9, and 10, Spring Quarter, 1967, U.C.L.A.

2. In some cases, indeed, to ask the question would be inappropriate, since the speaker may expect the hearer to understand the account as "obvious".

3. Harvey Sacks, unpublished lectures.

4. Harry Stack Sullivan. The Psychiatric Interview. W.W. Norton and Company Inc., New York, 1954, p. 26. At this point I would like to acknowledge my recognition that the relationship between psychiatric theory and psychiatric practice is an area worthy of investigation. I have not, however, attempted such an investigation since such a concern would entail a work of the same scope as the present report.

CHAPTER VI

SIGNIFICANCE MARKERS

Earlier in this thesis it was useful to consider the fact that the encounter between therapist and patient is methodically generated. It is important to note that not only is the encounter methodically generated but is initiated on the assumption that more than a "minimal proper conversation" will occur between the participants. Previously, we have also considered topicality and how 'topics' get interactionally initiated in the interview. The concern of this chapter is with what might be called the "importance" or "significance" accorded to talk produced by the patient. I will not be concerned with what psychiatrists might wish to regard as important in the sense of patients' talk being seen as "demonstratable" of some psychiatric problem, e.g., the patient is demonstrating her anxiety. Rather, when referring to "significance" or "importance" it seems to be empirically the case that patients during psychiatric interviews use common-sense notions of "significance" and "importance" and use routine interactional devices to manifest these criteria. What we are dealing with is a two-party conversation and I suggest that when members talk to one another they orient to the possible "importance" or "significance" their "hearer" can accord such talk.

The analysis presented will deal with the following exchanges between patient and therapist:

Example A:

1. T. I'm recording this. Is that okay by you?

2. P. Yes. But I don't have much to say today. (emphasis mine) [pause] I had a couple of dreams (( )). It was really vivid....

Example B:

5. T. What's so great?

6. P. Nothing. Just great. [pause] Nothing's great though, everything's the same. [pause] I'm feeling okay. I don't really have too much to talk about. (emphasis mine).

The above pieces of data occurred at the beginnings of psychiatric interviews. I would like to treat the remarks emphasized in the above utterances as being problematic, despite the fact that they may seem totally obvious given the fact that the encounter has been methodically generated and both parties are aware that 'talk' is supposed to occur.

If the remarks I am emphasizing are treated as obvious, then they are presumably explained in the following way. First, the patient has an appointment with the therapist. Second, while arriving at the appropriate scheduled time the patient discovers that she "does not have anything to talk about". I suggest that such a common sense interpretation will bypass the interactional

significance of the patient's remarks. Consider for instance, that on this account the therapist could engage in some type of "re-scheduling", e.g., "Okay, come back when you have something to talk about", or he could instruct the patient to call and cancel the appointment should she have nothing to say.

In both of the above examples, however, it is empirically the case that both interviews were not cancelled and that each interview lasted for its scheduled duration. This leaves us with two alternatives. An obvious solution would be to invoke some criteria of accuracy and say that the patient was mistaken, i.e. she did have something to talk about, despite her claim to the contrary. However, there seems to be a greater "pay off" in terms of understanding interactional devices if we at least entertain the possibility that such a remark as "I don't have much to say today" is an artful production and that we can seek to discover what it interactionally accomplishes.

In example A the patient and therapist as of yet have not engaged in any topical talk, i.e. a topic or more specifically a first topic has not yet been negotiated between the participants. The patient does, however, offer as a possible first 'topic' or at least a first 'mentionable', "I had a couple of dreams...." Sacks and Schegloff have discussed the importance accorded first mentionable in conversations and their comments are worth noting in full:

> If we can refer to what gets talked about in a conversation as "mentionables" then we can notice that there are considerations relevant to conversationalists ordering and distributing their talk about mentionables in a single conversation. There is, for example, a position in a single conversation for "first topic". We intend to mark by this term, not the simple serial fact that some topic gets talked of temporally prior to others, but that to make of a topic a "first topic" is to accord it a certain special status in the conversation. Thus, for example, to talk of a topic as a "first topic" may provide for its analyzability as "the reason for" the conversation, that being, furthermore a preservable and reportable feature of the conversation (where we mean by "preservable and reportable" that in a subsequent conversation this feature, having been analyzed out of the earlier conversation and preserved, may be reported as "he called to tell me that..."[1]

It is a feature of telephone conversations that there exists an "information gap" between the participants, i.e., the called party does not know who is calling or why the call was initiated. For this reason, much of the "opening work" of telephone conversation is concerned with overcoming this "information gap", i.e. to discover "who is calling and why the call was initiated".[2] It is for this reason that a "first topic" carries such importance since it can be seen as the rationale for the initiation of the encounter between called and caller.

With respect to the notion of "mentionables" it seems that members engage in some process whereby a "first mentionable" can be seen as characterizing the possible importance of the conversation. Extending the analysis, I suggest that not only is the

positioning of "mentionables" important but also that members when speaking to one another take into consideration what can constitute a "mentionable" to their fellow interactant. That is, what might be a "mentionable" to one person may not be a "mentionable" to another. Furthermore, the grounds for not "mentioning" something to one person while offering the information to another need not be ones of privacy or confidentiality, but rather may be attending to the fact that what would be "mentioned" is of no particular interest to the hearer. Put very crudely, there are some people you tell certain things because you assume that they would want to "know" and there are other people you do not tell the same things because to do so would be to "bore" them.

Earlier it was made apparent that a therapist can always 'hear' a patient's utterance as being "clinically relevant", e.g., "What's so great" from a previous interview where the therapist treated a patient's "ceremonial" answer to a greeting substitute as a "constructive". Since this is the case I suggest that patients often become aware of this special 'hearing' the therapist uses, i.e. patients are aware that often what they say can be subjected to interaction returns which are not those of common discourse. Such awareness, however, has a double edge to it. While patients may be in a position to realize that therapists often use a different set of criteria than normally used when dealing with patients'

utterances, the patient is really never in a position of knowing 'how' the therapist is going to suspend his interactional return. That is, while therapists often use interactional procedures that are at variance with the way one would normally 'hear' a patient's utterance, the patient is not in a position to be able to "pre-monitor" how the therapist will invoke such a procedure. Just as in routine conversations between the acquainted where the participants screen the introduction of mentionables for their possible "significance" to the "hearer" so patients seem to demonstrate exactly the same concerns in talking to their psychiatrist. It seems to be a matter closely attended to by conversationalists that they do not produce utterances that "go over like a lead balloon" on such grounds that the speaker has misjudged the "hearers'" interest or concern.

Returning to our discussion of the Sacks and Schegloff quotation, it was suggested that in telephone conversations a "first topic" can be seen as the rationale for the call. Consider the following hypothetical situation posited by Schegloff[3]:

1. Called: Hello.
2. Caller: Hi!
3. Called: Oh hi, Bill.
4. Caller: I just called to say hello.

The first point to make concerning the above is that while two friends may speak on the telephone and one may say "I just called to say hello", such a conversation does not expectedly terminate by the parties exchanging "hello's", but results in the two parties talking about some topic. Second, where Schegloff talks of the "information gap" in terms of "who's on the other end of the line and why did they call", I suggest that by saying "I just called to say hello" the caller is supplying information concerning the character of the call and its rationale for initiation, i.e., nothing important or urgent prompted the call. That is, we could set up a dummy model such that every time the phone rang it was something important and that would be the only reason for the phone ringing (and there are phones like this, e.g., the hot line between Moscow and Washington), i.e., someone had something urgent to report. Not only does U4 provide a rationale for the call but also tends to characterize the talk that follows as 'not urgent', 'important', etc.

Returning to our data I would like to consider the interactional consequences of the patient prefacing her initiation of a topic with such a remark as "But I don't have much to say today". I wish to emphasize that I hear the patient's remark, "But I don't have much to say today", <u>as</u> a prefatory remark and <u>not</u> merley occurring in some serial order prior to "I had a couple of dreams...."

In U2 I suggest that in terms of 'topic' or at least first mentionable that the patient offers something that we might wish to call a "dream report". Now assuming that I am correct in treating the patient's previous utterance as a prefatory remark, the question becomes what is the interactional consequentiality, if any, of such a preface.

I suggest that the patient's prefatory utterance "But I don't have much to say today" functions as what I wish to call a "significance marker" and serves to indicate to the hearer that the speaker does not attach much importance to, e.g., "the dream report". Furthermore I suggest that had the patient wanted to make the opposite claim, i.e. that the "dream report" was especially important,an alternative marker, e.g., "I have something to tell you" could have been used. This would give the patient's utterance the character of an announcement.[4]

I would now like to consider another piece of data that adequately demonstrates that members often engage in interactional devices to characterize the 'talk' that follows as being, e.g., 'important', 'urgent', 'confidential', 'trivial', etc. Consider the data:

47. P. I don't know. How much are sweaters for the male sex?

48. T. Twenty to thirty dollars.

49. P. Yeah. I think I'll get him a medical shirt, or something like that. [pause] They don't know my name (emphasis mine) I was going to ask you about something.

50. T. Do you want me to turn it off? [pause] As a matter of fact, if there were things you would rather not talk about I can turn it off, or I'll just simply erase it.

51. P. Oh, it's okay if they're not going to know who I am.

52. T. No. He's not.

53. P. Oh. Hmm [laughs] [pause] I was just wondering about birth control.

54. T. You were hey?

In the above data, U's 47-49, the patient has been discussing with the therapist what type of gift to get her boyfriend for his birthday. One of the noticeable features about U49 is that it contains a third party reference, "They don't know my name". My first concern is to account for the reasonableness of this utterance given the empirical situation of there being only a patient and a therapist present, i.e. who is the 'they'?

As a researcher I am aware of certain circumstances concerning this interview, i.e. that the interview was being tape recorded for the first time and that the recorder was visibly located between patient and therapist. With this knowledge the "reasonableness" of the patient's remark becomes evident. Explaining the reasonableness of such a remark still does not answer the more

interesting question of what work such an utterance is accomplishing interactionally.

In U49 the patient states that she was going to ask the therapist "about something". I suggest that 'asking' is an activity that is done all the time and furthermore an activity not needing or requiring an announcement. Given this fact, the question of interest is what is such an announcement accomplishing interactionally. "I was going to ask you something" is different from actually 'asking', and I suggest that such an utterance constitutes some type of marker which characterizes the question to be asked. Indeed, given the setting of a psychiatric interview such an utterance might be heard by a therapist as a patient's concern with the "appropriateness" of a question.

In the instance under consideration, however, such a remark is prefaced by "They don't know my name", and I suggest that this utterance tends to characterize the patient's forthcoming question as being, e.g., confidential, important, for the therapist only. It not only orients to the fact of the presence of the tape recorder but uses that feature of the encounter to produce an utterance that characterizes her question as being of a "confidential" nature. By orienting to the fact of the interview being recorded the patient's concern with respect to the "confidentiality" of the session becomes a warrantable concern. The therapist, in U50,

by offering to turn the tape recorder off or "simply erase it" treats the patient's concern for confidentiality with a reciprocal concern for confidentiality thereby demonstrating that he understood the significance or importance the patient attaches to her question. I suggest that the therapist's action substantiates my analysis of the patient's utterance being one which acts as a marker to characterize her question as "confidential", "private", etc.

The subject of importance to the patient turns out to be "birth control". Now I do not wish to argue that "birth control" is a subject that patients necessarily always attend to as being confidential. My only contention is that at least in this piece of data the patient has prefaced her question by what I wish to call a significance marker. The consequentiality of such a marker is that it allows her co-participant to attend to the importance she wishes her comments to be accorded, e.g., in this case with respect to their confidentiality.

This chapter has been concerned with a general feature of conversation, i.e. when members talk to each other they orient to the possible significance they expect their hearers to accord their talk. The psychiatric interview, however, poses a difficult problem for the patient since it is a feature of such occasions that therapists are entitled to treat patient's utterances in ways which are at variance with the way such utterances would normally

be treated in everyday life. While it was suggested that patients eventually become aware of this entitlement they are not in a position to know 'how' the therapist will give their comments such a hearing, and they therefore employ standard conversational resources to indicate to their co-participant what significance to attach to their talk. Thus I have demonstrated the use of what have been called "significance markers" to preface topic initiations, topic changes, etc. It is a basic assumption of this report that whatever theory the psychiatrist subscribes to, he must necessarily share with the patient the vocabulary of speech acts which form the repetoire of routine discourse.

FOOTNOTES

1. Emanuel A. Schegloff and Harvey Sacks. "Opening Up Closings". Paper presented at the A.S.A. meetings, San Francisco, September, 1969, p. 7.

2. Emanuel A. Schegloff. "Sequencing In Conversational Openings". American Anthropologist, Vol. 70, No. 6, December, 1968.

3. Ibid.

4. David Sudnow. Passing On: The Social Organization of Dying. Prentice-Hall, Inc., Englewood Cliffs, New Jersey, 1967. Particularly chapter 5.

CHAPTER VII

CONCLUSION

This thesis has been concerned with the social organization of the psychiatric interview and how that organization is produced and manifested via the talk that occurs during the interview. Most psychiatric research in this area is concerned with the effectiveness of the psychiatric interview and with the training of clinicians. The sociological liaterature which deals with the psychiatric interview, while not necessarily related to psychiatric problems, is often concerned with the interview from the standpoint of some pre-adopted theory of interaction. Thus such works are often concerned with, e.g., content analysis, scoring procedures, and attempts at quantification, directed at establishing typologies of interviews or participants. While I have not examined the interview in terms of any psychiatric theory I have also not adopted any explicit theory of interaction. Rather my concern has been with examining pieces of interaction for their "performative" character.

In this connection, one of the problems considered in this report was how topics become interactionally negotiated in the interview. It was suggested that settings typically place constraints on topicality by providing for the accomplishment of "core activities". The therapy situation, however, seems to be

one in which the "core activity" and hence criteria for identifying "main topic," are not obvious. Thus with respect to topical talk, what will become topics for discussion between patient and therapist is something that has to be negotiated between the participants, and it is apparent that such negotiation is accomplished by both members using natural language. This presumably legitimates analysis into speech acts.

Using some of the ideas and concepts developed with respect to topicality, chapter IV was concerned with the special character of the relationship between doctor and patient. It was shown that much of the talk that occurs in the interview involves the "sharing of news" on the part of the patient, i.e. some "resuming" behavior occurs in psychotherapy. It was suggested, however, that informational rights with respect to the sharing of news were not symmetrical and that (1) the "resuming" behavior exhibited by the therapist was concerned with producing talk on the part of the patient for possible topical development, and (2) such talk constitutes the data from which he does his work. That is, patients' personal biography also constitutes for the therapist patients' medical history.

In the data and analysis presented it would appear that the psychiatric interview is composed of the same "interactional stuff" of other settings and encounters, i.e. the members of the

psychiatric interview use the same repetoire of "speech acts" for producing the social organization of the settings, e.g., asking questions, telling stories, etc.,that would be available for use in other settings and occasions. Given this fact it would seem that while a large amount of the psychological literature is concerned with psychiatric practice in "theoretical" terms, in order to understand the interactional processes occurring in the interview one is entitled to make use of the resources available to any competent member of the society. The problems are of sociological interest in that they require explicit examination of such resources.

This approach suggests further areas of research. Thus, after a discussion of topic construction and greeting exchanges it was pointed out that therapists are often able to treat patients' utterances in ways which are at variance with "normal interactional routines" and thereby suspend conventional conversational practices. Since the conversational resources available to both patient and therapist are the same as those available to any member of the society, it may be that an area worth further investigation is how therapists are "taught" to suspend such interactional routines. I suggest that therapists have to "learn" how to interactionally "undercut" patients' comments and perhaps some insight into the social organization of the therapy situation might be gained by an examination of the training procedures of clinicians.

Further, since it has been established that the interactional resources are normally shared by both participants of the psychiatric interview, it might prove interesting to examine those encounters between patient and therapist where such interactional knowledge is not reciprocal. I am thinking of child therapy where it is either assumed by the therapist that (1) the child has not developed interactional competence and the therapist must contend with this fact as part of the psychiatric interview or (2) the child is operating using a different system of interactional rules for conversational encounters.

In conclusion, in recommending such further research, I would like to emphasize that the findings of this report are to be regarded as tentative. In so far as I make a claim it is that alternative (and perhaps more satisfactory) findings must be discovered by the employment of an approach best described as a "natural history" of interaction. I have tried here to show what such a natural history looks like.

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