RESEARCH ACTIVITIES AND PROFESSIONAL PRACTICES

R.J. Anderson

Manchester Polytechnic

Despite all appearances to the contrary this paper is about Sociology's methods. Or, at least, it's about one of them, the unstructured interview. My intention is to make a few fairly gross technical comments about some data by wrapping them around one methodological observation. Since much of what I want to say is not normally incorporated in the usual discussions of method, field practices and data collecting techniques, it may be as well to make the connection clear right from the start. On the face of it the data seems straight forward enough. It is a transcription of an interview between a researcher and one of his informants.[1] As such it should be familiar to all of us. For research purposes we generally treat data like this as displaying certain features. For example, we assume that the researcher is conducting the interview and that the interviewee or subject is providing information. Furthermore we assume that this structure of relationships underpins the very purpose of interviewing. Interviews, as interviews, following this general format are treated as relatively unproblematic. The identities of the participants can be allocated as a matter of course. On some occasions, as everyone knows, the interview turns out to be momentous; on others, alarming, amusing or memorable in some other way. In such instances we speak of informants who were forthcoming, interesting, threatening, accommoding or whatever. My purpose in this paper will be the investigation of how it is that an interview can come to produce some interesting data. By examining the detail of the interview, I shall try to substantiate a view which sees "interesting data" as the outcome of joint activities engaged in by both the researcher and his informant. Such data is not lying around the social world waiting to be discovered but worked up in situations such as that under investigation. This view will lead to the conclusion that treating the participants as an "interviewer" and "his informant" may well fail to capture the nature of the encounter altogether. For the lady in question is a patient suffering from certain problems and it is just these problems which make her case interesting to the researcher. It is here that the issues of methodology are to be found, for now we are faced with puzzle: 'how is it that some research, when it has been collected, collated and analysed, comes to be seen as routine, normal and expected, while other data may be found to be revealing, rewarding or exciting?' Our promised methodological observation is that such findings are accomplished outcomes of the practices referred to above, and is offered as a partial step towards resolving the puzzle. To elucidate what is meant by this, it will be necessary to sketch out an analysis of some of the practices engaged in in the data, and to do this in terms different from those simply describable as "reseacher talking to an informant". As a consequence, the apparatus used, albeit in a crude manner, will seek to lay out some of the specific features of research interviews. As we said, the topic is sociological practices as members activities.

To begin with we will need some delineation of the kind of data this is. Providing such data should not be thought of as bringing extraneous material into the analysis to facilitate the eventual conclusions: that, in effect, we are now busily hiding the bunny in the lining so that it can be pulled out of the hat at the appropriate moment. Rather, the detail is given because part of the apparatus we will sketch out comprises the sets of expectations that participants may have about situations such as this. These expectations are the commonsense interpretations of situations showed by informants, researchers and analysts alike. We have to rely on them since it cannot be sensibly proposed that investigators should abandon commonsense the better to analyse it. After all, rendering some particular components problematical does not entail jettisoning all of the normal practices of social life. Now, this might seem to lay us open to the threat of the 'infinite regress' type of criticism, with analysis being piled upon analysis like the proverbal fleas. But the threat is not

just trivial, it is illusory. Of course, one could analyse the analysis; and equally well one could analyse the analysis of the analysis. Whoever thought this was not the case? The threat of our infinite regress is only potent if it is presumed that the analysis of analyses is like the exercise of running up downward moving escalators: despite all efforts no progress is made. Such a view rests upon a further presumption, namely, that there is a point at which analysis should stop. A point at which the totality of findings can be summated, and a complete exhaustive account given. However, as has been widely noted,[2] the features of descriptions proliferate in the analyses that are given. Each subsequent analysis may be treated, not just as a refinement or further definition, but as a separate object of inquiry in itself, displaying its own distinctive features. The crucial questions then becomes not 'where do you stop analysing the analysis?' but 'what is the intrinsic interest of that kind of enterprise anyway?' The infinite regress criticism is not only misguided in its premises, it manages completely to miss the point of the endeavour.

As we have said, the transcript is part of an interview between a researcher investigating the social parameters of gynacological medicine and a female patient who has been referred to the hospital in which the researcher is working. One immediate tool of analysis we have available to contrast and explicate their activities would be the standard relational pair denoted by "interviewer" and "interviewee". However, people are not interviewed simply because they are informants. They are asked for information because of their position, status, interest, insight or for a host of other, equally suitable reasons. The lady in question, Pat, is being interviewed because she is a patient and not because she can tell Stork from butter or because she votes Labour. The fact that she is a patient provides the reason why she is interviewed on this occasion. Out of this fact we can propose that certain kinds of topics will become programmatically relevant. Since she is interviewed as a patient, then her medical condition is likely to be a major concern. For us to seperate the categories of "interviewee" and "patient" is pointless. Pat is not an interviewee who happens to be a patient. She is an interviewed patient. Our interest in the data can now be discerned. It revolves around the way that the woman's presentation of her medical symptoms becomes a mechanism for the introduction of a wide range of other 'non-medical' troubles. These 'troubles' make up the interest that the data was to have for the researcher. The interview takes on an importance for him because the patient reveals some of the things he wishes to investigate - the non medical (ie social) parameters of her condition. That is, during the course of the interview, she moves from being "just another interviewed patient" to a "subject for research". In order to organise the discussion, we shall propose that the lady becomes a "teller of non-medical troubles" and the researcher a "sympathetic listener". I shall not try to enlarge upon the organisation of the troubles, here, nor, indeed, upon the nature of the listening. Hopefully, these will be explored in other papers. For the moment, it will be enough simply to tease out the ways that agreement on the allocation of identities is achieved and the categories assigned. In the analysis, attention will be focussed on two distinct features; the statement of "troubles" and their amplification into "yet more troubles". This much is being said it is now time we considered the data.

1. Ian: ( ) ((Question of symptoms))

2. Pat: Well I've got er two things er I've got not control over me
3. bladder

4. Ian: Yeah

5. Pat: See I'm losing water all the time

6. Ian: Yeah yeah yeah

7. ((2 second pause))

8. Ian: When yuh say y've got no control is it continuous or y'know
9. or is it when you move jump around at little bit

10. Pat: Well its er if I drink a lot of fluid

11. Ian: Yeah

12. Pat: It comes from me all the time // y'know every time I move I
13. just have to move

14. Ian: // Yeah

15 Pat: And I've just had a very bad cough recently because I've just come
16 back from Australia

17 Ian: That'll also put some stress on you

18 Pat: Yeah I've just come back from Australia y'see the change of
19 wea [ther

20 Ian: [Climate yeah yeah

21 Pat: An that gave me a real bad cough an I was jist it was jist pouring
22 from me all the time

23 Ian: Every time you coughed you were // wet down below [yeah

24 Pat: // Yeah [yeah

25 Ian: How long have you been like this then

26 Pat: Well I've got that much on me mind just now y'know just coming
27 back from ((Australia)) that I can't even think straight

28 Ian: Yeah

The Statement of Troubles

The most obvious place to begin is with the patient's own description of her condition.

2. Pat: Well er I've got er two things er I've got no control over me bladder.

To start with, we can repeat the casual observation that Pat knows that this is an interview about her medical condition and so her medical problems are topically relevant. But what she does not know indeed what she cannot know is precisely what the interview is to be about. There is no pre-arranged. determinate list of topics. Therefore, she does not know what she is supposed to say about her problems. The lack of a pre-given formal structure does not mean that there is a lack of organisation to the talk that takes place. This may be an unstructured interview but it is nonetheless orderly for all that. The fact of this orderliness means that Pat must have methods by which she can provide an organisation to the things she talks about.

One mechanism we might choose to provide the organisation would see Pat

offering in her initial description, a generalised ticket via that most easily available topic. Such a ticket would function to get the conversation started. Using this we could, scan the range of topics touched on and show how they grew out of, and mark different phases in the trajectory of the conversation. An argument for this procedure could be constructed on the grounds that, since neither the patient nor the interviewer know each other, apart from the medical condition topic they have, as yet, nothing else to talk about. Operating like this, however, would not only give us very little analytic leverage but would also encourage wholesale depictions and classifications. So, too, would the suggestion that we range the topics talked about in terms of generality and attempt to locate the types of topics in different phases of the conversation, thereby implying that strangers move, gradually, from the general to the specific as they discover what they have in common. A generalisation of that type would surely soon come to grief. Since neither of these paths looks particularly promising, it might be just as well to reformulate the problems slightly. The interviewer's interest is not really in the patient's medical condition and its prognosis He can discover all he needs to know about that from her file. Anyway, he is likely to get more accurate information on what tests have been carried out, what drugs recommended and so on, there than he will from the patient. It is not that he has been vague in specifying topics, so that a general ticket is all that Pat could produce, but that he has a professional interest in not specifying any topics for he does not know the non-medical parameters of her condition. He can only discover these as she talks about them. Paradoxically, it is Pat and not Ian, who has to provide the topics. But at the same time, Ian wants her to talk about certain kinds of things and not just babble on about Cuban mercenaries or the best ways of growing tomatoes. Ian's task is to discover if her case has any interest for him. To do that, he must provide a structure to the conversation so that she can independently discover and produce the topics that be wants her to talk about.[3] Thus he must make his research interests available to enable Pat to talk about things he might find interesting without, at the same time, telling her what to say. Here, in a nutshell, we confront a standard methodological problem as a practical problem to which Ian has a range of remedies. He has to enable Pat to find out at what the interview is to be about, so that he can then discover whether she is of any interest to him. In a very real sense, therefore, the interview is a joint production.

We have already suggested that Pat can see herself as an interviewed patient and that, consequently certain topics become available to her. Yet again we have to note that she is not just a patient, she is a gynacological patient with a complaint serious enough to warrant her being referred to the hospital. So one category available, then, is "gynacological patient" and the adoption of that category might mean that her gynacological complaints are topically relevant and not, say, her ingrowing toenails, fallen arches, short-sightedness or anything else that might be wrong with her. This categorisation provides a mechanism for the organisation of Pat's complaints into those that can be produced now (her gynacological complaints) and those that, perhaps, should not. Our argument, at last unravelled, turns out to be a simple one. As a patient, Pat has a range of producible symptoms which constitute why she is at the hospital and why she is being interviewed. Instead of operating within a standard sociological framework and treating the data as an instance of "only an interview" with the participants as "interviewer" and "interviewee" we might be better advised to treat the whole encounter as one between a researcher and a gynacological patient whom, it turns out, has multiple troubles. The interesting thing then becomes the examinations of the ways in which this is accomplished. The methodological implication of this shift is to be found in the ways in which it highlights the work involved for the "researcher" and the "patient" in both "doing research" and "telling symptoms".

One of the features of Ian's research topic is the fact that although patients have symptoms which are tellable, they are not tellable to just anyone. That is to say, the patient's relationship to a doctor enables her to produce her symptoms for him where she might be loathe to do so if he were 'just another male'. It is this which precisely constitutes one of the social parameters Ian wishes to examine. Yet again, it seems, our methodological problem arises, this time in another form. The researcher is entangled in the self-same issues he wishes to study. Pat's immediate problems are not only what she is to talk about, but also to whom she is talking. Finding a category for Ian will enable Pat to decide which, if any, of her symptoms can be told. To see herself as a patient, would enable Pat to use the same device to find Ian to be a member of the hospital organisation. The device is made up of doctors, patients, nurses, non and para medical staff, drivers, cooks, welfare officers and so on. While this is an adequate in Sacks' terms,[4] It will not be of much use to Pat for it lumps together the very different interests and rights these categories have in her symptoms. However, she can use the activity of answering questions about her symptoms to find that it is typically medical staff who make enquiries in this manner. The researcher, Ian, might provisionally be treated as someone with a strictly diagnostic interest in her symptoms. This kind of interest might be contrasted with that usually shown by another patient. Ian's interest in the symptoms may be presumed to be similar to a doctor's. Where the latter is interested in them as signs of their causes, Ian may be interested in them for reasons of his own. What these may be she has yet to discover. The categorisation provides Pat with a way of organising her symptoms. The topics, at least first, will be medical and the relationships between the participants asymmetrical. She does not expect Ian to reciprocate with sets of symptoms nor to justify his being there. His reasons are both transparent (he talks to patients) and vague (but what about?). At the very least, we can find in her first utterance a specification as to what she thinks the encounter is to be about and an initial determination of who is who. However, it also does much more.

Although patients are very obviously people with troubles, there are great differences in the kinds of troubles that they have. Some, for instance, are much more noticeable than others; for example, some people have broken legs, open wounds or paralysis. Other people's ailments are 'hidden'. Pat's are of this latter variety and have the added dimension that their discovery by means other than her admission in particular circumstances (eg in a consultation) is likely to be embarrassing. Pat's admission that she has no control over her bladder is, in point of fact, a very remarkable one. A significant degree on control over one's body is one of the attributes of a mature, competent adult. Children, the weak minded, the senile, the delerious are all treated as incompetent at least partially on the grounds of their failure to exercise consistent control over their bodies. By her admission Pat is accepting that she possesses a similar degree of incompetence. But this incompetence is not like the inability to mend a fuse, make shoux pastry or read Sanskrit. It is, or can be, taken as criterial for the re-evaluation of a person's status as a competent adult.[5] The discovery of the loss of control might require the re-evaluation of Pat as a non-competent adult unless it can be normalised as expectable, unfortunate but inevitable, the usual outcome of certain conditions, or the like. The very nature of Pat's ailment means that she cannot display it and can only reveal it within a diagonostic setting. Everywhere else it has to be managed to make it unobtrusive. Pat's task can now be seen as the provision of a diagnostic sequence within which she can talk about what is wrong with her and her reasons for being at the hospital. Given that she is to talk about her reason for being at the hospital and that she can only do this within a diagnostic sequence, Pat's first utterance by starting a list of symptoms sets such a sequence up in a remarkably precise way.

2. Pat: Well er I've got two things er I've got no control over me bladder.

An examination of the data fragment will show that the two things she admits to are linked. The cough, which, superficially, is trivial, becomes serious when it is tied to the lack of control. That is to say, the cough is serious

because it is linked as a second thing to a first. Pat's initial problem is how to present what is wrong with her without her knowing exactly what kind of interest Ian might have in this potentially embarrassing admission. Her solution is the obvious one, she simply lists what she takes to be the two most important things wrong with her. This solution is generated out of the identities she allocates to herself and Ian.

For the next stage in the argument we will need to draw on a familiar distinction made between those that have a professional interest in other people's troubles, for example, lawyers, doctors, journalists and car mechanics, and those who profess a sympathetic interest such as friends, relatives, neightbours, or fellow sufferers. This kind of operative distinction will become clarified if you think about the activities of these people whose work consists in being 'professionally sympathetic' such as health visitors, priests and psychiatrists. As we have formulated them, the issues turn upon the resolution of Pat's identity puzzle.[6] We have seen that one very effective method that Pat can use for making that resolution is for her to produce some of her symptoms and see what the researcher, Ian, makes of them. Now we can say that such a diagnostic sequence once started might culminate in either 'professional talk' (leaving aside for the moment how we might decide what that is) sympathy or indeed 'professional sympathy'. The production of her ailments because it leads, or could lead, in all these directions provides a neat means whereby Pat can find out what the researcher wants of her and thus what the interview is to be about. For the ways Ian treats her symptoms will indicate how he sees the interview.

So far I have sought to establish that the interview is far from being the self evidently simple research procedure we often take it to be. I have suggested that, in this instance, we can see the interview as a joint production with neither Pat nor Ian knowing at the outset what it was to be about. They are in the process of constructing it without any pre-conceived notions of what it might finally be comprised of. Furthermore, we have suggested that the researcher's particular interests preclude him from formulating any specific design. Given these twin problems Pat's description of her symptoms provides one means of starting. It also froms the basis on which she can lay claim to further and more severe troubles which are not immediately available or obvious.

Yet More Troubles

Generally in this type of analysis, collecting together types of utterances or words proves to be of little value. On this occasion, however, I will suggest that some attention should be paid to the use of modification and qualification in the opening utterances, for it is by the use of such devices that Pat makes her presence at the hospital accountable. By accountable I do not mean justified, but simply that her treatment of her symptoms allows for the understandability of her presence at the hospital. It also provides a basis by which she can seek to link any other troubles she might have to her medical ones. Our concern is not with why the troubles are introduced but to show how they grow out of the conversation and are built into it. Thus the seriousness of Pat's other troubles may be found in the ways that they are linked to her medical ones. To begin with it would probably be best if we see how these non-medical troubles are introduced. This is achieved by a series of contrasts which serve to qualify or modify the medical ones.

(i) Normal Abilities

We have already noticed the significance of Pat's description of her loss of bladder control. This lack of control can be contrasted with what was normally expected of normal adults. In part, it is in this fact that Pat's patient status resides. Now we should notice that Pat is not claiming regular, occasional, partial or even sporadic loss of control. She is claiming no control whatsoever. This claim of 'no' control is a very special one. Compare, for a moment, the following sentences.

(a) John has no sense of direction

(b) There are no sheep in the field.

We take it, presumably, that 'no' in (a) is not offering the same order of description as in (b). That is to say we presume that the John is not in any sense totally incapable of moving from place to place but rather that on occasion he is apt to get lost, is unable to follow directions, cannot read a map and so on. In (b) on the other hand, the field is completely empty of sheep. Only one sheep would falsify (b) but one occasion when John follows directions would not necessary be taken as falsifying (a). Notice we are not seeking to build up this analysis in terms of a distinction between speaking literally and speaking metaphorically, or between the use of hyperbole or litotes. Rather, we are seeking to notice how in claiming 'no' control Pat is, in effect, trying to push a wedge between actions and their accountability. Pat is suggesting that some part of her problem at least, resides in the fact that she can no longer be held responsible for the actions of her own body. When it is remembered that this is one of the criterial features for the ascription of competent adult status, the potency of the admission is manifest. This is clearly linked to her next utterance.

5. Pat: See I'm losing water all the time

Thus Pat has not lost total control of her body but continuous control of this particular function. Two aspects of her troubles have been separately introduced the loss of control and its continuousness and then put together. By doing so, Pat is able to place her troubles in the category of both being uncomfortable and potentially embarrassing. This achieves the presentation of the magnitude of the problem. The fear of discovery and its social consequences means that Pat has to continually manage her symptoms in public settings. She has to be aware of her body in a way that most of us are not.

(ii) Frequencies

Pat's problems, then, are ever present. This issue is addressed directly in lines 8-9.

8. Ian: When yuh say y've not control is it continuous or y'know or is it when you move jump around a little bit.

Here Ian is offering two alternative temporal versions of the emission; the one in terms of a set of sequenced activities, the other in terms of its continuity. Pat re-emphasises her depiction by adopting at first a sequenced activity set but not the set offered;

10. Pat: Well its er if I drink as lot of fluid.

and then incorporating that into the alternative set with

12. Pat: It comes from me all the time.

The relation of the emission with an activity is expanded to emphasise its continuousness and then folded back into the activity sets by means of

12. Pat: // y'know every time I move I just have to move

Pat's formulations, then, take up the alternative sets provided by Ian and incorporating them manages to both extend and contrast with them. She loses water not just when she 'jumps around a little bit' but all the time. By re-constructing her symptoms in this fashion Pat is able to provide Ian with the resources to discover the kinds of interactional consequences her condition has for her. And so it will enable the expansion of her medical troubles into other kinds of problems.

(iii) The Extent of Secondary Symptoms

We will now turn to the distinction drawn between the designation of the cough as 'very bad' in line 15 and 'real bad' in line 21. Ian starts off treating the cough as just another symptom that Pat has produced. As such it might be said that he is perfunctorily dismissive of its importance. It causes some stress but is not especially important. By setting the cough up as the 'second' thing that was wrong with her

and saying that it was very bad, Pat provides a very different categorisation. This is accomplished by tieing the primary and secondary disorders together. If the emission is serious enough to warrant hospital attention then the cough must be seen in the same light. The cough is such that it exacerbates the emission.

21. Pat: An that gave me a real bad cough an I was jist it was jist pouring from me all the time

Ian's treatment of the cough is to be contrasted with the way that Pat forges a link between it and the emission. For her it is not just something else it is part and parcel of what is wrong. A link between the themes in the list is made. This tie is both accepted and legitimated by

22. Ian: Every time you cough you were wet down below

This second assessment is endorsed by Pat thereby demonstrating that she accepts that now he understands what the problems are.[7] She has, so to speak, accomplished her patient status by explaining the nature of her ailments and showing how they affect her. By line 24, then, Ian knows that although Pat's problems are medical in origin, some of them are social in manifestation. It just so happens that these are precisely what he is interested in, ie the social parameters of gynacological medicine.[8] The joint agreement on the nature of Pat's problems now casts Ian as a professionally sympathetic listener. Her troubles are the very thing he wants to hear about.

Having reached this agreement, Ian institutes the next and most obvious step. He enquires into the length of time that the problem has existed. Pat is asked to perform the relatively simple task of reviewing her own recent biography and matching her symptoms to it. Here Ian's use of the pro-term "this" is very important. By her answer Pat will have to show what she takes "this" to be - the emission, the cough, or both. What is interesting is that Pat proceeds by separating the question from its answer. By so doing she provides Ian with a package of materials to enable him to deal with the answer when it is eventually given. The materials provide for a hearing of why it is that Pat only 'thinks' that it started at X and that when she did Y she "realised" is was bad. This provision of the accountability of still to be produced actions is a standard practice which demonstrates members ability to read up in advance what might be inferred from what they have yet to say. It gives but another example of co-conversationists sequential analysis. The accountability is in terms of yet more non-medical troubles which prevent her from giving precise datings. The point is that the complaint she has is such that you would ordinarily expect anyone to take notice of it and remember when it started. She can hardly claim not to have noticed the emission. At the same time she says she cannot remember when it started. One line we could take be to see this as indicating that things are not really as bad as Pat has been making out, that her symptoms are not really sufficient to warrant her being treated and so on. To do that we would have to try and find Pat as being solely interested in preserving her patient status by avoiding the question. But this is not our concern. Instead we can look to the way in which Pat provides that her inability to perform the task set is caused by the fact that other, more momentus things have been happening to her. Thus Pat opens up wholly new areas by linking the loss of control to the loss of other normal activities. In doing so, she reduces the significance of her loss of control. She cannot do what we would normally expect anyone to be able to do but she has good reasons. These good reasons are the troubles that we do not yet know about.

In point of fact, Ian has already provided the linkage required. At line 17, in his assessment of the cough he says

17. Ian: That'll also put some stress on you.

By doing such 'professional sympathy' Ian provides a resource that Pat picks up. By his treatment of the secondary symptoms as stressful, Ian does not show anything like the same interest in them as he does in the emission. He does not ask when she coughs, if coughing is related to specific activities etc. Instead, he ties it straight back as something else that will cause stress along with the medical and social anxieties associated with the primary symptoms. In offering a summatory category "stress producing troubles" to describe the primary symptoms, the cough and the social consequences of them, Ian provies Pat with an organisation which shows one kind of interest he might have in such things. He demonstrates a device by which she can tie the things she has talked about so far to the things she should talk about in the rest of the interview. That is to say, Pat can find "stress producing troubles" to be what the interview is to be about. Consequently, she she may review her own life to find instances of them to tell. By offering "stress producing troubles" as the organisational device, Ian sets out his interest in the interview and provides the structure within which Pat can develop the kinds of topics Ian is interested in talking about. The device and its use is Ian's solution to the researchers problem posed at the beginning. Pat's linking of her non medical troubles to her medical ones is based both on that device and in the categorisations she has formulated. Her answers and his questions - ie the interview - are truely jointly produced.

Interviews, then, are unproblematic occasions in ways very different from those we often take them to be. In this brief paper, we have merely looked at one of the ways that a research interview can get started. How the researcher and his subject by resolving problems of categorisation are able to discover topics. That, in our data, this is accomplished within the first 28 lines is tribute not just to the fine grained methods that members have, but also to the ways that professional sociology is built upon them. As practicing sociologists, we know that interviews like conversations, meetings and debates are constructed by the participants. Yet all too often we present our subjects as passive; as bran tubs in which we dip for information. My concern has not been to show up yet more methodological inadequacies, but simply to say that sociology's subjects also contribute to the disciplines' professional practice. Were it not so, the whole enterprise would, in fact, be impossible.

NOTES

(1) My thanks are due to Joel Richman for permission to use this data.

(2) And none more famous than Garfinkel's account of his early experiments in Studies in Ethnomethodology. Prentice Hall 1967.

(3) I owe this particular formulation of the issue to Wes Sharrock.

(4) 'Pn adequacy' is set out in Sack's early work cf. H. Sacks 'An Initial Investigation of the Usability of Conversational Data for Doing Sociology' in D. Sudnow (ed) Studies in Social Interaction Free Press 1972 pp 31-74.

(5) This does not mean that a person will be found strange or eccentric but incompetent in the same way that a child or a lunatic is. Here lies a potent source of anxiety in adults. Pat has to control her symptoms because of what others might take them to reveal about her. Both Pat, and others, orient to the possible interpretations and their consequences. Here is to be found both a cue and a clue to what follows.

(6) This term does not correspond with Schenkein's usage Cf. J. Schenkein Identity Negotiations in Conversation. Unpublished manuscript and Some Methodological and Substantive Issues in the Analysis of Conversational Interaction. Unpublished Ph.D. dissertation Univ. California. Irvine 1971.

(7) This term is taken from Anita Pomerantz Second Assessments. Unpublished Ph.D. dissertation University of California Irvine 1975.

(8) We should not be deceived into thinking this mere serendipity. The whole thrust of this paper has been that the production of such symptoms is the outcome of the practices engaged in by the participants. It is a very practical accomplishment.