SYMPTOMS AND ILLNESS: THE COGNITIVE ORGANISATION OF DISORDER

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CONTENTS

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PREFACE

The research reported here is largely concerned with the theoretical development and empirical elaboration of a sociological concept of illness and a theory of social action related to that concept which would contribute to the understanding of illness and illness behaviour. I took this to be of relevance since the concept of illness employed by medical sociologists has been inadequate and the study of illness behaviour characterised by an absence of explicit sociological theory. That is, by a general failure to specify and systematically apply a set of assumptions regarding the nature of social phenomena and social action. As I argued in 1975(1), and as others have since argued(2), the social problem of why people do and do not use health services has been confused with the sociological problem posed by illness and illness behaviour. This confusion is rooted in the pragmatic origins of medical sociology, its patronage by medicine and its adoption of the epidemiological model of science.

The main theoretical assumption employed here is that illness is a social phenomenon constituted by the meanings actors construct in making sense of observed or experienced events. A related and equally important assumption is that the meanings imputed to these events have an influence on how they are subsequently managed. These ideas are derived from symbolic interactionism and labelling theory. For the most part, medical sociologists have ignored meanings; illness has been treated as an objective entity and causal explanations of illness behaviour offered whose implicit theories of action do not call for attention to meanings. The above assumptions have also been used to argue that disease and illness are distinct phenomena and must be studied in ways

which take account of their individual nature. While some medical sociologists have drawn this distinction between illness and disease, they have rarely followed up its implications in terms of theory or research. One reason for this is that the conceptual separation involved is usually asserted rather than having its origins in explicit propositions about the nature of social reality. The focus of the study reported here is on meanings. It aims to identify and describe some of the cognitive and interactional processes by means of which they are constructed. The methodological stance I adopt has been influenced by the sociological naturalists and the writings of the ethnomethodologists. Consequently, language, categorisation and social order are key and recurrent themes. It is then both sociology of illness and sociology of everyday life.

The theoretical and empirical problems identified as a result of the use of these particular perspectives are pursued using mothers' reports of the health and illness experience of themselves and their families as data. The research is to some extent about the management of disorders, mostly medically trivial, within the context of the family. There are two aspects to such management, cognitive and practical. The first refers to the process whereby common-sense knowledge is used to make sense of problematic experiences; the second to the actions undertaken in the attempt to solve those problems. Both of these are explored in the analysis of the talk contained within the respondents' accounts.

Though predominantly concerned with the construction of social order and social action the study is not totally devoid of practical significance. As Fay has suggested, interpretive social science "results in a kind of enlightenment in which the meaning of actions, one's own as

well as of others, are made transparent"[3]. The outcome of this is that "the possibility of communication" is increased. The analysis presented here facilitates communication between patients and those with whom they come into contact by offering a means whereby their experiences and actions may be understood. This contrasts with other sociological approaches which attempt to provide the means whereby experience and action may be controlled.

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INTRODUCTION

THE SOCIOLOGY OF ILLNESS: TWO TYPES OF DETERMINISM

Broadly speaking, the sociology of illness has been characterised by three main perspectives: the structural functionalism of Parsons' theory of the sick role, a positivist interpretation of Mechanic's essentially interactionist concept of illness behaviour and the more phenomenologically oriented, though in part determinist, account of mental illness provided by the labelling theorists. Each of these approaches have made a contribution to the sociological analysis of illness and its related phenomena though all have been subject to certain constraints and limitations.

Insofar as it is legitimate to identify sociological sub-disciplines only Mechanic's approach lies within medical sociology. Parsons' interest in illness arose out of his attempts to clarify his analysis of the social system by its application to an important sub-system of Western society, namely medicine. Though his concept of the sick role has provided the impetus for an impressive volume of work within medical sociology Parsons' original contribution lies outside the sub-discipline. Similarly, the labelling theorists and their approach to mental illness are rooted in the sociology of deviance rather than medical sociology per se. This identification of the origins of the approaches that make up the sociology of illness has more than a descriptive value: as I will argue, an understanding of the intellectual traditions out of which they have grown is an essential aspect of the critical appraisal of their theoretical propositions and implicit assumptions. This means that some attention must also be

given to the socio-historical contexts which have shaped the content of those traditions. For, as Horowitz has suggested:

> "Without an appreciation of the institutional setting of sociology - the place after all where most sociologists make their living and legitimate their careers - the analysis of theory appears a formalistic exercise in the passage of ideas from great man to great man. (Rather) sociological history is embodied in the educational agencies and research bureaucracies from which sociologists issue forth their proclamations and projections"(1)

The development and deficiencies of the sociology of illness are then the products of those institutional settings which provided the impetus for and the constraints upon its growth. Consequently, I would reject Fabrega's view that the failure of medical sociology to offer a viable model of illness lies in the complexity of the phenomenon itself(2). I would also reject Freeman's claim that "the limitations of current research efforts are solely technical, related to the present level of methodological expertise and the uneven training with which sociologists are provided"(3). These limitations are not due to the complexity of social life or poor methodology. They have their origins in the kinds of theoretical and methodological apparatus that have been used in the attempt to undertake a sociological analysis of illness.

The boundaries of sociological activity are drawn by the content of theory and the nature of method: more fundamentally they are delineated by institutional influences and by what Gouldner has called the infrastructure of sociology, the basis on which theory and method rest(4). Gouldner distinguishes between the explicit propositions of a theory and the assumptions out of which these emerge. These background assumptions are composed of world views, "primitive presuppositions about the world and everything in it", and domain assumptions which have less general

application and are "things attributed to all members of a domain"(5). In other words, they constitute a subtheoretical set of beliefs about members of symbolically constructed domains which influence not only the work of the sociologist but also the way in which all men approach the world. These assumptions arise out of man's experience of the material world. Their importance stems from the fact that they mediate between the sociologist, the world and his representation of it in theory. Consequently, all theory is, in part, an attempt by the sociologist to objectify and universalise some aspect of his own experience. According to Gouldner, the dominant theoretical traditions of sociology, what he calls Grand Theory, can be traced back to the personal reality of the theorists concerned(6).

If we are to account for the content of particular theories or methods it is necessary to consider both the kind of institutional contexts in which sociology is pursued and the beliefs sociologists themselves hold which provide a foundation for their work. As Stacey has argued, medical sociology, like mainstream sociology, tends to be parasitic on changes taking place in the wider society(7). These changes, which may involve the rise of political movements and the development of new institutions provide the stimulus for changes and developments within the discipline for they lead to a redefinition of problems and new ways of looking at them. As Gouldner says:

> "The most basic changes in any science commonly derive not so much from the invention of new research techniques but from new ways of looking at data that may have long existed. Indeed they may neither refer to nor be occasioned by data. The most basic changes are in theory and conceptual schemes, especially those that embody new assumptions. They are, thus, changes in the way the world is seen, in what is believed to be real and valuable"(9)

Thus, changes in society, which may involve a shift in the institutional location of sociology, are mediated by the changing sentiments, domain assumptions and the personal realities of the sociologist and those around him. The consequence is a shift in his material and intellectual interests, such that phenomena may be seen in new ways, give rise to new problems and new ways of attempting to solve them. The development of labelling theory within the sociology of deviance and its critique of orthodox criminology is a case in point. As I will explain in Chapter 1, labelling theory constituted a radical reappraisal of the sociological and social problem posed by deviance. Pearson has documented the connections between this and other "misfit sociologies" and the counter-cultural revolt of the 1960's(9). Labelling theory was an academic expression of the politics of dissent; as such its commitment was to the deviant and to a critique of society(10). This contrasts with what Matza has called the correctional perspective of orthodox criminology in which the commitment was to finding ways of minimising the threat deviance and the deviant posed to the social order(11).

In this Introduction I offer a critical review of Parsons' theory of the sick role and Mechanic's concept of illness behaviour in terms of the ideas outlined above. The aim is to identify the contributions and limitations of these two approaches and thereby to provide a point of departure for the alternative analysis that begins in Chapter 1. To the extent that the work of Parsons and Mechanic is derived from a distinct tradition of analysis in sociology, structural-functionalism and positivist empiricism respectively, the critique that follows is directed as much at those traditions as well as these authors. Although much of the published research in the sociology of illness is based on

the theory of the sick role or the concept of illness behaviour there has yet to appear a systematic critical appraisal of either. Here, I am not concerned with labelling theory and its conception of mental illness. Chapter 1 contains an evaluation of the propositions of labelling theory and their application to the phenomenon illness rather than specifically mental illness. I also examine and extend more recent writings on illness which have employed a social action perspective.

Parsons and the theory of the sick role

Though writings in the sociology of medicine can be found going back to the beginning of the century(12), and appeared sporadically in the half century that followed(13), the history of medical sociology proper does not begin until the 1950s. Since that time the discipline has grown rapidly so that it now holds the attention of a larger number of sociologists than any other sub-speciality. Until Parsons most of the classical theorists ignored medicine and its related concerns, except insofar as they related to the debate about social inequality and social class. However, although Parsons' analysis was wide-ranging and demonstrated the importance of medicine for society as a whole it would not be true to say that his work provided the stimulus for the growth of medical sociology. While his work was published at the beginning of this period of growth, intellectually it belongs to an earlier tradition.

Parsons is, first and foremost, Grand Theorist rather than medical sociologist. That is, his prime concern was with the specification and elaboration of the conceptual properties of the social system and the empirical analysis of its constituent sub-systems(14). Parsons'

work spans the decades prior to and following the second World War. Consequently, it has as its general social context the economic crises and social conflict of the thirties, and the economic reconstruction and expansion of the late forties and fifties. Poverty and prosperity have both made their mark on Parsons' theories. This is reflected in his pre-war emphasis on voluntarism and action theory and his post-war concern with systems theory(15).

Parsons' early stress on voluntarism, though apparently an abstract statement of human action(16), was essentially a conservative response to the crisis of its time. Intellectually, voluntarism took as its polemical target various types of determinism, emphasising the autonomy of man and the role and potency of moral values in action and social outcomes(17). Voluntarism saw man as a goal-seeking creature whose individual efforts can change his life. Men's actions, shaped by their own choices, motives and values were a major element in the interacting system of social forces. Given his belief in the viability of the capitalist economic system Parsons looked to individual moral commitment to provide the basis for social integration; the crisis was to be solved by individual effort acting in accordance with traditional values rather than by changes in the economic structure of society(18).

The post-war period, characterised by economic development and social integration, vindicated Parsons' optimism regarding the social order and led to a stress on its inherent stability. A qualitative change took place in his theory: the importance of moral values declined and the notion of the social system emerged. Here, society is seen as a set of interacting institutions which embody autonomous systems of integration and stabilisation. The focus shifts from the individual

to the system such that the main concern is not the outcome of moral commitment in terms of social order but the problem of how that moral commitment is produced. Although this systems theory reflects a reality in which Government intervention in the form of the Welfare State was part of the mechanism for distributing economic rewards and securing integration, Parsons retained his antipathy towards such intervention. Equilibrating processes were seen as social mechanisms which emerged independently of the conscious acts of men. Here Parsons breaks with his earlier stance for in this later work man becomes subordinate to and determined by the social system.

Both voluntarism and social systems theory were sociologies of non-intervention. That is, social stability and social integration were not to be produced by social engineering but arose out of conformity to values or spontaneous adjustments by the system itself. Both the explicit propositions of Parsons' theories and the infrastructure of conservative beliefs and sentiments upon which they rest are non-interventionist in character(19). This non-interventionist bias was also fostered by the immediate social context of Parsons' theorising. The relatively isolated academic milieu in which he was located meant that it was possible to define and pursue the problem of social order in a manner that was directed towards the production of coherent and internally consistent theory rather than knowledge that was socially useful(20). This was also encouraged by the absence of any opportunity for sociologists to contribute to national policy formulation for there was no direct link between sociology and Government(21).

Parsons' analysis of the sick role is located within the later theory of the social system(22). His interest in medicine and illness is empirical insofar as his analysis is designed to illustrate some of

the theoretical issues he raises in the the earlier part of the work[23]. His concern is not humanitarian, he does not seek knowledge of illness with a view to reducing human suffering. Nor is it practical, he is not interested in discovering means to improve or rationalise the delivery of health care. Consequently, his discussion of the sick role needs to be seen in terms of the theory from which it is derived. The majority of the work his formulation has inspired has been mainly concerned with the validity of the role expectations he describes. This tendency to abstract from the analysis those aspects which appear to be empirically testable stems from, and is evidence of, the general neglect of the theory itself. As a result, the nature of the theory of the sick role has been misunderstood.

Briefly, Parsons' theory of the social system, addressed to the general problem of order, is an attempt to formulate a systems theory derived from and incorporating an action or voluntaristic frame of reference. This attempt fails; firstly, because order is presumed rather than explained by Parsons' model and secondly, because of the conflict inherent in his concepts of action and system[24]. Ultimately, action becomes determined by the social system thereby removing the possibility of self-conscious action altogether[25].

The social system Parsons describes exists in an environment of systems, the physical, cultural and personality systems. These systems are inter-related in such a manner that the relationships of the one to the others determines the functional prerequisites of the social system. These functional prerequisites must be fulfilled if the system is to survive. Activity within the social system is then organised in such a way that these prerequisites are fulfilled. In turn this is dependent upon the participation of actors and the chanelling of their actions

in given directions. The content of human action is, therefore, based upon the a priori needs of the social system. However, the relationship between the actor and the system is a complex one. While determining human action the system is itself a product of that action, a consequence of social interaction between reciprocal role performers on an extensive scale.

The roles which structure human action and provide for system needs are internalised by the actor in the form of expectations which govern behaviour in social settings. At the level of the personality this represents an identification with such expectations in the form of a need disposition to conform to system prescribed patterns of behaviour. This need disposition is created in the process of socialisation where an individual learns an appropriate motivational orientation and a consensual value system. Deviance arises when such motivation is in conflict with inate personality needs such that appropriate motives are not instilled. One cause of deviance is then a disjunction between the social and personality systems(26). When such disjunctions occur mechanisms of social control come into operation to re-establish the necessary patterns of action.

Action is a product of the system in three ways. Firstly, roles are structured in terms of the needs of the system; secondly, they are received from the system and internalised by the actor and thirdly, action and interaction are the products of role-playing by reciprocal actors. Consequently, Parsons is not giving an account of social action but of externally determined behaviour or conduct. Role rather than action is the most important concept in the analysis since it provides the crucial bridge between the individual and the social system(27). Roles provide the link between the abstract needs of the system and the

activities which are functional with respect to those needs. As such, they have a cognitive dimension in the form of role expectations and a concrete aspect as manifest at the level of behaviour.

There are three aspects of Parsons' theory that are of relevance here:

1) the importance of the participation of individuals in the social system;

2) the structuring of human action in terms of specific roles;

3) the necessity to motivate individuals to act in accordance with the prescribed roles.

It is the problem posed by illness vis-a-vis these three elements that led Parsons to conceptualise illness as a form of deviance. There is then a direct relationship between his analysis of the social system, his view of illness as deviance and the institutionalisation of illness in the form of the sick role.

Illness, deviance and the sick role

Parsons defines deviance in two ways, from the point of view of the actor and from the point of view of the interactive system. Thus, deviance is the "motivated tendency for an actor to behave in contravention of one or more institutionalised normative patterns". In the context of the interactive system it is the "tendency for one or more actors to behave in such a way as to disturb the equilibrium of the interactive process". Deviance results in a change in the state of the interactive system or in its re-equilibration by the counteracting forces of mechanisms of social control[28].

Neither of these two definitions is explicitly used by Parsons in his analysis of illness as deviance. However, in stating that illness is disfunctional at the level of the individual and at the level of the collectivity he is primarily showing concern with the interactive system; "The individual who is incapacitated from performing his role functions would be a disturbing element if he attempted to perform them"(29). Additionally, "from the point of view of the social system too frequent a resort to illness represents a serious danger"(30). Here, Parsons is concerned with the ability of individuals to participate in social interaction; indeed, health is defined as, "the optimum capacity of an individual for the effective performance of the roles for which he has been socialised"(31), and refers to the individual's participation in the social system. Health is thus a functional requisite of a social system in that the accomplishment of the tasks essential for system survival are dependent upon it. Consequently, every society has an interest in the control and minimisation of illness.

Parsons, however, claims that illness is not purely a natural phenomenon, it is not something which just happens to people independent of controllable, motivated behaviour. Since it is not confined to the non-motivated aspect of social action its significance for the social system is greatly increased. Thus, its importance goes beyond that of dysfunction, which relates only to an individual's physical capacity to participate, and becomes an integral part of the social equilibrium itself. Since illness can be one way of avoiding social responsibilities the role of motivational factors in illness becomes of central concern. Consequently, medical practice becomes a mechanism for coping with the illness of collectivity members in both a therapeutic sense, restoring the physical capacity for interaction, and in a motivational

sense, preventing the use of illness as a form of escape. It is the latter aspect which determines the deviancy context of the discussion of illness, "because the balance of health and illness comes to be bound up with the balance of the motivation of individuals in their relationship to society as a system"(32).

For Parsons the evidence for the existence of the sick role is a set of institutionalised expectations which apply to the sick and he identifies four:

1) the sick person is exempted from his normal role responsibilities, such an exemption is not only a right but an obligation. It requires legitimation by and to the various alters involved. This legitimation is usually performed by a physician;

2) the sick person is not responsible for his condition; he cannot be expected to get well by an act of will, he must be taken care of;

3) illness is undesirable, the sick person has an obligation to want to get well;

4) the sick person is obliged to seek technically competent help and to cooperate in the process of trying to get well.

It is the opportunity that illness provides for escaping normal role responsibilities that makes the sick role an object of secondary gain. This entails a break in the individual's commitment to his normal roles such that "the elements of motivation expressed in the sick role are continuous with those expressed in a variety of other channels"(33). Illness is then regarded as "belonging to a system of such alternatives for the acting out of deviant motivations"(34).

Parsons attributes two main functions to the sick role which he conceives as a mechanism of social control. Firstly, it is functional with regard to the therapeutic process: "it constitutes one set of conditions necessary to enable the physician to bring his competence to bear on the situation"(35) and mobilises alters in support of the sick individual. Secondly, the sick role is functional with regard to motivation; it prevents the expression of deviant motives in the form of illness and reintegrates by ensuring motivation to recover and resume normal roles.

It is here that the problems begin to arise in Parsons' analysis. For, in order to maintain the view that illness is deviant, he is forced to claim that it is always positively motivated by a desire for secondary gain. While the avoidance of responsibilities may be a factor in malingering its role in respect of illness is more problematic. Consequently, Parsons has to conclude that these motives are mostly unconscious and operate to influence the nature and severity of the symptoms(36):

> ".... motivational factors accessible to analysis in action terms are involved in the aetiology of many illnesses"(37).

Such a contention is necessary so that illness fits the definition of deviance when viewed from the actor's perspective. This avoids the potential conflict of the alternative position, that illness defined in relation to the social system is a deviant state while the actor concerned is not a deviant as such.

A further problem can be identified in Parsons' claim that illness is the product of deviant motivation when seen in terms of the expectation that the individual is not responsible for his condition. It is this which distinguishes illness and other types of deviance:

> "Compared with other types of non-conformist behaviour, sickness entails passive withdrawal from normal activities and responsibilities. As such it must be distinguished from active rebellion against normal social expectations"(38)

Though he characterises illness as passive rather than active rebellion nowhere does he attempt to explain why deviant motivations are expressed in these different ways or why an individual is not held responsible for their passive as opposed to their active expression.

Once an individual has adopted that sick role it is not altogether clear how the expectations that go with it operate to perform the functions Parsons gives to them. While the system of reciprocal expectations involved does seem to function to mobilise therapeutic resources, which are to some extent independent of the incumbent of the sick role, how they act to restore the motivational balance of the individual is not so obvious. For one thing Parsons does not consider is deviance within the framework of the sick role itself. Thus, he fails to take into account deviant motivations which might lead an individual to manipulate the sick role so that he remains an occupant longer than is therapeutically necessary. It could be argued that the structure of the sick role does not allow for those integrative functions to which Parsons gives the majority of his attention. For, although an incumbent of the sick role is supposed to want to get well there is no way in which this can be ensured other than by commitment to the role. To assert that an individual will be committed to a role designed to lead to the readoption of a role from which he has been motivated, either consciously or unconsciously to escape, seems to be contradictory. Thus, how a desire to get well is inculcated during occupancy of the sick role is not explained. Nor does Parsons' analysis consider that

it may be the therapeutic benefits of the sick role that are the object of gain implying that a desire to return to normal roles is present prior to the operation of his system structured control mechanism.

There are, then, certain logical conflicts in the analysis of the sick role which derive not so much from the attempt to accommodate illness within a systems theory of society but from the manner in which this is attempted. The major problems arise from Parsons' contention that illness is a form of deviance. This makes it necessary, given his definitions of deviance, to show in what ways illness is a motivated tendency and to impute functions pertaining to motivational balance to the sick role. As I have argued, it is difficult to see how the sick role can function in this way given the role expectations that he describes. It may be noted that attributing such functions to the sick role and to medicine increases the functional importance of the medical profession, since commitment to perform the roles for which one has been socialised is at the heart of Parsons' view of social order. There is, perhaps, just a hint of ideology in all this(39), for though later theorists have accepted that medicine is an institution of social control(40), it has been so viewed from a critical stance, not one which sees such control as necessary for the viability of the social system.

The gap between the system of expectations which Parsons describes and the functions he claims it performs exists because in his analysis one is not directly derived from the other. He does not describe the parameters of the role and deduce its functions accordingly nor does he describe those parameters on the basis of the functions which are theoretically defined. The former is constrained by his systems theory and the latter by the need to describe expectations which can be recognised by reference to the real world. The compromise is to incorporate a set

of expectations which have the character of a common-sense abstraction into the framework of his social systems theory. As he says more than once, the system of expectations he describes "seem very nearly obvious on a common-sense level"[41]. At this level, the content of the sick role seems quite reasonable, it reflects to a certain extent what we all know about illness. This has been one factor important in its general acceptance by medical sociologists. However, Murcott, in claiming that the sick role "looks like the medical professional's blueprint for model patient behaviour" argues that their apparent validity stems from the middle class sociologist's tendency to share the ideas and values of the medical profession [42].

Parsons' analysis has been used or developed in several different ways:

1) Theoretical extensions of the analysis which take for granted its theoretical and empirical saliency. For example, Waitzkin has applied the concept of latent functions to the sick role in an attempt to demonstrate the contribution the sick role makes to "system adaptation or adjustment" in different institutional settings[43]. Bagley, attempts to fill a gap in Parsons' analysis and provide a discussion of deviance by patients and physicians within the formal boundaries of the sick role[44].

2) Discussions that are critical of the unimodal formulation of the sick role. For example, Freidson[45] considers it applicable only to middle class America; for others being sick in a socially acceptable way does not necessarily involve the elements that Parsons describes. It has also been suggested that the sick role be restricted to one type of illness. Kosa and Robertson claim that the idea of role implies a stable and long-lasting position within a social relationship and since

illness is seldom long-lasting or stable the sick role is applicable to chronic illness alone[46]. Others, notably Butler, and Kassebaum and Baumann, have maintained that it should be used only with reference to acute illness. What they suggest is the construction of a plurality of sick roles which apply to a wider range of empirical situations[47].

3) Empirical studies of the sick role. These have either applied the concept, treating it as a factor in positivist analyses, or have attempted to test the empirical viability of the system of expectations that Parsons suggests is relevant[48]. The latter have also been concerned with mapping variations in role expectations[49].

Few of the above studies have questioned the internal construction of the sick role. It has been assessed apart from the theory of which it is, in important respects, a product. It is for this reason that I have largely been concerned with understanding the sick role in terms of the social systems theory from which it derives. This undertaking has shown the sick role to be theoretically invalid, in which case it might seem irrelevant to assess its empirical validity. However, the particular character of the concept means that the two can be separated and judged independently. That is, the system of expectations that Parsons postulates represents a cognitive map, a scheme in terms of which people think about illness. As such, and because the system is not a logical product of Parsons' flawed theorising, it can legitimately be abstracted from its context and evaluated empirically[50]. This abstractionism I have criticised in others, but only because it does not derive from an understanding of the nature of Parsons' theory and the common-sense character of the expectation system. Rather, others have abstracted the expectation system from its context because it is the only aspect of sick role theory that is translatable into empirical

terms[51]. Any test of these expectations is not, then, a test of sick role theory, merely an empirical evaluation of Parsons' common-sense cognitive mappings. In fact, sick role theory, as a structural-functional theory, cannot be validated empirically. As Popper indicates, claims of functionality generally lack the attribute of falsifiability[52].

Studies which treat the system of expectations as a cognitive construct have provided some evidence that they do figure in common-sense conceptions of illness, though these studies are usually quoted as invalidating Parsons' formulation[53]. For example, Twaddle, Berkanovic and Gordon provide some evidence that some of the expectations apply to some people some of the time[54]. As a consequence, they argue for a plurality of sick roles or, with more promise, that behavioural expectations are specific to person-illness units. However, there are two major problems with these studies. They are constructed in ways which suggest that the findings may be an artefact of their method and, secondly, it is never clear that the cases the respondents report are instances of illness. Illness is used as a generic term to cover a wide range of events and is a sociologist's and not a respondent's category. Twaddle reports his respondents drawing a distinction between illness and sickness, and Apple distinguishes between illness and a health condition[55]. The inapplicability of Parsons' formulation may be a result of attempts to assess it by studying events other than those for which it was formulated. As I suggest in Chapter 1, a sociology of illness needs to be based upon a more specifically sociological conception which distinguishes disease and illness and pays attention to the categories which lay persons employ to define events and order their experience of the world. Data which demonstrates that something akin to Parsons' formulation is used as a resource in constructing definitions of illness is presented in Chapter 5.

A note on the rise of medical sociology

As others have documented elsewhere, the decline of the infectious diseases and the rise in the incidence of the aetiologically more complex chronic, degenerative disorders allowed sociology to gain a foothold in medicine via epidemiology where its contribution was to identify social factors which had a causal role in the onset and course of disease(56). While changes in medicine opened up the possibility of a sociological input, the most important factor in the development of medical sociology was the creation of the Welfare State and the increasing concern of governments with the health and wealth of the people. As Gouldner has indicated, the emergence of the Welfare State has been the most important stimulus for sociology as a whole for it was during this same post-war period that sociology became a respectable discipline within British Universities(57). The creation of the National Health Service in Britain not only provided a sphere for sociologists to investigate, it gave rise to problems of service delivery and interpersonal relations which sociologists were called on to solve. Thus, the involvement of governments in health, a generalised concern with social problems and the availability of resources to solve them stimulated not only the development of health and social services but also the disciplines needed for their support. Consequently, the history of medical sociology is largely the history of its patronage by the institutions of medicine and welfare.

Medical sociology is primarily an applied discipline; its origins and subsequent development have endowed it with the character of a discipline that is directed towards and best suited to solving problems. One important manifestation of this is the distinction frequently drawn between sociology in medicine and the sociology of medicine(58).

Sociology in medicine seeks to apply the perspectives and methods of sociology to medical problems; it has a certain continuity with social medicine and epidemiology. Its application is directed towards the discovery of the social factors which cause disease, documenting the distribution of disease in the community, assessing need for services and solving those problems of human behaviour and human relations which hinder the effective administration and delivery of health care. Thus:

> "Insights provided by the social sciences into the nature of social processes and into the structure of society and the relations between individuals are a necessary foundation to the practice of medicine, whether preventive or curative."(59)

The sociology of medicine is, however, exploitative. It treats medical settings and phenomena as objects of study, as resources to be employed in the formulation or testing of theories. Sociology in medicine generally involves collaborative research between the sociologist and medical personnel and entails participation in hospitals, research institutes or other medical settings. As a result much of the research is based on "premises borrowed uncritically from the common-sense of administration policy, the diagnostic categories of medicine and the ideology of the medical profession"(60). The sociology of medicine stands aloof from medical settings, for as Straus indicates, too close an identification with the profession would threaten the objectivity of the sociologist's work(61).

Freidson has claimed that there is a fundamental conflict between sociology in medicine and the sociology of medicine. For him, medical sociology is:

> ".... potentially liberating, in that it can remove both medical knowledge and the practical arrangement for applying that knowledge to human affairs from the rather unhealthy intellectual and political

> isolation it has enjoyed over the past half century, ever since medicine attained its present status as a dominant profession."(62)

Medical sociology is here used to challenge the power of the medical profession and to allow practical social policy to be based on rational principles rather than the ideas and prejudices of a powerful elite. It allows medical institutions to be critically evaluated in ways that provides the basis for change. Consequently, medical sociology needs to be independent of medicine and the interests of medical personnel so that the sociologist can adopt the ncessary critical stance. Given the relationship between medicine and medical sociology Freidson considers that much of what has currently been produced is sociology in medicine; it is directed towards reforms within the present structure of medical care and does not treat that structure as problematic.

The distinction between a theoretically oriented sociology of medicine and a pragmatically oriented sociology in medicine is of some importance to the current discussion of the work of Parsons and Mechanic. Although Parsons lacks the critical dimension that Freidson values he presents a sociology of medicine, albeit a sociology which offers ideological if not practical support to the medical profession. By contrast, Mechanic presents a sociology in medicine largely concerned with practical problem solving. The two biases to which this sociology has been subject accounts for what Johnson has recently called its "theoretical impoverishment" and for the ultimate demise of the Parsonian sick role(63).

Mechanic and the concept of illness behaviour

Mechanic, unlike Parsons, is primarily a medical sociologist rather than a social theorist. His work belongs in and owes much to the early

period of medical sociology's development. Though his writings span almost two decades they do not form, or attempt to form a systematic and comprehensive theory of society. Mechanic is no Grand Theorist. Rather, he addresses himself to the narrower concerns of medicine and its associated phenomena and does not try to situate them in a wider understanding of society. Nor is Mechanic's interest in medicine purely theoretical. Though he is involved in developing an understanding of medicine and illness the way in which this is pursued makes his work favourable to the requirements of social practice. As sociology in medicine it is an interventionist sociology based on different social and political beliefs and consolidated in different institutions to those that provided the infrastructure of Parsons' structural-functionalism. Mechanic's interpretation of social reality is not only favourable to the requirements of social practice those requirements have, in turn, helped shape the character of his sociology. The institutionalisation of medical sociology in the research bureaucracies of the Welfare State have transformed it into an applied discipline. Many of what I take to be deficiencies in the tradition of work that Mechanic represents can be traced to the social organisation of research practice. By that I mean the relationship between sociology, medicine and the State. Some would apply this argument not only to the sociology of illness but to medical sociology as a whole, while others would argue that medical sociology has begun to transcend the constraints I go on to identify(64).

Mechanic's concept of illness behaviour is defined as "the way in which symptoms may be perceived, evaluated or acted upon (or not acted upon) by different kinds of persons"(65). The concept does not seem to have been formulated on the basis of a critique of earlier work, nor is it presented as a development of such work. Its relationship to

the theory of the sick role, for example, is not explored. What Mechanic does is to demarcate a field of study:

> ".... the study of illness behaviour involves study of attentiveness to pain and symptomatology, examination of the processes affecting how pain and symptoms are defined, accorded significance and socially labelled, and consideration of the extent to which help is sought, changes in life regimen affected and claims made on others."(66)

and suggest that explanations of observed differences in the phenomena that constitute that field may be sought in the different attributes of individuals. He does, however, indicate the relevance of the concept to medicine:

> ".... illness behaviour determines whether, after the beginnings of the etiological process, diagnosis and treatment will take place. (Thus) systematic differences in illness behaviour in different populations have implications for public health programmes and needs for medical care."(67)

From its early formulation the notion of illness behaviour has been directed towards the medical setting, towards those providing care or those involved in the administration of health care resources. The concept has been addressed to the problems involved in the effective provision of health care rather than the sociological problems involved in explaining or understanding illness and social action. Moreover, its interpretation in research has been such as to make it acceptable to the health care professionals concerned.

Though the concept of illness behaviour was not formulated as a response to Parsons' analysis it does broaden the concerns of the sociology of illness by recognising the complexity of its associated phenomena. It also challenges Parsons' determinism by recognising the differential responses of individuals to those phenomena. That challenge is implicit

in the view of illness behaviour as a social process in which the definition and labelling of problems plays an important part:

> "The recognition of a deviation from a personal standard of functioning alerts a person to a problem. The recognition of such deviations is usually a prerequisite for a definition of illness, but not in itself sufficient for such a definition."(68)

> "Illness behaviour and the decision to seek care frequently involve, from the patient's perspective, a rational attempt to make sense of his problem and cope with it within the limits of his intelligence and his social and cultural understandings."(69)

The orientation involved in these statements in terms of assumptions about man and social action are quite clear. They are continuous with those contained within the concept of illness behaviour itself. That is, they imply a view of illness as socially defined and a view of social action as emergent out of the way in which problems are evaluated. However, one problem with Mechanic's work is that he does not systematically employ one theoretical perspective but merges cultural, social, socio-psychological and societal approaches in an attempt to explain the occurrence of disease, the reactions of the ill and the mobilisation of health resources(70). Fundamental conflicts in the assumptions upon which these approaches are based are totally ignored(71). As a result, Mechanic is able to make statements which are inconsistent, if not contradictory:

> "A science of behaviour would not be possible if we assumed that the ways people behave are largely a product of man's will and reason."(72)

> "Implicit in this orientation is the assumption that man can control events and that his ability to do this depends on his motivation, biological capacities, the symbolic environments available to him, the manner in which he organises his efforts and knowledge and access to the instruments of influence."(73)

It is the former assumption that has informed the majority of the research derived from the concept of illness behaviour. Rather than attempting to follow up the interactionist component of the concept studies have largely been confined to a positivist empiricism and the documentation of the socio-demographic and socio-psychological variables associated with observed behaviours such as the utilisation of health care facilities. The deterministic view of man that this entails is integral to an interventionist sociology and the liberal ideology in which it has its origins. It has much in common with a piecemeal social engineering approach which sees social problems as resolvable within rather than products of a particular social structure. The isolation of variables and study of the connections between them is, as Mills points out, the methodological counterpart of this liberal ideology. Its thesis of causal pluralism is eminently suited to such an ideology since its implications are for reform of rather than a challenge to an established order(74).

This resort to positivist empiricism is compatible with the necessity of an applied discipline to produce "scientific" and, therefore, useful knowledge. As Stacey remarks in discussing the British empirical tradition, "Because of its methodology, its use of carefully designed quantitative analyses and because it concentrates on the social attributes of individuals this work is more intelligible and acceptable to health care professionals than much of the more interpretive work currently being undertaken in sociology"(75). And as Freidson has said:

> "The necessary cooperation in research is likely to hinge upon the extent to which the proposed study conforms with the physician's notion of what makes sense, what he himself is interested in and what does not infringe on his own prerogatives."(76)

Consequently, the relationship between sociology in medicine and medicine itself has had an important influence on both the kinds of problems that have been studied and the methods used to study them. Roth has referred to the former as a management bias and the latter may be termed a methodological bias. This is not to claim that sociologists have been unwilling to undertake applied research or to accept definitions of what constitutes a problem or an appropriate methodology. For Kasl and Cobb see medical sociology as an extension of social medicine(77), Mechanic claims that "the statistical model is basic both to behavioural science and medicine"(78) and Butler subscribes to the view that medicine and sociology share common interests and a common approach. As he says:

> "The roots of the increasingly close collaboration of sociology and medical care are to be found in a common interest in certain aspects of disease and therapy, and partly in their similarity of approach to research problems: both disciplines share an interest in populations of individuals, a tendency towards abstract theoretical generalisations and a quantitative statistical methodology."(79)

The management bias in medical sociological research has meant that the study of illness behaviour has been reduced to the study of help-seeking since this is relevant to the practical problems of disparity between need and demand, inequalities in access to medical care, the provision of treatment at an early stage of serious disease and the allocation of a large part of the General Practitioner's time to the management of "trivial" disorder(80). The methodological bias in applied research has meant that studies of help-seeking have attempted to "understand the pattern of interacting social and psychological forces on the individual as he reacts to his state of health and its associated changes"(81). Theoretical explanations of help-seeking

based on an understanding of the processes of definition and evaluation out of which such behaviour emerges have been abandoned in favour of models constructed from complexes of causal variables. These models are thought to be useful for they allow for the possibility of prediction and control. Research which does not contribute to these objectives is superfluous and useless. As Matza has said of the sociology of deviance:

> "One reason for the overwhelming stress on etiology and the neglect of the phenomena themselves seems patent: etiology is more pertinent to the widespread aim of correction, whether it be restoration, reform or rehabilitation. Given the understandable dominance of the correctional perspective a concern with the nuances and with the character of phenomena themselves seems idle, literary and romantic."(82)

Thus, for Mechanic to indicate as his central concern "the varied social processes involved in recognising aberrance, labelling it, and dealing with it", is to contradict the methodology apparent in his approach to empirical research. However, for Mechanic social processes are nothing more than the interaction of factors or variables, a unidirectional pathway of cause and effect, and on this basis he is able to transmute a theoretical interactionism into a positivist empiricism. The failings of such an empiricism are accounted for in almost classic form:

> "Medical sociology as an organised research enterprise is in an infant stage and this stage is typified by the proliferation of hypotheses and impressions, in contrast to the accumulation of relevant and established facts."(83)

As I mentioned at the beginning of this critique, the problem is not one of youth or lack of sophistication in research methodology, it stems from the nature of the approach itself. This can be illustrated by a consideration of one of Mechanic's published studies.

The avenues open to positivists to develop their explanations of social phenomena are shown clearly in "Religion, religiosity and illness behaviour: the special case of the Jews"(84). This study, following the work of Zborowski, seeks to demonstrate an association between religion, ethnicity and the tendency to visit a doctor. We have here a classical positivist interpretation of the concept of illness behaviour, in which empirically observed differences are correlated with factors such as ethnicity, class, and religion. As a measure of illness behaviour the variable "tendency to visit the physician" is used, by means of which it is hoped to show gross differences in orientation to medical care. An index was constructed to measure "tendency to visit a physician" and scores on the index were correlated with the religion of the respondents. The results showed that Jewish students had a greater tendency to make use of a physician than students of Protestant or Catholic faith. This association held across social classes.

Mechanic tries to explain these correlations in two ways. Firstly, he locates the observation within the context of Jewish cultural traditions in which the basic assumption is that "an individual's recognition that a symptom or sign is abnormal is likely to result in part through learning and prior experience". Thus, the important role of health in Jewish culture and the over-protective role of the Jewish mother in the family form the basis and content of what is learned. What this does not explain is the differential tendency shown by sections of the Jewish research population, for the correlation is not perfect. Why do certain Jews escape this cultural conditioning? What variables distinguish one group from the other? A second explanation is that the observed tendencies represent differential responses

to stress by individuals of different religions. Here, an excessive concern with illness and symptoms is one mode of adapting to a stressful life. The underlying assumption being that "stress leads to an attempt to cope" and that a wide range of behaviours can be interpreted as coping responses, e.g. alcoholism, religious activity and illness. This explanation was supported somewhat by the observation that the Jewish respondents evidenced a lower level of religious practice than the other groups. What has further to be accounted for is why do Jews maintain their culturally derived orientation to illness while showing a low level of religious activity? For religion would seem to be an important factor in culture. And why is one mode of response chosen rather than another? Answers to these questions involves the formulation of more adequate explanations. This in turn requires the use of more rigorous variable analyses, both in terms of refining the measures of variables and by discovering further variables that correlate with the observed behavioural pattern or with other variables associated with that pattern. Thus each association between two variables, because it never accounts for the totality of cases, is explained by a further variable association which needs explanation in turn. For the associations always give rise to questions concerning those segments of the population not exhibiting the required trait. Ultimately, the research becomes an ad infinitum process generating series of factor associations or reaches a point which is no longer amenable to variable analysis; for example, the cultural learning thesis advanced above.

In this analysis the programme outlined in Mechanic's statements about illness behaviour is ignored; social action is not attended to as the outcome of the evaluation of problems and imputation of definitions. Meaning, symbolic environments and cultural understandings are

forgotten as are the cognitive and interactive processes out of which meanings emerge. They are taken for granted as "learned responses"(85), or treated as a variable such as "attitudes" or "beliefs". The interaction of variables is studied at the expense of the interaction of men and man reduced to a medium through which variables operate to produce behaviour.

While Mechanic's discussions of illness behaviour provide a more extensive foundation for the sociology of illness than Parsons' theory of the sick role its interpretation in research has resulted in another variety of determinism. As I have suggested, the form this determinism takes makes it compatible with the requirements of what Fay has called a policy science(86). Underlying this determinism is an infrastructure of beliefs and a conception of society which holds that social change is desirable and possible. The positivist approach, viewing social life as a complex of causally related phenomena means that interventions to effect change can be undertaken once those causal relations are known. Indeed, without this belief in its determined character the idea that society is open to scientific manipulation could not be maintained. As Fay says, the value of a social science is that it gives "an inter-subjectively verifiable account of how the social world operates". He goes on, "only a social science will give us causal explanations of the type that allow one to prevent the occurrence of an unwanted event or bring about the occurrence of one that is desired"(87). This type of determinism was not provided by Parsons' conception of the sick role. His view of the system determination of action and stress on society's self-balancing mechanisms meant that social change as a result of intervention was neither possible nor desirable. The non-interventionist character of this theory and its derivative the sick role made it

redundant in an interventionist sociology. Mechanic, for example, gies it only cursory attention even in his most extensive texts.

More recent developments in medical sociology, however, are beginning to provide the impetus for work which challenges the approach of Mechanic as well as of Parsons. The growth of medical sociology within university courses has meant that there has been an influx of students into the discipline who have been exposed to sociologies other than structural-functionalism and positivist empiricism. This is reulting in research which is theoretically and methodologically more diverse(88). Interpretive sociology and the ethnographic approach is beginning to appear in some quarters and is making an increasing contribution to the field. The rise of consumer, self-help and feminist groups in health is stimulating work of this kind. The editors of a recent collection of papers based on these perspectives have claimed that this signals medical sociology's emancipation from the medical model(89).

To summarise, I have presented a critique of two major approaches within the sociology of illness via an appraisal of their explicit propositions or their interpretation in research and an appreciation of their infrastructures of sentiment and belief and the institutional contexts in which they have been pursued. These approaches do not provide an adequate foundation for a sociology of illness since they are based on implicit and deterministic, that is, inappropriate, conceptions of social reality and social action. Parsons' notion of social reality involves a view of society as a self-balancing system of interrelated and functionally specific parts. Mechanic, along with much of the subsequent research on illness behaviour, ultimately subscribes to a view of the world as a complex of entities which exist in definite

and determinant relationships. Consequently, social action in the form of the sick role and illness behaviour is influenced by forces internal or external to the individual. The former consists of an internalised role given by the functional prerequisites of the social system, while the latter is the product of complexes of socio-demographic and socio-psychological factors. These are theories of social reaction rather than social action for the actor is a mere vehicle on which such forces operate. Moreover, they are theories which tend to reify social phenomena. That is, social phenomena are treated as objective entities having an existence separate from the consciousness and wishes of the actors who engage in or are influenced by them. What are essentially the creations of social actors are accorded the status of laws or facts which are not only external to those actors but which have a power over them such that it is they, rather than the actors themselves, that account for the order of social life.

Because of these inadequate conceptions of social action Mechanic and Parsons neglect or misconstrue the social character of illness. Parsons offers a theoretically problematic account of illness as deviance and the sick role as a mechanism of social control while Mechanic largely ignores the issue tending, in his few references to the matter, to subscribe to a view of illness as disease. As I will discuss further, this tendency to confuse illness and disease has constituted the main shortcoming of the sociological concept of illness. This arises because that concept has not been derived from explicit or viable propositions about the nature of social phenomena.

An alternative to the above perspectives which seeks to remedy the limitations I have identified is formulated in Chapter 1. Concepts

of illness and illness behaviour are developed based on the theoretical propositions of labelling theory and its precursor symbolic interactionism. Illness is viewed as a social construct, constituted by the meanings actors impute to make sense of observed or experienced events. As such it is not an entity but a property ascribed to a person. Accordingly, illness behaviour is defined as the consequences for social action of the imputation of given meanings to these observed or experienced events. Social reality and social order are thus treated as actors' constructs, the outcome of interpretive and definitional work. The writings of Schutz and some of the ethnomethodologists is used to identify some of the interactional and cognitive processes through which meanings, and thereby social reality, are constructed. Some of the procedures involved in the imputation of meaning, the allocation of events to categories and the emergence of action are located within the concept of a management sequence. They are explored in Chapters 4, 5 and 6 in an analysis of women's accounts of the health and illness experience of themselves and their families. The particular topics investigated were selected on the basis of the theoretical orientation presented in Chapter 1 and a detailed scrutiny of the data. The result of the subsequent analysis of the data is a description of the way in which the cognitive resources contained within a common-sense understanding of matters of health and illness are used to make sense of experience and provide for the stable orderly character of the world.

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2. He states "the large number of happenings or processes that can produce an instance of illness must be seen as a key factor that has impeded the development of an abstract model of the behaviours associated with illness", p.166 of Disease and Social Behaviour, M.I.T. Press, Cambridge, Mass., 1972.

3. Freeman, H., Levine, S. and Reeder, L., Handbook of Medical Sociology, Prentice-Hall Inc., Englewood Cliffs, N.J., p.484.

4. Gouldner, A., The Coming Crisis of Western Sociology, Heineman, London, p.46.

5. Gouldner, A., The Coming Crisis of Western Sociology, pp. 29-45.

6. The background assumptions embodied in any social theory also provide one pole of attraction whereby others are drawn to the theory. Consequently, the acceptance or rejection of a theory does not necessarily rest on its logical consistency or empirical validity. This is important in that it is one factor which determines whether a theory will be accepted or rejected by sociologists or lay persons who have cause to concern themselves with sociology. The not always academic debate over racial differences in I.Q. is perhaps a case in point.

7. Stacey, M., The Sociology of Health and Illness, Sociology, 12, 1978, p.285.

8. Gouldner, A., The Coming Crisis of Western Sociology, op cit, p.34.

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10. See Becker, H., Whose Side Are We On?, Social Problems, 14, 1967, pp. 163-76, where he argues for what Gouldner has called a partisan sociology.

11. Matza, D., Becoming Deviant, Prentice-Hall, N.J., 1969.

12. Warbase, J.P., Medical Sociology, Appleton, N.Y., 1910.

13. Roemer, M.I. and Mackintosh, J. (eds.), Henry Sigerist On The Sociology of Medicine, M.D. Publications, Inc., New York, 1960, a collection of essays written in the 1920s. See also, Henderson, J., The Physician and Patient as Social System, New England Journal of Medicine, 212, 1935, pp. 819-23.

14. David Morgan, Personal communication.

15. This discussion of Parsons' sociology draws heavily on the account given by Gouldner in The Coming Crisis of Western Sociology, op cit, Ch.5.

16. This statement was based on the writings of Weber and others of the Classical school.

17. Parsons adopted Weber's position which rejected the view of morals and ideals as super-structural, as determined, but gave to them a dynamic role in the development of social phenomena. See Weber, M., The Protestant Ethic and the Spirit of Capitalism, Scribner, New York, 1958.

18. Parsons, T., The Structure of Social Action, McGraw-Hill, New York, 1937.

19. Gouldner claims that this conservatism and optimism regarding American Capitalism originated in a personal reality shaped by the experience of a middle-class youth spent in the affluence of the 1920s and an adulthood spent in the confines of a nationally eminent and upper class University. Because of its financial autonomy this milieu provided a personal security in which the intellectual and career interests of the resident academics were protected from the harsh realities of the economic crisis.

20. A further factor influencing the production of abstract, technically coherent theory was the necessity for an emerging discipline to legitimate itself in the eyes of a sceptical academic community.

21. This might have been because the crisis was defined by Government as essentially economic.

22. Parsons, T., The Social System, The Free Press, Glencoe, Ill., 1951, Ch.10.

23. At the beginning of the analysis Parsons states, "It will perhaps help the reader to appreciate the empirical relevance of the abstract analysis if we attempt to bring together the threads of the foregoing discussion in a more extensive analysis of some of the strategic features of an important sub-system of Western society, that of medicine". Op cit, p.428.

24. Dawe, A., The Two Sociologies, British Journal of Sociology, 21, 1970, pp. 207-218.

25. Finlay-Scott, J., Changing Foundations of the Parsonian Action Scheme, American Sociological Review, 1963, pp. 716-735.

26. A second cause of deviance, and Parsons allows only two, is inadequate or inappropriate socialisation.

27. Dahrendorf, R., Homo Sociologicus, in Essays in The Theory of Society, Stanford University Press, 1968.

28. Parsons, T., The Social System, op cit, p.249.

29. Parsons, T. and Fox, R., Illness, Therapy and The Modern Urban Family, in Jaco, E., (ed.), Patients, Physicians and Illness, Free Press, Glencoe, 1958, p.234.

30. Parsons, T. and Fox, R., ibid, p.236.

31. Parsons, T., Definitions of Health and Illness in the Light of the American Social Structure, in Jaco, E., (ed.), Patients, Physicians and Illness, op cit, p.168.

32. Parsons, T., ibid, Second Edition, p.117.

33. Parsons, T., The Social System, op cit, p.429.

34. See Parsons essay, Definitions of Health and Illness in the Light of American Values and Social Structure, op cit, for a discussion of different ways individusls can deviate from expectations associated with institutionalised statuses and roles.

35. Parsons, T., The Social System, op cit, p.475.

36. Parsons, T. and Fox, R., Illness, Therapy and the Modern Urban Family, in Jaco, E., (ed.), Patients, Physicians and Illness, op cit, p.237.

37. Parsons, T., The Social System, op cit, p.430. His claim that "Illness is very often motivational in origin", p.429, rests on very flimsy evidence. He quotes the examples of psychosomatic illnesses and motivational elements in exposure to injury and infection. This point of view is restated in a more recent article, The Sick Role and the Role of the Physician Reconsidered, Health and Society, 53, 1975, pp. 257-278.

38. Parsons, T. and Fox, R., Illness, Therapy and the Modern Urban Family, op cit, p.237.

39. For example, Parsons claims that "(Medicine) is a functional alternative to the family for handling the motivational problems of personality adjustment". Parsons, T. and Fox, R., Illness, Therapy and the Modern Urban Family, op cit, p.227.

40. See, for example, Zola, I., Medicine as an Institution of Social Control, Sociological Review, 20, 1972, pp.487-504.

41. Parsons, T., Definitions of Health and Illness in the Light of the American Social Structure, in Jaco, op cit, p.177.

42. Murcott, A., Blind Alleys and Blinkers: The Scope of Medical Sociology, Paper presented at B.S.A. Annual Conference, Manchester, 1976. Similarly, Bloor, M. and Horobin, G. have argued that the sick role represents the professional's view of ideal patient behaviour, Conflict and Conflict Resolutions in Doctor/Patient Interactions, in Cox, C. and Meade, A., A Sociology of Medical Practice.

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Kassebaum, G. and Baumann, B., Dimensions of the Sick Role in Chronic Illness, Journal of Health and Illness Behaviour, 16, 1965, pp. 16-27.

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49. Gordon, G., Role Theory and Illness, College and University Press, 1966. Gordon identifies a sick and an impaired role.

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51. This is, perhaps, one of the few opportunities for subjecting Parsons' sociology to empirical test.

52. Quoted in Waitzkin, H., Latent Functions of the Sick Role, op cit.

53. A common criticism of Parsons' formulation is that it is uni-modal. Research showing that it has limited applicability invalidates this uni-modality and not Parsons' system of expectations. See, for example, Butler, J., Illness and the Sick Role, op cit.

54. Twaddle, A., Health Decision and Sick Role Variation, Journal of Health and Human Behaviour, 10, 1969, pp.105-114. Berkanovic, E., Lay Conceptions of the Sick Role, op cit, Gordon, G., Role Theory and Illness, op cit.

55. Twaddle, A., op cit, see footnote on p.110. Apple, D., How Laymen Define Illness, Journal of Health and Human Behaviour, 1, 1960, pp. 219-225. Many researchers have assumed that anyone who experiences symptoms of any sort defines themselves as sick, and may therefore be used to test the validity of the sick role expectations. Evidence is presented in Chapter 4 to show this is not the case. Consequently, many of these studies may not be a valid test of Parsons' system.

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64. For example, Johnson, M., Medical Sociology and Sociological Theory, ibid, in which it is argued that medical sociology as a whole is theoretically impoverished because of the dominance of medicine and the necessity for research to be sponsored by some agency. See also, Illsley, R., Promotion to Observer Status, op cit, where it is argued that medical sociologists are increasingly able to define and pursue their own interests.

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67. Mechanic, D., The Concept of Illness Behaviour, op cit.

68. Mechanic, D., Medical Sociology, op cit, p.22.

69. Mechanic, D., Medical Sociology, op cit, p.132.

70. Mechanic identifies cultural, social, social-psychological and societal perspectives. Medical Sociology, op cit, p.24.

71. It is, perhaps, the case that such conflicts are irrelevant in an applied discipline where practically useful research results are of more importance than theoretical coherence.

72. Mechanic, D., Medical Sociology, op cit, p.22.

73. Mechanic, D., Medical Sociology, ibid, p.24.

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CHAPTER 1

LABELLING THEORY AND ILLNESS

In this chapter I present a theoretical appreciation of illness and illness behaviour based upon propositions derived from symbolic interactionism and labelling theory. Propositions concerning the nature of social reality provide for an understanding of illness as a social phenomenon and propositions concerning the nature of social action provide for a theory of illness behaviour. Writings within medical sociology have, with few exceptions, neglected the former and allowed the theories of action assumed by their studies of the latter to remain implicit. Consequently, most of the models to be found in the literature are concerned only with the seeking of medical help, they treat illness, illness behaviour and help-seeking as if they were synonymous. Moreover, these models are usually founded on unexplicated conceptions of man and human behaviour.

Although there is a general absence of theorising about illness in medical sociology one area that has received some attention is that of the relationship between illness and deviance. Stimulated by Parsons' original statement, discussions of illness as deviance do constitute the beginnings of an attempt to formulate a sociological definition of illness. That such discussions have not formed a focus of controversy in medical sociology is, perhaps, testimony to the lack of concern with the discipline's conceptual apparatus. The debate about illness as deviance, such as it is, is reviewed here in order to demonstrate the limitations of the concept of illness that has been employed. It also provides a point of departure for the development of a conception of illness using theories originating in the sociology of deviance.

Illness as deviance

The notion that illness can be considered a form of deviance has its origins in Parsons' theory of the sick role, though its association with sin in specific historical settings was recognised earlier by Henry Sigerist(1). It is, however, Parsons' formulation that has informed much contemporary theorising, although few have attempted to extend Parsons' reasoning within the framework of a social systems theory. Only Bagley has attempted to remain faithful to this scheme in his analysis of counter deviance "the deviant performance by patients and physicians within the formal boundaries of the sick role itself"(2). Others have examined the proposition that illness is a form of deviance from different theoretical perspectives.

Parsons' analysis of illness as deviance has been dealt with extensively in Chapter 1 and does not need repeating here. His emphasis on actor motivation is however, shared by Mechanic although the latter approaches the problem from a societal reactions perspective and not a structural-functionalist one. From the societal reactions approach Mechanic distinguishes two ways of viewing deviant behaviour. These he calls health-illness and goodness-badness dimensions(3). Accordingly, an act is classified by those viewing it in terms of one of these two continua on the basis of the assumed motivation of the actor in performing the act. If the act appears reasonable in terms of the assumed motives then it is likely to be characterised along a goodness-badness dimension. If the act appears peculiar or at odds with assumed motives then it is likely to be viewed in terms of the health-illness dimension. Mechanic claims that most illnesses fall along the health-illness dimension. However, since he states that people are rarely held accountable for their physical ills, they are events rather than motiva-

ted acts, it would seem that an analysis founded on actor motivation is inadmissible. It is only in the case of malingering or self-inflicted injury that such an analysis can apply. Even if we distinguish, as Mechanic fails to do, between an illness condition and illness behaviour then actions such as the adoption of the sick role or the seeking of medical care may be seen to be reasonable given the actor's desire to get well. In this instance illness behaviour would be defined according to a goodness-badness dimension. Mechanic's analysis is faulty because he concerns himself with those situations in which unexpected behaviour may be interpreted as illness or deviance, a different problem altogether, and one which has been discussed more successfully by others(4).

Another approach to the problem of illness as deviance may be called the normative perspective. This employs a definition of deviance as behaviour which violates normative expectations(5), and considers the extent to which illness contravenes such expectations. Some theorists using this perspective have concluded that illness cannot be considered a form of deviance since it is unreasonable to postulate that individuals are not expected to fall ill(6). They support this position by comparing illness and crime; thus, though an individual is expected to fall ill at some time in his life he is not expected to commit a crime. Even those members of social organisations which control illness are not expected to escape falling ill at some time, while members of law enforcement agencies are expected not to commit criminal acts. This argument is however, somewhat weak. It is expected that some individuals will fall ill and some will commit crimes, the existence of complex institutions of health care and law enforcement are evidence of that. Additionally, though proponents of the normative perspective

may attempt to demonstrate differences between crime and illness, others have described their similarities. Twaddle indicates some of these[7]:

> "Most important is the fact that in both instances the behaviour of the individual in question mobilises agencies of social control. Social processes are initiated that are designed to alter behaviour. Second, there are related role changes. In both instances the person ... suffers from a 'presumption of irresponsibility' in which it is assumed that others must intervene to control behaviour. Accordingly, the area of personal autonomy is reduced as others presume to decide what is best for the individual and to determine appropriate behaviours for him."

There are then difficulties in advancing the argument that illness is not a form of deviance by showing normative differences between illness and crime, for the identification of such differences is arbitrary given that similarities may also be discerned. Even Parsons, though he insisted that illness is a form of deviance, was aware that illness was distinct in some ways from other types of deviance in that "the sick person is not regarded as responsible for his condition, he can't help it"[8].

Some writers using this approach have distinguished between an illness condition and the behavioural consequences of such a condition. It is claimed that catching a cold or pneumonia, breaking a leg or having a heart attack does not involve contravention of normative expectations. In fact, it would appear that there are no expectations governing these situations. They may be unexpected in that they are unforeseen but this does not mean that institutionalised expectations are violated. Robinson points out[9] that it is difficult to see how the behavioural consequences of these conditions can be said to constitute deviant behaviour as long as the individual conforms to the normative expectations about how a sick person should behave. It is perhaps only in

the case of venereal disease that the afflicted may be considered deviant, but this has to be seen in the light of the behaviour which is a contributory cause of the onset of the disease. However, this position is disputed by other analysts who use a normative frame of reference. Freidson, for example, states that illness is a type of deviance since it involves digression from a set of norms representing health or normality. The ill person, it is claimed, deviates from the statistically average state of the population and from the positive and social norm of optimal health. Therefore, illness constitutes both biological and social deviance(10).

Given that opposing positions may be adopted on the basis of the same frame of reference it is perhaps pertinent to ask about the value of an analysis of illness as deviance. For where does a conclusion one way or another lead? The majority of writers have not taken the discussion much beyond a consideration of the original proposition that illness is a form of deviance. Medical sociologists on the whole have not, contrary to Twaddle's assertion, used the deviance perspective to facilitate an understanding of illness(11). Only the functionalists have used the notion as an explanatory device. Others have merely suggested that sociologists should undertake comparative studies of crime, illness and other forms of deviance(12).

However, the importance of these discussions does not lie in their theoretical viability or the directives they give for future study. Rather, they raise fundamental questions about the conceptual apparatus that sociologists of illness have used. As I touched upon in the previous chapter the concept of illness to be found in the literature is crude and unclarified. It is rarely defined, the assumption being that reference will be made to commonsense to discover what is meant by

the term. Where it is defined it is often taken to refer to more than one thing. For example, according to Kasl and Cobb, illness is "a disturbance in the normal functioning of body processes" and "changes in the individual's capacity to carry out his normal social obligations"(13). As they state, "this conforms well to popular conceptions". That this sort of definition can give rise to confusion is evidenced by different ways of using the term. Sometimes it is used to refer to a social state, sometimes to a condition such as cancer or epilepsy. What is obscured by the blanket use of the term illness is the social and biological aspects of the phenomenon and the differences between them. The dual nature of what is referred to as illness was first made explicit by Parsons. He defined illness as "a state of disturbance in the functioning of the total human individual, including both the state of the organism as a biological system and of his personal and social adjustment". It is thus "partly biologically and partly socially defined"(14). A recognition of the duality of what is termed illness is perhaps implicit in the separation by some writers of the entities illness and illness behaviour(15), although this in itself does not provide an adequate foundation for a more precise sociological concept.

Freidson, in drawing a distinction between illness as biological and social deviance argues not only for the conceptual separation of the two dimensions but also for their mutual independence. He goes on to demonstrate the need for the epistemological autonomy of the sociology of illness. As he states, there is no substantive necessity for medical sociology to adopt the ontology of medicine unless it is expected to perform the same task, to test and refine medical conceptions of illness and its treatment. He maintains that in human societies naming something as an illness has consequences independent of biology and this is the

proper concern of the sociologist. The state of the biological organism is consequently, irrelevant. This fails to take account of the fact that in human experience illness is both biological and social, the former is of relevance insofar as it is related to the latter. Thus, a sociological concept of illness should specify what is biological and what is social and must also accommodate the sociologically relevant relationship between these separate dimensions. Although a start has been made, so far, no concept of illness has been successful in meeting these criteria. Freidson's contribution is, however, a valuable point of departure and a corrective to those whose use of the term illness is derived from medicine or commonsense.

In the remainder of this chapter I construct a concept of illness which conforms to the criteria just outlined, and provide an answer to the question "What is illness?". Propositions drawn from symbolic interactions and labelling theory are used, not because of any a priori definition of illness as deviance, but because these propositions are concerned with the nature of social phenomena and social life. There is then no reason why theories developed by sociologists of deviance should not be used to solve theoretical problems in other fields(16). The use of these theories also maintains some continuity with Mechanic's extensive writings which are not entirely devoid of potential. The processual view of social life they embody contrasts with the determinism that is a feature of structural-functionalism and positivism, a determinism I have attempted to criticise.

For the present, a brief critical assessment of labelling theory is on order. This will be selective and will concentrate on major tenets and their weaknesses. These have been chosen because they appear

to be most useful in dealing with the theoretical problem posed by illness. I will also examine some of the criticisms to which labelling theory has been subject.

Labelling theory: A selective assessment

Labelling theory, as initially formulated by Lemert, Becker and Kitsuse[17], attempted a radical shift from contemporary perspectives on crime and deviance. As such, it comprises a critique of those perspectives, a different view of the nature of the phenomenon under study and an alternative framework by means of which the phenomenon was to be explained. Prior to labelling theory, sociologists had viewed deviance commonsensically as an objective entity, and the only point that required investigation was the cause of deviant behaviour. Thus, correctional theorists attempted to discover why certain individuals indulged in deviant behaviour while others did not, generally by factor analysis of deviant and non-deviant populations. For these theorists, the official response to deviance was 'naturally' not a problem, since it was a 'natural' response to a 'given' state of affairs. At the same time, the perspective used to define deviance was 'naturally' not at issue. In challenging this causal approach of the correctional theorists, labelling theory took as its major concerns the following: 1) defining deviance as problematic, 2) recognising that deviance must be perceived as constructed from someone's point of view, 3) viewing officials' response to deviance as problematic, 4) stressing description rather than cure as the goal of deviance research, 5) shifting the temporal focus from the past to the present, 6) allowing for the development of field research methods, 7) acknowledging the importance of the actor's will.

The most succinct, but by no means comprehensive, statement on the labelling approach is made by Becker, who indicates the inseparability of deviance and social control from processes of social definition:

> "... social groups create deviance by making the rules whose infraction constitutes deviance, and by applying those rules to particular people and labelling them as outsiders. From this point of view, deviance is not a quality of the act a person commits but rather the consequence of the application by others of rules and sanctions to an 'offender'. The deviant is one to whom the label has been successfully applied; deviant behaviour is behaviour that people so label."(18)

This apparently simple dictum has given rise to a variety of responses, some derived from a misunderstanding of what it proposes, and others from unrecognised deficiencies in the proposition itself. Additionally, there are apparent contradictions in some of the subsequent categories created by Becker that make them inconsistent with the above statement. These problems will be considered in the light of various criticisms of labelling theory.

Several critics have noted problems with regard to labelling theory's definition of deviance. Gibbs in particular(19), has claimed that the labelling approach does not distinguish adequately between deviance and non-deviance, for labelling analysts fail to specify what kind of social reaction and how much social reaction are required before an act or an individual can be considered deviant. This, however, confuses a normative and a labelling definition of deviance; Gibbs takes the proposition that it is societal reaction that determines if an act is deviant or not and attempts to apply it in the same way that a normative definition is applied. Thus, he wants to use 'societal reaction' as a substitute for 'norm', as a fixed standard by which behaviour can

be judged. But, given the terms of the labelling perspective, what does and does not constitute deviance is determined in concrete social situations by the actors themselves, the categories are not created extra-situationally by means of theoretically constructed criteria. Thus, labelling theory has a conception of deviance, it indicates how deviance comes about, but it does not define what is and what is not deviant. Deviance can only be investigated empirically, it cannot be predetermined theoretically. Gibbs' criticism is then irrelevant, he wants to use the notion of social reaction as a measure of an objective social reality independent of processes of social definition.

Gibbs is also troubled by the notions of the secret deviant and the falsely accused, both categories explicitly recognised by Becker(20). Thus, Gibbs asserts that to be consistent labelling theorists:

> "would have to insist that behaviour that is contrary to a norm is not deviant unless it is discovered and there is a particular kind of reaction to it. Thus, if persons engage in adultery but their act is not discovered and reacted to in a certain way, then it is not deviant! Similarly, if a person is erroneously thought to have engaged in a certain type of behaviour and is reacted to harshly as a consequence, a deviant act has taken place!"(21)

This criticism cannot be answered satisfactorily at this stage. We can note, however, that though it appears a logical consequence of labelling propositions, it is in fact a crude mis-application of those propositions. Gibbs is much nearer the mark, and of more relevance, when he questions the labelling theorists claimed departure from normative definitions of deviance. For does not the category secret deviance suggest that deviance can be defined normatively and in the absence of social reaction (if the 'deviance' is 'secret' there can be none)? A similar criticism is made by Katz(22), with regard to Becker's other

categories, obedient behaviour and rule-breaking behaviour. For do these not imply also that deviance may be detected by the scientist or independent observer without the perception and labelling as deviant by community members? Does this not imply that rules exist which can be used to classify actions as rule-conforming and rule-violating independently of labelling? Katz's criticism is both correct and incorrect. Firstly, the categories obedient behaviour and rule-breaking behaviour do imply that a set of criteria can be applied independently of labelling, but these criteria do not establish anything more than rule-violation. Rule breaking behaviour and deviance, as I shall discuss later, are distinct as categories and as entities. Further, the rules or criteria used in evaluating rule-breaking behaviour are not the independent constructs of the scientist or observer but are those criteria that it is presumed would be used by witnesses to any act in question. The observer is thus not using normative definitions, merely indicating that witnesses to acts do assess behaviour according to their own criteria or standards. Again, this will be clarified later.

Pollner addresses himself to similar sorts of questions from a phenomenological perspective. He detects a deep ambiguity in Becker's concept of deviance as a community creation which derives from a combination of the absolutist proclivities characteristic of the commonsense actor and the relativistic model suggested by the labelling process(23). Pollner calls these two aspects commonsense and sociological models of deviance, or models I and II respectively. They are distinguished as follows:

> "Model I treats the deviance of an act as existing independently of a community's response. It implicitly posits that certain acts are responded

> to in particular ways because they are deviant, that is, their deviance is defined by criteria other than the fact that you or I happen to regard or experience the act as deviant. Model II treats deviance as a property which is created and sustained by a community's response to an act as deviant. It proposes in effect that while the commonsense actor may regard the deviance as a pre-existent cause of his action toward a particular act or person, deviance is being constituted by those very actions."(24)

These two versions of deviance "represent distinct epistemological models". The contradiction between them manifests itself patently in Becker's classification or typology of behaviours mentioned above. This typology is constructed by the cross-classification of obedient and rule-breaking behaviour, with whether or not an actor is perceived as deviant. Secret deviance and falsely accused are two categories so produced.

	Obedient behaviour	Rule-breaking behaviour
Perceived as deviant	Falsely accused	Pure deviant
Not perceived as deviant	Conforming	Secret deviant

According to Pollner, this typology does not illustrate features of the labelling model, model II, but is a "portrayal of how model I views the relationship between community perceptions and deviance". In fact, the typology is an amalgam of both. Given the presuppositions of the labelling model, the categories secret deviance and falsely accused are "conceptual anomalies", for, again, if deviant behaviour is behaviour that people so label, secret deviance where, "an improper act is committed but no-one notices it or reacts to it as a violation of the rules"(25), is theoretically inadmissible. If no-one reacts to the act as deviant it means that it is not deviant. Similarly,

falsely accused is inadmissible, for if such a reaction has taken place there can be no error, the person is a deviant. The categories of conformity and pure deviant are theoretically sound from the point of view of both model I and model II. A model II typology would consist of these two categories alone[26].

However, as Pollner goes on to say, a model II typology is deficient in that it precludes consideration of a variety of commonplace recognitions[27]. After all, the phenomena secret deviance and false accusations do occur in everyday life. The two models of deviance must, thus, be reconciled to take account of this. Pollner achieves this through recognising that "while a community creates deviance it may simultaneously mask its creative work from itself". The commonsense view of deviance is, then, a gloss for the accomplishment of deviance. As such, model I is an integral part of the process of creating deviance, model I reasoning is situated in a model II process. This is partially accepted commonsensically, though it is not necessarily recognised, in the delineation of Becker's four categories as distinct practical possibilities. What must be achieved, and this Pollner does not attempt to do, is to accommodate these four categories within the labelling frame of reference. It is a failure to do this, coupled with some of the difficulties described above, that has led some eminent deviance theorists to oppose the view that "deviance is not a property inherent in certain forms of behaviour, it is a property conferred on these forms by audiences that directly or indirectly witness them"[28], and to claim that most deviant behaviour is a quality of the act[29]. This is indicative of the necessity to clarify all the conceptual problems under discussion.

The ambiguities that the above critics have revealed in a labelling conception of deviance derive, I think, from two sources: the unexplicated use of terminology, and a failure to consider the possibly complex nature of the community that can label a given act as deviant. The ambiguities are not then inherent in labelling theory's approach to deviance, but can be resolved by further consideration of the distinctions and the relations between rule-breaking behaviour and deviance, the notions of rules or standards used by labelling theorists, and an examination of the theoretical intentions that lay behind the construction of labellings conceptual apparatus.

Becker's maxim that "the deviant is one to whom that label has successfully been applied; deviant behaviour is behaviour that people so label", is a theoretical rendition of the commonsense observation that not all people who break a law or rule are categorised as deviant, and not all those so categorised have in fact broken a law or rule. Though the theory is derived from an interactionist understanding of the social object(30), it is also shaped by its polemic against earlier theories of deviance which based their explanations on 'known deviance'. Deviance rates and officially collected statistics on crime were, thus, taken to represent an aspect of objective social reality, a 'deviant population', and compared with the 'non-deviant' population to produce explanations of the causes of crime(31). According to Becker's proposition, this is not a valid methodological strategy, for the populations identified as deviant and non-deviant are not homogenous. The former contains instances of individuals who have not committed the given act, but who appear in deviance statistics, and the latter contains individuals who have committed the given act but who have not been labelled deviants, and who do not, then, appear as a unit in official

statistics[32]. The distinction between rule-breaking behaviour and deviance was thus made to give added thrust to this critique, for it illustrates the uselessness of deviance theories based on rates of deviation, for the actual distribution of rule-breaking behaviour does not, following the selective and erroneous action of agencies of social control, correspond to those rates. Thus, rule-breaking behaviour identifies similar acts only a proportion of which get labelled as deviant.

The concept of rule-breaking behaviour only implies a normative definition of deviance if it can be shown that the labelling theorist is assuming a normative consensus, when he imposes definitional criteria that he assumes are operational. This is a very different matter from recognising that individuals and social groups construct their own criteria for recognising deviance. To use Gibbs' example, 'adultery' may well be considered contrary to norms in certain middle class milieu, but this is certainly not the case in hippy communes[33]. Thus, undetected extramarital sex may constitute rule-breaking behaviour as far as the former group is concerned, and at some time may be labelled as deviant, but not for the latter, for there extramarital sex is both expected and condoned. Yet, from the quote given above, Gibbs would have us believe that there is some normative consensus whereby 'adultery' is always a manifestation of deviance. Obviously, it is incorrect to interpret either middle class or hippy milieu in terms of the standards of the other, or to assert common standards. Of course, an observer can detect rule-breaking behaviour in either setting, but only by reference to the normative or rule systems used by the individuals in that setting. Thus, when Becker speaks of secret deviance it is to unlabelled rule-breaking behaviour that he refers; an act is committed,

but no label is applied. The category falsely accused refers to the application of the label in the absence of the commission of the act. This indicates the somewhat arbitrary nature of the imputation process. It also demonstrates how the problems that Pollner detects in these two categories can be resolved, at one level, by changes in terminology. For it shows how they merely refer to different relations between the commission or non-commission of a rule-breaking act and the application of a label.

These problems can also be resolved at another level if we consider further the nature of the audience that witnesses and/or labels given acts as deviant. Most labelling theorists, and their critics, have concentrated unduly on law enforcement agents as their referent audience. To fully comply with one tenet of labelling theory, however, that deviance is always constructed from someone's point of view, all possible audiences should be considered. Schur, outlines three such audiences:

> "One audience is the society at large, the complex of interwoven groups from which emerge general reactions to various forms of behaviour. Another audience comprises those individuals, including significant others, with whom a person has daily interaction and by whom he is constantly labelled in various ways .... A third audience includes official and organisational agents of control."(34)

and I would add a fourth, the self(35). From this, the notion of secret deviance is not necessarily inadmissible. For an act may be considered deviant by the actor performing the act, even though it is hidden from all other audiences. Thus, a covert homosexual or adulterer may consider himself a deviant because he shares the standards and criteria that he knows would be applied by other audiences. This deviant is self-labelled. In the case of the falsely accused, the individual may be a

deviant from the point of view of the agencies of social control, but he himself and perhaps others know that 'he didn't do it', and therefore is not a deviant. The labelling conception of deviance is thus complicated by the inclusion of the points of view of all possible direct and indirect audiences. For any given act may be viewed differently by different audiences who apply different evaluative criteria or rules of evidence. This confirms Gibbs' opinion that labelling theory is relativistic in the extreme. One consequence of this is that the notion of rule-breaking behaviour is only valid as long as an audience is specified. It is essential to know whose rules rule-breaking behaviour violates. Otherwise, rule-breaking behaviour becomes rule-breaking behaviour per se which does imply a normative definition. In addition, it also enables us to understand the origins of the confusion in Becker's four-fold classification, for here, Becker collapses different audiences together; he implies but does not specify their existence.

The overemphasis of the labelling theorists on agencies of social control can, I think be explained by their political leanings and their resultant polemic against law enforcement organisations. Their neglect of the concept of the self, a central aspect of Mead's interactionism, is, however, particularly surprising given their debt to his analysis of the social object. The implications of this ommission will be discussed later.

Labelling theory, then involves a reconceptualisation of and a re-orientation to the phenomenon deviance. It does not, as I indicated above, provide a definition of what does and what does not constitute deviance. This, according to Schur(36), has been a major reason for the confusion and controversy surrounding labelling. The literature

contains criticisms of labelling theory on definitional grounds both from positivist criminologists and sociologists with phenomenological tendencies. Hagan, characteristically, complains that, "the concepts utilised in interactionist explanations (of deviance) lack clear empirical referents, and when provided operational indicators are vague ... This failure to specify independent measures obscures the possibility of prediction ...."[37]. Box, while he would probably agree that one implication of labelling is the impossibility of defining deviance objectively, claims that the labelling theorists have continued to use legalistic definitions of deviance. Warren and Johnson[38], make a similar point when they state that the proponents of labelling theory have allowed deviance to be predefined for them by officialdom; they have studied only those acts officially viewed as deviant and have neglected what other groups in society define as deviance. Their recognition that deviance is a relative phenomenon has been rhetorical, for they have not taken account of it in their sociological practice.

However, though disputes may exist over the definition of deviance, it is labelling theory's conception of deviance that is both radical and profound in its consequences for the sociology of deviance. Labelling entails a significant shift from the long dominant efforts to differentiate supposedly causal characteristics of offending individuals to processes that produce deviant outcomes. Thus, it is meaningless to attempt to understand or explain deviance without taking into account the fact that in a given social order it is inevitably defined and reacted to in various ways. Deviance is not "a static entity, but is a shaped and reshaped outcome of dynamic processes of social interaction"[39]. What comes to be regarded as deviance is the result of complex processes involving an act perceived as rule-breaking and the social reaction to

that act. This stresses the way in which reality is constructed from individual's interpretations and definitions. As a consequence, deviancy rates are treated as constructs, as themselves requiring explanation, rather than a resource on which to base explanations of deviance. Again, critics such as Gibbs are confused when they claim that the labelling approach cannot explain variations in the incidence of deviating acts in different populations, for the existence of such variations is a product of the way official statistics are assembled. Gibbs' criticism stems from a misunderstanding of the nature of these statistics(40). That these rates have also been invalidated empirically goes some way towards supporting the idea that the breaking of a rule is not the sole determinant of whether an act becomes a deviant act and the actor a deviant person.

Though labelling theory supposedly eschews the idea of causation and replaces it by one of becoming, the substitution of a sequential model for a multivariable simultaneous model does not do away entirely with the notion of cause. As Becker puts it:

> "... all causes (of deviance) do not operate at the same time, and we need a model which takes account of the fact that patterns of behaviour develop in an orderly sequence."(41)

It is at the level of causal analysis that labelling has been most successfully criticised, for here it is not merely confused or vague, but theoretically and empirically incorrect. This is the result of its total reliance on the distinction drawn by Lemert between primary and secondary deviance for the construction of its sequential model.

The statement that 'social control leads to deviance' can mean three things:

1) that rule-breaking is not deviant until it is so labelled by an audience;

2) an actor will become deviant as a result of experiencing the reaction to an initial rule infraction; reaction by social control agencies is so powerful in its implications for the self, that an individual comes to see himself as deviant and he becomes increasingly committed to deviation;

3) the everyday existence and practice of social control agencies produce 'deviance rates'; indices of crime are the products of the workings of organisations such as the police, the courts etc.

Labelling theorists have examined all three of these meanings, but it is the second which contains the sequential model of deviance and the causal link between primary and secondary deviation.

Primary deviance simply refers to rule-breaking(42) and is viewed as behaviour having "only marginal implications for the psychic structure of the person concerned"(43). It is "an initial act of deviation" (44) which is important as far as the labelling orientation is concerned only in that it may give rise to a social reaction. Such acts of rule-breaking are not seen by labelling theorists as requiring an explanation; their cause is not of great significance and, thus, "etiological questions are relegated to an ambiguous position subsidiary to societal reaction" (45). Exactly why an individual performs a rule-breaking act cannot be dealt with by labelling theory; structural and psychological explanations of these acts are not necessarily dismissed, rather, they are considered to be less fruitful sociologically than an examination of

the processes involved in labelling. This lack of concern with etiology is probably an over-reaction to earlier absolutist or correctional sociologies of deviance which saw such questions as central to an understanding of deviance. Consequently, the only attention that labelling theory gives to primary acts is to state that rule-breaking behaviour is either more widespread than deviance rates allow, or so widespread that it may be considered normal(46).

Labelling theory locates its causal explanations in the sphere of secondary deviation, which Lemert defines as "a special class of socially defined responses which people make to problems created by the reaction to their (primary) deviations"(47). In this definition lies the origin of the tenet "social control leads to social deviance"(48). This rests heavily for its viability on the distinction between primary and secondary deviance, and upon the socio-psychological consequences of societal reaction for the rule-breaker. Primary and secondary deviance, the latter being committed by people "whose life and identity are organised around the facts of deviance"(49) are, or so Lemert would have us believe, qualitatively different. The physical acts involved, i.e. theft or sexual deviation, remain the same, but differ in their etiology. There is also a difference in the extent to which the 'offender' has a deviant identity. The assumption is made, therefore, that the causes of the initial act cease to operate once the process of deviance escalation occurs; the 'cause' of the secondary deviance subsumes or makes unimportant the original etiology. As Mankoff has argued:

> "There is a premise in the writings of the labelling theorists that whatever the causes of the initial rule-breaking, they assume minimal importance or entirely cease operation after initial rule-breaking. Without such a premise, one might attribute career deviance and its consequences not to societal reaction but to the continued effects of the (causes) which produce the initial rule-breaking."(50)

Thus, the assumption of etiological discontinuity is vital to labelling's causal theory, at least in the form presented by Lemert and others[51]. As an assumption it is probably theoretically unwarranted and empirically incorrect. Taylor et al support this opinion by an examination of what they refer to as political deviance[52]. However, in the absence of viable causal theories of rule-breaking and empirical evidence of causal continuity, it is not possible to accurately evaluate either position, both remain theoretical possibilities.

It is because labelling theory has neglected the question of primary etiology that several writers have called for a combination of structural and processual theories to produce what Taylor et al call a comprehensive social theory of deviance[53]. Downes and Rock[54] have noted the failure of both types of theorist to incorporate insights from the other in their explanations, and Cohen[55] has attempted a synthesis of Mertonian anomie theory and Meadian role theory to incorporate a "recognition that deviance develops in the course of an interaction process with a theory of the structural origins of deviance". The possibility of such an enterprise appears doubtful. The combination of structural and processual approaches must lead to problems of reconciling opposing ontological assumptions, unless a theory can be found that can explain the total phenomenon without recourse to eclecticism. Alternatively, different aspects of the phenomenon may be explained by different theories which do not evidence such ontological conflicts. Sack's attempt to combine a Marxist and an interactionist approach may constitute such a venture[56].

Clearly, the central causal assumption of labelling theory is that the individual, having performed an act of primary deviation,

undergoes a transformation of identity as a result of the societal reaction to his act and progresses to a state of secondary deviance in which his life stiuation is fundamentally altered. This transformation relies heavily on assumptions derived from interactionism, but at the same time it contains elements which contradict key aspects of this school of thought. On the one hand the actor is viewed as being largely at the mercy of the labelling processes that are part of the reaction to his acts, these processes determine what he becomes, while interactionism stresses the independence of the actor in shaping his own projects and lines of action. It is this contradiction which gives rise to determinism in labelling theory. This is well illustrated by Lemert's description of the sequence of events involved in the development of secondary deviance:

> "....1) primary deviation, 2) social penalties, 3) further primary deviation, 4) stronger penalties and rejections, 5) further deviation with the development of hostility and resentment towards the penalisers, 6) formal action by the community stigmatising the deviant, 7) strengthening of the deviant conduct as a reaction, 8) acceptance of the deviant social status and adjustment on the basis of the associated role."(57)

This obviously ignores the concept of the self so important to symbolic interactionism; its "implicit notions of human passivity are out of place in a sociological tradition that has been founded on penetrating observations of the creative potential of human beings"(58). Thus, the theory is not only one-sided in its considerations of etiological factors other than social reaction, it also overstresses the audience component of the actor-audience dialogue. This is in fact made explicit by Erikson when he states:

> "Sociologically, then, the critical variable is the social audience ... since it is the audience which eventually decides whether or not any given act will become a visible case of deviation."(59)

What this fails to take into account is that the actor, as a self, is able to evaluate not only his own acts, but also the interpretations put on them by others. This is not to say that the social reaction to an act does not in some ways fundamentally alter the experience of the actor; it does, but the nature of this experience and its results are not as straightforward as labelling theory postulates. That social reactions give rise to a potential for identity change is admitted, but the differences in the nature of the experience due to variations in the rule-breaking act, the meanings imputed to it by actor and audience, and the meaning imputed to the reaction of the audience by the actor are important considerations in the restructuring of identity. But exactly how the identity is transformed, how the transformed identity is maintained and gives rise to repetitive acts of deviance remains problematic. As Box states(60), the theoretical links between social control and further deviance have never been completely forged. It is then a matter of contention how frequently, why and under what conditions identity change does occur.

The importance of the self and self-labelling has been demonstrated by Warren and Johnson who, referring to Carrol Warren's studies of homosexuality, describe the way in which the self can act as an audience to produce a deviant identity. Homosexuals who participate in the homosexual subculture are secondary deviants insofar as at least part of their lives is organised around the fact of being deviant. However, most have escaped the kind of organisational processing seen in some instances of criminal deviance. Becker's statement that

"one of the most crucial stages in the building of a stable pattern of deviant behaviour is likely to be the experience of being caught and publicly labelled"[61] is not, then, applicable. The homosexual labels himself as a result of the recognition of the meaning of his sexual orientation. This meaning originates in the meaning structure of the wider society, but the application of the label is the result of a process of self-definition. It is also likely, in some cases, that the homosexual, while retaining the label as a description of his erotic tendencies, will come to redefine its meaning in terms less derogatory than that of wider society. It is also likely that the practical acts of the homosexual, often involving secrecy and the maintenance of a straight front, will be determined by the meanings attributed to their acts by other more powerful audiences. The entry of the self-defined homosexual into the appropriate subculture is not necessarily a total product of his identification, for his identity may reinforce but will not replace the motivational factors associated with his sexual orientation. It is also necessary to recognise that certain material constraints are also involved, for the homosexual subculture is one of the few places in which sexual partners may be found; the choices of the homosexual are limited. Thus, labelling and the meaning structures that the wider society employ do not 'cause' secondary deviance directly, but they determine the form that it takes[62].

This brief discussion, based on empirical observations, indicates what is a theoretical possibility within the frame of reference of a labelling theory purged of its determinism and contradictions. In these terms, the sequence of events which transform an initial act or acts of deviance into a more stable pattern of activity, rather than representing a necessary sequence as implied by Becker, also becomes a

theoretical possibility. The extent to which it occurs is, as Becker has since recognised, an empirical question, "one to be settled by research into specific cases rather than by theoretical fiat"(63). As Taylor et al have similarly said:

> "What we must do is develop a clear view of deviance which allows that further commitment to deviancy can sometimes be explained or partly explained by social reaction, while at other times it can be explained simply in terms of initial motives."(64)

Thus, labelling theory can and must broaden its theoretical point of view to encompass the wide range of events that inevitably exist in reality. Its prime task is to outline the theoretical possibilities, empirical research must determine which of these are salient, when, and for what types of deviance.

It is hardly surprising, given the problems involved in the major propositions of labelling theory, that many writers have noted the lack of empirical evidence to support them(65). Others have produced evidence which has invalidated them(66). In the field of mental illness empirical research has indicated that the deterministic theory of how a person becomes mentally ill is substantially incorrect. Former proponents of the theory have, thus, been forced to change their position. How a revised labelling theory would have fared can only be determined by further study(67).

Labelling theory and illness

In the previous section I identified two types of statements which make up what is known as labelling theory; ontological statements concerning the nature of deviance and explanatory statements which attempt to account for the development and stabilisation of deviant behaviour. Since it is only the latter that has been presented as an A therefore

B type proposition, and since this proposition has been shown to be theoretically invalid, it is more correct to speak of the labelling perspective than labelling theory. The labelling perspective as it stands contains a conception of the nature of social reality which owes much to the symbolic interactionist concept of the social object. Here I am concerned with the relevance of this position for understanding illness.

Analyses of illness from the labelling perspective are to be found in the literature though these are largely confined to studies of mental illness(68). Some of this work is continuous with the critique of the notion of mental illness proposed by Szasz and others(69), and some applies the idea of a deviant career to mental illness, arguing that labelling and institutional control create and reinforce the sorts of behaviour to which the label was initially applied(70). All of this work has been the subject of vigorous critical debate. One exception to this is Freidson's account, presented in his programatic work The Profession of Medicine(71). Here the labelling perspective is applied to the category illness and not specifically mental illness. Although Freidson uses the perspective to advance the position that "illness as a biophysical state exists independently of human knowledge and evaluation" whereas "illness as a social state is created and shaped by human knowledge and evaluation" he ultimately does not take us very far(72). His initial error lies in his characterisation of illness as deviance; in terms of the labelling perspective this is inadmissible since definitions of what is and what is not deviant are lay and not sociological constructs. Consequently, he goes on to create a typology of illness which draws heavily on Parsons' sick role in order to "distinguish the meaning of illness from that of other forms of deviance"(73).

This results in a classification of meanings which are imposed on situations rather than being derived from them. It contradicts the assumption that meanings are created by actors in the course of interaction and not by sociologists' theoretical schemes. In effect, Freidson uses the terminology of the labelling perspective rather than its conceptual apparatus. He is, perhaps more concerned with a political and moral critique of the profession of medicine than providing a foundation for a sociology of illness. However, this is not to deny the significance of his contribution.

At first glance the way in which the concept of deviance has been developed by Becker and others might not seem to be applicable to illness. For while deviance may be a property conferred on a person or an act, illness would appear to be an inherent property of a person having an objective existence in a biological state which manifests itself in observable entities called signs and symptoms. Paradoxically, Szasz and the radical psychiatrists subscribe to this position in claiming that the disorders we call mental illnesses are not illnesses at all since they are not the product of demonstrable biological abnormalities. As Morgan points out, this implies a view of illness "as an objective factual condition of nature" and leads to "an unwarranted distinction ... between mental and bodily illness"(74). Thus, illness is equated with disease and the biological and social realms of experience confused. It is the clarification of this confusion that is sought in the use of the labelling perspective.

Deviance, according to the labelling approach, is constituted by meanings imputed by an audience to observable or reportable entities called acts. If an analogy is drawn between these entities called acts and other entities I will call signs and symptoms, then by means

of the same reasoning illness is constituted by the imputation of meanings to signs and symptoms. Disease and illness are thus distinct phenomena. Disease is a biological category applied to a variety of changes in physiological, biochemical or anatomical structure and function. Illness is a social category, a symbolic ordering of observable or reportable events by the application of a label. Dingwall has usefully termed these events problematic experiences(75). Thus a biological phenomenon is transformed by the process of labelling into a social phenomenon and thereby becomes organised according to socially structured concepts and beliefs.

The conceptual separation of disease and illness, a separation of the same order as that drawn by Becker between rule-breaking behaviour and deviant behaviour, does not derive solely from the labelling perspective. Feinstein(76), defines disease in purely morphologic, physiologic and chemical terms and illness as the result of the interaction of the disease with the host individual. Particular emphasis is given to the mechanism by which the disease develops and 'produces' the illness. Field(77) identifies disease as an objective entity seen in terms of a specific impaired state while illness is the subjective and diffuse consequences of the disease process. Fabrega and Manning make the distinction on the basis of a discussion of the way medical events are handled in preliterate settings(78). As they state:

> "Labels and interpretations that are placed on perceived bodily impairments or on maladjustments of a sociopsychological nature constitutes the illness that actors and audiences deal with by means of various socially structured interactions."(79)

However, labelling theory is useful, if not essential, because it provides a theoretical grounding for the conceptual separation of illness and disease.

Thus far the analysis is only a partial clarification. While the definitions I have offered specify the nature of particular entities they do not encompass the sometimes complex relationships between them. Though disease and illness are often empirically linked they may also be empirically distinct. As Field states[80], an individual may suffer from a disease without defining himself as ill or being so defined by others. Conversely, he may be defined as ill in the absence of any medically verifiable biological disorder. Many instances can be found in the anthropological literature to illustrate this point; definitions of illness vary from culture to culture and are independent of disease[81]. For example, dichromic spirochetosis is so common in some South American Indian tribes that the minority who escape infection and fail to show the characteristic pigmentation of the skin, i.e. the biologically normal, are treated as abnormal and socially ostracised. Recent observations by medical sociologists have also confirmed that many of the signs and symptoms consequent upon disease do not become defined as illness. Thus, the nature of the consequences of events such as acts, signs and symptoms is dependent upon self and societal reaction.

At this point some qualifications need to be made with regard to those entities I have called signs and symptoms. The use of these terms is to some extent context bound. Medically speaking signs are discoverable by means of observation or examination while symptoms are the subjectively reported experiences of the patient and are not directly available to the examining doctor. From the patient's point of view signs and symptoms may not be differentiated as such, for they may be just as likely to report swellings or rashes as changes in the way they feel. Moreover, though medical science is able to specify what

signs and symptoms are indicative of disease lay persons may not recognise them as such. That is, problematic experiences which are the product of disease processes are not necessarily defined as indicators of disease. On the contrary, they may be seen as consistent with a normal order. For example, the elderly frequently accept joint pain and problems with their feet as part of the experience of being old, they are not viewed as conditions that can be treated and cured(82). Alternatively, some individuals may take events which fall within the medically prescribed range of normal structure and function as indicative of disease(83). Thus, some problematic experiences may be the product of a pathological process while others may not and some may be taken as symptomatic of an underlying disease while others may not.

It should also be apparent that experiences which are accorded the status of signs and symptoms do not necessarily result in definitions of illness. A case that comes to mind is that of injury, where technically speaking a state of disease does exist, but the known causal origins of the symptomatology results in the substitution of the definition "ill" by "injured". Physical disability is a product of disease processes but the individual concerned may be defined as handicapped rather than ill.

However, it should be noted that when a definition of illness is applied by lay actors it presupposes that an underlying biological disorder is present. Szasz and his colleagues employ such a commonsense notion in their critique of the idea of mental illness, as do those more orthodox psychiatrists who hold that advances in medical science will eventually lead to the identification of biological abnormalities underlying these "problems in living". Sociologically speaking, whether or not problematic experiences have a foundation in biology is

not essential to their designation as illness. As Morgan states, this applies both to physical and mental illness for "how we apply the label illness is contingent upon the prevailing rationality of social life, and not upon the biological character of what is labelled"(84).

I would suggest that problematic experiences, to the extent that they are interpreted in terms of a medical frame of reference, may be symbolically ordered in two ways. Firstly, an individual may define himself or be defined by others as suffering from some biological abnormality. That is, the experiences are interpreted as the signs and symptoms of disease. Secondly, the individual may define himself or be defined by others as ill. There is a qualitative difference between these two states. The latter, while it presupposes the former, involves the allocation of the individual concerned to a social status. This carries implications for that individual's behaviour and relations with others. Thus, the definition of someone as ill has consequences beyond the mere attachment of a label. The former definition, while it may result in that problem solving conduct called illness behaviour does not result in a change in a person's social status.

The changes in biological and social functioning that may in some circumstances give rise to definitions of illness are, as Morgan indicates(85), judged against the standards of health and behaviour current in a given society, or its subgroups, at a particular point in time. Definitions of illness are neither ethically neutral or value free. As social constructs, they are moral constructs. Sedgwick has also argued that the category disease is equally a social and moral construct since it involves man's cognitive organisation of nature according to his own self-interests(86). As he suggests, potato blight consists of a relationship between two living things, a potato and a virus.

The designation of this relationship and its consequences reflects man's desire to cultivate potatoes rather than viruses. It is therefore an evaluation of the worth of a given state of affairs. The essential difference is that what is labelled disease has an existence independent of human knowledge and evaluation while illness has not(87).

On the basis of the above argument, illness is not an entity but a property imputed to a person. As such it is distinct from disease and illness behaviour. As an explanation of a given state of affairs it may have consequences for behaviour but is not synonymous with that behaviour. Accordingly, I will define illness behaviour as the consequences for social action of the imputation of given definitions to problematic experiences of various kinds. Of course, an individual may do nothing as a result of these definitions; alternatively, he may adopt something akin to what Parsons described as the sick role or merely indulge in some kind of help-seeking behaviour in an attempt to solve the problem. The theory of social action contained within these statements is derived from the symbolic interactionist concept of the social act(88). That is, it assumes that social action has its basis in the meanings which actors construct to make sense of the events, objects of states of affairs with which they are confronted. This implies that actors possess the cognitive resources to order the world around them and the material resources to carry out the actions they believe to be appropriate.

The concept of illness career

The concept of career generally found in sociology has much in common with that used in everyday life. According to Freidson:

> "The shape of a career can be constructed out of the sequence of agents and agencies (an individual) passes through, much as the shape of an occupational career is often constructed out of the sequence of jobs a man holds."(89)

Career, then, refers to the progression of an individual over time through a series of positions in an institution or a social system. These positions carry implications for the social status of the individual concerned. Roth, for example, has described how the treatment of patients in a tuberculosis hospital is organised according to a career and how knowledge of that career is employed by patients to chart their progress towards recovery and discharge. A career then is usually seen to be unidirectional and progressive.

Many authors have conceived of illness as a career and have described stage models of illness. Suchman divides the sequence of events into five such stages; symptom experience, assumption of the sick role, medical care contact, dependent patient role and recovery and rehabilitation. The development of each stage is dependent upon two factors, occupancy of the prior stage, and the making of a particular kind of decision which signals the onset of the next one(90). Kasl and Cobb offer a more complex model which is both multi-stage and multi-level(91). Thus, they describe a sequence of stages characterising the progression of most diseases and the resultant sequence of events occurring at three other levels, those of role performance, identity and behaviour(92). Kosa and Robertson employ the concept of morbid episode which is broken down into four stages, the assessment of a disturbance in physiological or psychological health, the arousal of anxiety, the application of general medical knowledge to the disturbance and manipulative actions for removing the anxiety and disturbance(93).

In the first and the third of these models cognitive processes play a central role although they remain unexplored.

On the basis of his interpretation of labelling theory Freidson undertakes an analysis of illness as process(94). However, he does not apply the concepts of primary and secondary deviance to illness in order to explain the way in which one is transformed into the other as a result of societal reaction. Rather, just as diseases "pass through identifiable stages" the stages of illness are "to be observed in human efforts at finding meaning in experience"(95). In his elaboration of these sequences of meaning Freidson describes the progression of an individual among and between his six sociological types of illness. Each of these types is defined according to the degree of seriousness imputed and whether the condition is seen to be illegitimate, conditionally legitimate or unconditionally legitimate. Thus, an individual may initially believe that his symptoms are due to a cold (minor, conditionally legitimate), subsequently be diagnosed as having poliomyelitis (serious, conditionally legitimate) and recover to the extent that he must learn to play the stigmatised role of the cripple (serious, illegitimate). It is these meanings, imputed by lay actors and agencies of social control which define the illness career(96).

Fabrega and Manning employ a similar perspective in their discussion of four types of illness career(97). These careers are viewed as the product of the medical and social implications of disease and its labelling in medical and lay contexts. The careers are distinguished by the extent to which the disease process is short or long term, curable or incurable or of sudden or insidious onset since these determine whether significant modifications in life habit are imposed, relationships with others affected as a result of the meaning the disease

holds for them and whether or not there is significant and long term change in the evaluation of the person by self and others. Fabrega and Manning would thus claim that illness careers are structured by the labels applied to disease and its consequences, they are not entirely independent of biological reality or the nature of the problems which are organised by means of the label illness. Thus, disease may affect the physical capacity of an individual to behave in certain ways. In addition, the nature of the problems that are experienced may carry different implications for the identity of the person concerned. A short term acute infection may not involve significant changes in self-identity, it may merely be sedimented into the person's biography, whereas perceptual and behavioural "disorders" that come to be called mental illness may bring about a substantial revision of that identity.

In many respects the analysis presented by Fabrega and Manning is closer to the notion of career used by the labelling theorists than that of Freidson. For the initial consequences of the disease might by analogy be termed the primary state, the secondary state being influenced by the reaction of lay and medical audiences, the labels that are applied by those audiences and the meanings those labels hold for the individual concerned(98). While this does away with what the labelling perspectives' critics have called the problem of etiology, since the primary state is not a sociological problem(99), it does not assume etiological discontinuity. For the underlying disease and the nature of the problems to which it gives rise may be of some ongoing relevance. Consequently, Fabrega and Manning do not assume that one career sequence is universally applicable(100).

The concept of illness career is a useful one in that it identifies and organises meanings and actions as key components of the social

processes that constitute or are the product of illness. However, on the basis of the terminology developed in the previous section it is limited by definition to those situations in which the label illness is applied. Consequently, it is preferable to speak of a management sequence or episode since problematic experiences which are not ordered by means of such a definition are also managed by a sequence of meanings and actions. Thus, the management sequence begins when some problematic experience is encountered. It is the outcome of the social response to multiple phenomena including observed or experienced events, their interpretation in lay and medical contexts and the socially structured actions taken to cope with these events. The career is neither universal nor unidirectional. Moreover, the meanings and actions by means of which it is constituted are reciprocally related; the imputation of given meanings may have consequences for action which, in turn, may reinforce or bring about a revision in the meanings applied. In Chapters 4, 5 and 6 I explore in some detail some of the cognitive processes involved in the management sequence.

Labelling, meaning and the study of help-seeking behaviour

As I indicated in the Introduction, studies of illness behaviour have largely been concerned with explaining help-seeking by means of perspectives which do not allow the cognitive and interactional processes involved to be examined. There is, then, a general shortage of material which could be used to illustrate some of the theoretical points made above. Such illustration can only be provided by a reinterpretation of the limited data that is available. I refer here to work by Zola, Robinson, Davis and Cowie.

As Zola notes, many studies of help-seeking, particularly those concerned with delay in seeking treatment for cancer, have assumed that most of the time people are free of symptoms and that when symptoms do appear they represent such an infrequent and dramatic event that the individual decides to go to some health practitioner(101). Consequently, failure to attend for treatment is seen as evidence of a disturbance in rationality(102). This model has been shown to be inappropriate by numerous studies that have documented the clinical iceberg. That is, data derived from health surveys on specific and general populations have shown that at any given point in time there are scarcely any individuals who do not complain of some symptoms of evidence disorder worthy of medical attention while only a minority have sought medical advice(103). The failure of most people to seek help for these problems cannot be explained by the severity of the symptoms. Investigations have shown that where even serious disorders are concerned there are several people out of treatment for every one receiving it(104). Moreover, those conditions that do get presented differ in no way from those that are ignored, tolerated or dealt with in some other way(105).

Zola casts some light on these observations in his own study of why people sought medical aid at particular points in time. He offers a model of help-seeking behaviour that is derived from studies of the first admission to hospital of male schizophrenics:

> "Most striking about their findings was the lack of any increase in the objective seriousness of the patient's disorder as a factor in this hospitalisation. If anything, there was a kind of normalisation in the family, an accommodation to the patient's symptoms. The hospitalisation occurred not when the patient became sicker but when the accommodation of the family, of the surrounding social context, broke down."(106)

Zola translated these findings to symptoms of all sorts and attempted to show that breakdown of the social context was an important factor that led to the seeking of medical care. Following interviews with patients attending a hospital clinic for the first time, many of whom had had their symptoms for fairly long periods, he described five "non-physiologic" triggers to help-seeking behaviour:

1) the occurrence of an interpersonal crisis,
2) interference with social or personal relations,
3) sanctioning on the part of others,
4) interference with physical or social activity,
5) temporalising of the symptomatology.

While Mechanic has argued that it is the character of the symptoms themselves that is the most important determinant of the seeking of medical care Zola sees them as functioning "as some sort of constant" such that a medical professional is consulted only following the intervention of one of these triggers(107).

Zola's study has been subject to a number of methodological objections(108). However, its theoretical limitations are of more concern here. Firstly, Zola does not explain what he means by accommodation to symptoms, nor does he illustrate such accommodation by means of his case studies. Secondly, he gives no indication of how the triggers themselves function to stimulate help-seeking; that is, he is short of a theory of social action(109). Using some of the theoretical ideas formulated above the observations leading to the notion of the clinical iceberg may be seen to be the product of differences in the way problematic experiences are defined and subsequently managed. Consequently, a given problem may be defined as an indicator of serious disorder in

one context and not in another. Zola's triggers may be interpreted as situational factors taken into account when the meaning of events is being constructed, such that the advent of a trigger leads to a change in the way a problem is defined and a change in the action taken to deal with it. As Douglas has said, "the relation between meanings, situations and actions are developmental"(110). Though Zola's study has been rightly criticised it does provide for a view of meanings and actions as emergent and context bound.

Robinson also provides data which illustrates the situational construction of meanings and actions. He quotes the case of Mrs. M. who, in an interview following her husband suffering a knee injury, attempts to assess the problem in the light of Mr. M's current life situation:

> "Mrs. M.: 'It wasn't too bad when he came in, just tender round the knee. It was stiff Sunday and I said he'd have to go to the surgery Monday ... but he wouldn't. He started his new job with X's and you can't go sick on the first day. He'd have got his note no trouble last month. Last week he was home anyway (between jobs) and I could have looked after him. Just rest and he wouldn't have needed the doctor. Trust him to do it when he can't be on the sick. Next week he can make out he did it on the site. It's not that bad, mind." (111)

Mrs. M. has certain notions about when it is appropriate for Mr. M. to be on "the sick". These notions and the context of his work situation influence the definition applied to Mr. M's problem and the choice of a course of action. Different contexts are anticipated as giving rise to different interpretations and actions. "Last month" when Mr. M. was with his old employer he could have "gone sick" after getting a note from the doctor. "Last week" when he was at home between jobs he could have defined himself as sick and acted accordingly

without recourse to medical approval. "This week", however, Mr. M. had started a new job and because it would create a bad impression to have gone sick on the first day Mr. M. Had not been able to stay at home and rest the knee.

Something of the emergent and contextual character of meanings can also be discerned in the studies by Davis and Cowie of the process by means of which lay diagnoses of poliomyelitis and heart attack were reached.

In Davis' account of fourteen families with a poliomyelitic child the initial problems reported by the children, sore throats, stomach aches or fatigue, were often diagnosed as common childhood ailments or interpreted in terms of some prior activity. These ailments were managed by a variety of home remedies(112). Only one family were alerted to the possibility of polio at this stage since they knew of several other cases in the neighbourhood. In some cases, where the child had a history of malingering, these initial complaints were seen as attempts to gain attention. However, these early diagnoses of the problem were revised when certain events intervened which could not be accommodated within the diagnosis. Davis refers to these as cues. Some were symptomatological, the onset of a stiff neck or the dragging of a leg, and some were behavioural, the inability of a child to win a fight with a younger sibling. In other cases the cue was authoritative; the doctor called in to treat the child's minor illness alerted the parents to the possibility or fact of polio. Cowie describes how the majority of his respondents normalised the onset of pain by attributing it to indigestion, injury sustained at work or the reoccurrence of a prior illness(113). The particular diagnosis chosen seemed to depend

upon the biographical context in which the pain was experienced. These initial diagnoses were revised and the doctor summoned following a "critical incident" which was a sudden increase in the severity of the chest pain felt by the patient and the fact that the pain persisted despite the actions taken to relieve it. The remainder of the respondents quickly realised that they were having a heart attack because of the severity of the pain. It was such that it could not be normalised by reference to previous experience and less serious diagnostic labels. During the period of hospitalisation which followed their contacting the doctor the patients again situated the heart attack within their respective biographies. It was assumed that the heart attack was not a sudden or unanticipated event and causal antecedents were sought in their life history in order to account for it. In this way it became both intelligible and meaningful.

These two studies not only provide data which illustrates something of the process whereby meanings are constructed they also challenge Zola's conclusion that symptoms function as a sort of constant. They support the position that I adopted earlier and which is expanded by Fabrega and Manning in their discussion of illness careers that the underlying biological reality cannot be entirely neglected. On some occasions the disease process may manifest itself in ways such that it becomes what Schutz called an imposed relevance. Alternatively, changes in the experiences to which the disease gives rise may merely call for changes in the way the problem was originally conceived.

The examples quoted here clarify some of the theoretical points raised in the previous sections. They also indicate the necessity to understand help-seeking behaviour as an emergent property, as the outcome

of the interpretive work employed to organise experienced or observed states of affairs. It cannot be understood in isolation from the management sequence of which it is a part. Perhaps the most telling critique of conventional studies of help-seeking is that they fragment this sequence and attempt to see consulting a health practitioner or using some health care facility as a circumscribed entity in itself.

The situational construction of meaning

So far, I have attempted to clarify illness and illness behaviour by means of a theory of social reality and a theory of social action. Central to both are the construction of meanings. I have used the work of others to argue that two possible influences on the process of meaning and action are the nature of the problematic experiences with which an individual is faced and the nature of the situation within which they occur. How these two concerns may contribute to that process has not yet been fully described. What is now required is a more detailed theory of meaning. This demands an analysis of the way the world is cognitively organised and an understanding of the interactional context in which it takes place. As writers going back to Parsons have shown, the designation of illness and its actualisation in social action requires shared meanings and reciprocal gestures on the part of others.

It is at this point that labelling theory ceases to be directly useful for, as Douglas has indicated, it is deficient on both of the above counts(114). It either treats the process of meaning construction as non-problematic and does not explore the process that leads individuals and acts to be assigned to categories or, as I have shown, it has been guilty of an "assymetric bias" in which meanings are seen as imposed on the actor by those around him. It is necessary to look

towards that brand of sociology commonly referred to as phenomenological for some insight into the process of meaning construction[115]. I take this to be valid insofar as there is a phenomenological thread which unites symbolic interactionism, labelling theory and ethnomethodology [116]. The analysis will be extended using the writings of Schutz and the ethnomethodologists, in particular Schutz's description of the cognitive setting of the life world and Cicourel's outline of interpretive procedures. To the extent that they explicate the cognitive tools via which social reality is constituted they provide the basis for a theory of meaning. Here, I am largely concerned with Schutz. In the next chapter I give a fuller account of interpretive procedures in the context of a discussion of their role in the research interview.

One notion that expresses the phenomenological view of deviance and illness is that of outcome. Deviance and illness as socially constructed realities are contingent upon complex social processes that result in the application of a label. The central feature of such processes is the decision. As Cicourel says, "... The assembly of a product, a juvenile labelled delinquent, is generated by practical decision making"[117]. This practical decision making is the focus of the ethnomethodologist's attention for according to Blum, "labelling is a socially organised process of theorising. The issue for research is not to identify the features of the finished product but rather to describe the activity of theorising itself"[118]. Consequently, Garfinkel's work is directed towards the study of the methods by means of which social reality is produced and the world experienced as a shared, orderly, repetitive world[119]. Commonsense reasoning is integral to social order since it is via the imputation of meaning and the assignation of individuals, acts or events to categories that a

sense of stability and continuity is created. As McHugh points out, knowledge and order are inseparable[120].

At this point we can usefully turn to Schutz's discussion of the cognitive setting of the life world, what Heeran has called his sociology of commonsense knowledge[121]. A useful point of departure is Schutz's idea of the world of everyday life which is "the scene and also the object of our actions and interactions[122]. This world is seen from within what Schutz calls the natural attitude, it is taken for granted as a world of well circumscribed objects with definite qualities which is known and shared by others. Man's interest in this world is practical rather than theoretical, he is largely concerned with doing and achieving and not with acquiring a coherent understanding of the world. At any point in time an individual finds himself in a unique biographically determined situation, the culmination of a chain of prior experience. This experience and the stock of knowledge at hand that goes with it provide the means whereby the world may be interpreted. Part of this stock of knowledge is socially derived and part originates in the individual's own experience such that it is constantly enlarged and enriched[123]. Since the experience of any situation is determined by a unique biography and a unique stock of knowledge it follows that no two individuals can experience the world in the same way. This gives rise to two problems which Schutz clarifies and explains. Firstly, how do members of a group come to hold a common view of the world given their individual perspectives, and secondly, how is interaction possible when this presupposes the sharing of experience? Further, how are acting and planning possible when the future orientation involved requires that events are repeatable yet every situation we enter is unique[124]? The solution to these problems is important in

understanding how social order is both given in the form of cultural recipes and created by individuals through their everyday activity.

Insofar as the stock of knowledge at hand used to interpret events in the world is handed down the world is prestructured for the individual. Contained within this stock of knowledge are interpretations of the many phenomena and relationships that constitute the world of everyday life that have been developed by the collectivity to which the individual belongs. But this does not mean that a conception of the world is imposed on the individual, for the sense of social structure communicated to him is employed for finding the way through the world; social order is recreated as a result of this interpretive work. However, a common conception of the world is, to begin to answer the first question posed earlier, generated by the interpretation of unique experience in terms of a shared sense of social structure(125).

Though every phenomenon that an individual encounters is unique it becomes part of a known order by means of a process of selective attention Schutz calls typification(126). This consists of the pragmatic reduction of the unique to the general. This concept of typification is a key one in Schutz's sociology of commonsense for typifications are "the mode of our knowledge of the everyday world" and "the factual world is experienced from the outset as a typical one"(127). In order to make the world cognitively manageable what is newly experienced is seen to be recurrent, it recalls similar or equal things formerly perceived. The process of typification involves the sorting of phenomena into a limited number of classes such that their attributes are equalised and their differences disregarded. Commonsense knowledge then consists of a multitude of types such that once an object is seen

to be a member of a given class characteristics may be imputed to it that are not directly perceived at any point in time. It is this which makes the social world appear to be stable and orderly.

The typifications that make up an individual's stock of knowledge were formed, in the main, by his predecessors and learned by him during the process of socialisation. The learning of language is important in this acquisition of typifications for the language of everyday life is primarily a language of named things and any name includes a typification. Thus, the labelling of an individual as a deviant transforms the way he is experienced by others for the label carries with it a variety of traits he may be assumed to possess on the basis of his membership of a type. However, since typifications are not only given but may be constructed by the individual on the basis of his own experience(128), a common language in which names are shared does not necessarily mean that the objects so named are typified in the same way. Rather, the use of common names has an homogenising effect, it masks different senses of social order.

Typification, as a reduction of the unique to the general, is not only a prerequisite for the cognitive ordering of the world, it is also a prerequisite for interaction, for interaction can only proceed on the basis of mutual understanding. As Schutz states, the chances of successful interaction depends upon the establishment of a congruency between the typified scheme used by the actor as a scheme of orientation and that used by his fellow men as a scheme of interpretation. While typification and language generalise experience they cannot eradicate completely the difference in individual perspectives. This difference is finally overcome and interaction allowed to proceed by

means of two idealisations or assumptions. Garfinkel and other ethnomethodologists have called these background expectancies. Firstly, there is the idealisation of 'the interchangeability of standpoints' in which I assume that if I exchange places with my fellow man "his here becomes mine, I shall be at the same distance from things and see them with the same typicality as he actually does; moreover, the same things would be within my reach as are actually within his". Secondly, there is the idealisation of 'the congruency of systems of relevance'. Here, I accept without question "that the differences in perspectives originating in our unique biographical situations are irrelevant for the purposes at hand of either and that he and I assume that both of us have selected and interpreted the actually or potentially common objects and their features in an empirically identical manner, that is, one sufficient for all practical purposes"(129). Experiments by Garfinkel and McHugh which create disorder by the violation of these assumptions have demonstrated that they are an integral part of the commonsense world.

The system of relevances and typifications, learned and acquired through experience, is organised into a series of routines or what have been previously referred to as recipes. These recipes are culturally or personally prescribed sequences of typifications involving typical problems, typical solutions and typical actors. It is through the use of these recipes that much of social life becomes routine and stable; the individual "looks in one single glance through the normal social situations occurring to him and catches immediately the ready made recipes appropriate to its solution. In these situations his acting shows all the marks of habituality, half-consciousness and automatism"(30). These recipes are used both as a precept for action, whoever wants to bring about a given end has to proceed as indicated, and as a scheme

of interpretation, whoever proceeds by a specific recipe is taken to intend the correlated result. Thus, a recipe transforms "unique individual actions of unique human beings into typical functions of typical social roles, originating in typical motives aimed at bringing about typical ends"(131).

As a precept for actions, recipes are involved in what Schutz called anticipating and projecting, that is, in the planning of future action. Anticipating and projecting, however, involve knowing what the future might be. Given that all situations are unique and never repeated in their wholeness, we must return to a problem previously raised: How is planning in daily life possible? Again, this depends on two idealisations; 'and so forth and so on', and 'I can do it again'. The former implies the assumption that what has proved to be valid knowledge so far will prove to be adequate again, and the latter implies the assumption that I may bring about by my actions a given state of affairs similar to that produced by a previous similar action. These two assumptions are taken to be valid until counter-evidence appears. The future then is addressed according to the typical structures that have held good so far in our past experience. Thus, in order to travel from point A to point B I go to a certain point at a certain time to catch a bus because in the past that has provided the means by which I have travelled from A to B. If the bus does not appear at the expected time I may assume that it is 'late' or 'delayed' because that has happened in the past. I do not assume that it will never come because that is not a possibility in terms of the recipe that is used. Conversely, any person seen to be standing at a certain point at a certain time may be assumed to be intending to catch the bus in order to travel from A to B.

Schutz's sociology of commonsense knowledge provides the foundation for a theory of meaning construction and a theory of social order. For order is contingent upon the cognitive processes whereby the environment is rendered meaningful. Interaction can proceed only if participants can make sense of what others are saying or doing. This is the outcome of interpretive work. Consequently, the world does not necessarily always appear to be stable or ordered because an individual's stock of knowledge at hand, his typifications and cultural recipes may and do fail him. The idealisations that are employed in making the world intersubjective are only valid until counter evidence appears, and counter evidence frequently does appear. This gives rise to the experience of "doubt, of questioning, of choosing or deciding, in short of deliberation"(132). It may also result in an individual failing to make sense of the world around him, to understand what is happening.

The problem of the failure of commonsense knowledge is dealt with by Schutz somewhat briefly in his discussion of the social distribution of knowledge. As he notes, the "man in the street" is interested in the logic, clarity and range of his knowledge only to the extent that this is a prerequisite for bringing about his chosen ends. The problem that arises from the inadequacy of commonsense is not seen by Schutz or, he suggests, by the man in the street as a problem for, "it is sufficient for him to know that there are experts available for consultation should be need their advice for achieving his practical purpose at hand. His recipes tell him when to see a doctor or a lawyer, where to get needed information and the like"(133). This is only a superficial solution, for it does not tell us how an individual recognises the failure of his chosen recipe and substitutes for it one that involves consulting "the expert". This, I think, can be taken as an

indication of Schutz's more general failure to cope with the problem of disorder.

What I have referred to as problematic experiences, which may or may not be the manifestations of disease, introduce an element of disorder into man's experience of the world. Their resolution requires that they be routinised in terms of a particular conception of the world and acted upon. Here, routinisation does not refer to normalisation, the interpretation of disorder in terms of a framework of normality(134); rather, it has more in common with Sudnow's concept of normal crimes and suggests conceptions of normal disorders(135). These problematic experiences may be readily and unequivocably interpretable in terms of such conceptions as are derived from individual experience or socially given knowledge; for example, a sudden or massive loss of blood. The nature of the problem may then facilitate the process whereby they come to be defined. However, it is also likely that their presence results in a situation of doubt in which their significance or insignificance cannot be determined. As Wagner puts it:

> "External phenomena which come to the attention of an individual may be experienced in ambiguous forms. Thus, doubtful situations arise for the individual, situations apparently containing mutually exclusive tendencies, each of them equally plausible. As a consequence, if a person faces such an ambiguous situation, he will oscillate between possibilities and counter-possibilities. His indecision will last until he finds additional evidence in favour of one or the other alternative or else his own interests or motivations push him in one direction or another."(136)

These ideas may be used to extend the previous analysis of Zola's triggers. As situational influences, triggers may provide the evidence which facilitates the choice of alternatives and assists in assigning significance. Some event or object is not attended to as an isolated

object but an object in the context of and in relation to a variety of other objects. When the interpretive scheme available is insufficient to make sense of or otherwise identify an object then its context may furnish the grounds for imputing status and significance. In this way definitions emerge out of situations, they are not imposed on those situations by culture.

Schutz's analysis of commonsense knowledge, all too briefly treated here, outlines how such knowledge provides an actor with a scheme for interpreting his environment and how a set of assumptions or idealisations are employed to enable the actor to transcend the isolation that his unique perspective in the unique situations in which he finds himself entails. These two aspects of Schutz's work would appear to have been clearly demarcated by some of the ethnomethodologists so that we can distinguish between an interpretive scheme and interpretive procedures. As Cicourel states:

> "The interpretive procedures activate short and long term stored information (socially distributed knowledge) that enables the actor to articulate general normative rules with immediate interaction scenes. The interpretive procedures and surface (normative) rules provide the actor with a scheme for partitioning his environment."(137)

An understanding of interpretive procedures is seen by Cicourel as fundamental to an understanding of how an interpretive scheme is actually used in social situations. The former he calls 'basic rules', and sees them as invariant properties of everyday practical reasoning necessary for assigning sense to an environment of objects. By surface rules Cicourel would appear to mean what I have referred to as an interpretive scheme. Rules, and norms, as elements of a stock of knowledge are presumably proscribed and prescribed typical courses of action

for typically motivated actors in typical situations. That is, recipes endowed with moral or legal authority and sanction.

Because the stock of knowledge at hand is inconsistent and incomplete meaning construction is always potentially problematic. It is also problematic because it does not take place within a vacuum but, as Douglas indicates, within the context of "actual and potential interactions with others"(138). Consequently, meanings must be acceptable to actual or potential co-interactants if interactions are to be maintained. However, because an individual's own constructs are independent of this interaction and may be contrary to it disagreements may arise. This calls for three interrelated aspects of meaning construction within interaction, those of negotiation, consistency and biographical reconstruction. These features have been explored to some extent by the labelling theorists with regard to definitions of an individual as deviant although they are equally applicable to all instances of labelling or meaning construction. Negotiation involves the generation of agreement concerning the meaning of acts or events and seeks to remedy differences in the way the world is interpreted. What Scott and Lyman have called accounts, explanations of acts, objects or events, are key features of the attempt to persuade others to revise their definitions of the world. All instances of labelling may also require justification in terms of the consistency between the characteristics implied by the label and the characteristics of the item so labelled. This is particularly the case with deviance in which one label may supplant another higher up in the moral hierarchy. This "recasting of the objective character of the perceived other"(139) may call for a demonstration of the fit between the label and all it implies and what is otherwise known about the individual. This consistency may be

achieved by biographical reconstruction. The past is reinterpreted so that acts, events and objects formerly interpreted as something else come to be seen as indicative of what is now known. These procedures not only provide the basis for agreement, they also provide for the stable orderly character of the world(140). What is of interest in this process of mutual influence is the typifications and commonsense theories that are used as evidence to support the labels that are applied. In the case of illness this may involve notions of illness careers and typical courses of events that happen or will happen to typical individuals. Some of these are described in detail in the analysis presented in later chapters.

The theoretical ideas I have outlined in this chapter have been used to remedy the failure of structural functionalism and positivistic sociology to cope with the theoretical problem posed by illness and illness behaviour. Using an approach that may be broadly termed phenomenological I have offered concepts of illness and illness behaviour based upon specific assumptions about social phenomena and social action. In addition, definitions of disorder and illness related behaviours and decisions have been located within an overall notion of the management sequence.

The central tenet of the perspective I have elaborated is that an understanding of social life and its constituent phenomena must be derived from a theory of meaning. Social reality and social action are constituted by and emerge out of the meanings that actors construct as they attempt to make sense of and manage the experiences they encounter in everyday life. Consequently, one task for sociology is the documentation of the meanings employed in rendering experience sensible and

manageable and the analysis of the processes by means of which the definitions involved are constructed(141). Manning, talking specifically about the sociological study of organisations, describes the issues to be pursued in empirical research in the following way:

> "How (the actor manages the problems that face him) is seen in the devices he uses to make them consistent, repetitive, normal and natural. By means of his linguistic behaviours the actor selects things which through naming become social objects. That is, they have a potential for action when they are named, counted, assessed and ordered. The fashioning or order takes place as objects at hand become named as part, in the context of, or standing for, order. The primary rule for the study of organisations from a phenomenological point of view is that one must study the ways in which terms of discourse are assigned to real objects and events by normally competent persons in ordinary situations."(142)

This specification of the topics which require empirical clarification means that the ensuing analysis is directed towards elucidating the way in which events and phenomena are assigned to categories. This is the central aspect of the process which results in the imputation of meaning and the construction of social order. As Phillipson expresses it, "the constitution of socially meaningful realities, achieved largely through language, becomes a basic issue for investigation"(143). As far as the sociology of illness is concerned this programme indicates that sociological analysis should describe the use of the categories normality, disorder, health and illness by an examination of the procedures and practices involved in the labelling of persons as ill, the interpretation of events as indicators of abnormality and the practical reasoning involved in situating these events within a known order of things. A phenomenologically based sociology is then primarily concerned with meaning, language and the nature of social reality.

The above issues and further consideration of the theoretical and methodological problems presented by the study of illness behaviour are pursued in later chapters using respondents' accounts of their experience of health and illness. In the chapter that immediately follows and the Appendix I describe some of the problems that emerged in the collection and analysis of those accounts.

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96. Freidson places the emphasis on agencies of social control and the way these structure illness careers rather than on the way a career is organised in terms of the subject's definitions and actions. As he states, "constructing the career on the agencies he moves through is analytically more useful than constructing it out of changes in the deviance imputed to him or out of his own changes in self", p. 243. Again this reflects Freidson's interest in medicine as an agency of social control. What it ignores are those illness careers that do not come into contact with formal medical services.

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98. Of course, some audiences are more powerful than others so that definitions may be imposed on the individual. It is the doctor's definitions that are officially sanctioned and administratively processed.

99. That is, the problematic experiences that are organised by means of labels may be the product of an underlying pathological process that can only be explained by medical science. Even where these experiences are the behaviour of others the problem of etiology is a member's problem and not the sociologist's. See Chapter 6.

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101. Zola, I., Pathways to the Doctor: From Person to Patient, Social Science and Medicine, 7, 1973, p. 677-8.

102. See for example, Lewis L. , and Lopreato P. , Arationality, Ignorance and Perceived Danger in Medical Practice, American Sociological Review, 27, 1962, pp. 508-514.

103. Wadsworth, M., Butlerfield, W. and Blaney, R., Health and Sickness: The Choice of Treatment, Tavistock, London, 1972.

104. Williamson, J., Stokoe, I., Murphy, H. and Deasy, L., Old People at Home: Their Unreported Needs, Lancet, 1964, pp. 1117-20.

105. As Zola puts it, "neither the obviousness of symptoms, their medical seriousness nor objective discomfort seems to differentiate those episodes that do and do not get professional treatment", op cit, p. 679.

106. Zola, I., ibid, p. 679.

107. Zola, I., ibid, p. 681. There is something of a debate about the role that symptoms do play in the process of help-seeking. Some such as Mechanic and Kosa and Robertson claim that the symptoms are the primary determinant. On the other hand, Zola claims that non-physiologic triggers are the key influence.

108. Tuckett, D., Introduction to Medical Sociology, Tavistock, London, 1976. Dingwall, R., Aspects of Illness, Martin Robertson, London, 1976.

109. Consequently, one could extend his rather ballistic analogy to suggest that in some way the trigger causes the individual to be projected at high velocity into the doctor's waiting room.

110. Douglas, J., American Social Order, op cit, p. 189.

111. Robinson, D., The Process of Becoming Ill, R.K.P., London, 1971, p. 14.

112. Davis, F., Passage Through Crisis, Bobbs-Merrill, Indianapolis, 1963.

113. Cowie, B., The Cardiac Patient's Perception of his Heart Attack, Social Science and Medicine, 10, 1976, pp. 87-96.

114. Douglas, J., American Social Order, op cit, pp. 142-3.

115. I say commonly referred to as phenomenological in that there are varieties of opinion as to whether Schutz's phenomenological sociology is at all continuous with Husserl's phenomenology. See Best, R.E., New Directions on Sociological Theory?, British Journal of Sociology, 26, 1975, pp. 133-143. See also Heap, J. and Roth, P., Phenomenological Sociology, American Sociological Review, 38, 1973, pp. 354-367.

116. Warren, C. and Johnson, J., A Critique of Labelling Theory from the Phenomenological Perspective, In Scott, R.A. and Douglas, J., op cit.

117. Cicourel, A., The Social Organisation of Juvenile Justice, Wiley, 1968, p. 15.

118. Blum, A.F., The Sociology of Mental Illness, in Douglas, J., Deviance and Respectability, Basic Books, New York, 1970.

119. Garfinkel, H., Studies in Ethnomethodology, Prentice Hall, New Jersey, 1967.

120. McHugh, P., Defining the Situation: The Organisation of Meaning in Social Interaction, Bobbs Merrill, Indianapolis, 1968, where he says, "Knowledge in this sense involves concrete information, rules, social norms - anything that gives meaning to an observation", p. 23.

121. Heeran, J., Alfred Schutz and the Sociology of Commonsense Knowledge, in Douglas, J. (ed.), Understanding Everyday Life, R.K.P., London, 1974.

122. Wagner, H.R., (Ed.), Alfred Schutz on Phenomenology and Social Relations, Univ. of Chicago Press, 1970, p. 73. All quotes from Schutz are taken from this edited volume of his relevant writings.

123. "It is the sedimentation of all man's previous experiences organised in the habitual possessions of his stock of knowledge at hand, and as such is unique possession given to him and him alone". Wagner, H.R., ibid, p. 105.

124. This arises because an individual enters every situation with an enlarged stock of knowledge and more extensive biography. Consequently, no two situations can ever be the same.

125. Schutz emphasised that this common world view was based on the belief by members of a community that they share their views about the world and upon their using the same standard expressions and formulations when applying or explaining those views. Wagner, R.H., op cit, p. 17.

126. This is only one type of selective attention that Schutz describes. The other leads to a hierarchical ordering of the elements of a situation at hand according to an individual's chosen purpose or interest in that situation. The stock of knowledge at hand is organised into zones of relevance according to the individual's current interest. These relevances may be intrinsic to a given purpose that is consciously chosen or imposed by events over which the individual has no control.

127. Heeran, J., op cit, p. 48.

128. As Schutz says "typifications ... are refined, interpreted and modified by the individual in the ongoing accumulation of experience from situation to situation". These form personal types on top of the social types previously given.

129. Wagner, R.H., op cit, p. 183.

130. Wagner, R.H., ibid, p. 91.

131. Wagner, R.H. ibid, p. 94.

132. Wagner, R.H., ibid, p. 29.

133. Wagner, R.H., ibid, p. 241.

134. For an illustration of the concept of normalisation see Yarrow, M., Schwartz, C., Murphy, H. and Deasy, L., The Psychological Meaning of Mental Illness in the Family, Journal of Social Issues, 11, 1955, pp. 212-224.

135. Sudnow, D., Normal Crimes, Social Problems, 12, 1965, pp. 255-276.

136. Wagner, R.H., op cit, p. 29.

137. Cicourel, A., Cognitive Sociology, Penguin, Middlesex, 1973.

138. Douglas, J., American Social Order, op cit, p. 203.

139. Garfinkel, H., Conditions of Successful Degradation Ceremonies, American Journal of Sociology, 61, 1956, pp. 420-4.

140. The most detailed exposition of these issues is to be found in McHugh, P., Defining the Situation, op cit.

141. Schutz would claim that this is the first task for sociology while the ethnomethodologists consider it to be the only topic for professional as opposed to "folk" sociology. More conventional theorists see it as one among many topics available for sociological analysis.

142. Manning, P., Talking and Becoming: A View of Organisational Socialisation in Douglas, J., (ed.), Understanding Everyday Life, op cit, p. 244.

143. Phillipson, M., in Filmer, P. et al, New Directions in Soicological Theory, op cit, p. 81.

CHAPTER 2

THE ACQUISITION OF DATA: METHOD AND THEORY OF METHOD

Varieties of naturalism

Many of the recent critiques of positivism, conventional or absolutist sociology have been developed from within a naturalist perspective[1]. Symbolic interactionism, labelling theory, phenomenological sociology and ethnomethodology are united in their critique of these sociologies. On the basis of a commitment to meanings and the view that social life is the product of cognitive and interactive processes it is claimed that positivism and absolutism not only mistake the character of the social world but distort that character in the application of a natural science methodology. Such a position is implicit in the critique I offered of the research generated by Mechanic's concept of illness behaviour and the alternative theoretical perspective I subsequently outlined. Consequently, the methods employed to investigate the issues identified in the previous chapter must be consistent with the theoretical assumptions involved. Since this is tantamount to a recommendation of naturalism it seems best to begin by clarifying what naturalism is and is not.

Positivism is not simply a set of methods or techniques which may be used to study the material or social world; it is a paradigm, and involves assumptions about the nature of man, society and social phenomena. Though positivist methods are based on those assumptions they are not in fact derived from them. Rather, the methods used originate in a certain conception of science and what constitutes a scientific enterprise. They stem from the view that there is only one general set

of criteria for scientific validity and truth, those embodied in the classical works of the natural sciences. That the use of the methods of the natural sciences in the study of social life assumes that the material and social worlds are similar in some respects is not only unstated, it is irrelevant insofar as ontological questions are subordinate to the search for "objective" knowledge. For the positivist, science is constituted by the application of a given set of procedures to the phenomenon being studied; the character of that phenomenon is accorded scant, if any, attention.

By contrast, naturalism cannot be called a paradigm. It does not specify methods by means of which the social world may be studied nor does it entail any stated or unstated assumptions about the social world. It is not, as commonly conceived, the opposite of positivism. Naturalism is a philosophy of method that seeks to establish a different conception of science to that which confuses science and particular techniques of research. Integral to the naturalist conception is some notion of a relationship between the phenomena under investigation and the methods by which they are studied. That is, methods cannot be considered valid or invalid, scientific or non-scientific in isolation from those phenomena. The central tenet of naturalism is simply expressed:

> "The true method follows the nature of things to be investigated and not our prejudices and preconceptions."(2)

The naturalist critique of positivism is not then a debate about methods but a debate about the appropriateness of the methods that the positivist uses to study man and society. However, it is possible for the positivist to claim that he does work from within the naturalist

perspective, since his methods are geared to what is taken to be an objective, real world. As Matza says:

> "An objective view of naturalism was positive and appropriate when the object of enquiry was an object."(3)

Whether any sociological positivist would attempt to argue such a position would depend upon whether they subscribed to a hard or soft variety of determinism. According to Matza, the former involves the view that social reality is object while the latter merely treats social reality as object for the purpose of scientific study. However, the important point here is that the naturalist critique determines the content of any methodological debate. That debate is primarily an ontological one. It is incumbent upon the positivist and the naturalist to demonstrate the appropriateness of their methods by stipulating the nature of the realities to which those methods are applied. In this sense, naturalism determines the fundamental question to be asked of any scientific paradigm. Thus, though positivism has been criticised on many grounds the major criticism invalidating its use is that its methods fail to take into account the nature of the phenomena that it studies. Rather, its methods do violence to the objects of study and can only provide distorted knowledge of them. Naturalism as "a philosophical view that strives to remain true to the phenomenon under study" may set the terms of this methodological debate, but it does not intervene in the debate to resolve the ontological disputes that arise. Though questions pertaining to the nature of phenomena are central to the philosophy of naturalism they are not resolvable by reference to the premises of that philosophy. This is contrary to what might be supposed.

How then is the ontological debate to be resolved? Since the use of positivist methods involves the assumption that natural and social phenomena are essentially similar any naturalist argument must rest on a demonstration of the differences between them. Schutz, in a comparison of the activities of the natural and social scientist makes the distinction clear:

> "It is up to the natural scientist to determine which sector of the universe of nature, which facts and events therein, and which aspects of such facts and events are topically relevant to their specific purpose. These facts and events are neither preselected nor pre-interpreted; they do not reveal intrinsic relevance structures. Relevance is not inherent in nature as such, it is the result of the selective and interpretive activity of man within nature or observing nature. The facts, data and events the natural scientist has to deal with are just facts, data and events within his observational field but this field does not 'mean' anything to the molecules, atoms and electrons therein.
>
> "For the sociologist, his observational field, the social world, is not essentially structureless. It has a particular meaning and relevance structure for the human beings living, thinking and acting therein. They have preselected and pre-interpreted this world by a series of commonsense constructs which determine their behaviour, define the goal of their actions, the means available for them - in brief which help them find their bearings in the natural and sociocultural environment and to come to terms with it."(4)

Because the social world is inherently meaningful it cannot be studied by methods derived from the natural sciences. Such methods objectify social reality and treat man as if he were determined by internal or external forces outside of his control. By contrast a phenomenologically oriented sociology sees man as subject and the social world as his construct. It is these ontological assumptions which determine which methods are appropriate for the study of social life for naturalism's main commitment is to the retention of the integrity of the phenomena with which it is concerned. But as Douglas points

out, such a commitment does not necessarily lead to the rejection of inappropriate methodology[5]. For some proponents of symbolic interaction and labelling theory have produced research which owes much to the techniques of positivism[6]. As a result, Douglas has attempted to discredit sociological naturalism and counterpose it to phenomenological sociology. He distinguishes three approaches to the study of the phenomena of everyday life; these he terms the absolutist stance, the natural stance and the theoretic stance. The first largely corresponds to what I have termed positivism; the second is "that supposedly taken by man in everyday life .... it is a stance that does not raise serious and persistent questions about the nature of everyday experience but takes that experience as fact"[7], while the third "is to stand back from, to reflect upon, to review the experience taken for granted in the natural stance"[8]. As an example of the natural stance Douglas quotes the work of Matza and of the theoretic stance he points to the phenomenological sociologists. To the extent that both attempt to employ methods of observation and analysis which retain the integrity of social phenomena they are both conducted from within the auspices of naturalism. That is, they are <u>varieties</u> of naturalism. The difference arises in the extent to which the respective stances depart from the "commonsense experiences of members themselves"[9]. As Douglas says of the work of Matza and Goffman:

> ".... it winds up largely restricting itself to the description of experience and then treating that experience as if it constituted the entirety of justifiable generalisation or theorising."[10]

Naturalism taking the theoretic stance demands an enquiry into the constitution of experience. It goes beyond a description of the social world and attempts to understand how that world is created and

sustained by the activities of the individuals within it. There is then, the makings of a debate within naturalism concerning the nature of the social world and the preferred strategy for analysing it. For the different theoretical positions involved in the two versions have different implications for the way in which we observe and interpret that world. Both types of approach use the same techniques for gathering data, the distinction arises in how that data is analysed and how it gives rise to theory.

Naturalism and methodology

All varieties of sociological naturalism take as their point of departure the premise that the social world is subjectively meaningful. Emphasis is placed upon the categories actors employ to structure their experience of the social world and make sense of their social and physical environment. These categories take the place of the constructs sociologists create in their own attempts to explain social reality. As Bruyn, paraphrased by Silverman, puts it:

> ".... in particular we should seek to understand the subjective categories of the actors for ordering their experience. These take the place of operational definitions constructed by the observer. They lead us to search for socially shared categories and help in understanding the participants' explanations of phenomena in their social universe."(11)

However, an emphasis on the subject's own categories and the methods he uses to create order does not mean that sociology's task is solely one of providing subjects' descriptions of their activities. As Silverman remarks of Bruyn:

> "Bruyn is content to describe the subjective world as it appears to the participants. This world, he argues, is capable of being explained in terms of itself alone, without reference to the constructs of the observer. The world of commonsense is complete

> in itself, any analysis does an injustice to the reality which it possesses for all of us."(12)

This emphasis on 'letting the data speak for itself' is also evident in Blumer's methodological writings(13). His methodological exhortation to 'go direct to the world', to 'take the role of the other' and to see social action 'from the position of whoever is forming the action' involves similar limits on the extent to which it is necessary to analyse such data and a similar view of the status of such data. 'Letting the data speak for itself' restricts sociology to documenting descriptions of lived experience:

> "To the extent that there is a role for science and the observer, it must be to move beyond individual experience in order to reveal the shared assumptions about social reality and the activities associated with them which generate and sustain such experiences."(14)

Such a view of sociology moves away from the natural stance variety of naturalism towards that done from within the theoretic stance. The implications of the latter for the investigation of substantive issues is to attempt to reveal the shared meanings people attach to their situations and the procedures by means of which meanings are constructed and come to be shared. According to Phillipson and Roche(15) this meets to some extent phenomenology's critique of conventional sociology.

This approach determines the methods to be used to study social life, for:

> "The premise that social action is built up through a process of noting, interpreting and assessing things and of mapping out a prospective line of action implies a great deal as to how social action should be studied. Basically put, it means that in order to treat and analyse social action one has to observe the process by which it is constructed .... The

> required approach is to see the acting unit confronted with an operating situation that it has to handle .... This means seeing the acting as it is seen by the actor, observing what the actor takes into account, observing how he interprets what he takes into account, and seeking to follow the interpretation that led to the selection and execution of one of these pre-figured acts."(16).

But Blumer's recommendation to observe the construction of social reality needs to be supplemented if the cognitive processes of meaning construction are to be revealed. As Douglas says:

> ".... there is no way of getting at social meanings except through some form of communication with the members of (a) society or a group."(17)

Communication with the subjects of sociological research may be characterised as direct or indirect. Indirect communication occurs via the medium of a rigidly structured questionnaire. Such a questionnaire provides the respondent with a set of preformed categories to be used to describe his experience. At best this distorts that experience by the imposition of a given structure; at worst, the data produced bears no relationship to the respondent's experience and merely represents his attempts to accomplish the task of respondent by providing answers to the interviewer's questions(18). What I have termed direct communication allows the respondent to describe his experiences in his own terms; it gives access to his categories and the procedures he uses in the construction of a cognitive order. Since language is the vehicle through which a cognitive order is produced the data collection techniques employed must lead to the collection of what Garfinkel calls accounts(19). The data that forms the basis of naturalist research is, then, respondent talk. The necessary accounts may be collected by observing what has been referred to as naturally occurring talk(20) or by the open-ended interviewing of informant-respondents(21).

The informant-respondent is an individual chosen because of his participation in or observation of the events and settings under study which, for a variety of reasons, may not be open to participant observation by the observer. The difference between the two approaches is important in that it has an influence on the status of what is treated as data and how that data may be analysed.

For reasons described more fully in the Appendix, the interviewing of informant-respondents was chosen as the data collection technique. I conducted 23 semi-structured interviews with six women over a period of 13 months in which they described in some detail the health and illness experience of themselves, members of their families and others known to them. The choice of this strategy and the use of married women with children as informant-respondents was based upon assumptions about the settings in which the lay management of problematic experiences took place and the practical problems involved in gaining access to them. It was also based upon assumptions about the sexual division of labour within the family. The research was not designed to validate these commonsense theories; rather, they are mentioned because the research is in many ways a product of them. The 23 interviews used as data, some of which were based on health diaries the respondents kept for two weeks prior to interview, were tape recorded and provided approximately 40 hours of material which was transcribed in full[22]. As I go on to explain, it is necessary to view the data contained within those transcripts as a construct, as a phenomenon in its own right, and not as a more or less accurate description of some aspect of social reality.

Of the six women I interviewed, five were contacted through their general practitioner and one was introduced by a mutual acquaintance.

They were told that I was interested in the kind of health problems they or members of their family experienced and how they coped with them. Although I presented myself as an independent researcher all seemed to have an idea that I was working for their doctor or some other authority. The women were interviewed in their own homes and were usually alone, a husband being present at an interview with one respondent and children present at some others. The first interview was based on a common schedule designed to encourage the women to talk in general terms about health and illness and to provide details of their family's medical history. I also asked for details of problems that had been experienced more recently, how they had arisen and how they had been dealt with. At subsequent interviews I followed up what had been said in previous interviews and collected information on problems which had been encountered in the intervening period. The respondents were interviewed between 3 and 6 times.

As I recount in the Appendix, my original intention was to interview ten women. About half-way through the field work I revised this intention and decided to take advantage of the relationship that had developed with this initial group of respondents and continued to interview them rather than making contact with another group of women. This seemed justifiable given the quality of the data that I was collecting at the time; the descriptions the respondents offered were both detailed and, for much of the time, spontaneous. Since the unit of analysis was not 'women', 'families' or 'individuals' but what I came to call management sequences this did not reduce the number of 'cases' I was able to study. However, since the women and cases were not samples of or representative of some population or universe the actual numbers involved is irrelevant. As I discuss later in the chapter,

the theoretical and methodological stance that I have adopted means that I am committed to a description of some features of commonsense knowledge that may be employed by individuals in the management of their everyday affairs. Such a description is not dependent on the size or randomness of the group of respondents studied. For the resources they use in constructing both their accounts and the social order they experience is common by definition and does not have to be shown to be so by the analysis of accounts provided by large and/or representative samples of populations of women.

The situational construction of data

Conventional sociological methodology draws a distinction between two separate aspects of the sociological enterprise:

> ".... the processes by which the sociologist constructs an abstract view of social phenomena are viewed as independent of the means he subsequently adopts for testing his ideas."(23)

As Phillipson goes on to say, this separation of theorising and data collection entails the view that research procedures are merely neutral devices for providing data to support or falsify theoretical ideas. This position is based upon several key assumptions. It assumes the existence of an objective social world whose order may be represented in theory. It assumes that research methods collect data about that world which may be used to judge the viability of the order suggested in theory. Consequently, research techniques are attended to as devices which enable the researcher to 'see' that which is not directly observable. Even Blumer subscribes to these assumptions when he says, "Methods are mere instruments designed to identify and analyse the obdurate character of the empirical world .... the task of scientific activity is to lift the veils which obscure or hide what is going on"(24).

The fit between what is 'seen' by means of data and the objective underlying order that is assumed to be there are judged according to criteria taken to define scientific activity. Research which conforms to those criteria is taken to result in data which reveals the world 'as it really is' rather than data which is 'biased', 'invalid' or 'unreliable'. Methodological problems encountered in conventional sociology thus revolve around issues of random sampling, response rates and the validity of indicators used to chart the underlying order(25).

From a phenomenological perspective these assumptions are invalid. Theorising, whether it be lay or sociological does not represent an existent order it creates that order. The social world is not objective but objectified. Similarly, data is not a descriptive or numerical representation of an objective world revealed through the application of neutral research techniques, it is a direct product of those techniques. Just as crime rates are the outcome of the social processes that constitute agencies of social control, data is the outcome of the social process of research activity. Consequently, the social world, theorising about it, sociological research and the data to which it gives rise are not discrete or independent of each other in the way conventional procedures assume.

The difference between the conventional and the ethnomethodological position has been described by Garfinkel in his discussion of correspondence and congruence theories of social reality(26). According to the latter, accounts given by respondents are not more or less accurate descriptions of past or present events but merely one account of events that have been accounted prior to the interview and will, doubtless, be accounted again in the future. The interview produces one account out

of "indefinite elaborations of the same scene"[27]. Each of these accounts may, as Cicourel recognises, produce different outputs so that the reconstruction of an event in the context of the interview may not resemble that given in another context[28]. Each of these accounts is of equal validity, for none can be judged against an independent reality to determine the extent to which it is a correct representation of it. Rather, reality and the facts of the matter are reconstituted anew in individual accounts. As far as these accounts are concerned the focus of interest is the "temporarily constituted production and comprehension processes"[29] via which social reality is constructed. Conventional notions of validity do not then apply since there is no fixed point from which accounts may be seen to deviate. Absolutist sociologies impute such a fixed point and employ elaborate procedures for judging the degree to which the data has strayed[30].

So far I have advanced two claims: firstly, that accounts given by respondents about their experience of health and illness are to be treated as phenomena in their own right and not as representations of objective events or states of affairs and secondly, that these accounts are the product of a particular social encounter, a research interview. Simply put, "statements by the (respondents) are behaviour towards the investigator in the research situation"[31]. Thus, what the participants say in the context of an interview is integral to their management of the encounter. As Cicourel indicates:

> "Both interviewer and respondent are likely to be taken in by the same efforts to manage their utterances so as to make them acceptable to each other, while minimising remarks that make trouble for either. Each will seek to figure out what the other intends by certain phrases, voice intonations and the like in an effort to better categorise the utterances to which they are exposed."[32]

Cicourel argues that field research is negotiated in much the same way as routine social interaction and says that some way of accounting for the influence of the researcher's presence on what passes as data is a critical part of the reported findings(33) and Phillipson claims that "in order to obtain any data at all the sociologist must form minimally meaningful relationships with other men: The data from such relationships emerges from a process of mutual interpretation in which meaning must always be regarded as problematic"(34). In this way every field study provides an opportunity to develop theory on basic social processes as well as on some substantive topic. For, studies "of interviewing procedures and the commonsense rules of everyday life are essentially studies on the same phenomenon; the same model will explain the data of both kinds of study"(35). Consequently, the conversation that constitutes the interview has as much to tell us about face to face interaction as about the substantive topics health and illness. In fact these two concerns are related for their accomplishment as social phenomena depends upon the procedures by means of which a cognitive order is accomplished. That is, the interaction can only be maintained given the ability of the participants to utilise interpretive procedures to make sense of each other and to recognise what is going on.

The context of interaction may influence what is said or the interpretation of what is said in more than one way. Firstly, as Garfinkel indicates in his characterisation of utterances as indexical expressions the meaning of what is said is relative to such contextual matters such as who was saying it, to whom it was being said, where it was being said, on what sort of occasion and the social relationship between teller and hearer(36). Wieder has provided an example of the way context is

invoked to impute meaning in his discussion of the inmate code employed by parolees in a half-way house. The same remark by an inmate and a member of staff would have been interpreted differently because in the former case its meaning would have been determined by reference to the inmate's code of conduct(37). In the context of an interview knowledge of conversational rights and duties appropriate to each participant may be used as a resource in interpreting what is said. That is, the interviewer's right to determine the course of the conversation may be employed by the interviewee to interpret utterances that do not have the form of questions as questions(38). Additionally, the accounts that respondents give in research interviews may be influenced by their perception of the type of person the interviewer is, their relationship with him/her and their assumptions about his purposes in conducting the interview(39). Finally, one account may be selected out of a range of possibilities according to the respondent's purpose in the context of the interview. For example, a criminal may present one account of his behaviour in court and another to his associates according to what he identifies as appropriate to each milieu in the light of his purpose at hand. Similarly, a shoplifter may be more likely to present his attempt to carry an article out of a shop without paying as 'absentmindedness' rather than a wilful act of stealing if he wishes to avoid the consequences of the latter depiction. As I explain and illustrate in the next chapter I assume that the respondents presented accounts such that they could be identified as moral persons, competent members and adequate performers in particular social statuses and their experiences seen to be consistent with a known order of things. In this way the conversation between interviewer and interviewee which is treated as data can be considered to be an emergent product of a particular social encounter.

The analysis of conversational data

Having briefly described the status of what I intend to treat as data, tape recorded conversations derived from interviews, it is necessary to indicate how that data will be analysed. From the argument presented above, it follows that an appropriate method of analysis is that which may be referred to as conversational analysis. Thus, I intend to use the strategy documented by Turner[40] and elaborated by Wootton[41] as a point of departure. While the adoption of this strategy is a logical outcome of a consideration of the nature of the data, it should also serve to extend the theoretical framework for understanding illness developed in Chapter 1 by taking note of the following critique:

> "Both Schutz and the symbolic interactionists place language in a critical position in their analysis of meaning, but treat language itself as simply a medium of meaning, an intervening variable, without paying attention to the problems attached to the retrieval of meaning from people's talk."[42]

Conversational analysis, and the paradigm from which it is derived, ethnomethodology, elevates the "retrieval of meaning from talk" to a central theoretical and methodological position.

Ethnomethodology holds a particular conception of the nature of language and, consequently, of the relationship between language and meaning. As Anthony Wootton discusses, ethnomethodology rejects the possibility of developing general criteria for deciding the meaning of words and general criteria for recognising what sort of utterance an utterance is. As a result, it holds the view that it is not possible to "extract incorrigible formulations of the meaning of talk"[43]. Rather, the use of language is loose and imprecise by its very nature[44], such that any rendition of the meaning of an utterance can always be

faulted in various ways because it is always possible to provide alternative meanings and interpretations of the same piece of talk. Ethnomethodology sees words and utterances as indexical, that is, "bound up with and occasioned by the particular context in which words are uttered". This reliance on context means that attempts to delineate the meaning of utterances in a more general way, as certain linguists and philosophers are keen to do, is fundamentally misguided. Talk, then, is a form of glossing; an analysis of the meaning of the words used in talk does not provide for the meaning of the talk itself. For, in Garfinkel's words, since talk is a gloss, much more is talked about than is actually said(45). Because utterances are indexical glosses, "it is not possible to specify the meaning of an expression independently of a particular occasion of its use, nor, even within a specific context, to specify the meaning of expressions in a determinate manner"(46). Talk is, thus, essentially and necessarily ambiguous. Ethnomethodology's particular concerns are based upon the fact that despite the nature of language use talk is routinely heard by participants in a conversation as an ordered phenomenon. It seeks to explicate the methods whereby utterances as indexical glosses are produced and heard as ordered. Empirically, this demands the study of the practices and procedures individuals utilise in order to construct the meaning of utterances. It is in this sense that talk is an accomplishment, a product of the interpretive work of the participants in a conversation. The aim of conversational analysis is to elucidate the machinery involved in this interpretive work.

Turner's methodological strategy starts with the location of units of analysis in the piece of conversation under study. These units of analysis are activities, instances where words are acts in

themselves. That is, in uttering certain words a person is doing something as well as saying something. Thus, in saying 'I order you to ...' an individual is not just saying a particular sequence of words but also doing commanding. There are no predetermined or explicit criteria for locating such activities; rather, the analyst must use his commonsense or member's knowledge to recognise such activities as commanding, complaining, insulting, etc. in the conversation under study. Then, having recognised an activity, the sociologist must pose as problematic how the utterances come off as the activities so recognised. Thus, the analyst has to explicate the resources he uses in making that sense of that piece of talk. In addition, given the ethnomethodological concern with indexicality, a further task of the analysis is "to make explicit just what features of the occasion and talk are appealed to as providing for the force of an utterance or the character of an activity"(47); to attend to the problem of how the known context is used as a resource in recognising the activities so designated. The intention behind this method of analysis is not to determine the meaning of any given utterance but to clarify the resources required to hear that utterance in a particular way. It is only through the competent use of such resources that an individual can construct meaning, negotiate interaction and perform as an everyday member. The principles on which conversational analysis is based are as follows:

1) that in constructing their talk, members provide for the recognition of "what they are doing" and "what they mean" by invoking culturally provided resources;

2) that "total speech situations" or "contexts" are to be elucidated as features oriented to by members in doing and recognising activities and constructing meanings and assessing their appropriateness;

3) in undertaking such elucidations sociologists do and must employ their own expertise in recognising methodical procedures for accomplishing activities;

4) that the task of the sociologist in analysing naturally occurring scenes is not to deny his competence in making sense of activities but to explicate it(48).

Thus, the strategy outlined in Turner's paper provides the means whereby apparently trite, though sociologically opaque, conversational data can be utilised to explore the production of a cognitive order. However, one limitation of Turner's approach seems to be that he restricts his analysis to stretches of conversation that are recognisable as activities of particular kinds. Though he does say that "all and any exchange of utterances can in principle be regarded as doing things with words"(49), he does not go to any great lengths to demonstrate that this is the case. This also assumes that the construction of the meaning of an utterance depends upon it being heard as an utterance of a particular kind. Again, it is not clear that this is necessarily so. Conversational analysis is usually conducted on short extracts from naturally occurring talk whereas I am interested in the analysis of respondents' detailed descriptions of various events and states of affairs. Here, I am not so much concerned with locating conversational structures or investigating the machinery whereby utterances are heard in given ways, I am concerned with the cognitive processes by means of which events and states of affairs are categorised and recognised as part of a known social order. Consequently, the method of analysis I will use, which may be called the analysis of respondent talk, adopts the same stance as conversational analysis but provides an ethnography of talk rather than a description of the rules presupposed in conversation.

It emphasises the substantive topic under investigation rather than theory about basic social process and attempts to answer a broader question posed by Cicourel:

> "How are natural sequences of descriptive accounts recognised as meaningful by members of a group or collectivity? How do members decide that particular accounts are adequate for understanding what is being communicated so that a response, also taken as adequate, is forthcoming?"(50)

Though ethnomethodology is the most programmatic attempt to follow Schutz's directives for the study of the constitutive phenomenology of the natural attitude there has been little elaboration of his sociology of commonsense knowledge other than the work of Garfinkel, Cicourel and McHugh. Garfinkel's description of the documentary method of interpretation, which consists of "treating an actual appearance as the document of, as pointing to, as standing on behalf of a presupposed underlying pattern"(51), has been elaborated by Cicourel in his discussion of interpretive procedures(52). Cicourel draws a distinction between basic rules and surface rules; that is, between interpretive procedures and norms. The former are basic mechanisms which allow an actor to identify settings and thereby invoke appropriate norms. They function in a similar way to the documentary method for they are used to identify the pattern or meaning which underlies a given appearance. Only when such a pattern or meaning is imputed can a situation be defined and the relevance of surface rules decided(53). These interpretive procedures are the methods whereby members "produce and sustain the sense that they act in a shared orderly world in which actions are concerted in stable and repetitive ways that are recognisable and reportable"(54). Garfinkel's earlier analysis of the components in terms of which behaviours, settings or states of affairs are evaluated

in producing a sense of social order have been extended by McHugh[55]. McHugh has demonstrated, by the use of conversations obtained in experimental situations, the ways in which the construction of social order is developmental and characterised by processes of emergence and relativity[56]. Via these processes subjects were often able to make sense out of senseless and random conversation. The analysis of respondent talk is informed more by these writers than those who have subsequently developed the field of conversational analysis.

While the adoption of this perspective and methodology may be justified on the grounds that there is an important theoretical continuity between symbolic interactionism, labelling theory and ethnomethodology, "the integral part played by interpretive work in social processes"[57], the implications of this method of analysis need to be considered.

A first point to be made stems from the view of respondents' descriptions of 'what happened' as situated accounts. The accounts contained in respondent talk are not practical reasonings which generate social action with regard to states of affairs variously labelled health, illness, symptoms and the like but are accounts constructed to accomplish the interview and demonstrate competence as a respondent[58]. More straightforwardly expressed, the research strategy chosen allowed the researcher to participate in and observe interviews with several respondents but did not give rise to direct access to situations of practical decision making in which meanings are attached to physical and other manifestations and courses of action constructed on the basis of those meanings. As explained in the Appendix, practical constraints and other dispositions meant that such direct access was not a possibility. Thus, there is no way of knowing that the procedures and practices

revealed in an analysis of the interview data are employed in other social situations to generate relevant social action. Cicourel provides a way out of this dilemma when he says of the interview:

> ".... continuous situational imputations, strategies and the like occur which influence how actors treat each other and manage their presence before each other. Now these are precisely the conditions found in everyday life."(59)

The interpretive procedures and other commonsense resources utilised in the interview have the character of what Garfinkel calls "invariant properties" or "background expectancies" which I assume are utilised in contexts where meanings and action pertaining to the phenomena health and illness are constructed. That is, these practices and procedures are used routinely in everyday life, and while respondents' accounts are not taken to be indicative of 'what happened' the resources used in the construction of those accounts are assumed to be integral to the construction of any account, whatever the situation in which it is given. A similar assumption is made by Turner and other conversational analysts in their search for conversational structures generalisable across contexts.

A closely related problem is this; can an analysis of the resources employed to construct the meanings of utterances tell us anything about how the meanings attached to various manifestations are constructed? Is there any significant similarity or difference between utterances and manifestations that would lead to the conclusion that such meanings are constructed in fundamentally similar or different ways? At one level utterances and manifestations are qualitatively similar, for both are apprehended as visual, auditory or other perceptual stimuli, they have an independent physical existence and only take on a social character

when they are cognitively organised. But the relevance of conversational analysis of interview data for the sociology of illness does not rest on the demonstration of an ontological similarity between utterances and manifestations. For I am initially concerned to demonstrate the process or methodology by means of which meanings come to be imputed to given states of affairs. It is then assumed (and this assumption is, perhaps, contained in the one made in the paragraph above) that this methodology has common properties independent of the nature of the entity to which a meaning is attached. For example, I have suggested elsewhere that the meanings of both utterances and manifestations are situational constructs. Whether this theoretical issue can be illustrated by an analysis of the interview data is problematic if not doubtful.

A final problem to be considered stems from the principles which guide conversational analysis as outlined above. For adherence to these principles means that the analysis reveals the procedures the analyst would need to use in order to hear utterances in given ways. Two crucial points are thus raised: Do participants in the conversation hear utterances in those given ways, and do they use the resources described by the analyst in order to do so? That is, is the reconstructed logic of the analyst the same as the logic-in-use of the participants[60] and does it have the same results? This is a problem of some magnitude; for in order to suscribe to a theory of social action that locates the basis of action in meanings it is necessary at some point to be able to state that actors do interpret given states of affairs in certain ways. If ethnomethodology is not prepared to make such a commitment, then it cannot provide a theory of social action, only a theory of the production of a cognitive order whose relevance for a theory of social action is

unknown[61]. The issue to be considered then is, "What relationship is there between the analyst's hearing and machinery and those of the participants in the actual conversation being studied?"[62]. Turner solves the problem by an assumption contained in the following statement:

> "(Conversational analysis) ... requires the sociologist to explicate the resources he shares with participants in making sense of utterances in a stretch of talk."[63]

Other conversational analysts such as Sacks and Schegloff make a similar claim when they state that the procedures revealed in the analysis of conversations are not just analysts' constructs but are "descriptions of the orientations of conversationalists in producing proper conversation"[64]. However, they are careful to note that this claim requires documentation and a search for evidence which suggests that the individuals concerned do orient to the procedures the analyst explicates. But as Wootton notes in a discussion of Turner's analysis of a piece of conversation the necessary evidence may not be forthcoming. In which case Turner's assumption must stand if it is to be said that participants did use a certain set of resources for interpreting things in a particular way. This is of course an assumption made by participants themselves. The idealisation described by Schutz and termed the reciprocity of perspectives allows everyday members to assume the existence of common meanings until evidence to the contrary appears.

As far as the present study is concerned, it is a considerable advantage that the researcher was one of the participants in the conversation for field notes and recall should provide access to how respondent utterances were interpreted at the time of the interview itself.

The resources taken for granted then and to be made explicit in the analysis, including commonsense knowledge of illnesses, persons, actions, motives and their typical structure and interconnectedness, used as an interpretive scheme are taken to be routinely employed by competent members of our culture. It is in the description of commonsense knowledge about illness and its related phenomena utilised in the social construction of illness that the study makes its most direct contribution to the sociology of illness.

REFERENCES

1. All absolutist sociologies assume that social phenomena can and should be studied only in terms of clear, formal or scientific categories distinct from the commonsense categories of man in everyday life defined by the scientist in advance of the study of those phenomena. For a discussion of absolutism see Douglas, J., Understanding Everyday Life, R.K.P., London, 1971, p. 13. On occasions naturalism is used as a synonym for absolutism, i.e. to refer to a conception of science based on the natural sciences. See for example, Keat, R. and Urry, J., Social Theory as Science, R.K.P., London, 1975. Here naturalism refers to a philosophy in which the methods used to study any phenomenon are selected on the basis of some understanding of its nature. Its use is derived from Matza, D., Becoming Deviant, Prentice Hall, New Jersey, 1969.

2. Husseri, E., quoted by Silverman in Filmer, P., Phillipson, M., Silverman, D. and Walsh, D., New Directions in Sociological Theory, Crowell Colhier MacMillan, New York, 1972, p. 184.

3. Matza, D., Becoming Deviant, op cit, p. 7.

4. Schutz, A., Collected Papers, Vols. I and II, Nijhoff, The Hague, 1962 and 1964, pp. 5, and 5 and 6.

5. Douglas, J., Understanding Everyday Life, op cit, p. 18.

6 For example, see the discussion of the interpretation of symbolic interactionism by the so-called Iowa School, in Meltzer, B., Petras, J. and Reynolds, L., Symbolic Interactionism, R.K.P., London, 1975.

7. Douglas, J., Understanding Everyday Life, op cit, p. 14. Here Douglas confuses naturalism with Schutz's discussion of the natural attitude.

8. Douglas, J., ibid, p. 15.

9. Douglas, J., ibid, p. 16.

10. Douglas, J., ibid, p. 21.

11. Silverman, D., in Filmer, P., Phillipson, M., Silverman, D. and Walsh, D., New Directions in Sociological Theory, op cit, p. 190.

12. Silverman, D., ibid, p. 191.

13. Blumer, H., Methodolcgical Principles of an Empirical Science, in Symbolic Interactionism, Prentice Hall, New Jersey, 1969.

14. Phillipson, M., in Filmer et al, op cit, Chapter 5.

15. Phillipson, M. and Roche, D., Phenomenology, Sociology and the Study of Deviance, in Rock, P. and MacIntosh, M., (eds.), Deviance and Social Control, Tavistock, London, 1974.

16. Blumer, H., Symbolic Interactionism, op cit, p. 56.

17. Douglas, J., Understanding Everyday Life, op cit, p. 9.

18. My own experience of using structured questionnaires has reinforced this view. Attitude statements in particular seem subject to this sort of problem. It is contentious whether these problems arise in the use of bad instruments or whether they are inherent to data collection techniques of this kind.

19. Garfinkel, H., Studies in Ethnomethodology, Prentice-Hall, New Jersey, 1967.

20. That is, talk which occurs between two participants in everyday interaction.

21. McCall, G. and Simmons, J., Issues in Participant Observation, Addison-Wesley, Reading, Mass., 1969.

22. In fact 26 interviews were recorded but for the reasons explained in the Appendix only 23 could be used.

23. Filmer, P., Phillipson, M., Silverman, D. and Walsh, D., New Directions in Sociological Theory, op cit. See Chapter 5 for an extensive discussion of the relationship between theory and methodology.

24. Blumer, H., Symbolic Interactionism, op cit, pp. 27 and 39.

25. Here data is assessed by reference to a set of criteria consensually agreed to constitute scientific activity rather than by reference to the empirical world itself. Blumer makes a similar point. However, because he subscribes to a view of the social world which emphasises its obdurate character and its ability to "talk back to" our images of it, he solves the problem of validity by advocating that all such images be judged in terms of the empirical world to see if they are "true". This is unacceptable from a phenomenological perspective since the empirical world and our images of it are inseparable.

26. The correspondence theory seeks to maintain a distinction between the subjectively perceived object of the world and the concrete object so that an analysis may distinguish what "appears" to be the case and what actually "is". By contrast, the congruence theory proposes that the perceived object out there is the concrete object and that there is no distinction to be drawn between them. For a discussion of this point see Anderson, J., Discovering Suicide: Studies in the Social Organisation of Sudden Death, MacMillan Press, London, 1978.

27. Cicourel, A., Cognitive Sociology, Penguin, Middlesex, 1974, p. 111.

28. Cicourel, A., ibid.

29. Cicourel, A., ibid.

30. The fixed point to which I refer is illustrated in the following warning given by Tuckett of a problem that may be encountered in studies of illness behaviour, Introduction to Medical Sociology, Tavistock, London, 1976, p. 176:

> "The main problem is the fact that data collection at one point in time tends to be obstrusive and can therefore influence data collected at subsequent times. Filling in a health diary or being questioned about health could create a new pattern of illness behaviour; in short, improved internal validity could threaten external validity."

Here envisaged is a 'real' pattern of illness behaviour which is disturbed and rendered invalid by the intrusion of the researcher. The pattern of behaviour created by the research effort is not taken to be of any interest. Nor is the process of the research and the means whereby these new patterns of behaviour are created seen as having anything to tell us about social life. The research is merely a means to an end, the documentation of a real pattern of behaviour, subject to certain kinds of trouble which ideally must be eliminated. But as Cicourel points out, these methodological problems are not technical obstacles to ideal research but are natural and inevitable problems of the study of social life.

31. Voysey, M., A Constant Burden: The Reconstitution of Family Life, R.K.P., London, 1975, p. 73.

32. Cicourel, A., Fertility, Family Planning and the Social Organisation of Family Life, Journal of Social Issues, 23, 1967, p. 69.

33. Cicourel, A., Method and Measurement in Sociology, Free Press, New York, 1964, p. 73.

34. Phillipson, M., in Filmer P. et al, New Directions in Sociological Theory, op cit, p. 99.

35. Cicourel, A., Method and Measurement in Sociology, op cit, p. 81.

36. Garfinkel, H., Studies in Ethnomethodology, op cit, pp. 4-7.

37. Wieder, D., Telling the Code, in Turner, R., (ed.), Ethnomethodology, Penguin, Middlesex, 1974.

38. That such a structure of rights and duties is oriented to by parties to an interview was evidenced by a remark from one of the respondents after she had asked me a question at one point in an interview. She said, "I shouldn't ask you questions".

39. The fact that none of the women interviewed talked about menstruation I take to be due to notions of what it is appropriate or inappropriate for women of a given age to discuss with young men. A female interviewer might have been able to gain access to such

data. The respondents did make inferences about my purposes, at least to the extent that on occasions their accounts were prefaced by remarks such as "You'll be interested in this".

40. Turner, R., Words, Utterances and Activities, in Douglas, J., (ed.), Understanding Everyday Life, op cit.

41. Wootton, A., Dilemmas of Discourse: Controversies in the Sociological Interpretation of Language, George Allen and Unwin, London, 1975.

42. Wootton, A., ibid, p. 99.

43. Wootton, A., ibid, p. 94.

44. Schutz subscribes to a similar view when he talks of "horizons of meaning".

45. Garfinkel, H., Studies in Ethnomethodology, op cit, Ch. 1.

46. Wootton, A., Dilemmas of Discourse, op cit, p. 61.

47. Turner, R., Words, Utterances and Activities, op cit, p. 186.

48. Turner, R., ibid, p. 186-187.

49. Turner, R., ibid, p. 186.

50. Cicourel, A., The Social Organisation of Juvenile Justice, Wiley, New York, 1968, p.10.

51. Garfinkel, H., Studies in Ethnomethodology, op cit, pp. 77-78.

52. Cicourel, A., The Acquisition of Social Structure, Toward a Developmental Sociology of Language and Meaning, in Douglas, J., Understanding Everyday Life, op cit, p. 146.

53. The relationship between the documentary method and the interpretive procedures described by Cicourel is unclear. Some procedures are distinct from the documentary method though others seem to be intimately involved with it.

54. Wilson, T., Normative and Interpretive Paradigms in Sociology, in Douglas, J., Understanding Everyday Life, op cit, p. 28.

55. McHugh, P., Defining the Situation, Bobbs-Merrill, Indianapolis, 1968.

56. "Emergence concerns the temporal dimension of activity" whereas "relativity characterises an event in its relationship to other events across the boundaries of space", pp. 24 and 28.

57. Wootton, A., Dilemmas of Discourse, op cit, see pp. 98-99 for elaboration of this point.

58. They represent what Cicourel calls reconstructed logic, logic used to speculate about past and future action, rather than logic-in-use, which generates actual behaviour. See The Social Organisation of Juvenile Justice, op cit, p. 10. This is one important distinction between interview talk and naturally occurring talk.

59. Cicourel, A., Method and Measurement in Sociology, op cit, p.75.

60. See footnote 29. Some writers recognise this point when they refer to the reconstruction of events in an interview. See Cowie, B., The Cardiac Patient's Perception of His Heart Attack, Social Science and Medicine, 10, 1976, pp. 87-96.

61. Cicourel's statements about reconstructed logic and the generation of action assumes that actions are based in actors' meanings such that the former gives rise to the latter. It is then necessary to specify what meanings were operative prior to a given act.

62. Wootton, A., Dilemmas of Discourse, op cit, p. 73.

63. Turner, R., Words, Utterances and Activities, op cit, p. 177.

64. Quoted by Wootton, op cit, p. 74.

CHAPTER 3

THE RESPONDENTS: GENERAL AND SPECIFIC CONTEXTS OF INTERPRETATIONAL WORK

In this chapter I present some of what the respondents said to me about themselves, their families and others whose health was discussed during the interviews. My aim is to set the scene so that the respondents' statements reported in later chapters and my interpretation of them may be better appreciated. To preserve anonymity the women are identified by letter only. I also give an indication of the number of times the women were interviewed. For ease of reference this is summarised in Figure 1.

Mrs. P.

Mrs. P. was interviewed six times. She was forty-four when first seen. Before her marriage she had worked in an office doing secretarial and clerical work but had given up when her children were born. Her husband was the same age and was "a draughtsman cum office manager for an architect". They had two children; Lindsay was eight and went to a local primary school, and Martin was four. He was due to start school within six months and was going to play school two mornings a week.

Mrs. P. said she had lived in the area "practically all my life. We moved here just before I was six and that's what ... getting on for forty years". She had been registered with the practice since she was six years old although Dr. M. did not take over until she was about thirteen or fourteen. She usually saw Dr. Z. or one of the other doctors rather than Dr. M. Mr. P. and the children were also registered with the practice.

Mrs. P. had a brother who lived with his wife "just a few doors along the road". Her father lived "in a maisonette just around the corner". He had lived alone since Mrs. P's mother died nine months previously. Mrs. P. saw her brother and sister-in-law "almost every day" and she went round to see her father every day "specially since he's been on his own".

Unlike most of the other women I interviewed Mrs. P. was not altogether optimistic about her family's health, "I suppose we're sort of average really". Referring to the children she said "You know these sort of childish complaints they get now and again", although at a later interview she did say "I suppose on the whole they are healthy. They enjoy themselves, they're out playing and everything". At the start of the study year Mrs. P's daughter was being treated for an upper respiratory tract problem which was initially thought to be "an allergy or hay fever". According to Mrs. P, "she's had quite a bad spell over the last few weeks". This respiratory problem was talked about at each of the subsequent interviews and gave rise to considerable concern:

> Mrs. P: I'm going to watch it, it makes her a bit listless. I wonder if another year she could have injections if it keeps on. I would like to stamp it out naturally because I think it's miserable for the child really.

Over the course of the study year Mrs. P. made frequent visits to the doctor about Lindsay's chest problem. Just prior to the third interview it had been diagnosed as bronchitis and she was prescribed antibiotics. Over the next few months she had four more courses of antibiotics when the infection recurred and Mrs. P. began to feel that they were not getting to the root of the matter. As Mrs. P. recounted

in a later interview, "I got desperate in the end" and after a talk with Dr. S., Lindsay was referred to an outpatient clinic for chest X-rays. Mrs. P. also sent her to stay with a friend in Switzerland, "and of course the open air life out there and the exercise she seemed fine and the doctor was very pleased". At the last interview Mrs. P. said Lindsay had been discharged from the outpatient clinic and told to come back if the infection returned. Although Lindsay did have another chest infection which was treated by the GP, Mrs. P. had not contacted the clinic "because at the start of the winter she didn't seem too bad". Mrs. P. thought "that there is just that bit of a weakness with her" and said "I think it's unfortunate with Lindsay that she does suffer a little bit with this but on the whole she seems to enjoy life and pretty active and flying around. It doesn't seem to bother her. I think possibly that I worry more about it than maybe she does".

Mrs. P's other child, Martin, was "pretty tough on the whole". Though he did seem to get "a fairish number of coughs and colds through the winter" this was because he went to play school "and when there are so many children with colds I think when they're in a crowd they do pick them up more quickly". But because he had learned how to blow his nose properly as a toddler "he can sort of clear it that way fairly quickly". Mrs. P. also said that he sometimes woke up coughing violently, "he will cough and cough and cough and sometimes he gets into a panic about it, I think cus it sort of takes his breath away, but during the day it often won't bother him at all, but there again medicine will usually clear it up, you know". At a later interview Mrs. P. had just received a lengthy questionnaire to complete about Martin's health before he had a medical examination at school; "most of the things just didn't apply to him at all, he's very healthy I'm glad to say. He goes out

like a light when he goes to bed and sleeps right round until seven in the morning. Then he's off again. He's so incredibly lively". Mrs. P. said that her husband's health was "pretty good", although he was overweight. In the past he had been treated for "a type of nervous breakdown" but "he's got over that, he's perfectly O.K. now". He had also had pneumonia twice when he was younger and Mrs. P. was constantly on the lookout for signs that this and the nervous breakdown were about to reoccur. At the second interview she said she had noticed him rubbing his chest once or twice and was going to keep an eye on him; "I think they're things one should watch, it could be dangerous really, especially with him being overweight". At the fourth interview Mrs. P. said that her husband had become depressed again and despite her attempts to persuade him he refused to go to the doctor.

Of herself, Mrs. P. said "some days you feel better than others but on the whole I don't have any complaints". She had suffered with a duodenal ulcer for the past ten years which troubled her periodically throughout the study year. She was usually able to manage the discomfort herself using a regimen that had been recommended by her brother, a fellow sufferer. Eighteen months prior to the first interview she had had an ectopic pregnancy which had been "a bit of a shock". She had also slipped a disc and had occasional pain from that. She said that she always felt tired "but I'm usually on the go pretty much and I never get to bed that early".

Mrs. P's father was eighty-five and at the first interview Mrs. P. said "he's wonderful". He did have a circulatory problem in his legs and had "been taking tablets for a number of years" for hardening of the arteries. Mrs. P. had recently noticed that "he gets very wheezy on his chest" but thought that this was due to inactivity; "When he's

had a walk out and that he's a lot better whereas if he's had a sleep in a chair he sounds very wheezy". Only a few weeks before Dr. M. had given him "a thorough check over" and pronounced him to be "remarkably good for his age". By the time of the fourth interview, however, he had been told by Dr. M. that he must no longer live alone. He had lost the use of one of his legs and because the other was not too good he needed a frame to help him walk. Following a series of falls Mrs. P. and her sister-in-law had taken it in turns to go round and get him out of bed. They also went in during the day to prepare his meals and he was put to bed by Mr. P. and the brother. The doctor had been calling in regularly and the district nurse was coming to see him once a week. Mrs. P. said "It's just a constant worry, you can only leave him now a couple of hours and he can have a fall, you know". Because of the danger of his falling and the inconvenience of maintaining him at home it had been decided that he would go and live with Mrs. P's brother and sister-in-law. They were in the process of converting a back bedroom for him to occupy. As he was due to go to hospital for a routine check on a prostate operation they were going to ask the ambulance to take him there rather than back home. Mrs. P. was happy with this arrangement because someone would always be available to look after him and he would no longer be a cause for concern. Apart from the problem with his legs Mrs. P. said he was "remarkably fit". By the time of the fifth interview Mrs. P's father was living with his son and daughter-in-law. He was finding it increasingly difficult to walk and because he lived in an upstairs room he was effectively housebound. Mrs. P. said "really he's sort of stuck now because of his leg". He only went out when Mrs. P's husband or brother were available to carry him downstairs and then he had to be taken out in the car. Consequently, Dr. M. was making arrangements for him to go to a day centre for three

days a week. Despite the fact that Mrs. P. had noticed that he had become depressed she thought he was very happy living where he was.

Mrs. S.

Mrs. S. was interviewed five times. She lived in a semi-detached house built in the 1920's about ten minutes' walk from the doctor's surgery. At the first interview she was 38 and her husband, Mike, a statistician with a large manufacturing company, was 39. They had been married for sixteen years. Their first child, Michael, was nearly six and Joanna, their only other child, was nearly three. Michael had been physically handicapped since birth; as Mrs. S. said, "he's spastic".

Mrs. S. had been born locally and had lived in the area all her life. Her parents had lived in the area for the forty years before they died, "so I can say I'm pretty much (name of locality), you know". Prior to her marriage Mrs. S. had worked as an assistant in a chemist shop. Mrs. S. had been with Dr. M. "since he first started". "It must be about 1935, I know I was about 11 or 12 or something like that". In fact Mrs. S. must have joined the practice somewhat later since at one interview she remembered receiving treatment from her previous doctor during the war. Mrs. S. had changed doctors when this doctor left the practice and Dr. M. took over, and now her husband and children were registered with him.

Both of Mrs. S's parents were dead though her mother-in-law was still alive. She lived up North and came down to stay once a year for ten days or so. "She's an old age pensioner, not that you'd think so, she's absolutely marvellous", despite ulcerated varicose veins which prevented her from walking very far and "her nerves" for which she was

on tranquillisers. The only relatives Mrs. S. had living in the immediate area were two aunts; her father's two sisters and their families. "We don't ever see them. One of them rings up every so often". Mr. S. had an uncle who lived "just down the road". He came up to visit every Tuesday, "he's as fit as a fiddle".

Apart from her husband who Mrs. S. said was "very good", there was no-one in the family she talked to about her health or other problems. She did, however, confide in a close friend:

> Mrs. S.: I see her sort of every day, you know. She's the same age as me, she's got three youngsters, you know, we've a lot in common and I think she and I talk more than anybody really about our health problems. We're very much alike in a lot of ways, we suffer from the same sorts of things, you know, nerves, the children .... We met each other when we went to relaxation classes for our first children and erm we always talk things over as regards ourselves, our children and, you know, it helps.

Like most of the others Mrs. S. said that herself, her husband and the children were very healthy. "Really and truly on the whole I think I can safely say we're pretty healthy. None of us ever has a thing wrong". Consequently, the only time they went to the doctor was for things that happened to the children. "We can go for an awful long time without seeing him and then things crop up with the children and we go probably two or three times in a couple of months. I don't go all that much, it's mostly the children".

According to Mrs. S., Mr. S. couldn't be fitter. "There's very rarely anything wrong with him" nor did he ever complain of anything. He walked to the station every morning and walked home again every evening; "He believes in having a bit of exercise, he keeps pretty fit". Mrs. S. thought that all this walking was the reason why he was so

healthy. "We haven't got a car so, you know, a lot of people seem to go down in cars you know as they're not as healthy as we are". In fact, the only problem Mrs. S. reported for her husband in the survey year was a severe nose bleed which had happened at work. He went to the casualty department of a local hospital where the nasal membranes were cauterised and he had no further trouble. The only other problem that Mrs. S. mentioned was ear trouble which resulted in his being deferred from National Service for six months. It had not bothered him since; "his mother always says he's deaf but I feel he does that on purpose". Subsequently Mrs. S. said, "that's the only thing with Mike, his ears and his nose, he never gets any other kind of thing wrong with him".

Joanna, Mrs. S's younger child, "seems to get a lot of colds". The main reason she ever went to the doctor was for what Mrs. S. called "throat troubles". Mrs. S. always took her up to Dr. M. "if her throat gets bad" as she had been told that it might be necessary for her to have her tonsils out later on. The winter prior to the first interview she had had a cold almost every month, "I've never known a girl have so many colds", and no sooner had she got rid of one she got another. Mrs. S. thought it was due to the fact of her not eating. "She went through this dreadful phase of not wanting to eat. I think that was a lot to do with it. She would not sit down and eat a proper meal. I'm sure that's why she got a lot of colds." This was a problem that Mrs. S. had never had with Michael; "he eats like a horse and that's why he's never had a cold this year".

Michael was brain-damaged at birth, he was incontinent, could not talk or walk. Mrs. S. said at several interviews how healthy he was. "Well, though he's a spastic he's healthy. I think he has a

cold here and there but apart from his actual condition, you know, handicapped, I can't think of anything that he has". A year before the first interview he had had an operation on both hips and spent six months in plaster. Of three children who had the operation at the same time his was the only one to be a success. Mrs. S. had been told by the staff at the hospital that this was because he was so big and strong. Unlike other similarly handicapped children he had no problem feeding and, consequently, had escaped the frailty that was often associated with his condition. Mrs. S. often spoke of how lucky she was:

> Mrs. S.: I suppose I'm luckier than most that Michael isn't worse than he is. I mean I've seen so many dreadful things that I count my blessings that he's as good as he is.
>
> Mrs. S.: I know that some people have handicapped children they're permanently on the phone (to the doctor), not because they're always worried but because their children aren't as fit as Michael.

Despite the fact that he was so healthy and better off than most handicapped children he was a constant source of worry. "Obviously, with Michael being handicapped he is a big worry". Because of his handicap Mrs. S. could not take for granted his normal physical and social development. With non-handicapped children parents can assume the acquisition of skills according to a more or less predictable time-table. They can also assume the eventual independence of their offspring such that their own mortality is of limited significance. With a handicapped child these assumptions may be untenable and give rise to parental concern. On more than one occasion Mrs. S. said she did worry about Michael's future:

Mrs. S.: I worry because I think well, how's he going to be in the future. I mean, you know, is he ever going to walk, is he ever going to talk, is he ever going to be capable of ... what happen when anything happens to my husband and I ...

As well as the future being problematic relatively routine events may constitute a problem in the context of handicap. The week prior to one interview Michael had been to the dentist to have some teeth out:

Mrs. S.: Just before going to the dentist I was worrying myself to death about him. I mean I don't worry about the dentist as a rule but of course it was him and he had to go without any breakfast and drink and I was worried how he would feel and all the rest of it.

A further source of worry for Mrs. S. was Michael's hip operation given that she had been warned by the surgeon that it could be a failure and had seen it fail in other children:

Mrs. S.: It was you know apart from the actual operation it was the six months in plaster, you know, it was pretty nerve racking not being able to get out, worrying about Michael, was he in pain. It was in the summer and you can imagine how hot it was. So the thought that he might have to go in and have that operation again ... we did it, we got through it yes, but to do it again would be awful.

Consequently, Mrs. S. was unable to accompany Michael when he went back to hospital to have his hips checked. Her husband had to take him "because if they'd said that the operation had been a failure I would just have made a fool of myself, I'd probably have burst into tears or something stupid", while Mrs. S. stayed at home. By contrast, the six monthly visit Michael had with his paediatrician the week before the last interview was not a source of anxiety; "his ordinary six monthly check-up doesn't bother me because it's just the doctor from

the hospital where he was born, they watch just to keep a check on him to make sure ... it's just a normal routine visit".

At the last interview Mrs. S. talked about the progress Michael had made over the year. Six months previously he had been unable to move if he was placed on the floor. "Now he can creep around the floor and this last week he's just started turning from his tummy to his back and that, I mean it doesn't sound very much but to Michael that's a big thing. Once he gets going there's no stopping him". Not only were Mr. and Mrs. S. "very pleased" with his progress, the paediatrician had told them that the improvement was remarkable. Despite this improvement Mrs. S. was still apprehensive about the next visit at which his operation would be reviewed. "Knowing me I shall be a bag of nerves from the moment I get that letter from the hospital". At the last interview Mrs. S. did say that she might worry needlessly, "but then I'm like that, you can't change yourself can you, I mean if that's the way you are".

Physically, Mrs. S. was "very healthy", unlike most of her friends "who always seem to be having things wrong with them". She did say that she was always "dead tired" but was bound to be because "life is so hectic, there's always such a lot to do".

Mrs. G.

Mrs. G. was interviewed three times. She was initially contacted for a pilot interview, subsequently included in the study and interviewed on two further occasions. At the time of the first contact she was seven months' pregnant, and at the third and final interview had a son twelve months old. She was twenty-five and her husband was twenty-six. He worked as a contract surveyor for a large construction company.

Within the last few years they had spent eighteen months in the Middle East and three months in the Caribbean while Mr. G. worked on company projects. Prior to her marriage Mrs. G. had been a teacher. She had taught while they were abroad and had only recently given up pending the birth of the child.

The G's lived in a semi-detached house on a large estate built in the late 1960's, bought on their return from the Middle East. The estate surrounded a complex of community facilities, including the health centre where they were registered. They had joined the practice two and a half years previously when they moved into the area. Their son was also registered with the practice but with a different doctor; "In this particular practice they sort of you know one doctor sees the parents and the child has to see a different doctor that specialises in children".

Mrs. G. always referred to the practice as "the clinic" and she thought that the doctors were always busy, so much so that her son would not receive his full quota of routine check-ups:

> Mrs. G.: You know when they test children in the first so many years of life, they do, don't they ... you know, I.Q. tests, reflex tests and all sorts of tests like that and when we first came, well up to six months ago, it used to be a test at three months, six months, one year, eighteen months, two years. Now it's six weeks, nine months, two years and that's it so we missed out.

Originally from the North, Mr. and Mrs. G. now lived a three-hour car journey away from their families. Consequently, they saw little of their relatives. "We see them about once every six weeks, some of them I do at least every six weeks, but it varies, it's not a rigid thing". However, since many of the occupants of the estate were married

couples most of whom had young children, Mrs. G. said "we've got lots of friends near us, we see quite a few people". Out shopping, "you meet the world and his wife up here".

At each interview Mrs. G. said that she thought all of them were very healthy. At one, she said, "we've never had any serious illness at all", and at another she referred to the extent to which they needed to see the doctor:

> Mrs. G.: Roger's never been to the doctor since we've been here, the only ailments he ever gets are common colds. I mean Daniel, obviously, he's seen the doctor on an illness basis probably three times last year. Myself, I just went for antenatal care and that's all really.

Mrs. G. thought she was particularly susceptible to tonsillitis and sore throats; three out of the four visits she had made to her doctor prior to her pregnancy had been for antibiotics for her throat, although at the last interview she said, "it's a long time .... at least two years since I went to the doctor for that".

Not only had Mr. G. never visited his doctor, Mrs. G. said that he never complained:

> Int.: Has he never complained about his health or the way he's feeling?
>
> Mrs. G.: Not really, no .... not now, not now he's ..... he used to before he stopped smoking actually, that's the reason he did stop smoking because he felt so tired and sort of you know listless I suppose .... since he stopped smoking he doesn't complain at all.

Mrs. G. did think that this might be because his illness threshold was higher than hers:

> Mrs. G.: I would say that I was ill probably when, if Roger had the same symptom, he'd carry on, he wouldn't think he was ill.

and this differential tendency to define symptoms as illness, a product of one's "upbringing":

> Mrs. G.: Probably if you've had parents that made a fuss over an illness, sort of treated it as a severe thing each time, er ... you'd feel different than if you had parents that sort of said you're alright, get your coat on and off to school.

Despite the fact that they were all healthy, Mrs. G. didn't think that they were any better or worse than any of the other families that they knew, "we're just similar really". Apart from making sure that they had a varied diet she took no other precautions to maintain their health, "we just accept things and deal with them as they come".

Mrs. F.

Mrs. F. was interviewed four times. At the first contact she was 46 and a housewife. Prior to giving up work she had been a school secretary for eight years and spent two years as an educational welfare officer. "It was full time, I found it just too much, I got to a point where I wanted to be home, I wanted to get my home straight you know, decorate and clear cupboards and things". She occasionally returned to work if the school where she had been were short staffed. "Every time there's a panic they phone up and say could you come and help for two or three weeks and like a fool I keep saying yes. I keep trying to retire but they won't let me". Mr. F. was also 46 and a liaison engineer for an industrial concern making car instruments. "He's partly on the design side and partly seeing through new projects, finding out if they're going to work and how much they're going to cost, you know. It's a complex sort of job, he's worked his way through the factory and now he's doing this which is quite fun". The F's had two daughters; Clare was 15 and still at school, Madge was 17 and had done two jobs since leaving school the previous year, "she doesn't know what

she wants to do yet".

Mr. and Mrs. F. had lived in the same house for 24 years:

> Mrs. F.: We had this house before we were married and we've been here ever since. We bought a house in between the in-laws, they're about four or five miles away, so we're not terribly adventurous.

The F's had been registered with Dr. M's practice for 16 years. Prior to that they were with another doctor for eight years. They changed when their former doctor joined the practice of another and moved. "It was something of a bus journey to get to him. Dr. M. was reasonably close .... I think a neighbour recommended him". At the second interview Mrs. F. told me that her elder daughter had left the practice after a dispute with one of the doctors, "she walked out in a high dugeon and went to a private doctor", although she had gone back by the time of the third interview.

When I asked Mrs. F. about her family's health she said her husband was "very healthy" and her daughters "very fit". She went on, "That's what worries me about joining in your survey, really I don't feel we're the right family". Mr. F. rarely saw the doctor and "never has time off work unless he's dying". Her elder daughter, "she's on the pill, that's the only thing she goes for, to twist his arm and say she must have it". The younger daughter "has had one or two bouts of sort of she gets these swollen glands and sort of a slight temperature. I have had the doctor round a couple of times when she's had a high temperature and I've kept her in bed, but as I say, it's very seldom".

Mrs. F. herself was "pretty fit. The only reason I've been to the doctor which was three months ago I had a sort of exzema of the

outer ear, but that has cleared up". Mrs. F. did, however, suffer from allergic attacks in which her face and her eyes in particular became swollen and painful. Despite numerous tests it had never been definitely diagnosed as an allergy nor had an agent which was responsible been identified. Mrs. F. had been told to live with it and usually managed occurrences herself. It bothered her periodically throughout the study year.

Although Mrs. F. thought that her family were healthy she did not think this made them unusual in any way:

> Mrs. F.: I just thought we were too healthy to be involved in the sort of er census that you're doing. I felt you would have liked a family who succumbed to all sorts of things .... who had all sorts of peculiar er .... regular ailments. No, I don't necessarily think we're that healthy, there are plenty of healthy people about. I just felt we were too healthy for you to be bothered with.

One problem Mrs. F. talked about at all four interviews was her mother. At one interview she said, "I think there's more to tell you about my mother than there is about the rest of us". Mrs. F's mother was eighty-four and living on her own "trying to cope and not be a burden to anyone". Mrs. F. saw her several times a week to take her shopping, collect her pension or to see relatives. "She's more or less housebound except when I take her out". At one point Mrs. F. listed her mother's complaints:

> Mrs. F.: She's got everything, you know, aches and pains, arthritis, a swollen hip, a slightly twisted spine, she's got cataracts and can't see very well, worries an awful lot, terribly lonely, you know, depressed. We do what we can but she's very determined to look after herself.

Because her mother hated to call in the doctor Mrs. F. frequently

took the responsibility for deciding when medical attention was necessary. In addition Mrs. F. had to take her to the doctor or be there to let him in if he made a home visit. However, getting her to the doctor was not an easy thing. "As I say, there's always an excuse, I haven't had a bath, I haven't got my clean underwear on, Thursdays it's not his day .... anything rather than go". Mrs. F. thought her reluctance stemmed from her old-fashioned conception of the doctor:

> Mrs. F.: She should have had him this week ... she's had arthritis really bad, you know, pains all down her legs. But she says oh no can't bother him for that, you know. She's got this very old-fashioned idea of the doctor as God and God mustn't be bothered not unless you're really dying you see. She'll do anything rather than go to the doctor.

Mrs. F. thought that her mother had stopped asking for advice for her medical problems because "she knows I would say let me take you to the doctor's".

Some years previously Mrs. F's mother had an operation on one eye for a cataract. It became infected and she ended up spending six weeks in hospital instead of the few days she had been led to expect. Consequently, she was too frightened to have the other eye done although she was still partially blind. Mrs. F. thought she would be less housebound and dependent if she did have the second eye operation and spent the study year trying to persuade her to have it done:

> Mrs. F.: She really ought to have the other one done ... obviously she'd be better ... she could see with both eyes. But she's very cautious about it and I don't want to push her in case anything goes wrong, cus then it would be my fault, you know, I overpersuaded her. So I'm just sitting back and hoping ... I'm waiting for her to get to the point where a little shove will do it, you know, without it seeming my idea.

Mrs. F. thought that the answer might be to get her to go to a local hospital rather than the one in Central London where the first operation was performed, access to which was difficult for someone with her disabilities.

Mr. and Mrs. F. and both daughters were heavily involved with and committed to a number of local amateur dramatic companies. At one interview Mrs. F. said, "we do amateur theatricals, we're up to our necks in amateur theatricals". Much of their spare time was taken up with this activity and Mrs. F. often said how busy they all were: "You know, we lead such busy lives we haven't got time to be ill or to go to the doctor's unless it's really desperate". Much of what Mrs. F. said about her own and her family's health was related to this interest. For example, when talking about the precautions they took regarding their health Mrs. F. went on:

> Mrs. F.: As I say, if it's vital for us to be well we do take extra precautions, it's only for shows that we care about being ill.

Similarly, when her mother developed a tremor in one arm Mrs. F. insisted she went and saw the doctor:

> Mrs. F.: You see, she felt so conscious of it she wouldn't go anywhere. We had tickets for three shows, cus I told you we do amateur theatricals, she missed a show that my husband was in, a show that my daughter was in and a show that I was in. We got seats, you know, good front row seats and she wouldn't go because she didn't want to sit next to anyone and perhaps for them to think the poor old dear's got the shakes you see, she wouldn't go. Now that she's got these pills from the doctor she's coming next week to see my daughter doing Orpheus at school.

Mrs. F. was also able to see her changing involvement with a local company as evidence of her maturity and the development of her personality:

> Mrs. F.: My life was empty it meant so much for me to have a part, to have a leading part. But the older I get the less I care. I don't need it any more. I seem to be ... I'm a more rounded ... I'm a more mature person and I honestly don't need it. As I say, I've changed, I don't need to do it any more because I'm mature enough not to need it. It is odd isn't it? You know, acting it's a person whose own personality is not sufficient for them, they want to pretend to be someone else. I don't need it any more to feel complete whereas in the past I needed it desperately.

More recently, Mrs. F. had been spending her time helping other societies with problems such as finding stage crews. This was work which was "not extrovert" and which no-one, apart from herself and the company she assisted, would know about. This work she enjoyed very much and which she found was "satisfying me sufficiently I don't need to go on". According to her theorising about personality Mrs. F's discovery of intrinsic value in this activity which did not involve the approval of others substantiated her view of herself as a "more rounded person".

Mrs. N.

Mrs. N. was interviewed three times. She was forty-three at the first interview and a housewife. Her husband was forty-five and a manager with an investment company dealing in property bonds. They had two daughters; Tina was seventeen and Lesley was fourteen. They lived on the first floor of a small, modern block of flats a few minutes' walk from Dr. M's surgery.

Mrs. N. had been registered with Dr. M. for nearly eighteen years, "since my eldest daughter was eight weeks old I first went to him and he's been my doctor ever since". Her previous doctor's surgery was three miles away and she had changed shortly after the birth of her first

child because Dr. M. was more accessible "with a baby". Mr. M. and both daughters were also registered with the practice. When I asked Mrs. N. how frequently they went to see the doctor she said, "You know how it is, you needn't seem him for six months and then one, two, three, everybody's down there, that's how it seems to be".

Mrs. N's mother and father were still alive and lived three miles away. Her mother-in-law lived "a bit further away". She saw all of them several times a week. She also had a cousin living nearby who she didn't see much of because "she works". Mrs. N's mother was "not a healthy person"; she had a long history of osteoarthritis, had numerous operations and still had to go to hospital three times a week for treatment.

At the first interview Mrs. N. said that her family's health was excellent; "they only just have minor things, a headache or .... unless something crops up they're not really unhealthy at all". She went on, "I'm more nervous than the rest of them, I mean I see Dr. ... I see him mostly because of that". Mrs. N. described herself as a "natural worrier" and found her family's health a cause for concern:

> Mrs. N.: I must say I'm the type of person that anything more than a headache does give me a hell of a lot of worry, you know, I'm happy when everything goes smoothly but obviously something crops up and then I do worry terribly.

Later in the interview she said "Thank goodness we're a pretty healthy family so there's not really any problems .... my mother's the only source of worry because of the operations and troubles she has".

Mr. N. suffered from recurrent headaches. At each of the interviews he was said by Mrs. N. to be complaining. Mrs. N. thought it was due to hard work and said there was "a lot of strain" attached to his

job. He had been prescribed Valium and sleeping pills by the doctor but these had not stopped him getting them. The elder daughter had had nothing more serious than her tonsils out and was currently in pain because her wisdom teeth were erupting. Mrs. N's younger daughter had only recently returned to school after having glandular fever, "she had it very mildly which was very lucky". Mrs. N. described her as obstinate and said she was going through "an awkward phase".

Mrs. R.

Mrs. R. was interviewed five times. She was interviewed alone except for the second occasion when her husband was present. At the time of the first contact Mrs. R. was thirty-three. She was a housewife, although one morning a week she worked outside the home doing bookkeeping and secretarial work. Mr. M. was 36 and a director of a charity; "(the job) is related to public relations and the salesman ... there's bags of desk work, I mean one does masses of paperwork and is involved with computers and that goes potty from this point of view, but the work itself is erm sort of motivation and ... if you relate it to a salesman or public relations bloke that's nearer than relating it to some ... nearer than relating it to an accountant". Mr. M. said that the job was very demanding and he was often required to go on trips which meant working long hours. He went on to talk about the capabilities required for the job:

> Mr. M.: You need a lot of self-discipline for the great deal of paperwork, you need administrative ability ... erm to be sociable, to have the ability to converse to set up difficult things like meetings, i.e. A doesn't want to meet B but you fix it ... that kind of capability.

The R's had lived in the same house for the past thirteen years. They had been registered with Dr. M. for two years. They changed

practices when their previous doctor became ill and cut down on the size of her practice. Since they lived further from the surgery than most of her patients they were dropped since the doctor would not have been able to make any home visits that might have been necessary. The R's had two children, a boy of six and a girl of eight.

Both of Mr. M's parents were alive and lived a ten minute car drive away. Mrs. R's widowed mother lived a twenty minute drive away. Mrs. M. saw her mother and her in-laws at least once a week. Apart from her own brother and his wife and Mr. R's brother and his wife she saw other members of the family only rarely. While Mrs. R. said that she would discuss family problems with the brothers and their wives she avoided doing so with the respective parents. Although Mr. R. was being treated for depression at the beginning of the study year both he and Mrs. R. were anxious that his parents should not find out. They were told only when it became necessary for him to enter hospital for in-patient treatment. Mrs. R's mother would, however, always talk about her health and discuss her latest visit to the doctor although she never asked for advice. Mrs. R. said, "this makes us sound as if we were always ailing and always discussing which isn't the case".

At the first interview Mrs. R. said that her own health was excellent; "Generally, I feel very well. I've had one or two things, obviously, but on the whole I usually feel very well." Almost a year before this first interview Mrs. R. had an operation to remove the root of a tooth from her sinus where it had been causing an infection. The operation had not been entirely successful since Mrs. R. still had occasional facial pain. "I haven't had it lately so maybe it's clearing up. I'm a great optimist, I keep hoping things will clear up."

Mrs. R. said that her daughter's health was "pretty good", although she had recently gone through a period when she had complained frequently of abdominal pain. The problem had never been diagnosed because the doctor had been unwilling to subject the child to investigation. Mrs. R. had thought "she might be becoming a bit of a hypochondriac". Mrs. R's son "has had problems almost all his life. He suffered from tonsillitis from the age of three months very severely. It fizzled out when he was four, just before we changed to Dr. M. He still gets a lot of coughs, colds and earache .... which is a bit of a problem with him because I do worry about his ears". When Mrs. R. was asked at one interview if either of the children had been to the doctor in the previous four weeks she said, "I should think my son has about his ears, this would apply at almost any time. He does have to go fairly frequently". Other than that, Mrs. R. said that he was "alright".

A few weeks before the first interview Mr. R. had visited his doctor complaining of depression and had been prescribed antidepressants. At several interviews throughout the study year Mrs. R. spoke of her husband as being her "biggest problem"; "my husband is the only real problem ... what the rest of us have had is nothing". Though his condition deteriorated during the year, at the last interview Mrs. R. was hopeful about his future.

Mr. R. had originally been treated for depression in 1968, "that was just sort of limited treatment on valium, that's all I did have at that time". Although the antidepressants Mr. R. had been prescribed by the doctor seemed to have a beneficial effect initially "in the end they were not successful". By the time of the second interview Mr. R. had been referred to a psychiatrist and later Mrs. R. complained about

the doctor's reluctance to make the referral which they had finally demanded. Because the first experience with psychotropics had been "pretty disastrous" Mr. R. refused further drugs and was put on the waiting list for group therapy. Following a bad weekend when he had been very depressed he had phoned the psychiatrist and said he would take antidepressants. In the end, however, he did manage without. Mr. R. described himself as "nutty as a fruit cake" while Mrs. R. said "Basically what he's got it's diagnosed as depression, but it also has the effect of sometimes making him agitated which apparently is part of depression and it comes on without warning."

During the middle part of the study year, while waiting to join a therapy group, Mr. R. had become considerably worse. He was finally admitted to a group after Mrs. R. phoned the hospital to say that he was no longer able to face work. Initially, the group therapy seemed to be useful and Mr. R. went back to work although after attending three or four sessions he stopped going to work altogether. Mr. and Mrs. R. then went back to Dr. M. and asked to see the psychiatrist again, and after a wait of four weeks they received an appointment. The psychiatrist recommended in-patient treatment and Mr. R. was admitted for two and a half weeks. He spent a further week as an out-patient and then returned to work.

After the hospital treatment there had been a "steady improvement" though Mrs. R. did add "he's better than he was, he's got a long way to go, he's not cured as yet". She was, in fact, surprised by the progress he had made, "it's faster than I thought it would be, I thought it would take a lot longer than it seems to be doing", but was unsure as to how complete a recovery he would make.

Mrs. R.: Up to what stage he will erm ... I'm very hopeful that he, because I can see the improvement definitely, the only worry of course there's always a little worry at the back of my mind that he could slip back so up to what stage he's going to get so that I no longer worry about this I don't know, I think it's too early to tell cus this is a long term thing.

At the last interview Mrs. R. was more reserved about her husband's progress. She was unsure about whether the group therapy he was continuing to receive was actually helping, although she did encourage him to continue with it because "if he gives up he's got no support at all". Mr. R. had spoken to another member of the group who had said that his previous psychiatrist thought that group therapy was a waste of time. Consequently, Mrs. R. said "I don't know if it's done him any good." She thought the in-patient treatment had helped a lot but all she could say of his group experiences was that he might now be worse if he had not gone.

Another factor which made it difficult to judge the extent to which he had progressed was the fluctuating nature of his condition. One day he could be fine and the next day he could be depressed. Moreover, "there's progress and then setbacks and then progress and then setbacks ... it isn't like after an operation you feel a little bit stronger week by week this is why it's so difficult to judge". Mrs. R. was able to make sense of all this by drawing on the experience of friends:

Mrs. R.: It's a very long struggle ... because I think I told you about a friend of ours who had a bad breakdown and I saw the wife the other day when I'd had rather a trying day and I said it really is tough and she said you don't have to tell me. After her husband was discharged from hospital it took eighteen months she said to get back to any kind of normality, she said eighteen months of sheer hell. So obviously, it's just a long term thing and nobody can put a time to it.

Despite her husband's continuing problem and her anticipation that it would only be solved in the long term, Mrs. R. was not too pessimistic about her family:

> Mrs. R.: I think on the whole we are healthy apart from my husband's problem. I would say that we are quite a healthy family erm ... my husband's physically quite healthy, I wouldn't say we were an ailing family at all erm ... we don't have anything that causes any real worry other than my husband's problem. No, I think we're fine.

Some relevant aspects of the everyday life of wives and mothers

The above descriptions are sketches of the contexts upon which disorders of various kinds intrude and within which they are managed. The women I interviewed frequently made reference to aspects of these respective contexts in constructing definitions of problematic experiences and the actions they claimed to have undertaken in response to them. While each of these contexts is specific, in the sense that each family is a unique social unit and each individual within it unique in terms of biography and life experiences, certain features of those contexts are shared. Though individuals, the respondents were all women, wives and mothers. That is, they all occupy a number of related social statuses by means of which their experiences may be typified. Thus, though the experiences of the respondents are unique they are assumed to be typical of those statuses and common to all who occupy them. What is known about those statuses provides the respondents with a vocabulary for describing their experiences in ways which renders them common. As I indicated in the discussion of the work of Schutz in Chapter 1, it is via this process that the world becomes cognitively manageable and intersubjective.

As Chapters 4, 5 and 6 will reveal, these statuses are important for two reasons. Firstly, they or what is associated with them, may be invoked to account for action. Irrespective of whether occupancy of these statuses does act as a constraint on action by limiting choice or other means, they may be presented as so doing in explanations of what was or was not done. Secondly, some of what was said by the respondents in the interviews may be read as demonstrations of adequate performance in given statuses, primarily that of mother. Voysey has argued that there exists an "official morality of family life" by means of which parental performance may be judged(1). Adequate performance in the role of wife and mother requires success as the manager of family and household and fulfilment of the material and psychological needs of children. The women themselves used these and related criteria in criticising the performance of others. They also reported feeling guilty when their own conduct did not meet the requirements they set:

> Mrs. R.: (When my husband gets depressed) I get inpatient all round and instead of being more patient with the children I'm less and then I get guilty about what I'm doing to them.

Dingwall has suggested that representatives of formal agencies of family support employ such commonsense notions of good and bad mothers in dealing with their family case loads(2).

More fundamentally, however, the women I interviewed are, in Pucetti's terms, 'persons' and in Garfinkel's, 'members'(3). Pucetti has argued that the ascription of personhood requires that an object is accorded both an intellectual and a moral character. This presupposes "access to and familiarity with a conceptual scheme" and "the ability to assimilate a conceptual scheme in which moral words and phrases have a place"(4). Garfinkel's notion of a member involves the possession

FIGURE 1. The Respondents: Characteristics of Family Context

Name	Age	Occupation	Husband's name and age	Husband's Occupation	Children, name and age	Housing	Years at current Practice	Times interviewed	Comments
Mrs. P.	44	Housewife, formerly worked in office.	Colin 44	Draughtsman/ Office Manager	Lindsay 8 Martin 4	Terraced house.	38	6	Mr. P. had a history of pneumonia and depression. Mrs. P. suffered with a duodenal ulcer and a slipped disc. Lindsay had recurrent attacks of bronchitis.
Mrs. S.	38	Housewife, formerly shop assistant.	Mike 39	Statistician	Michael 6 Joanna 3	Semi-detached house.	26	5	Michael was physically handicapped and confined to a wheelchair. Mrs. S. suffered with her "nerves".
Mrs. G.	25	Housewife, formerly teacher.	Roger 27	Contract surveyor	Daniel 1 (at final interview)	Semi-detached house.	$2\frac{1}{2}$	3	No major problems reported.
Mrs. F.	46	Housewife, formerly school secretary and educational welfare officer.	John 46	Liaison engineer	Madge 17 Clare 15	Semi-detached house.	16	4	Mrs. F. had a recurrent allergy which caused her some discomfort. It had never been diagnosed despite specialist attention.

(contd. over/....)

(Figure 1 contd.)

Name	Age	Occupation	Husband's name and age	Husband's occupation	Children, name and age	Housing	Years at current Practice	Times interviewed	Comments
Mrs. N.	43	Housewife	Harry 45	Manager with an investment company	Tina 17 Lesley 15	First floor flat	18	3	No major problems reported.
Mrs. R.	33	Housewife, formerly secretary.	Peter 36	Director of a charity	Alison 8 Lee 6	Semi-detached house	2	5	The major problem was Mr. R's depression. He was treated as an in-patient at one stage during the study year.

of natural language and a body of culturally accredited knowledge. Where a moral character is not imputed the individual concerned may not be viewed as a person. Children are temporary non-persons since their moral characters are assumed to be in the process of formation. Similarly, the mentally handicapped and the mentally ill may be viewed in these terms; since it is assumed that they are not capable of making moral decisions because of an inherent or acquired defect, they are not usually held responsible for their actions. Children and the mentally handicapped may also be viewed as non-members, as incompetents, given their limited access to and use of natural language and the stock of knowledge necessary for making adequate sense of the world. The behaviour of children, the mentally ill and the mentally handicapped may be interpreted as the inevitable product of the categories they occupy. As Voysey says, parents "know what children in general are like" and may use this knowledge to make sense of their own children's behaviour. Conversely, behaviour which appears "senseless" may be comprehended when it is learned that the agents of that behaviour were children. For example, in talking to Mrs. P. prior to my final interview with her I was describing how the offices where I worked had been broken into and property stolen. The following week there was a second break-in when some of the property stolen at the first was returned:

Mrs. P.: The same lot came back?
Int.: Yes, but it was only children.
Mrs. P.: Oh, well.

Subsequently, Mrs. P. went on to describe a series of break-ins at the local church hall:

Mrs. P.: They left it in an absolute shambles. And when they got in last week they threw black paint all over the floor and all down the walls as well. It's upsetting really because I mean gosh for a

> church you don't expect this really. I don't know, but it does seem ridiculous doesn't it? There again, I'm sure it's children ....

In both of these cases apparently irrational actions are understandable as the actions of children. Children's behaviour is not, then, to be interpreted in terms of the motives assumed to inform adult conduct. As non-persons and non-competents they cannot be judged in terms of the criteria by which persons and competents may be judged since they are not assumed to be rational actors. Similar actions on the part of adults may, as Morgan has suggested, be seen as the symptoms of mental illness since they cannot be explained in terms of culturally acceptable motives(5).

That children are considered to be non-persons and non-competents has implications for the parental role. Firstly, parents may be held to constitute the moral character of their children insofar as they are held responsible for his or her behaviour. The behaviour of a child reflects on that of the parents such that deviant or aberrant conduct on the part of a child may be interpreted as an indicator of moral defect in the parents. Mrs. P., talking about local children who used bad language and were generally rowdy and ill-mannered said:

> Mrs. P.: One time they called out abuse to me and I turned round and said just watch what you're up to, but, erm, you can't do much about it, I don't suppose if their parents don't bother, you don't stand much chance.

Even where a child's 'deviance' is non-motivated, as in the case of a handicapped child, the parents may be held responsible or may feel that their moral character is threatened. Davis and Strong, in a study of clinics for assessing the development of potentially handicapped children suggest that:

> ".... one possible effect of such testing is to call into question the motivation and competence of the parents. When a child is compared with an 'ideal type' there is always the possibility that discrepancies between the particular child's development and the ideal type can be explained in terms of the quality of the family. Therefore, there is considerable pressure on the parents to have their child accepted as normal and thereby get their own normality confirmed"(6).

Secondly, parents are held responsible for providing an environment which satisfies the material, social and emotional needs of their children. Inadequate parenthood consists in failing to provide for these needs. Given that any competent adult is assumed to be capable of adequate parenthood on the basis of knowledge acquired through socialisation and personal experience of family life, such failure is a further indicator of moral defect. Alternatively, it may call for an account by means of which failure may be justified.

The significance attached to a "normal family life" is evidenced by the fact that a family life identified as deficient in some way is often accorded a causal role in the genesis of delinquency, mental illness and deviance of other kinds. One needs only to refer to the maternal deprivation thesis, the association of delinquency and broken homes and Laing's work on the origins of schizophrenia. Underlying these there is some notion of "needs" which must be satisfied if normal social and psychological development is to take place. The failure to satisfy children's needs may then be invoked to account for aberrant behaviour on their part and employed to construct a criticism of parents' actions. When Mrs. S's daughter was badly bitten by a boy at nursery school Mrs. S. was able to find an explanation in the character of his family life:

Mrs. S.: I don't know if it's anything to do with it but his mother, both her and her husband play for a symphony orchestra and of course they're never at home, they've had a succession of au pair girls and now they've got a permanent nanny so you just wonder if it might be something to do with that, you know, you know what children are like, they get a bit funny if they haven't got mother there all the time. I don't care what anybody says there's no substitute for a mum.

Here Mrs. S. explains the boy's behaviour as a product of an absentee mother. As she said later, "I don't know whether it's just something that Simon's lacking at home, you know, because they're going away to Japan for three weeks in May to play with the orchestra". Contained in the account are assumptions about what children are like, in terms of the way they may respond to situations, and also about their need for a mother. Not just any female will do; au pairs and nannies "are no substitute for a mum". This of course, carries implications for a mother's role in that it identifies appropriate conduct for one who occupies that category.

It is not only a child's behaviour that may bring about moral condemnation of parents, other observable indicators may be taken as evidence of parental neglect. Later in the interview Mrs. S. expressed concern about the interpretations to which the bruising resulting from the boy's biting may be subject:

Mrs. S.: I'm worried about the marks it's left, they're taking an awful long time to heal. I can imagine when she starts school they'll think I've been ill-treating her. I'm quite worried about that.

As Davis and Strong point out, our notion of the nature of children requires that they be treated in a special way by adults such that

their maltreatment is seen as particularly reprehensible. This is reflected in the legal system whereby crimes against children are more heavily sanctioned than crimes against adults. Similarly, ill-treatment of a child by a parent is an especially condemnable form of inadequate parenthood. Hence, Mrs. S's concern lest a formal authority suspect that she be guilty of this misdemeanour.

One of the functions of the family is the care of children and part of that care involves the maintenance of health. An absence of health in a child may cast doubt on the adequacy of parental care. This is particularly so if those routine procedures assumed to contribute to good health are not implemented. When Mrs. G. was talking about a neighbour's child who was always ill she commented:

> Mrs. G.: Well, I often see him without a hat on or anything like that so, you know ....

Underlying statements of this kind are theories about what contributes to good health. These theories provide the basis for action on the part of a mother in caring for her child. Typically, the practices derived from these theories involved making sure the child had a good and varied diet and keeping them warm if it was cold. The women I interviewed were identifiable as good mothers since they knew of these theories and acted accordingly:

> Mrs. S.: I like to make sure that they eat well, I think that's very important that they go out with a good breakfast in the morning. I think, erm, you know if they went out on an empty stomach they might not be so fit.
>
> Mrs. P.: If they've not been well I do give them a bit of a tonic, some vitamin drops and a bit of extra stuff like that or make sure they eat a bit of extra fruit and things you know. They have vitamin drops every morning through the autumn and winter months right through to

late spring. Most of my friends seem to give their children something you know.

Mrs. G.: I keep him well wrapped up if it's cold, you know, a warm jumper on and a warm coat, that sort of thing.

These precautions are not to be seen as the actions of overprotective or fussy mothers; rather, they constitute the routine activities of a mother in caring for a child. Mrs. S. indicated as much when she stated that she did not believe in "mollycoddling":

Mrs. S.: We don't mollycoddle, I don't believe in mollycoddling children but erm just the normal care that you would take, you know, the way our parents did.

These activities then are no more than the normal care expected of any parent. While it is important that mothers take normal care it is also important that such care is not exaggerated. Mrs. P., in attempting to solve the dilemma of her daughter suffering recurrent respiratory infections despite her routine care, identified the possible consequences of being over-protective:

Mrs. P.: I sometimes think perhaps well really the more you try and coddle them up perhaps the worse off they are. Often the more you try and take care of them they seem worse off, I don't know ....

However, Mrs. P. did say that she tried not to fuss over them, "I let them go out and get plenty of fresh air and enjoy themselves". Consequently, her failure may lie in the invalidity of the theories she employed in her attempts to keep her children healthy:

Mrs. P.: It's amazing some of these children that play out. I've seen them in all weathers, they seem to be out with no big coats on, they seem to be as tough as old boots.

Despite evidence which suggests that the theories of health maintenance employed by mothers are ineffective in promoting health it is likely that the actions to which they give rise will be continued. Such actions have a symbolic as well as a practical value. As indicators of parental concern, they allow others to identify mothers as providing proper care. That there is a consensus about these matters was suggested by Mrs. P. when she said, "Most of my friends seem to give their children something".

While parents are held to be responsible for their children's health it is inevitable that children do fall ill. For this not to reflect on the character of them as parents some of the women I interviewed pointed out that there were limits to parental control. As Mrs. R. explained, children are to a certain extent independent and, for some of the time, outside parental supervision:

> Mrs. R.: Although you try to keep them clean and everything at home alright you never know when they're not in the house or where they go or exactly what they do.

At another interview, Mrs. P. invoked the nature of children as a constraint on her ability to provide the sort of care she thought appropriate:

> Mrs. P.: You air their clothes and try and see they're warmly dressed up and they come flying out of school with coats half buttoned up and perhaps it's raining you know but, well, that's kids you can't stop them.

Eventually, children reach an age when they will not allow parents to exercise control. Moreover, once they are at a stage of life where they are accorded the status of persons and competents parents may reasonably abdicate their responsibility such that failures of health

reflect on the individual concerned and not the parent. Mrs. F. talking about her seventeen year old daughter said:

> Mrs. F.: She won't go to the dentist, she's an individual you know, can't be bothered, you're not allowed to look after her, she's a big girl now. Anyway, last week she was having pain so she did have to go. It was more or less an emergency, but it was her own fault for leaving it so long.

In these cases parental responsibility may be fulfilled by providing adequate warning of the consequences of certain actions. At the second interview Mrs. N. talked about her younger daughter who was having to have a lot of fillings. She went on, "In her younger days too many sweets and sickly things, but then you see she's rather obstinate, when she wants to eat it she would go ahead and do it. I was always warning her about it".

As I have mentioned above, parents are held to be responsible for their conduct as parents on the basis of the assumption that any adult is capable of an adequate performance in that role. That is, it is assumed that an adult will know of what is involved in bringing up a child and be motivated to act accordingly. It is expected that ordinary experience provides the opportunity for individuals to acquire knowledge about children, their needs and how to fulfil them. It is also expected that parents will acquire knowledge of their own children as a result of interaction with them so that what Voysey calls "normal recipes of child rearing" may be adapted where necessary to the individual child. Statements illustrating both of these points were made by Mrs. S. during my interviews with her. The first is taken from an exchange where Mrs. S. was telling me how she preferred to deal with her children's problems herself rather than bothering the doctor:

Mrs. S.: I would never call the doctor out unless it was really serious you know for us, but if it was the children and I thought they really should come then I would do. I wouldn't, you know, just leave them to it sort of thing. But if it's something I can sort out myself then I'll do that. I mean I think it comes naturally to a parent to a mum to know what to do for your child if they're poorly.

The second is taken from an exchange where Mrs. S. was describing how Michael, her handicapped son, was sometimes brought home from nursery school looking pale and unwell. Mrs. S. thought it might be due to his being strapped incorrectly and uncomfortably in his wheelchair:

Mrs. S.: When he's with me he's never ill cus I know what I'm doing with him.

For Mrs. S. her competence in managing her children's problems is a product of her status as a parent, a natural consequence of motherhood. It is also enhanced by her specific knowledge of her own children such that she is able to provide for their particular needs. Consequently, when Michael went in to hospital for his operation Mrs. S. stayed with him:

Mrs. S.: He went in for nine days to have the operation. I stayed in with him which I'm glad I did, he needed me, you know. Some people said Oh you're silly, you've got Joanna, but I think he needed me more than she did, she had Mike at home looking after her and he well he had nobody and he's a helpless child and he can't communicate. I know everything that he needs and what he wants so it helped the nurses too.

The special knowledge that mothers employ in dealing with their children's problems may also be used in dealing with the problems of other family members. Wives, for example, may acquire an intimate knowledge of their husbands which allows them to recognise when all is

not well. Mrs. R. said that she always knew when her husband was going through one of his depressed phases although others may not have been able to recognise this:

> Mrs. R.: Usually he becomes very quiet, doesn't want to talk, he can't bear any kind of noise ... I can tell just by his face, just by looking at him. Maybe that's because I know him so well, I don't know if anybody else could, to me his face seems to change, he just looks thoroughly miserable.

Having recognised such a phase Mrs. R. was able to take action to "slow the pace of life down" and shield him from routine family business. Although the knowledge acquired through her status as wife and intimate allowed Mrs. R. to identify when her husband was not well, limits to her competence to help were imposed by this and other statuses. At the last interview Mrs. R. talked at length about the group therapy her husband was receiving for his depression. He thought that it might be contributing to his depression and Mrs. R. was unsure that it was having a beneficial effect. However, she was quite keen for him to continue attending the sessions:

> Mrs. R.: If it doesn't itself do any good it's a place he can go and talk things out other than with me. Obviously, I'm too involved to be very much good to him and besides I haven't got the knowledge.

Here, Mrs. R. invokes her status as a wife to explain her inability to be of help to her husband. As an intimate she is "too involved" to be of much use, unlike the disinterested professionals and fellow sufferers Mr. R. met at his group therapy sessions. Though the group which Mr. R. was currently attending did not seem to be leading to an improvement in his psychiatric state, the group therapy sessions he experienced as an in-patient had enabled him to "recognise a lot about himself". As an interested party Mrs. R. was not able to be objective

about his situation or the origins of his depression and was unlikely to contribute to this process of learning about himself. In addition, Mrs. R. claims to be limited by her status as a lay individual, as someone who does not have the knowledge or experience to provide a solution to this particular problem.

Thus, while mothers did assert that they were competent to deal with the health problems of their respective families, they did recognise that there were limits to that competence. These limits were sometimes offered as justifications for seeking expert help. Mrs. G., for example, said on more than one occasion that she would only consult the doctor about problems that she could not handle herself. As Schutz indicates, an individual's recipes for achieving his practical purpose at hand tell him when it is necessary to consult an expert. The inadequacy of common sense knowledge is both recognised and accepted by the lay actor given the existence of professional problem solvers(7). Consequently, mothers are not expected nor do they expect to be able to handle all the problems that may arise since some require the attention of those who possess specialist knowledge. However, they may be expected to be able to recognise when a child is unwell and when it is necessary to seek the advice of an expert. As Mrs. R. said:

> Mrs. R.: I'm reasonably confident I would recognise if there were anything wrong, I'd only get worried if there were anything unusual or something unexpected happened to one.

However, as I will argue in Chapter 6, the problem is not necessarily this simple. The ambiguity surrounding problematic experiences frequently presented the women I interviewed with a problem, that of deciding whether they were dealing with a routine or trivial disorder or something needing expert attention. Where children were concerned

they often chose to be "on the safe side" and consulted the doctor for his opinion.

As mothers, the women I interviewed expected their children to be a routine and continuing source of trouble and anxiety. In fact, worrying about the children was presented as a natural and inevitable consequence of being a parent:

> Mrs. S.: I do worry about the children. I think everybody does. It wouldn't be natural if you didn't worry about the children.

Later in the interview Mrs. S. emphasised the same point:

> Mrs. S.: Of course you worry about them. I think you would do unless there's something inhuman about you and you just didn't care.

For Mrs. S. anxiety about her children's welfare is an ever present fact of life common to all parents such that it is only the pathological who could fail to be worried. For Mrs. N., worrying about her children was also a fact of life until they got to the stage where they had outgrown the problems normally associated with childhood:

> Mrs. N.: You find you have more problems when they're toddlers. I had my hair falling out .... but I'm older and wiser, much better because I think they're past chicken pox, they've both had their glandular fever, they're past this, they're past that, you know ....

That things would be better when her children were older was not anticipated by Mrs. S., however:

> Mrs. S.: From what I've been told you worry more. Everybody that has got older children says as they get older you worry more about them erm there just seems to be more problems one after the other, they say they're better when they're young like this.

Mrs. S's brother had a daughter of fifteen and a son of eighteen and he "worries just as much about them now", and her next door neighbour "she's got a married daughter and a son in South Africa and she still worries about them". Accounts by others of their experiences of parenthood thus allows Mrs. S. to construct a conception of her own future vis-a-vis the problems that she can anticipate. For her, the normal problems of childhood give way to the normal problems of adolescence and so on, "You worry about them as long as you've got them".

The accounts of others not only allows mothers to anticipate that child rearing will be fraught with problems, it also enables them to interpret the problems they do encounter as typical experiences of motherhood:

> Mrs. S.: Sometimes I find that everything gets on top of me, the children get too much, Joanne she can be a little so and so, you know, like they all can at three years old and I've warned the next door neighbour she's been exactly the same she said, she you know used to feel the same with her children when she was young, so I said don't take any notice of me if you hear me having a good scream, it's just getting it out of my system and I feel much better then.

The typicality of experiences of this kind is also reinforced if they can be seen to stem from the nature of children:

> Mrs. S.: You can't take it out on your children .... children are children, they get naughty, they get bored, I do know some people take it out on their children but I wouldn't want to do that.

Thus, a conception of what children are like and assumptions about the typicality of her response means that Mrs. S. can constitute these experiences as 'normal family life' rather than as indicators of family pathology.

As I mentioned earlier, a pathological family life is assumed to be the cause of various types of pathology in its members. Children in particular are viewed as being vulnerable to abnormalities in family life such that when family troubles do occur attempts are often made to conceal this from them by the presentation of a normal front. At two interviews Mrs. R. made statements about the possibility of her husband's depression having an adverse effect on the children:

> Mrs. R.: I get worried about the children, whether it's going to have an effect on them as they see he's not quite as he should be.
>
> Mrs. R.: I've been very worried about them. Well, you know, we told them that he's tired and that he needs to rest which I don't really like doing because I don't want them to get the idea that their father's an invalid, I don't think that's very good for them. I haven't wanted to tell them exactly what's wrong because I think that could worry them very much.

In these statements Mrs. R. claims that the identification of their father as deficient in some way will be harmful to her children. That is, their assumed need for a normal father will not be met and will have untoward consequences. Mrs. R. is anxious to avoid telling them exactly what is wrong with their father since "that could worry them"; at the same time she is worried about the explanation she offers for her husband's symptoms since it may lead them to identify him as "an invalid" which given the need for a normal father is not very good for them. Mrs. P. also expressed concern about her husband's depression and tried to conceal this from the children by normalising his symptoms:

> Mrs. P.: I get worried about the children, they keep saying to me what's the matter with daddy and I say well he's rather upset, he's overtired and he's not too well, you know, and you sort of pass it off, but it does get a bit difficult at times.

Mrs. R. also supplied her children with a normalising explanation of her husband's problem and went on to express doubts about whether they had fully accepted it:

> Mrs. R.: When he went into hospital we told them that he'd overworked, he has in fact worked very hard over the past years, and that all the work had made him very tired and he needed a long rest and he was going into hospital. And I think they accepted it er .... I think, one can never be very sure because I think children notice more than one gives them credit for and they don't always speak about it, they pretend to accept things sometimes without .... perhaps I think they're afraid to stir things up.

Mrs. R's doubts about the success of her attempts at concealment stem from her conception of the nature of children. That is, children are often wise to situations to a greater extent than their ascribed status as incompetents would allow. Their sensitivity to trouble in the family may be hidden from others by their pretence to accept adult versions of the world and reluctance to challenge that version by speaking about it. Their response to Mrs. R's explanation cannot then be taken as an indicator of their failure to see through her account since they are equally capable of the presentation of a normal front. Consequently, "one can never be sure".

General conceptions of what children are like thus render problematic the management of troubles such as parental illness and may create the kinds of dilemma Mrs. R. describes. Such conceptions also inform parental responses to more mundane problems of child rearing that may be encountered. Mrs. S., in managing her young daughter's refusal to eat made recourse to common sense knowledge about children:

Mrs. S.: I didn't force her or make a fuss because I don't think that's right. I think the more you make a fuss the more they get awkward, you know, they play you up which is very true they do. I just didn't take any notice. I'd put it on the table and if she didn't eat it I'd take it away again .... but I thought we'd get it over and done with eventually.

The possession of a stock of such recipes for coping with various aspects of family life enables mothers to respond in ways which may be considered to be appropriate. In the context of interaction with others accounts which draw on these accepted recipes enables them to construct and maintain a good identity. As I have argued in Chapter 2, a research interview, where mothers are questioned directly about their management of family problems, is one context where such an identity may be reaffirmed. I assume then that the accounts that the women I interviewed gave were constructed in ways which allows them to be seen to conform to socially accepted criteria defining good performance in given social roles. I also assume that their descriptions of their own conduct or other aspects of the world around them are displays of their personhood and their membership. That is, these descriptions provide for the interpretation of their actions as the conduct of moral actors acting in ways that might be reasonably be expected of anyone in given circumstances. They also demonstrate their access to a culturally accredited stock of knowledge which they are able to employ to make reasonable sense of their experience of the world. In making reasonable sense they are able to present those experiences as part of a normal order of things.

In this chapter I have presented some descriptive data about the respondents and their families. I have also presented data to illustrate some aspects of what might be called the everyday life of wives

and mothers. In particular I have attempted to describe something of their conceptions of children, their own role as wives and mothers and their conceptions of the normal experience of motherhood and family life. In the following chapters I will be concerned with three issues: 1) the construction of definitions of illness; 2) the recognition and explanation of departures from what are considered normal or routine states of affairs; and 3) accounts given of the way a variety of problematic experiences are managed. These three themes constitute important aspects of what I have previously conceptualised as a management sequence.

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CHAPTER 4

INTERPRETIVE PROCEDURES AND COMMONSENSE KNOWLEDGE IN THE CONSTRUCTION OF DEFINITIONS OF ILLNESS

In Chapter 1 I argued that illness is a social construct analytically, and often empirically, distinct from those biological realities referred to as disease, constituted by the imputation of meanings to various observed or experienced states of affairs. The investigation of the cognitive and interactional processes whereby illness is realised as a social phenomenon has been identified as one task of a sociology of illness.

In managing problematic experiences of any kind there are several problems facing an actor which must be solved with the cognitive and material resources at his disposal. He must be able to recognise departures from some state considered usual or routine for himself or others. He must employ some stock of knowledge to assess the significance of those departures and to formulate plans of action to deal with them. He must be able to realise those plans, evaluate their outcome and, if necessary, formulate alternatives. He must also be able to employ the necessary interactional skills in order to deal with those individuals he encounters in his attempt to solve his problems. Distinct from, though sometimes involved in this management sequence, is occupancy of the status ill. An individual must know how to demonstrate the legitimacy of any claim to that status by showing situationally appropriate behaviour. Alternatively, he must be able to assess the claims of others or make adequate claims on their behalf. As Engel points out, the identification of someone as ill begins with an initial complaint, either by the sufferer or by others[1]. In this chapter I

will examine the interpretive work integral to the formulation of such complaints and the grounds available to support or defeat them.

In Chapter 1 I drew a distinction between two definitions which may be applied to any individual. Firstly, an individual may be defined as disordered; that is, exhibiting some departure from what is conceived of as a routine or normal state. Secondly, an individual may be defined as ill; that is, occupying a particular social status. The implications of these definitions for the individual concerned and those around him are quite different. It is because of the implications of the definition ill that I refer to illness as a social status. Though illness may be constituted by the imputation of meanings it has consequences beyond the mere attachment of a label. A failure to draw this distinction between disorder and illness allows Stacey to state that "only those who feel ill will present for medical attention"(2), when this is obviously not the case. The claim is made on the basis of Field's definition of illness which "refers primarily to the person's experience of ill health and is indicated by the person's feelings of pain, discomfort and the like"(3). Illness is not a subjective state but one of many labels that may be applied to such subjective experiences. Neither these subjective experiences nor a definition is a necessary precursor of the seeking of medical aid.

I have indicated that there are two aspects involved in the construction of meanings that may be analysed sociologically, the cognitive and interactional dimensions. The former refers to the organisation and interpretation of events and the production via language of a recognisable social order. The latter refers to the location of meaning construction within interpersonal activity. The meanings that individuals construct are frequently, if not always, influenced by those with

whom he interacts. This influence may be direct, as in various forms of negotiation where meanings may be overtly problematic. Or it may be indirect, where meanings are not regarded as overtly problematic but constrained by the fact that they must be adequate for others. Meanings always involve joint effort; cognitive processes must be utilised both in their production by one party and interpretation by another. Here, I am primarily concerned with the cognitive dimension since any analysis of the interactional dimension would be confined to an examination of the production of meanings within the context of a research interview. While I assume, on the basis of the argument presented in Chapter 3, that those meanings are a product of interviewer-interviewee interaction, the cognitive processes involved are not confined to that particular context but may well be employed in others(4). The aim, then, is to describe "the cultural resources and inferential procedures involved in any warrantable instance of (illness) ascription"(5). The basic theoretical point is that social reality is constituted via the use of these procedures and that talk is the medium through which that reality is created and ongoingly maintained.

The extracts analysed in this chapter are taken from sections of the interviews where the respondents discussed individuals known to them who were or had recently been ill. These accounts are analysed as phenomena in their own right and not as representations, good or bad, of past or present states of affairs. Here, language is viewed as a resource, a medium for practical reasoning, rather than a means for providing copies of an independent reality(6). For example, consider the following extract from an interview with Mrs. G.:

G1 Int.: Now, during the period in which you kept the diary and all these things we've mentioned would you ever say that you were ill?

Mrs. G.: No.

Int.: Why not?

Mrs. G.: Well, because I .... I didn't have to stay in bed or anything like that and I didn't have to go and see a doctor.

This exchange came at the end of a lengthy discussion of a number of symptoms and actions recorded in a health diary Mrs. G. kept for a period of two weeks prior to the interview. As the extract shows Mrs. G. claimed that during this time she had not been ill. Now it may be the case that during the period under discussion Mrs. G. did have one or more experiences which at the time were defined as illness but which were not recorded as such in the diary or talked about during the interview; they may have been forgotten at the time of recording or deliberately omitted from the diary or the interview. From the point of view of someone interested in counting say the frequency of episodes of illness the diary and subsequent interview may not be a valid record. Consequently, the information obtained would need to be checked in various ways before it is accorded the status of fact and subject to analysis(7). This notion of validity is of no significance here, for the data is not to be used to estimate the frequency of a particular event but to investigate the rationale underlying the use of a particular label. In a sense, a deliberate 'lie' is of as much interest as the 'truth' since in order to pass as fact it must contain an account of some event that is credible to a culturally competent hearer. What Scott and Lyman call justifications and excuses(8), and what Taylor calls "socially acceptable motives"(9) have much to tell us about social order.

Illness relevant behaviour

While the theoretical problem of illness as deviance is still

the subject of sociological debate there is agreement that disease and illness involve some departure from a previous state considered normal. These departures become noticeable events the meaning of which is located by their identification as a member of a given class of phenomena. They may take a variety of forms. The departure may be a change in the physical structure or appearance of the body such as a lump, ulcer or loss of facial colour; or it may be a change in subjective experience such as pain, dizziness or feeling sick or its report by another; or it may be a change in activity, mood or behaviour. All these may be viewed as problems and as such subject to interpretation and organisation. While any of these may be defined as having their origins in an underlying disorder it is not necessarily the case that the individual concerned will be defined as ill.

That a conception of what is normal or usual is involved in imputations of illness is revealed in the following extract taken from the second interview with Mrs. R. At the first interview Mrs. R. had said that her husband was being treated by the doctor for depression:

R1 Int.: Has any of your family er .... your husband or two children been ill over the last .... the last two months?

Mrs. R.: My husband, yes.

Int.: You would say .... you would call your husband ...

Mrs. R.: I would call as having been ill, yes.

Int.: Why would you say that?

Mrs. R.: Er, because he's er .... are we talking now .... let's see, he went on the anti-depressives at the beginning of May. Previous to that he was very depressed, enough for me to say I think he was ill. And after about .... I suppose about two or three weeks on the anti-depressives, again I would say he was so unlike himself as to warrant being called ill. He's in fact very much better since he stopped taking the drug. Oh yes, more like himself.

Int.: Could you describe what his normal self is like?

Mrs. R.: Well .... (laughs) there you've seen him.

Mrs. R's definition of her husband's depression as an illness involves the observation that this constitutes a sufficient departure from a normal state of affairs, 'he was so unlike himself'. His improvement after he stopped taking the drug is supported by a similar rationale, 'Oh yes, more like himself'. However, when I asked Mrs. R. to describe his normal self she was unable to supply any sort of description. Rather, she laughed and referred to the fact that I had seen him. As Dingwall has suggested, "given the unobtrusiveness of what is normal, by virtue of its very normality, the unusual may be easier to identify. But it is recognisable only as a result of our trading on tacit and unexamined knowledge about normality"(10).

While Mrs. R. had some difficulty in offering a description of normality the respondents I interviewed appeared to have no problem in identifying the grounds on which definitions of illness were applied. Those grounds frequently contained reference to events I will call illness relevant behaviours. These include such things as staying in bed, staying away from work, seeing the doctor and the like. I call them behaviours rather than actions since they are only partially organised when described in this way. They only become actions, that is, socially relevant, when some meaning is imputed to them. Staying in bed may be construed in more than one way, as indicative of tiredness, laziness or illness. Because a number of such alternatives is always possible interpretive work is necessary to resolve the ambiguity this entails.

Considering in more detail the data presented in fragment G1, it is a relatively unelaborated account of Mrs. G's state during a period in which she kept a health diary. This account consists of a denial of the relevance of the category illness for characterising her state

during the period under discussion and an accompanying rationale. These two components are connected by their location in a specific sequence of talk, as answers generated by my questions(11). They are also connected to the extent that the rationale presented is adequate to the task of ascribing the category illness. What is presupposed by Mrs. G. in offering this rationale is that having to stay in bed and having to see the doctor are actions typical of people who are ill; moreover, that the absence of these behaviours is sufficient to indicate the irrelevance of illness as a description of a given state of affairs. Common sense knowledge about the behaviour of people who are ill, assumed by the respondent to be shared by the interviewer, is used to make the connection and construct an adequate definition of the event.

Seeing the doctor and staying in bed are, then, conceived of as typical courses of action exhibited by people who are ill. They form part of a commonsense construct of how ill people behave. On occasions this construct may be used normatively as a description of how ill people ought to behave. In this instance, however, the construct is not used to prescribe certain forms of behaviour, it is used as an interpretive scheme to characterise events or states of affairs. While Cicourel would maintain that interpretive procedures are necessary to assign sense to settings so that actors can invoke appropriate norms it also seems to be the case that settings can be characterised according to whether certain norms are seen to be operative. That is, the presence or absence of behaviour appropriate to the status illness may be used in assigning the category to given events or denying that it is applicable. Or it would appear to be so for retrospective interpretations in the context of an interview. This is not to say that these

behavioural characteristics must be observed for a definition of illness to be applied. As I will show later, other grounds are available to legitimate the imputation and denial of illness.

Though it is not necessarily the case that an actor's reconstructed logic, the procedures employed in the reconstruction of events, is the same as his logic in use, the procedures used to assign sense to settings so that the actor can decide on proper actions[12], it would seem that illness relevant behaviours are invoked routinely as an interpretive device and not confined to the reconstruction of events. For example, commonsense observation would indicate that the claim to illness is frequently denied by others on the grounds that the individual in question refuses to see a doctor or modify his normal activities in appropriate ways. The assumption involved is that someone who is genuinely ill would behave accordingly, unless, as I will show in the analysis of further data, good reasons can be found for failure to show proper behaviour.

Because illness relevant behaviours are typical courses of action of those who are ill they may be assumed to be characteristic of anyone occupying that particular status. As the following extracts show, they either figured in respondents' descriptions of illness or were the subject of my questioning about it:

F1 Int.: You say your husband has been ill?

Mrs. F.: He had a very bad cold, not really flu .... a bad fluey cold and a temperature so he spent two days in bed.

Mrs. R. had been telling me about her daughter and son who had both recently had chicken pox:

R2 Int.: Did you have to keep her in bed at all?

Mrs. R.: Erm .... she stayed in bed one day when she really didn't feel well, but other than that she was at home. She didn't go out of course. In fact the first day she did go out for a nice .... it was a nice bright day and we took her out for a walk. That evening she had a temperature and the following day she stayed in bed and felt quite miserable.

Int.: And then your son picked it up?

Mrs. R.: Yes.

Int.: Did he show the same kind of symptoms as the girl?

Mrs. R.: Yes, except that his prior to the spots didn't last very long he just said the night before he just said he didn't feel well and so I said you know you can go to bed and I think he went up to have a bath and called down I've got it too, I'm full of spots and he did have and that was it.

R3 Mrs. R.: A friend of mine is ill. I spoke to her this morning, she's got erm .... she's been ill before, something the matter with her blood, she's very anaemic and she has extremely low blood pressure and apparently the two combined aren't very good. She's been feeling quite ill since before Christmas but when I spoke to her today she said at last she is feeling a bit better, but it's been you know, she's erm as I say before Christmas, it's only now she's beginning to feel better and she's really been quite ill.

Int.: Has she sort of been in hospital or er .... has she had to stay in bed?

Mrs. R.: Erm no .... she hasn't had to stay in bed but in fact she has been in bed most of the time because she's been too ill to get up, she's resting at home most of the time. The main thing is she mustn't walk because walking lowers her blood pressure, she just walks a very little bit, erm she really does very little, she rests.

These extracts are taken from parts of interviews where the respondents were asked if they, members of their families or others known to them had been ill. All three contain references to disorders and the behavioural consequences of those disorders. That these consequences are presupposed by the questions I asked to stimulate further talk about the cases is indicative of the fact that the commonsense construct involved is oriented to by both parties to the interaction.

That is, the interviewer must use that construct as a resource in formulating sensible questions while the respondent must use it in formulating descriptions.

That behaviours such as staying in bed, not going out, doing very little and resting are presented as the consequences of certain disorders is of some importance. As I have suggested, these behaviours may be subject to a variety of interpretations. Illness is only one of many labels that may be applied. Consequently, for a definition of illness to be warranted those behaviours must be seen to be the product of some underlying disorder. The significance of explaining illness relevant behaviours in this way is such that its origins were often made explicit. This is illustrated by the next two extracts.

Mrs. S. had just described how her three-year-old daughter had felt unwell one evening and had subsequently been very sick for no apparent reason:

S1 Mrs. S.: In fact, it's rather funny, oh it's all coming back to me, you know, I'm terrible, yes, she had it on the Tuesday she had that and the next day as I say I woke up feeling a bit sick myself and erm .... I wasn't sick at all all day but I felt pretty rough and in the morning Joanna went off to nursery school and I was going to take her up to nursery and then go on to Michael's (respondent's son) school where they were having their school concert in the afternoon and erm .... I couldn't go because I felt so sick and I thought oh I'm going to be ill and all I wanted to do was to lay down. So my friend said to me oh you're silly, while Joanna's at school you want to go and lay down for a little while .... so I did.

R4 Int.: Have you had anything you can remember you haven't been to the doctor with or ....

Mrs. R.: Yes, oh yes. I was terribly sick one night which is quite unusual erm .... I felt this terrible nausea and just felt absolutely terrible and had to go to bed and I was really very sick and had diarrhoea and felt absolutely awful.

In both of these cases illness relevant behaviours are presented as the result of feeling "absolutely awful" and "pretty rough". These subjective experiences are offered as reasons for particular activities. As Mrs. S. says, "I couldn't go to the concert in the afternoon .... because I felt so sick". Consequently, "all I wanted to do was to lay down .... so I did" is not to be seen as an act that stemmed from some motive on her part. Rather it was unavoidable because it was not within her control. Similarly, when Mrs. R. says, "I had to go to bed" her action is to be read as the only possible course open to her and not an act that was undertaken for any purpose on her part. For both of these women certain actions are the product of and legitimated by the subjective experiences that stem from an underlying disorder. In turn these actions verify and indicate the severity of that subjective experience(13).

As extracts R3 and S1 demonstrate, illness relevant behaviours may be prescribed when an individual claims to be feeling ill. When Mrs. R's son complained that he was unwell she told him to go to bed and Mrs. S. was advised by her friend to "go and lay down" when she felt sick. When Mrs. P. noticed that her daughter was listless and "looked a bit flushed" she took her temperature and finding it was 103 "put her to bed". However, these actions are not only appropriate for someone who claims to be ill they may be taken to be indicative of the fact that a person is ill. They may be seen as pointing to a hitherto unknown disorder. In the next data fragment Mrs. S. talks about the occasion on which her daughter was sick referred to at the beginning of extract S1:

S2 Mrs. S.: Talking about her, she was sick. Er, it was just before their Christmas party at the nursery school. It was about the 17th or 18th of December ....

Int.: Yes ....

Mrs. S.: And it was on a Tuesday evening. I remember that because the party was on the Wednesday and erm I'd got all the evening meal ready and she just said I want to go to bed, I don't want any dinner I want to go to bed. So I really knew there was something ....

Int.: That's unusual is it?

Mrs. S.: wrong with her, for Joanna to want to go to bed at .... well it was five o'clock. And I said alright, we'll take you up to bed sort of thing. She went in, I tucked her up and that .... er, she didn't tell me what was wrong, she didn't say she felt sick, I just thought she was probably feeling a bit tired, you know .... once again, neither of them are sickly children, and erm about half past eight she was banging on her door and my husband said he'd go up and he went up and he came straight down and said you'd better come up she's been very sick.

Our common sense conception of children and the problems which parents often face indicates some of the difficulties which child management entails. This, of course, is frequently borne out by the accounts of parents of their own experience. One of the problems which arises is persuading children to go to bed at a reasonable hour. This is not only typical of children in general but typical of specific children. For a child to request to be put to bed may then constitute a breach of a normal order. As Mrs. S. says, 'she just said I want to go to bed' so 'I really knew there was something wrong'. Initially Mrs. S. thought she was feeling a bit tired and supports this interpretation by the absence of a claim on the part of her daughter, 'she didn't say she felt sick' and by the fact that it is unusual for her children to be sick, 'neither of them are sickly children'. Though her daughter's request to go to bed was taken as signifying that something was wrong, information was not available at the time to specify more accurately what the trouble was. It is only in retrospect, after the event, that wanting to go to bed was seen as the product of her feeling sick. The major point, however, is that this behaviour was a departure from usual

activity and signalled a disorder of some sort. It is important to distinguish two separate aspects of this signal. Firstly, the child wanting to go to bed at an early hour was a departure from a state of affairs considered normal; secondly, it was a departure of a specific kind. If wanting to go to bed at five o'clock was a usual occurrence the child's request would probably not have warranted much attention. Further, because it was a departure of a specific kind it pointed to a limited set of underlying disorders. In this case, tiredness, which was initially suspected, and illness, which it was seen to be following later developments, are two problems that such a departure may signify. Departures from usual behaviour of another kind, for example, hitting another child or damaging property, would probably be organised by means of other categories(14).

The interpretive rule that is involved in the above account by Mrs. S. may be employed in another way. If illness relevant behaviours are the unavoidable consequence of some disorder then the renunciation of those behaviours by an individual defined as ill may be taken as evidence that the disorder is beginning to resolve. At one interview Mrs. N. used the rule in this way:

N1 Int.: Have any of your family been ill recently?

Mrs. N.: Yes, my youngest daughter a few weeks back with glandular fever.

Int.: And was she seeing the doctor?

Mrs. N.: Yes, the doctor came and well, they sent somebody from the lab. to assess whether it was or not .... you know, glandular fever.

Int.: And was it glandular fever?

Mrs. N.: Mm, yes .... but she had spots come up before so they didn't know what it could be. She had it very mildly which was very lucky.

Int.: And did she have to take time off school?

Mrs. N.: Oh yes, and she'd just started this new school as well and she did miss quite a bit of time.

Int.: And it meant staying in bed?

Mrs. N.: Oh yes, she wanted to stay in bed .... they always want to stay in bed, then all of a sudden they want to get up so that's a very good sign.

Here, wanting to get up is an indicator that behaviour is no longer constrained by the underlying disorder. It is a "good sign" because it means that the person is beginning to recover. Getting better is not only a biological process in which the body overcomes infection or acheives tissue repair, it is a social process in which normal activity is resumed. Resumption of normal activity was often described by the respondents in demonstrating a return to health. Following the description of the episode presented in R4 Mrs. R. went on, "But next morning I was fine and went out". Similarly, after telling me that Michael had woken up one night with a "funny tummy" Mrs. S. said, "Next day he was a bit sick in the morning erm .... he was alright the next day and went to school". In these cases going out and going to school are evidence that things were "alright".

Illness relevant behaviours and the construction of definitions of health

The last data extract above indicates that what I have termed illness relevant behaviours are not only employed in the construction of definitions of illness but were also employed by the women I interviewed to construct definitions of health. On some occasions this involved not having to see the doctor.

Mrs. S. is talking about her husband:

S3 Mrs. S.: He is healthy, yes he's very healthy. Always has been. We've been married nearly 17 years now and I don't think I've .... I think he's only ever visited Dr. M. twice. Only time he ever has off work is to take Michael for hospital visits and that sort of

thing. He had to take him for his six monthly check-up, he had a half day then you know.

F2 Int.: What about your husband?

Mrs. F.: He's very healthy.

Int.: Very healthy?

Mrs. F.: Yes, he hardly ever sees a doctor .... he was about eight years without ever being on anybody's books when we came from Edgware to here. And he contacted Dr. M. mainly said please will you take me on because it's got something to do with the children. In fact, he had flu about a month ago and he was so unused to going to a doctor that he hadn't got a clue about the insurance thing or who he sent it to or what sickness pay he was entitled to .... and he had a couple of days off and you know it was quite complicated to him. He's a very fit man.

G2 Int.: What's your husband's health like?

Mrs. G.: Roger is very good. He's never seen the doctor in the four years we've lived here.

Theoretical discussions of the concept of health have often noted that it cannot be taken to mean simply the absence of disease but must include some broader notion of well-being(15). Nor does the lay perspective define health solely in terms of the absence of disease. In fact, someone may be defined as healthy even though they may from time to time suffer a variety of disorders. Rather, as these extracts demonstrate, health is the absence of illness which in turn is indicated by the absence of behaviours such as going to the doctor or taking time off work. The underlying assumption is, of course, that someone who was not healthy would have to resort to behaviours of this kind. As Mrs. G. said of a neighbour's child who was always ill, "he's always on antibiotics, you know, they say to her up at the clinic are you the Mrs. so and so, you know, they know her name she's had that many prescriptions". Consequently, not having to see the doctor over a period of time may be sufficient to indicate that someone is healthy. Even

professionals such as doctors were seen by respondents to use this interpretive procedure. For example, at one interview Mrs. G. described how her son had been sick one afternoon after her doctor's surgery had closed so she phoned him at home:

G3 Mrs. G.: He (the doctor) said to me, mm, have I seen this baby before so I said yes once at a three month check-up, by this time he was eight months old and that was the first time you know that he'd ever been ill and I'd rung the doctor and he said to me, mm, been remarkably healthy up to now then.

On other occasions the respondents supported their characterisation that someone was well by pointing to the maintenance of normal activity. For example, Mrs. S. said of her children, "They've both been very fit, in fact neither of them had any time off school the whole of last term or this term", and Mrs. F. said of her daughters, "Neither of them has had any time off. We've got Clare right through her 'O' level mocks without having any time off". At her third interview Mrs. P. said that her daughter had been prescribed two courses of antibiotics the previous month for bronchitis. Because she still sounded "a bit wheezy" when she laughed Mrs. P. had been keeping an eye on her in case it was necessary for her to go back to the doctor. She went on, "But as I say at the moment, well, you can hear she's up and down stairs and in and out she seems pretty good on the whole so ...". As I will show in a later section, it is this maintenance of normal activity which distinguishes definitions of disorder and definitions of illness.

Defining someone as healthy does not, however, mean that they are free from disorder of any kind. Mrs. S., Mrs. F. and Mrs. G. all described disorders their husbands had experienced which did not threaten their conception of them as healthy. At the same time it was also common for them to make statements about their husband such as "He never

complains of anything" or "He never has anything wrong", when in fact they did on occasions complain and suffer a variety of troubles. This discrepancy I would suggest arises for two reasons, one to do with the nature of the concept of health, the other to do with the nature of the disorders their husbands were seen to experience. Firstly, health is a master status ascribed on the basis of certain features of an individual's biography and is independent of their state at any point in time. "He never complains' is then a statement about a biography and not a statement about the here and now. Moreover, that biography is not necessarily modified by particular instances where the statement does not apply. This can be contrasted with the definition ill which, at least on some occasions, refers to the here and now. It is possible then to assert that someone is healthy although at that particular point the person is defined as ill.

For example, Mrs. S. often spoke with concern of her three years old daughter, Joanne, who seemed to get repeated throat infections; as she expressed it, "It's just one cold and bad throat after the other". When I called to interview Mrs. S. for the second time Joanne was not well with a sore throat, yet Mrs. S. was able to maintain that "Joanne's very healthy apart from the sore throats". That is, recurrent episodes of this kind do not threaten Mrs. S's conception of her daughter's master status since they pertain only to individual here and nows. In Turner's terms, the person conception she holds is relatively stable(16). Similarly, when speaking of her father she said, "Dad was alright apart from his heart, he had angina and hardening of the arteries in his legs".

Many of the disorders experienced by the respondent's husbands did not challenge their status as healthy since explanations could be found which enabled them to be routinised. As Mrs. F. went on to say of her husband:

F3 Mrs. F.: He occasionally gets a headache .... but then I persuaded him to get glasses which he doesn't take to work with him .... but I think this is all it was, you know .... I think he gets strained with his job when he has a heavy day and it's very complicated and he's seeing lots of people and talking technicalities and he tends to come home with a sort of sick headache then.

Int.: I see ....

Mrs. F.: But that's .... it can always be put down to that.

Here, Mrs. F. is able to offer reasons for her husband's sick headaches which identify them as part of the normal order of things. Since they are caused by his not wearing his glasses and job strain they are to be expected rather than matters relevant to health. Similarly, when Mrs. G. says of her husband "All he ever gets are common colds" she is asserting that the problems he does get are shared by everyone, are to be expected and need not be taken into account in making judgements about his health.

I would also suggest that the status healthy is more amorphous than the status ill. It is not a status that has implications for action on the part of the individual or those around him. Defining someone as ill, however, does have practical implications since that individual and those with whom he interacts have to formulate and undertake a variety of actions designed to solve the problems it creates. Illness has to be managed whereas health can be taken for granted. Contrary to Dingwall's suggestion based on the work of Sacks, health, normality and ordinariness do not constitute the same kind of practical problems as illness or deviance. They require to be displayed only when challenged(17). This is, perhaps, the reason why accounts of health are usually less complex than accounts of illness and the reason why we know more about what Dingwall has called ethno-illness than we

do about ethno-health. There is just more to know. This would affirm the conclusion often drawn from ethnographies of non-industrial societies; that is, a culture is likely to contain a more detailed and complex body of knowledge about those phenomena which present themselves as practical problems than it is about those which do not.

Definitions of disorder and definitions of illness: Maintaining normal activity

Implicit in much of the analysis so far is the distinction I have drawn between definitions of disorder and definitions of illness. The former definition is applied when the problematic experience involved does not result in a change in activity. Mrs. P., talking about one of the episodes of bronchitis that affected her daughter said, "She had this rattly cough, terrible at night you see, really aggravating then. But in herself she was O.K., it didn't put her off eating or anything like that". At the previous interview she described how her son had "A mild dose of tonsillitis" the week before; "he had just a shortish course of antibiotics and er .... he wasn't ill with it". Mrs. P. had not known about the tonsillitis until Martin told the doctor about it at one of her daughter's visits. I take it that Mrs. P. had not been alerted to the problem because it did not lead to any modification of his behaviour.

Some problematic experiences the respondents talked about were not located within the category illness because of the way they had arisen. For example, though Mrs. R's daughter had recently been taken to hospital the problem was not defined as an illness:

R5 Int.: Have your children had any problems since I last saw you?

Mrs. R.: My daughter fell over and hurt her leg .... and er .... but that's not an illness, that was an accident and she went to hospital to have the leg dressed.

Mrs. S. employed a similar rationale while attempting to define in more general terms what she would include in the category illness. I had just asked her about her own health:

S4 Mrs. S.: I don't have any illnesses, mine are the sort of thing I've got now, I'm not ill, I never get ill, the only thing I have are pulled muscles which can happen to anybody. I always call illnesses something that you get, if you know what I mean, not something you do, get me, something that ... well an illness as far as I'm concerned is erm .... I don't know, well I wouldn't call a pulled muscle an illness anyway .... I'd just call it something I've got which I'll get rid of in two or three days.

At the next interview she made a similar statement while talking about her friends some of whom always seemed to have something wrong with them:

S5 Mrs. S.: One of them said to me you never seem to be ill of anything like that. I said I'm not actually ill. I don't call having a pulled muscle ill or having nerves ill, you know, it's just something you seem to suffer with.

For Mrs. S., the type and origins of the problems she encountered influence the definitions she applies. Illness is "something you get, not something you do". There is, perhaps, more to it than that. At three of the interviews Mrs. S. talked about her nervous problem and at one we discussed the effect it had on her:

Int.: Still getting out and about?

Mrs. S.: Yes, oh yes, I mean nothing, it's nothing like that you know ever stop you doing anything. I went to the Ideal Home Exhibition on Monday, I went there the whole day sort of thing, you know, nothing stops me from going anywhere. I just carry on as normal. It's not stopping me from doing any work, I still do it.

The sorts of disorders which Mrs. S. experienced from time to time were not problems which limited her activity or affected her ability

to carry on "as normal", she was able to go out and do her housework. Because her problems did not constrain her in any way they were not classified as instances of illness; rather, they were merely something she "suffered".

Illness relevant behaviours such as staying at home or going to see a doctor are not only imposed on the sick they are also actions which convey particular benefits. As Mrs. R. said of her husband after he was admitted to hospital during an acute phase of his depression, "he was removed from everything, from his responsibilities and even the children playing around in the evening". Consequently, anyone claiming to be ill is expected and obliged to undertake these changes in activity. Anyone refusing to do so may find their definition of self challenged. This may take the form of a charge of irrationality; for example, when Mrs. F's mother complained of a tremor in one arm Mrs. F. suggested she go to the doctor "cus it's silly to keep on complaining or worrying", or it may lead to a denial of the right to complain. At one time, Mrs. R's husband frequently complained of stomach ache and indigestion:

R6 Int.: He's not thought of seeing the doctor about that?

Mrs. R.: Well, yes, I have suggested it to him when he's complained for long periods erm but he doesn't want it, he says he doesn't want to start having stomach x-rays and all the rest of it so I'm afraid once or twice I've said alright shut up about it, you know.

Though Mrs. R. offers a reason why he does not wish to go to the doctor this is not accepted by Mrs. R. Rather, she assumes that nothing much can be wrong if he is not prepared to put up with the inconvenience of having treatment. As a result she is not prepared to continue to listen to his complaints. However, refusals to see the doctor do not threaten the status of a complaint where acceptable explanations are

offered. Just prior to my fourth interview with Mrs. P. her husband had begun to complain that he was depressed. He had been treated for "a sort of breakdown" some years previously but this time he refused to go to the doctor:

P1 Int.: How's your husband?

Mrs. P.: Depressed.

Int.: Is he?

Mrs. P.: Mm ... he ought to go to the doctor but he won't go so ....

Int.: You can't persuade him to?

Mrs. P.: No. I know if I was to phone Dr. M. and tell him immediately he'd say send him up to me and I'll put him on some drugs again but he won't go.

Int.: But you think he ought to be seen by Dr. M?

Mrs. P.: Well, you see, why he won't go back is probably because he thinks Dr. M. will send him off to the place where he had treatment before you see, he had electric shock treatment.

Int.: Yeah. He's not very keen on that?

Mrs. P.: No.

Despite the fact that Mr. P's depression was not obvious, it had no external manifestations and Mrs. P. was not aware of it until he told her, his reluctance to see the doctor is not taken to mean that his claim is dubious. That he is depressed and needs treatment is accepted; as data presented in Chapter 6 will reveal, Mr. P's breakdown is not a closed event but a state of affairs Mrs. P. anticipates could happen again. His claim to be depressed is legitimated by his biography and the confirmation of his wife's expectations. Consequently, a reason must be found for his refusal to seek treatment. That reason is also located within his biography. The likely consequences of going to the doctor, judged on the basis of what happened last time, is the explanation of his reluctance to consult Dr. M. Because this explanation is

acceptable to Mrs. P. she remains concerned about his depression and does not try to silence his complaints.

This point can be illustrated by a further example. At an interview later in the year Mrs. P. told me how her husband had woken up one morning and felt unwell:

P2 Mrs. P.: Monday morning when he got up he felt really dreadful and he looked it too, so I said look, you go back to bed. Well, wouldn't have the doctor, wouldn't go to the doctors, so I thought right, I let it get round to the Tuesday and he'd had er well not a very good night, very restless and coughing on and off and so the Tuesday morning I phoned the doctor and made an appointment.

Int.: Was it difficult to get him to see the doctor?

Mrs. P.: Well, he wasn't very keen to go. I think well, I realise now he didn't know he was as ill as he really was, you know, he thought he could probably sort of dose up and shake it off like he's done before, but of course nothing doing.

Again, Mr. P's refusal to see the doctor is not used as a resource in making judgements about the validity of his condition; that is given by its external manifestations. Rather, it is something for which an explanation must be sought. In this instance Mrs. P. is able to impute a reason retrospectively and attributes his reluctance to see the doctor to the fact that initially he did not realise how ill he was. By using his past experience to structure his present action Mr. P. did not perceive the need for professional attention but assumed that what has proved successful in the past will prove to be successful again. However, given the failure of this procedure and practice Mr. P. spent a "very restless" night and Mrs. P. was able to go ahead and make an appointment for her husband to see the doctor.

Though a failure to engage in situationally appropriate behaviour

may result in a claim to be ill being rejected the women I interviewed did assert that they or others known to them had been ill although normal activity was maintained. Mrs. S. managed this discrepancy by invoking her status as a housewife to account for such activity:

S6 Mrs. S.: If I'm ill I don't go to bed or if I feel poorly I don't I just carry on because if you've got children you can't you just you just work and carry on and I find mostly that it makes me feel a darned sight better. And Mike can't afford time to be off work to look after me if I was poorly anyway, so I think you'll find not just me but most of the housewives among my neighbours just carry on as we are and get on with it.

Mrs. S's status as a houswife imposes obligations which rule out the possibility of her engaging in what otherwise would be situationally appropriate behaviours. Her responsibility for her children means that she must carry on as usual and 'get on with it'. This is not peculiar to her but is a general situation common to others who occupy a similar status, 'you'll find not just me but most of the housewives among my neighbours just carry on as we are'. Role responsibilities are thus given precedence over those behaviours customarily expected of the sick; consequently the definition ill is not subsequently challenged. That this is taken to be an adequate explanation of the failure to display illness relevant behaviours requires that commonsense knowledge of social statuses and their attendant obligations is used to recognise the sorts of constraints imposed on those who occupy the role of housewife. Mrs. S. also appeals to features of the organisation of her family to reinforce the conclusion that her maintenance of normal activity was imposed on her and not therefore an indicator of an illegitimate claim to the definition ill. As she explains, her husband would not be able to forego his responsibilities with regard to work to be able to look after her if she was not well. The need for the major participants in the family to

fulfil their obligations in order to maintain it as a functioning unit legitimately prevents the expected change in usual activity.

In a subsequent interview Mrs. S. reaffirms this rationale while discussing her parents' response to problematic experiences. The need to look after children is offered as an explanation of the differences in reaction on the part of her mother and father. It is also elevated to a general proposition to account for the differences between men and women:

S7 Mrs. S.: My mother was always quite a poorly person, she never was very well, you know, and yet she was marvellous she would get on with whatever she was doing no matter how she could be at death's door nearly, but if my father was ill he was, that was it, he'd just sit down, I mean he'd just have a pain in his little toe and I think nine men out of ten are just the same. This is how I find it because they never have children to look after. If you've got kids you can't afford to be ill.

Here, responsibility for children is seen to impose a constraint only on women. While women, like her mother, carry on despite the fact that they "could be at death's door", men are not limited in this way and are able to dispense with normal activity for relatively trivial conditions. Not only does this account rationalise a discrepancy which might obviate any definition of illness it also illustrates the moral superiority of women who place obligation before self-interest. As Mrs. S. says of her mother, "she was marvellous".

Biography as context

In the previous sections I have shown how what I have called illness relevant behaviours are used in the construction of definitions of health and illness. I have attempted to specify some of the interpretive procedures employed and outlined some aspects of commonsense know-

ledge about health and illness used as an interpretive scheme. Illness relevant behaviours are not only included in descriptions of episodes of illness but are invoked to demonstrate the legitimacy of the application of these constructs. Although the presence or absence of illness relevant behaviours is frequently adequate for the task of constructing definitions it is also the case that more complex rationales may be employed. For example, these behaviours may be situated within a biographical context. In this section I will use further data to show how biography as context functions as an interpretive device.

Consider the following exchange:

G4

Int.: Can you remember the last time that you or anyone you know was ill?

Mrs. G.: Yes. My dad.

Int.: When was that?

Mrs. G.: About two months ago.

Int.: What was wrong with him?

Mrs. G.: He had sciatica.

Int.: Tell me about it. What happened?

Mrs. G.: The reason I remember it probably more than anything is the fact that he's never .... I can't remember a time before that when he was ill. I can't really ever remember him going to a doctor's before that. Er .... he had this severe pain in one of his legs and er .... had to go to the doctor's to get something. But obviously, apparently it's something that he can't sort of give you tablets for and it goes away. You know he had time off work .... it's just something that .... extraordinary, non-typical of him.

What is to be noted in this extract is that Mrs. G's depiction of her father as ill does not rest on a description of the disorder as such but other "non-clinical" matters are introduced to convey the meaning of the event. That is, the symptom, "a severe pain in one of his legs", the diagnosis, "sciatica" and the nature of the disorder,

"it's something that he can't sort of give you tablets for and it goes away" are situated within other facts deemed relevant to the categorisation of the event. These other facts consist of the behavioural consequences of the disorder and their location in a biographical context.

When asked to elaborate Mrs. G. offers reasons why she can remember this particular event. This takes the form of biographical information; she cannot remember her father ever being ill nor can she really remember him ever having to consult a doctor. This medical history provides a context by means of which the disorder under discussion can be interpreted. It not only serves to convey the uniqueness of the event in question it also allows her father to be identified as a particular type, as someone who is never ill and who never consults a doctor. This typification is reaffirmed when she says that his having time off work is "extraordinary .... non-typical". On the basis of this typing other relevant characteristics can be imputed to him such as typical courses of action and their motivational and intentional antecedents. Consequently, the fact that on this occasion he "had to go to the doctor's to get something" and "had time off work" constitutes grounds for seeing this "severe pain in one of his legs" as particularly significant. Given what is known of her father in terms of a type grounds also exist for establishing the nature of the connection between these events. That is, seeing the doctor and taking time off work are the inevitable consequences of an organic disorder. That is, the claim to be in pain and the subsequent course of action cannot be seen to be specifically motivated. Although pain, because it is not subject to direct observation, may figure in many illegitimate claims there is nothing in this description that can be taken as evidence of malingering

or exaggeration. This is ruled out by the commonsense association between a type and the kind of motives known to inform their actions. Given that the facts of the matter are presented in this way it would be difficult to question Mrs. G's definition of her father as ill.

The reasoning involved in the imputation of illness made here is more complex than those analysed above, although they share many features in common. Both make reference to a commonsense construct of how ill people behave and identify these behaviours as the product of a biological disorder or the experiences to which it gives rise. In this instance, however, they are contrasted with the subject's biography vis-a-vis doctors and work and the typification thus invoked reinforces the interpretation of these behaviours as signifying illness by providing for the impuation of appropriate motives(18).

These features can also be discerned in the following exchange taken from another interview with the respondent quoted above. The two interviews were carried out exactly one year apart and in both extracts the respondent's father is the subject of the discussion:

G5 Int.: What's your father's health like?

Mrs. G.: I think it's very good. I sort of can't remember him being seriously ill. Actually, the first time I've known him have time off work was about a couple of months ago when he had flu, and he must have been bad because he had a good week and a half off, he saw the doctor and got a sick note and everything, but that's the only time I can ever remember him, you know, in years sort of thing. Because it really surprised me .... I think in a way he'd got to a point where he thought he might take ad .... you know sort of make the most of it. I think he and my mum had quite a good time that week.

Int.: Was he not confined to bed or anything?

Mrs. G.: He was at first sort of four or five days, you know, but he had .... I think he must have left finished work the Wednesday and he

> didn't go back till a week before they'd (moved) and towards the end of the week sort of they went to Derby and had a good time and I had a feeling that he thought he might as well.

The biographical information presented here is somewhat similar to that in the previous example. The respondent cannot remember her father being seriously ill, and the only time that she can remember him having time off work is the occasion she goes on to describe. The sciatica episode is not invoked here, it is either forgotten or has not significantly modified her conception of his biography. Whatever, given this conception of her father's normal pattern of activity having a "good week and a half off work" and "seeing the doctor and obtaining a sick note" are taken as indicators that he "must have been bad". The connection between these events as indicators, the biography as an interpretive scheme and the underlying pattern to which the indicators are thus taken to refer are not made explicit in the respondent's talk. The expectation is that reference will be made to a stock of knowledge at hand to fill in and make the necessary connections. This seems to require a more complex interpretive procedure than that suggested by Garfinkel in his discussion of the documentary method(19). For taking time off work and going to see a doctor are not unambiguous as indicators. They may also be interpreted as motivated acts, i.e. indicative of malingering. Hence the necessity to warrant the connection being made by the invocation of biography. However, in order to function as an adequate interpretive scheme the biographical facts offered need to be embellished. They are themselves documents of an underlying pattern consisting of types of persons, their actions and the motives that generate them. Thus, for the purpose at hand persons can be divided into two types, malingerers and non-malingerers. Inferences about observable

actions such as staying away from work and seeking medical advice can be made on the basis of the motives known to inform the behaviour of these types. This involves a common sense theory of the basis of action and constitutes work necessary for the imputation of illness(20).

The respondents I interviewed not only used aspects of an individual's biography in constructing and legitimating definitions of illness, they also clearly expected anyone they assumed to be in possession of biographical information to use it to arrive at the same interpretations. The following extract illustrates this expectation. It is taken from a part of an interview in which Mrs. F. describes changes in the organisation of her doctor's practice of which she did not approve. Those changes consist of the introduction of receptionists and an appointment system. The account is offered as an illustration of the way in which her doctor's practice had become more impersonal:

F4 Mrs. F.: This is a barrier and .... I feel quite annoyed about it really, because, I don't know if I mentioned it before, my husband is really fit, luckily, for years and years, well I think all our married life, I think all he ever went to Dr. M. for was an examination prior to taking out an insurance policy, and he had very bad flu, it's the first time he's been ill since we've been married, and I couldn't get the doctor to come and see him. O.K., so everybody has flu, but he had a high temperature for about three days and all I got was the receptionist fending me off, oh well, you can call in for a prescription, you know, sort of describe his symptoms and I'll give you a prescription and this I was so annoyed about because I felt that if Dr. M. and his old receptionist had been there the only two there they would have thought Mr. F. never ever comes near us, he must really not be well, or even if he's it's only flu and he'll get better, we owe him a visit ....

Int.: Yes ....

Mrs. F.: .... you know, for all these years that he hasn't bothered us, and that has made me very resentful.

Many of the procedures analysed above are readily discernable in this account. While the respondent believes that the request for a visit from the doctor was justifiable on clinical grounds, "so everybody has flu, but he had a high temperature for three days", i.e. this was no ordinary case of flu, she anticipates that the doctor and his old receptionist, knowing her husband's biography as she describes it, would have been competent to recognise that a request for a visit means that "he must really not be well". Or even if a visit was not warranted on clinical grounds, knowing the kinds of demands he had made on them in the past the doctor would have recognised an obligation to comply with his demands. The new receptionist who was not in possession of this knowledge is clearly not considered competent to judge whether or not a visit by the doctor is required though ultimately it is her decision. In this instance a visit by the doctor was not forthcoming and resulted in annoyance and resentment on the part of the respondent. As she emphasises later in the interview:

F5 "As I say, in that particular incident with my husband, Dr. M., knowing that he'd never been to him in all those years would have come to see him. He would have known that this man must be ill if he's asking for a doctor because he's never been to us, never bothered us. Under the new set-up with three bustling receptionists with their overalls on and three doctors in the practice who knows the individual any more?"

Here, knowing the individual is taken to be the basis of good medical practice. Only by knowing the individual can the doctor make proper inferences about his patient's state of health and thereby make competent decisions as to how to act. The growth in the size of her doctor's practice and the increasing complexity of its organisation are identified by Mrs. F. as constraints upon the extent to which the individual can be known. The new set-up either prevents the patient gain-

ing direct access to those in the know, "all I got was the receptionist", or prevents the personnel involved in the practice from getting to know their patients, "who knows the individual any more?"

It is possible to discern within the interviews that I conducted two distinct types of biography invoked by the respondents in depictions of matters of health and illness. One I have illustrated via the extracts above which is used to typify individuals in terms of routine patterns of illness relevant behaviour. The other I will refer to as a diagnostic biography since it makes reference to diagnoses and not to actions conventionally associated with illness. These diagnostic biographies are used in much the same way, as interpretive contexts for assigning a health status or otherwise ordering observed events(21). Though the data I have collected is insufficient to be definitive analysis of some of the extracts in which diagnostic biographies occur does point to a status intermediate to health and illness.

In an interview I conducted with Mr. and Mrs. R. they gave me the following information about Mr. R's father:

R7 Mr. R.: You'll shortly meet my ailing dad by the way who's come to do wallpapering with me. You know, he has this .... he's been terribly ill for twenty-five years or .... well, more in fact ....

Mrs. R.: As long as I've known him.

Mr. R.: .... since about 1936 he's been very ill and it isn't hypochondria, I mean he has genuine illnesses. He has if I have the right name for it diverticulitis and he has erm .... hiatic hernia he has erm ....

Mrs. R.: He's had a heart attack.

Mr. R.: He's had a heart attack and he has ....

Mrs. R.: He has colitis ....

Mr. R.: Yes, nasty colitis.

Mrs. R.: Very nasty that.

Mr. R.: And so about every other night my mother tells me he, he, you know, he practically went last

night sort of thing. But he's another creaking gate who's been going along for years and today he's feeling well and today he's been down here helping with the wallpapering.

N2 Mrs. N.: Oh, my mother's not a very healthy person.

Int.: Why would you say that?

Mrs. N.: Well, she has so many things wrong with her.

Int.: Like what?

Mrs. N.: Well, she has very bad osteoarthritis and that is really terrible. She's having treatment about three times a week for that and she's had many operations .... it's a very long story ....

Int.: Does she find that very restricting?

Mrs. N.: Well, she's in constant pain. She is a source of worry because of her operations and troubles that she has.

Int.: So you don't think her health is particularly good?

Mrs. N.: I should say physically she's O.K. .... no, I don't know how you would put it with her, she's one of these old cracked lags that keeps going. she doesn't look a sick woman when you look at her but er .... terrible trouble.

Int.: I see, it's not a disease that er .... I mean you wouldn't immediately strike you as being, you know, she wouldn't immediately strike you as being ill if you sort of saw her until you actually knew that there was something wrong with her.

Mrs. N.: Well, no but .... well she's had been, was in hospital for nearly a year with another complaint and we get hospitals and umpteen operations .... we have this worry.

R8 Int.: What's your mother's health like?

Mrs. R.: Not very good.

Int.: Not very good? Why do you say that?

Mrs. R.: She has various complaints including very high blood pressure and she's on medication all the time trying to keep it within reasonable limits .... and she tires very easily, she had a heart attack about eleven years ago, a slight one, and she has generally been quite er .... she's supposed to be careful, put it that way, I don't think she is particularly, she has to take it a bit easy .... she has various other minor complaints; well not so minor .... things like Reynaud's disease and .... well I

can't think of any of the others at the moment but she's not a very healthy person.

Int.: Mm .... so do you find she's quite restricted in what she can do?

Mrs. R.: Well .... (laughs) this is our family joke, we, we .... not really, she does an awful lot really .... well, she .... in fact she leads a perfectly normal life. No she doesn't restrict herself.

These three cases share the following features: the respondents provide a catalogue of the disorders from which the subjects under discussion suffer; these diagnostic biographies are taken to be relevant in assigning the subjects to a health status; the potential conflict between the diseases listed and their consequences is managed by the use of a category I will call 'not healthy' which defines a master status.

Mr. and Mrs. R. offer a number of diagnoses to support their contention that Mr. R's father "has been terribly ill for twenty-five years .... or more". His status is thus defined by his biography and not by his current situation; "today he's feeling well and today he's been down here helping me with the wallpapering", is to be seen within its biographical context and is not the criterion according to which he is to be judged. Here, the present takes its meaning from the past and does not alter the meaning of the past. "Today he's feeling well" is then to be read as a temporary state within an overall master status and is not an indicator independent of that status. Similarly, Mrs. N. provides a diagnostic biography for her mother on the basis of which one is expected to make relevant interpretations. The fact that "she doesn't look a sick woman when you look at her" is not to be employed as an indicator but is to be situated within her history of "very bad osteoarthritis" and her "umpteen operations". Mrs. R. also assesses

her mother according to her biography of "various complaints" rather than according to the fact that "she leads a perfectly normal life". In this way the respondents not only provide interpretations but provide for them by supplying the interpretive scheme to be employed and denying the relevance of indicators which could lead to alternative conclusions.

However, it is not clear from these accounts whether the individuals described should be defined as healthy or ill for certain discrepancies occur which violate our commonsense conception of illness. Note that in two of the cases I assumed following the presentation of the respective biographies that the individuals concerned would be restricted in some way. Yet Mr. R. is able to assert that his father has been terribly ill for twenty-five years or more although "today he is well". Mrs. N. claims that her mother has "terrible" osteoarthritis but does not "look a sick woman", and Mrs. R's mother has a variety of "not so minor complaints" yet leads a perfectly normal life. The contradictions that these statements embody are managed by assigning the subjects a special status. Mr. R's father is a "creaking gate who's been going along for years" and Mrs. N's mother is one of these "old cracked lags that keeps going". Mrs. R. manages the discrepancy in her mother's situation by characterising it as "our family joke" and defining her as "not a very healthy person". Consequently, the behaviours seen as appropriate to illness do not necessarily apply; "she has to take it a bit easy" and "she's supposed to be a bit careful" can be seen as the behavioural prescription for this intermediate category not healthy. This category would seem to have much in common with what Kassebaum and Baumann have referred to as the chronic sick role[22] and Gordon has termed the impaired role[23].

Motives, morality and the attribution of responsibility

In the preceding analysis I have touched upon the relevance of moral and motivational concerns to the construction of definitions of illness. In this section I want to consider in more detail issues of morality, motivation and responsibility.

In the next extract Mrs. G. talks about her grandmother. These issues are central to the way in which her grandmother's problems are presented. What is to be noted here is how Mrs. G. constructs a denial that her grandmother is ill while admitting that she does suffer from a number of disorders:

G6

Int.: What about your grandmother?

Mrs. G.: You could write a book on her.

Int.: Why, does she have a lot of problems?

Mrs. G.: Well she's .... she was an usually healthy person till about twelve years ago when my grandfather died and she decided that she was .... that this was the end, and so sort of arthritis, you know, and she suffers from blood pressure as well, she has tablets .... she has more tablets than .... I don't know what they're called but she takes a lot of tablets a day.

Int.: Would you describe her as being ill?

Mrs. G.: No.

Int.: Why not?

Mrs. G.: Well, I think that it's more through her own cause that she's ill rather than .... fair enough, perhaps she's .... she had cataracts on both eyes which she had operated on ....

Int.: What do you mean her own cause?

Mrs. G.: Well, more than if she'd .... well that she gave up .... rather than anything else.

Int.: Do you mean that there's nothing really wrong with her or ....

Mrs. G.: Well, the fact that her joints have gone stiff because she's not used them very much ....

Int.: You think that she has got one or two things wrong with her but that she's brought them on by her own actions?

Mrs. G.: Yes, I do.

Int.: Is she at all limited by any of her problems?

Mrs. G.: Not really, no .... she's ....

Int.: Can she get out and about?

Mrs. G.: Yes .... I mean she wouldn't walk very far now because erm it's so long since she did walk a great distance, but she can do. You know she can walk, I mean she can walk. But she's not particularly bothered about it she .... you know even on a nice day she doesn't really want to walk into the garden or anything.

Though the respondent provides a catalogue of her grandmother's problems, "sort of arthritis .... and she suffers from blood pressure .... she takes a lot of tablets a day .... she had cataracts on both eyes which she had operated on", these are not adequate in themselves for the purpose of ascribing or denying illness. Typically, other matters are introduced to facilitate the construction of definitions. In this case the respondent is able to deny that her grandmother is ill by locating an explanation of her grandmother's problems which renders the definition illness inapplicable.

This is achieved by invoking moral responsibility and seeing her disorders as the product of her own actions; "it's more through her own cause that she's ill". In refusing to characterise her grandmother as ill the respondent does not claim that "there is nothing really wrong with her" (to use the interviewer's formulation) but that problems such as "stiff joints" stem from the fact that she has not used them very much. This failure to use her joints does not have its origins in a pathological condition preventing her from walking, "I mean she can walk", rather, it is lack of motivation on her part. "Even on a nice day, she doesn't really want to walk into the garden" which a reasonably motivated person would be expected to want to do.

This attribution of moral responsibility is based upon what the respondent considers to be inadequate motivation. The problems under discussion are depicted as states of affairs that might have been, and might still be, otherwise. That her grandmother's limitations, inadequate motivation and moral responsibility are connected is made explicit by the respondent when she presents further biographical information. That is, her grandmother was "an unusually healthy person" until her husband died and she "decided that this was the end" and "gave up". The lack of normal motivation imputed later in the interview is both product and indicator of her having given up. This response to her husband's death, which was neither inevitable nor outside her control, is identified as the point at which her health problems began. The expectation that the bereaved will eventually return to normal activity can be used to construe the grandmother's response as unreasonable, as indicative of a moral defect and an unjustifiable state of affairs.

As Parsons has suggested in his analysis of the sick role persons who are ill are not usually held responsible for their condition, they cannot be blamed for it. Even where they may be held responsible for having exposed themselves to a particular condition, having contracted it they cannot be expected to get rid of it by willpower. This feature of commonsense reasoning about illness is integral to Mrs. G's denial that her grandmother is ill. The problem selected to warrant the denial of illness, stiffness of the joints, is not only seen to be something for which she is responsible but the nature of her responsibility, lack of motivation on her part to lead a "normal" life, means that her condition is resolvable by willpower. The commonsense association between illness and responsibility is here used as a resource to legitimate the respondent's refusal to grant her grandmother the status ill.

The respondent is not only able to construe her grandmother's disorders as the direct result of motivated actions she is also able to interpret her claim to be ill as a motivated act. In the subsequent exchange the respondent provides further grounds for rejecting this claim:

G7 Int.: Do you think she thinks of herself as being ill?

Mrs. G.: Oh yes, definitiely. Yes.

Int.: Why?

Mrs. G.: Well she, you know, I mean .... she's eighty-six and sort of a lot more fit than most people of that age. And yet you ask her if she's well and oh no, you know, she's never well. And yet she's not, you know, she's not .... well she doesn't appear to be ill.

Int.: So what do you think underlies her saying that she's not well?

Mrs. G.: Well, probably she wants sympathy or something.

Int.: Do you give it?

Mrs. G.: No .... (laughs).

A claim to illness, like any other illness relevant behaviour, is not unambiguous as an indicator. It may be taken to signify genuine illness or it may, as in this instance, be seen to be motivated by anticipated gains. In determining which of these alternatives the claim signifies evidence must be sought to lend support to one or other interpretation. Here, two such items of evidence are offered. Firstly, the claim to illness is to be seen in terms of the grandmother's age and her situation with regard to her contemporaries. As the respondent says, "she's a lot more fit than most people of her age". This presupposes a conception of what I have referred to as normal disorders[24]. That is, certain categories of persons are expected to experience certain types of disorder as part of the normal course of events. These disorders are characteristic of types of persons or life stages and not indicators of illness. The respondent's grandmother is presented as displaying less disorder than might normally be expected

at her life stage yet still considers herself to be unwell. The expectation is that she should assess her own wellbeing in terms of that of her contemporaries, and this she manifestly refuses to do; "and yet you ask her if she's well and oh no, she's never well". Secondly, the respondent is able to render the claim to illness suspect by noting a discrepancy between that claim and observation. As Mrs. G. puts it, she does not "appear to be ill"(25).

These procedures allow the claim to illness to be seen to be specifically motivated. At the same time the respondent finds no difficulty in supplying a relevant motive. Here she trades on commonsense knowledge of the way in which someone who is ill can legitimately expect other persons to act towards them. If someone who is ill can expect sympathy and support then any illegitimate claim to illness can be seen to be the result of a desire for sympathy and support. In finding this as the motive for her grandmother's claim Mrs. G. not only construes that claim as illegitimate but absolves herself from any responsibility. Her refusal to give sympathy can thus be seen to be warranted(26).

In offering the above account I would suggest that Mrs. G. is constructing a moral condemnation. In his analysis of the commonsense ascription of deviance McHugh describes two rules upon which moral condemnations of this kind depend. Any behaviour may be morally reprehensible according to the view that potential ascribers of deviance take of the conventionality and theoreticity of that behaviour(27).

Conventionality is ascribed to behaviour which an observer considers might have taken place in some other fashion, that is it is not behaviour which is inevitable. An observer evaluates the conventionality

of behaviour to determine whether it is unnecessary under the circumstances or whether there are reasons which can be found to support it. Those reasons typically take the form of appeals to circumstance. Theoreticity relates to the extent to which an actor is considered to be aware of what he is doing. A theoretic actor is assumed to know what relevant conduct is in any situation and to intend his action in the light of this knowledge. Consequently, an actor may attempt to defeat a charge of deviance by showing good reasons for why he behaved in a certain way, by denying that he knew the rules governing a particular situation or by denying that the act in question was intentional.

Dingwall uses the conventionality rule to claim that illness falls under the general category deviance; that is, it constitutes a breach of public morality. As he puts it, "illness is not in accord with what might reasonably be expected so that the ill person is someone who might have behaved otherwise but has failed to do so". The previous analysis of illness relevant behaviours would indicate that this is not the case. Illness relevant behaviours, although considered to be departures from normal activity, are explained as the inevitable consequences of a biological or experiential state. Illness relevant behaviours are not conventional behaviours since adequate reasons can be found to account for them. Only where these behaviours are motivated can a charge of deviance be made.

In McHugh's terms, Mrs. G. is able to see her grandmother's limitations as a state of affairs that might have been otherwise and for which no adequate grounds can be found. Since they are self-imposed, the result of defective motivations on her part they are also intentional. Her claim to be ill can be similarly judged, as behaviour that is not inevitable and an intentional breach of the rules.

During the interviews I conducted with Mrs. F. we talked extensively about her mother and her mother's problems. Following an operation for a cataract six years previously she had become increasingly dependent and would no longer leave the house on her own. Mrs. F., however, was able to interpret this dependence as having origins other than the physical limitations imposed as a result of the operation. Here issues of motivation and responsibility are not so clear cut due to the explanatory device that Mrs. F. employs to account for her mother's dependence:

F6 Int.: Yes. Anything else with your mother, I mean she seems to be the one we talk about a lot isn't she?

Mrs. F.: Well, we're still humming and haaing about whether she should have the other cataract done, she's had one done about six years ago, I think I told you. She had a very bad time because she had this infection and she was in there six weeks instead of a few days and she's never really honestly pulled herself together since. I mean I know now she's eighty-five but then she was what eighty-one and active but from that operation she has not been outside the door ever on her own.

Int.: No?

Mrs. F.: No she just, cus she can only see with one eye now because she hasn't had them both done.

Int.: So although the cataract operations improved one eye ....

Mrs. F.: Yes, she can never see with both eyes, you see.

Int.: Yes. It's not really improved her situation much.

Mrs. F.: No, because as I say, she won't go out on her own any more .... if only she .... I think it's just a personality thing with her really, she's that type of person, she's sort of introvert and withdrawn and it's never .... she never encourages you to do anything, it's always oh, I wouldn't if I were you. You know, she'd much rather I stayed at home and never went anywhere and never went to a show or anything, you know, if I say to her I'm going to .... say if I audition for a part and I don't get it and I say Oh mum, I didn't get the part she says oh good, now you won't have to go to rehearsals, you know, it's not oh, what a shame ....

Int.: Yes ....

Mrs. F.: You know it's, it's erm .... so she's that sort of person so ....

Int.: Cautious .... ?

Mrs. F.: Yes. So this has been enough this operation to stop her as I say even ever .... she could .... if only as I say .... I know another woman who is a conductor actually and she's had both eyes, she had one eye done, carried on working, and then she had the other one done, because she can't drive unless she's got, unless she can see with both eyes and she wants to drive because she wants to go round all these orchestras, amateur orchestras that she conducts and she's seventy something but this is a totally different personality you see. She's got something to get up and go for ....

Int.: Yes.

Mrs. F.: so she gets up and goes, two cataracts, you know. As I say there's my dear old mum she wouldn't even walk round the block to the pillar box, you know, which is on the same side of the road and you can't get lost round a block can you?

Int.: Not really. I mean you think in fact that she's physically capable of ....

Mrs. F.: Well, she was when she first had it done you see but she's never pulled herself together, I can only see with one eye therefore I am housebound, full stop, you see. I mean I ... the neighbour gets a lot of her shopping and I take her once every two or three weeks to get her pension and a bit of shopping erm ... she comes to me one week-end she goes to my brother one week-end but she never ever goes anywhere on her own, you know, she's very very, you know, totally dependent now on us. Except that she's still in her own home and managing to do her own bit of cooking and housework and so on.

In this account age, "I mean I know she is 85 but then she was what 81 and active", and physical incapacity are dismissed as explanations of the fact that Mrs. F's mother has never been outside the door on her own since her operation. Rather it stems from the "bad time" she had in hospital since which "she's never really pulled herself together". While this implies a defect of some sort the role of motivation and responsibility is ambiguous since Mrs. F. sees it as a consequence of her mother's personality, as a characteristic of a type of

person. It is her personality which prevents her undertaking those actions of which she is assumed to be physically capable; "she wouldn't even walk round the block to the pillar box which is on the same side of the road .... and you can't get lost round a block, can you?"

Mrs. F. sees her mother as withdrawn and introverted and presents examples to demonstrate the consequences of these character traits. She also contrasts her mother's situation with that of another individual and whose case history is essentially similar but who carried on working despite two operations for cataracts, "but this is a totally different personality you see". Instead of defining herself as disabled, "I can only see with one eye therefore I am housebound", the conductor "gets up and goes" despite two cataract operations. In this latter case the role of motivation is clear. The conductor, unlike Mrs. F's mother, has had both eyes operated on because she wants to do things which require sight in both eyes. Her interests provide the motivation and the necessity for adequate sight. Mrs. F's mother, however, has been "humming and haaing" for the last six years about a second operation which would improve her situation. As Mrs. F. puts it, she has "nothing to get up and go for" and is content to slip into a dependent role.

Although Mrs. F. presents her mother's dependence as a consequence of lack of interest in life and an attendent lack of motivation to make the most of her capabilities responsibility is not imputed in the same way as in data extract G6 since this sequence is explained as the product of an internal constraint. Personality is not something over which an individual has control, it is something that must be accepted however irritating the consequences. This account then does not carry the same moral condemnation as G6 since her self-definition and subsequent actions

are not intentional but consequential. They may stem from a lack of motivation but they are not motivated by potential gains.

Later on in the interview Mrs. F. outlined her commonsense theory which posits a relationship between interests, motives and illness. At most of her interviews she had referred to the fact that she herself, her husband and her children were "very healthy". In the following exchange she offers a theory which accounts for her family's good health:

F7 Mrs. F.: Do you think it equates to leading an interesting life? I mean can you draw any conclusions or did I ask you this last time cus I've got a theory about this. If you've got things to get up and do you will fight off illness it is ....

Int.: Mm.

Mrs. F.: doesn't, you know, assume the major proportions that it does to someone who never goes anywhere and never does anything but sits and knits and watches television.

Int.: So you think one of the reasons why, why you ...

Mrs. F.: I think we're all healthy because we're all happy and busy ....

Int.: Yeah.

Mrs. F.: We're happy because we're busy. I mean there's Madge in there she's learning the piano, the saxophone, she's having singing lessons and driving lessons, that's her. My daughter, Clair, at school you know she's in the er theatricials at school she was Venus ....

Int.: Oh yes, that was quite recently, wasn't it?

Mrs. F.: Yes, quite recent. She's got a nice boyfriend who's very muscial too, plays the cello, you know, they've got lots of interests in common, he was in the school productions as well. Really nice lad. He takes her to concerts and things like this, she's got lots of friends, she does a Saturday job in a chemists, you know, she's busy and interested. There's my husband .... his job is very demanding and I think possibly worrying but not to the ulcer point, you know....

Int.: Yes.

Mrs. F.: (Laughs) erm absorbing, you know. And of course he's got the amateur theatricals as well you see, we both belong to the local Operatic, he's

also producing for another society erm he occasionally gets asked to do concerts for the disabled and people like that so he is well he's too busy ever to decorate or anything like that you know. But erm I don't think we've got time to be ill.

Int.: Do you know anyone in fact who, who maybe does less you know is less active than your family you know who, who does seem to be like this ....

Mrs. F.: Well, not specifically but you get the feeling that people who haven't got very much to do will talk about themselves and their ailments ....

Int.: Yes.

Mrs. F.: you know it would never occur to me to if anyone phones up and says how are you I say oh fine, I mean I could be behind me dark glasses (with my allergy) but I forget to mention it ...

Int.: Yes .... yes.

Mrs. F.: because I want to forget it and I've got other things more important to do.

Int.: Yes.

Mrs. F.: I mean I'm doing, I'm doing the props for my husband's play which is in a fortnight. I've never done props before and er it's so interesting and it's a play where there are so many props .... I'm cutting my teeth backstage on this and then I want to, I'd like to go on a lighting course because I know nothing about lighting, I mean I know when I can see a thing and I know when I can't but I don't know why ...

Int.: So do you think you're too busy to bother about ...

Mrs. F.: I'm too busy to be really ill and if I was ill and there was a show to .... I mean you know it's like it's like actors I mean how many actors actually drop dead on stage, they never do. I mean they might occasionally drop dead in the wings erm you know is there a doctor in the house thing, but you know they can't afford to be ill because they're too busy and they're too involved in, in what they're doing, it's too important. Unless they're really struck down with some dradful virus you know.

Int.: So you think, I mean a lot of people who aren't busy have a tendency to dwell on ....

Mrs. F.: I always feel this at the back of my mind although I can't quote you any specific people I've always had this feeling that we all keep well because we want to be well because we've got things to be well for and if you're unhappy or you're bored or lonely or you know you've got nothing to get up and go out and do if you

> have a cold it's the flu, you know if you
> have a headache it's a migraine erm you
> know everything is that bit worse because
> you've got no interest to take it off ....

The theory presented here by Mrs. F. to account for her family's good health consists of linked sequence of events encapsulated in her statement "we all keep well because we want to be well, because we've got things to be well for". Thus, leading a happy, busy and interesting life means that there is a motivation to be well, "we've got things to be well for" and "if you've got things to get up and do you will fight off illness". That motivation has its origins in a style of life which is busy and interesting and fundamentally incompatible with illness. Pursuing these interests is more important than occupying the status ill. Moreover, it means "we've got no time to be ill" and "I'm too busy to be really ill".

Because of life interests and the motivation to maintain them, disorders are not organised as illness by Mrs. F. and her family in contrast to "people who haven't got very much to do" who "talk about their ailments" and allow them to "assume .... major proportions". As Mrs. F. says of herself, if someone asks how she is she says she is fine even though she "may be behind my dark glasses" with a recurrent allergy which affects her eyes. In the absence of the kind of life she and the members of her family lead, "everything is a bit worse because you've got no interest to take it off". Consequently, a cold becomes flu and a headache becomes a migraine. Mrs. F. sees health and illness as responses to disorders of various kinds with motivation playing an important part in determining how a person will respond. To a certain extent then illness as a response to problematic experiences may be seen to lie within a person's control except in extreme cases such as the

instance she quotes with regard to actors who "can't afford to be ill because they're too busy and too involved .... unless they're really struck down with some dreadful virus, you know". Hence, Mrs. F's disappointment over her mother who could be more active and independent "if only" she possessed the appropriate motives and interests.

In these accounts illness and motivation are linked in several ways. Firstly, a lack of motivation to lead a normal life can produce the problems that form the basis for the adoption of the status ill; secondly, a lack of interests and motivation to maintain those interests can lead an individual to organise disorders which have their origins elsewhere as illness and thirdly, claims to illness may be motivated by anticipated gains. The case of Mrs. G. and her grandmother illustrate the first and third of these, while Mrs. F. and her mother illustrate the second.

The motivated manipulation of definitions of illness

It is a major thesis of this chapter that where a definition of illness is applied the assumption is that some underlying disorder is present and potentially identifiable. The mere presence of such disorder is not, however, usually sufficient for someone to be defined as ill. Rather, illness is conceived of as certain typical behaviours directly attributable to an underlying disorder. A definition of illness may be denied because these typical behaviours are not seen to follow or be reasonably absent, or because no underlying disorder can be found to account for these behaviours.

Where claims to be disordered or ill are denied, explanations of those claims are, as I have mentioned, frequently formulated in terms of motives and anticipated gains. Mrs. G's grandmother was seen to define herself as ill because she wanted sympathy. Conversely, as was also illustrated by this case, denials of illness may also be manipulative, attempts on the part of others to avoid responsibility for the sick. The ambiguity to which such claims are subject provides others with these interpretive and manipulative opportunities.

Claims to be symptomatic or ill may, then, be subject to a variety of interpretations. They may be accorded factual status or they may be seen to have other origins which renders those claims suspect. Even where conditions exist which could account for the claim legitimacy is not necessarily conferred. In these next two extracts I present more detailed data to show how various claims come to be seen as manipulative by the location of motives. In the first Mrs. N. describes how conditions existed which account for her daughter's claim to be in pain and indicates how the link between those conditions, and attributing factual status to the claim, is mediated by certain inferences. These inferences are used to provide for Mrs. N's subsequent actions and those of her daughter:

N3 Int.: I remember that you told me that you and your husband occasionally get backaches, have you had any ....?

Mrs. N.: My younger daughter had terrible backache. I had her down at the doctor for that.

Int.: Could you just tell me a little bit about what happened with that?

Mrs. N.: Well, she was lying around on the floor and her back got locked and she was in terrible pain and couldn't straighten up. We were going to take her to see an osteopath but what happened was I took her down to see Dr. M. after a week or so because she said it was going up into her neck and he said that she'd sprained

a ligament in her back and fortunately it's cleared up and we haven't had any complaints.

Int.: Did she find that the pain in her back meant she had to have any time off school?

Mrs. N.: No .... but erm, she didn't do any PE but the doctor said she could have done, it just suited her not to.

Int.: And it was about a week since she had er the before the pain first came before you went to Dr. M.?

Mrs. N.: Oh I let her have it a bit longer than that because I thought she was having me on a bit.

Int.: Really?

Mrs. N.: Mm .... then when she mentioned her neck I thought I'd better have her seen to.

Int.: And did Dr. M. prescribe any treatment for her?

Mrs. N.: None whatsoever. He just said if it doesn't get any better come back in a fortnight .... well, obviously within the fortnight there was nothing left.

Int.: And she's had no complaints with her back since then?

Mrs. N.: Oh well, usually when it suits her it becomes bad again, you know what I mean?

Although Mrs. N. does say that her daughter "locked her back" and was "in terrible pain and couldn't straighten up", this was not her original interpretation of the event. She did not take her daughter to the doctor for more than a week "because I thought she was having me on a bit". That is, the claim to be in pain was taken to be an exaggeration and not a true description. While no reason is given in this extract for that interpretation, Mrs. N. did talk later on how her daughter was "going through that awkward phase" and it was certainly the case that they argued quite ferociously while I was there conducting the interviewing. While this interpretation is a justification of the delay in seeking treatment for her daughter it also provides for Mrs. N's strategy for handling the situation. She adopts a wait and see attitude, "I let her have it a bit longer", assuming that her daughter

would not persist with a claim that was not genuine. It was only when she began to complain that the pain was spreading up into her neck that this interpretation was revised and Mrs. N. says "I thought I'd better have her seen to". Despite the fact that the doctor did diagnose a disorder, a sprained ligament in her back, Mrs. N's original depiction is not to be seen as wholly unreasonable. Subsequent events demonstrate that her daughter is the type of person to indulge in manipulative claims of that kind. Though the sprained ligament was nothing serious, it required no treatment and had "obviously" cleared up within the fortnight the doctor established as the period required before another consultation was necessary, Mrs. N's daughter used the legitimation of her complaint for her own ends. For example, she avoided doing PE at school because "it suited her not to" even though this was not contraindicated by the doctor. She also invoked the definition of herself as injured and in pain on those occasions when it could be used in pursuing her own ends, "when it suits her, it becomes bad again". Mrs. N. does not see her daugher's subsequent behaviour as the unavoidable consequences of an organic disorder, rather, she uses the doctor's definition of the situation to show that it was wilfully undertaken for her own benefit. In McHugh's terms, the behaviour is conventional. It is also theoretic since Mrs. N's daughter is clearly assumed to be aware of what she is doing. In seeing these actions as inappropriate Mrs. N. provides for a view of them as deviant and morally reprehensible.

In the final extract, Mrs. S. describes how, in concert with the doctor she was able to arrive at a depiction of a problem with her three year old daughter's right foot. Again, the way in which the problem is depicted provides for Mrs. S's subsequent action. It is also the reason for her reluctance to talk about the problem since her daughter was present in the room during the interview:

S8 Mrs. S.: I did go to the doctor's, I knew there was something, I've been for Joanne, yes. I should think it's quite important. She started walking with her foot turned in, her right foot .... so I was getting a bit worried about that so I took her up to Dr. M. and he said there was nothing wrong it was perfectly normal .... mustn't talk about it now .... said it was just to do with Michael ...

Int.: Yes.

Mrs. S.: .... you know, everybody taking a lot of notice of him when we go out and all the rest of it, so he said just ignore it and it's been fine ever since.

Int.: You just noticed that did you?

Mrs. S.: Er, yes, yes, she was you know very .... I'm not supposed to talk about it in front of her but ....

Int.: That's alright.

Mrs. S.: in case it starts again then you know if she thinks you're noticing it.

Int.: It's gone now?

Mrs. S.: Mm, hasn't had it for ages. It's just the right one. You know, it's been awfully bad, looked dreadful, everybody was noticing it and talking about it so we had to ....

Int.: So it was more than you noticed it?

Mrs. S.: Yes, yes I knew, we never used to talk about it because we had a feeling it might be this and er Dr. M. said it was. He said he's had this problem before so he said that probably this is the reason. Cus it's perfectly normal, nothing wrong with it at all.

When Joanne started walking with her foot turned in Mrs. S. was able to formulate an explanation which was subsequently confirmed by the doctor. His diagnosis that the foot was "perfectly normal" legitimates her view that the problem has its origin in a realm other than the biological. The doctor and Mrs. S. draw on their knowledge of the family situation and commonsense assumptions about typical modes of childhood behaviour to construct their account of the event. An important feature of the family context in which this behaviour occurred

is that Joanne's ten year old brother, Michael, is severely disabled. He could not walk and was confined to a wheelchair, was incontinent and unable to talk. Consequently, much of Mrs. S's efforts revolved around Michael and what she identified as his special needs. It would also seem that he was the focus of attention for others; as Mrs. S. puts it, "everybody taking a lot of notice of him when we go out and all the rest of it". Seen in this context Joanne's walking behaviour is to be interpreted as attention seeking, an attempt on her part to present herself as similar to Michael so that she will receive the same in the way of notice. This explanation is not in fact explicit in Mrs. S's description. She presents a shorthand version, "it's just to do with Michael", which she expects will be elaborated by reference to a shared stock of knowledge about her family and children in general. Though attention seeking is not mentioned by Mrs. S. there is no difficulty in seeing this as a reasonable explanation since aberrant behaviour on the part of small children and those other social incompetents, the mentally subnormal, is frequently so depicted. Without reference to this body of knowledge Mrs. S's account would be incomprehensible.

This explanation of Joanne's behaviour suggests its own remedy. That is, Mrs. S. is to ignore it. Her reluctance to talk to me about it while Joanne was in the room stemmed from her attempt to follow the doctor's advice. Her action, however, presupposes further knowledge about the basis for children's behaviour. She clearly draws on a theory of behaviour reinforcement to make sense of what she has been advised to do. "I'm not supposed to talk about it in front of her .... in case it starts again then you know if she thinks you're noticing it". This theory is often presented to young mothers who are advised to ignore a baby's crying. Since crying is attention seeking once the baby learns

that it can successfully command attention by this method it will cry all the more. A professionalised version of this theory has recently been employed in the institutional management of the mentally handicapped[28].

What is surprising about this account is that it imputes an intent to manipulate the definition of a situation to a three year old child. As I have pointed out, children are not usually regarded as so competent. For example, Atkinson describes the case of a thirteen year old boy found hanged at home in which suicide was not imputed as he was not considered old enough to formulate an intent to kill himself[29]. Attention seeking as a category of behaviour seems to constitute a special case in which incompetents may be seen to be motivated by a desire to achieve certain ends but cannot be judged to know what they are doing. While the moral status of such behaviour may be problematic the imputation of such a category constitutes grounds for refusing to treat such behaviour seriously.

Mental illness and motivation: A case study

While issues of motivation and responsibility are relevant in imputing illness to individuals with various physical conditions they take on even greater significance when the condition under consideration is "mental". The reason for this lies in the nature of the manifestations of what is referred to as mental illness. The experiences which come to be defined as the signs and symptoms of mental disorder are behavioural and emotional, entities usually regarded as being within an individual's control. The ascription of mental illness as opposed to malingering may, then, depend upon whether forces external to the individual can be found to account for any observed behavioural or

emotional aberration. The data that I have, though limited in some respects, would suggest that where no such cause can be identified the problem of motivation and responsibility becomes prominent.

During the year in which I conducted the interviews the husbands of Mrs. R. and Mrs. P. were or became depressed. As I have already mentioned in passing, Mr. R. was eventually treated as a psychiatric in-patient and subsequently attended group therapy sessions, while Mr. P., whose depression was a reoccurrence of a former state, refused to seek professional help.

One important feature of disorders of this sort is that emotional disturbances are seen to occur in the absence of any antecedent event that might explain them:

R9 Int.: And how is he now?

Mrs. R.: Erm, he's better than he was, definitely better. He still has his bad times, it's still a bit erratic .... you know, he can still get very agitated about nothing or depressed about nothing.

As Mrs. R. says in the above exchange, her husband gets depressed or agitated "about nothing". Similarly, as Mrs. P. said of her husband, "the children couldn't understand why Daddy was so cross, so irritable and would shout at them for no apparent reason". That no immediate reason can be identified for these emotional difficulties opens up the possibility of a definition of mental illness. If depression, irritability or agitation were to follow life events such as loss of job, working too hard or death of a relative they may be seen as normal reactions to the problems that people face from time to time. (This will be illustrated in the next chapter.) If an explanation cannot be formulated in terms such as these then an answer is required to the

question, 'Why does X get depressed for no reason?' The crucial difference in these two cases is that Mrs. P. was able to find an answer to this question and identify an underlying cause while Mrs. R. was not. As I will describe in more detail in the next chapter, Mrs. P. accounted for her husband's problem as a product of childhood experiences and familial relations. By contrast, Mrs. R., despite extensive and elaborate causal theorising was unable to see the sense of it and locate an underlying order(30). As she said at various points in the interview, "I think, why the hell are you depressed, there's nothing to be depressed about", and "you haven't got any real deep problems so why don't you forget about whatever it is and carry on living". Although Mrs. R. does recognise that responses of this kind are unreasonable, her inability to supply a cause, to create order, leaves her in something of a dilemma. Despite the fact that she does accept that her husband is ill, an ambiguity remains that was not completely resolved by the time I had completed the interviewing. Mrs. P., however, evidences no such ambiguity, she expressed nothing but worry and concern and a desire to get her husband into treatment.

Mrs. R's dilemma, and its consequences for the way in which she reacts to her husband's problems is illustrated in the next extract:

R10 Int.: And when he gets these bouts of depression do you have to treat him in a special way?

Mrs. R.: I don't know, I find this a very difficult one to answer, it's one the psychiatrist asked me and again I .... he asked me how did I react and I said I couldn't really answer, he, he got a little impatient with me because he felt I should be able to answer and I said I found it difficult to judge myself how I react.

Int.: Is that because you react spontaneously in a way without necessarily ....?

Mrs. R.: Well, I don't always react the same way you see he asked me am I tolerant when he's depressed and the answer is yes sometimes I am and other times no I'm not, you know sometimes I get fed up and I get irritable with it and I think well why the hell are you depressed there's nothing to be depressed about which I know is unreasonable because I know it's an illness although I think I have been less so since he's been in hospital and I think I have understood a little bit better what it's like because I've seen so many others there as well you see and eventually although one realises it's an illness and that the persons not doing it deliberately you know this intellectually it's sometimes difficult to accept it emotionally and therefore my reactions are not always the same, they do differ.

While on the one hand Mrs. R. defines her husband's condition as an illness, that is, as something for which he is not responsible, "one realises that it's an illness and the person's not doing it deliberately", on the other hand there are times when she gets "fed up" and "irritable" because she can see no reason for her husband's emotional state. Then, she finds it difficult to accept that her husband is in some ways not responsible for his situation. The ambiguity exists because of the gap between what she knows intellectually and what she can accept emotionally. This split between her intellect and her emotions accounts for her varying reaction to her husband; sometimes she is tolerant and sometimes she is not, sometimes she is able to accept that he is ill and to respond accordingly and sometimes she is not. As I indicated in the analysis of G7 sympathy and tolerance are only appropriate when someone is seen as genuinely ill.

Mrs. R. enlarged on some of these points in a later interview when I asked her how other people were responding to her husband's depression:

R11 Int.: How are you finding the response of other people to his problems, I remember you saying when we talked last time about how it's one of those things that people didn't seem to want to mention and didn't seem to want to know about ....?

Mrs. R.: I think a couple of people I happen to speak to or I happen to meet who .... they know but I know that they know that he's been ill have spoken a little, well, asked how is he and how's he getting on .... erm, but I suppose really basically I think, I think that if people haven't had direct experience simply don't understand, you know, I think the general attitude is oh somebody's depressed well he should pull himself together and go to the cinema or go to a party what have you and cheer up and I think this is very prevalent until you really .... because this was my attitude at the beginning, you know, you haven't got any real deep problems so why don't you forget about whatever it is and carry on living .... it's difficult to understand this seems to be outside the person's control .... that for no reason that anybody else can understand or even that they can understand they just get very depressed .... I mean he doesn't know himself why he gets depressed at all, no obvious or logical reason, so you know people don't understand. I don't expect them to because I found it difficult.

Mrs. R. sees the general attitude to depression as being similar to her own initial response. That is, emotional problems of this kind are things for which a person can be held responsible and can be expected to effect a remedy by their own efforts; "somebody's depressed well he should pull himself together .... and cheer up". Again, the absence of a cause is invoked by Mrs. R. to explain this initial reaction of hers. However, those who hold this attitude are not to be condemned since it is something that Mrs. R., on the basis of her own experience, expects. If people "haven't had direct experience" they don't understand, nor can they be expected to understand. Mrs. R. herself found it difficult to accept that "this seems to be outside the person's control" and as I have shown, still reacts to her husband on some occasions as though this were not the case. In arguing in this way,

Mrs. R. not only provides an explanation of the general attitude, she also legitimates her own problem in coming to terms with her husband's situation and her occasional denial that he is ill. Obviously, anyone, until they have had experience of these matters would find it difficult to cope.

At the end of this exchange Mrs. R. encapsulates the cognitive problem with which she and others are faced. Not only is she unable to find or be supplied with a cause to explain her husband's depression there is no cause to be found, "that for no reason that anybody else can understand or even that they can understand they just get very depressed". The contradiction that arises is that making sense of what is going on involves accepting that no sense is to be made of it, even though in most cultures and Western scientised cultures in particular it is anticipated that explanations can ultimately be found for all the phenomena with which members of a society are presented.

One important factor in influencing Mrs. R's view of her husband and his problem was the period of time he spent as an in-patient in a psychiatric hospital. She also saw this as bringing about a dramatic improvement in his condition not so far achieved by psychiatric consultations and drugs:

R12 Int.: What was it about the in-patient treatment do you think that was the most helpful to him? I mean you seem to think that if there was any dramatic improvement it was that that did it.

Mrs. R.: It was then .... it was then .... I think there were two things I think first of all the fact of just being removed from everything .... erm a sort of sanctuary that's how my husband put it and also I think the fact that going into hospital he was able to say well yes I am ill because with this kind of thing I mean he said half the time he wondered was there really something wrong with him or was he just malingering or erm dramatising whatever he felt and

> the psychiatrist understood this very well when he said to him I think it's best if you do go in then you will acknowledge yourself to be ill. Once having been in this was a very definite statement he is ill.

Going into hospital was for Mr. R., and I have no doubt for Mrs. R., a powerful legitimator that his condition was really an illness. It enabled the alternatives, that he was just malingering or dramatising to be rejected. These are, as I have indicated, always possibilities "with this kind of thing" since the issue of responsibility is not unequivocal. Though having hospital treatment constituted " a very definite statement" that Mr. R. was ill and allowed Mrs. R. to begin to see it in those terms, it did not entirely resolve the ambiguity with which she is faced. As she said at the last interview, "I do get impatient sometimes, I just feel so weary with it, I just feel oh for God's sake when's this going to end even though I know logically he can't help it I still get like that".

Professional definitions may, then, only partially legitimate self-definitions. What is also of interest in this extract is that going into hospital and needing hospital treatment are assumed to be the ultimate indicators that a person is genuinely ill. The psychiatrist expects that Mr. R. will use this assumption as a resource in arriving at a definition of his situation.

Although Mrs. R. attributed the change in her attitude to her husband's problem to "direct experience" and "seeing so many others in hospital", she had in fact known of or had contact with other people who had been or were depressed or had had breakdowns. At the end of the interview from which fragment R12 was taken we discussed several such cases from among her relatives and acquaintances. In one case I was able to raise the issue of willpower:

R13 Mrs. R.: One woman I know, I mean she didn't have a breakdown I mean that would be she got as far as seeing the psychiatrist and she saw him I don't know twice, three times, and one day she said she got up and she took all the tablets and put them in the bin and thought right, that's the end of all this rubbish and she was fine.

Int.: Really?

Mrs. R.: Yes, she was living on I don't know Librium and Valium and heaven knows what and she thought what is all, why am I taking all this rubbish and she just threw it away.

Int.: It just took a bit of willpower and er ....?

Mrs. R.: Yes, yes .... but then she wasn't very bad to begin with although she was depressed and she wasn't herself she didn't get to the stage where my husband, you know, my husband got to where he just couldn't go to work any more and he couldn't face people and he couldn't answer the telephone and this kind of thing, she never got to that stage.

The woman discussed above is seen to be able to take control of her situation and, in effect, to decide to be well. Mrs. R. accepts my formulation that all it took was a bit of willpower. However, she denies the relevance of this case for her husband's problem by demonstrating important differences between the two; "she wasn't very bad to begin with" and "she didn't get to the stage where my husband got to". The severity of Mr. R's depression means that he cannot be expected to get better by taking a similar course of action. Though on occasions problems of this sort may be brought under a person's own control and resolved by an act of will this does not define a universal rule applicable to all cases.

Because the attribution of responsibility or motivation means that sympathy and support may be withdrawn and some form of moral condemnation applied it is in the interests of the individual concerned to refute such attributions when they arise. Mr. and Mrs. R. were able to use Mr. R's admission to hospital and the legitimacy it conferred

on his illness to challenge the view that he was in any way responsible for his condition. At times Mrs. R. reacted angrily to suggestions that her husband was responsible for his depression. Commenting on the fact that her parents-in-law wanted their son's admission to hospital to be kept a secret she said:

R14 Mrs. R.: I got cross once or twice I said he hasn't committed any crime, he hasn't done anything shameful, I just don't see why it should be like this.

As she went on to say, someone admitted to hospital with a heart attack would receive nothing but sympathy and interest from others, "you know, people running round with flowers"(31). Here, Mrs. R. takes her in-laws' desire for secrecy as evidence of the attribution of moral blame.

Mrs. S. was also very indignant when it was suggested that she could avoid the pulled muscles she incurred when lifting her handicapped son. "It's not the way I lift him, everybody says if you lift him right but they haven't tried to lift him". In claiming that this criticism is offered by people who are not qualified to judge because of a lack of experience she is able to dismiss the idea that she is in any way responsible for these problems. They are not the product of the way she lifts him but arise because he was so heavy: "I'm only four foot ten and lifting him is quite a hard job, he's a dead weight". Consequently, she expected them to happen and was prepared to put up with them.

Conclusions and implications

In this chapter I have attempted to describe some features of respondent talk about illness which figure in the practical reasoning involved in constructing definitions of health and illness. I have given some attention to the way in which claims to illness are handled,

focussing on denials of those claims where, I would maintain, the practical reasoning involved in the construction of a definition of the situation is usually more explicit. It is not suggested, however, that any of the features I have described are in any way necessary to the definition of illness, or inevitably point to a definition of illness. They do not constitute a set of rules to which an event must comply before it can be defined as illness. Rather, they are the rules used by the respondents I interviewed for constructing definitions of illness in the context of what was presented to them as a research interview. Situations were thus analysed by them according to a variety of taken for granted assumptions about appropriate behaviour, biographies, types of persons and the sorts of motives that inform their conduct.

Much of the interview talk that I collected consists of ad hoc theorising directed towards demonstrating a sense of order in response to the questions that I asked. Though methodical, it does not have the organised character of the categorisation activities of the coroners described by Atkinson(32). Organising deaths as suicides requires an active and public search for evidence of intent. The coroner is subsequently held accountable for the category imputed. The accounts given by my respondents were not designed to pursue such a specific ends; they are descriptions of events and not explicit attempts to locate evidence on which to base particular depictions of those events. The accounts given by my respondents also have little consequence outside the context of the interview. As a result they may be contradictory or loosely organised since the context does not impose any constraint on theorising. The health centre participants interviewed by Beales, for example, were able to find the spatial organisation of the

health centre as a reason for the increased interaction between staff and as an explanation for the decreased interaction among staff since the move from the former premises. Common-sense theorising may be as flexible as the need to demonstrate order requires(33).

In the cognitive construction of illness it is possible to discern two analytically separate though empirically inter-related processes. Firstly, the use of interpretive procedures and secondly, the use of common-sense knowledge of persons and illness. The former constitutes the logic of practical reasoning and is generalisable across contexts, the latter a scheme of typifications applicable to a substantive topic. These processes are implicit in respondent talk; the assumption is that a culturally competent member will use them as resources in making sense of talk. They are usually only made explicit when this assumption is breached. Much of the talk then proceeds by the way of indicators which are taken to be the surface appearances of an underlying order. At the same time information is presented which it is expected will be used in concert with common-sense knowledge as an interpretive scheme to discover what the indicator signifies. For example, the identification of a disorder or the recognition of illness relevant behaviours is not always sufficient for the imputation of illness. Other facts are introduced to provide a context for the interpretation of disorders and behaviours, typically biographies. However, these only function as an interpretive scheme if they are elaborated by a hearer by reference to commonsense knowledge. In this way an interpretive procedure and knowledge of the typical structure of the world are combined in the process of drawing reasonable conclusions about given events.

The common-sense knowledge that it is expected that the interviewer and respondent share and employ in reaching conclusions has much in common with Parsons' description of sick role expectations. This does not mean that Parsons' analysis of the sick role has any validity. Rather, it supports an earlier assessment of sick role theory which identified the expectations pertaining to the sick role as a common-sense construct located somewhat unsuccessfully within a social systems analysis of illness. Various aspects of this construct were used by the respondents I interviewed as a resource for ascribing illness or otherwise ordering observable events or states of affairs. This would cast doubt on the characterisation of Parsons' system of expectations as solely a professional typification of how sick individuals ought to behave(34). For it forms part of some lay theorising about illness. This theorising is used to constitute illness as a social phenomenon and to demonstrate the legitimacy of the definitions applied.

The definitions the respondents present are a negotiated product of the interaction between interviewer and interviewed. Not only does the respondent assume that the interviewer has available a shared stock of knowledge, the interviewer draws on that knowledge in formulating and asking questions. Questions such as "Does X stay in bed?" and "Did X consult a doctor?" presuppose the very same common-sense conception of illness that it is the analytic task to describe. Negotiation also occurs at those points in the interview where the interviewer selects topics for further probing and where he is called upon to formulate what the respondent means. This latter in particular may be taken as evidence of bad interviewing, especially in those methodological circles which assume that it is possible to present each respondent with the same stimulus such that the meanings of the responses are not problem-

atic. Here, following Cicourel, they are taken to be essential features of interviewing and all other forms of social interaction. Without them social situations could not be maintained(35).

Two other major points emerge from the foregoing analysis, the issues of ambiguity and morality. The meaning of any event or situation is, as I have shown, frequently ambiguous and often cannot be determined from observing the event or situation alone. Hence, the general interpretive procedure of locating such events and situations within an interpretive context. Thus, judgements about the meaning of events are made by seeing them in concert with other events so that an underlying pattern may be identified. Moreover, those judgements are essentially moral judgements. As Douglas says:

> "All common-sense descriptions and explanations of social action implicitly assume some kind of evaluation and some social response, at least that of approval or disapproval."(36)

Illness is a moral category because it is an explanation of a state of affairs, usually behaviours, and is therefore an evaluation. It involves judgements about what is desirable or undesirable and about what is appropriate conduct for a given social status. Moreover, it is a moral category because it involves judgements about responsibility. Again, as Douglas puts it, "it must be possible for an individual to have chosen to do other than he did do or there can be no moral responsibility"(37). As I have shown, a definition of illness implies that potentially socially disruptive behaviour such as staying in bed or requiring social and economic support from others are unavoidable and outside the individual's control. The label illness thus removes behaviour from the realm of moral judgements because the individual is not to be held responsible. Paradoxically, illness is a moral category

because it does away with morals. As Friedson has shown, imputed responsibility may be an important factor in the social response to illness. Hence, the tendency on the part of some to redefine what was once conceived of as deviance as illness, an aspect of what Zola has referred to as the medicalisation of society[29] and Friedson has seen as the result of the moral entrepreneurial activity of the medical profession[30]. Recently, however, social policy developments are increasingly adopting the view that health and illness do fall within the control of the individual since many of the major contemporary diseases are seen to be the consequence of behaviours which are wilfully undertaken[40]. The historical tendency may be one in which disease and illness come to be defined as deviant.

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3. Field, D., The Social Construction of Illness, in Tuckett, D., Introduction to Medical Sociology, Tavistock, London, 1976.

4. This can only be verified by the study of those contexts.

5. Coulter, J., Approaches to Insanity, Martin Robertson, London, 1974, p. 114.

6. Coulter, J., Perceptual Accounts and Interpretive Asymmetries, Sociology, 9, 1975, footnote p. 396.

7. Given the problems posed by ascertaining the validity of this type of information its factual status is often taken for granted.

8. Scott, M. and Lyman, S., Accounts, American Sociological Review, 33, 1968, pp. 46-62.

9. Taylor, L., The Significance and Interpretation of Replies to Motivational Questions: The Case of Sex Offenders, Sociology, 6, 1972, pp. 23-39.

10. Dingwall, R., Aspects of Illness, Martin Robertson, London, 1976, p. 62.

11. Labov describes this connection as a sequencing rule. See Rules for Ritual Insults in Sudnow, D., (ed.), Studies in Social Interaction, Free Press, New York, 1972.

12. Cicourel, A., The Social Organisation of Juvenile Justice, Wiley, New York, 1968, p.10.

13. See Chapter 5 where this issue is dealt with in some detail.

14. For example, such behaviour may result in a child being characterised as "naughty" or "aggressive".

15. The W.H.O. definition of health states that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

16. Turner, R., The Self Conception in Social Interaction, in Gergen, K. and Gordon, J., (eds.), The Self in Social Interaction, Wiley, New York, 1968, pp. 93-105.

17. Dingwall, R., Aspects of Illness, op cit, pp. 67-76.

18. It is interesting to speculate to what extent the nature of the disorder described necessitates this more elaborate rationale. Is it the case that common-sense knowledge about sciatica is not in itself adequate to justify its depiction as illness? Would diagnostic categories such as pneumonia or cancer have required this degree of elaboration? That is, can persons with these types of disorders be assumed to be ill irrespective of their actions and biographies? Answers to these type of questions cannot be explored to any great extent by means of interview data simply because the degree to which any account is elaborated is partially a product of the interviewer's questioning. However, there is a point in an interview where questions about the respondent's common-sense observations can no longer be made without threatening the interviewer's status as competent member. While it may be justifiable to ask 'Do you consider someone with sciatica to be ill?' a question such as 'Do you consider someone with cancer to be ill?' is likely to violate common-sense assumptions. Consequently, it is tempting to assert that there is a relationship between the nature of the condition described and the extent to which a justification of the imputation of illness can be legitimately demanded. Smith has also suggested that more complex rationales are required to support a definition of mental illness where the behaviours upon which the definition is based could be subject to alternative interpretations. See Smith, D.E., "K" is Mentally Ill: The Anatomy of a Factual Account, Sociology, 12, 1978, pp. 23-53.

19. Garfinkel, H., Studies in Ethnomethodology, Prentice Hall, New Jersey, 1967.

20. At the same time grounds exist within the respondent's account for finding the impuation of illness challengeable. For the respondent does say that during the period of absence from work her father did have "quite a good time". My question "Was he not confined to bed or anything?" is oriented to a potential contradiction between "being ill" and "having a good time". Illness and pleasurable activities are incompatible. The respondent, however, is able to see this as a consequence of a specific point of view on his part. Having legitimately been given time off work he adopts the attitude that he might as well make the most of those days on which he did not need to stay in bed. By locating his having a good time in his period of convalescence, it was only "towards the end of the week", the respondent is able to manage the possible challenge to her characterisation of him as genuinely ill. His actions are, then, reasonable in context.

21. The use of biography as context is elaborated more fully in Chapter 5.

22. Kassebaum, G. and Baumann, B., Dimensions of the Sick Role in Chronic Illness, Journal of Health and Social Behaviour, 16, 1965, pp. 16-27.

23. Gordon, G., Role Theory and Illness, College and University Press, 1966.

24. This is derived from Sudnow's concept of normal crimes. See Chapter 5.

25. Claims to be ill, like the communicative cues described in the next chapter, may refer to experiences not observable by others. This absence of objective verification may be used to cast doubt on a particular claim.

26. That illness does involve a responsibility on the part of others was often referred to by the respondents. It can be seen in the following data fragment:

> Int.: Now your husband seems to have been unwell ....
>
> Mrs. P.: Oh, yes, he was .... erm, we went down to Reading on the Sunday and really he shouldn't have gone, he wasn't at all well. In fact, his mother's been so unwell we felt we had to go and see her. That morning he woke up and said my chest does feel tight and uncomfortable and he started to cough and I thought, hello, you know, this is it sort of thing, that tight nasty cough, but as I say we went down anyway.

Here Mrs. P. asserts that she and her husband felt obliged to go and see his mother who had been unwell. "We felt we had to go and see her" even though this was obviously contrary to his own interests, "he shouldn't have gone, he wasn't at all well". Mrs. R. described how a friend, apparently afraid of breaching the conspiracy of silence, had initially been unsure of whether to telephone Mrs. R. after Mr. R. had been admitted as a psychiatric in-patient. Mrs. R. reports her friend as saying, "I thought, hang it all, if he's ill he's ill and I must phone".

27. McHugh, P., A Common-sense Conception of Deviance, in Drietzel, P., Recent Sociology, No.2, Collier-MacMillan, London, 1970.

28. Here, "appropriate" behaviour is "rewarded" and therefore reinforced by staff attention whereas destructive or aggressive behaviour, previously the object of such attention is to be ignored.

29. Atkinson, J. M., Discovering Suicide: Studies in the Social Organisation of Sudden Death, MacMillan Press, London, 1978.

30. Paradoxically, getting depressed for "no apparent reason" is an indicator of mental illness when an underlying cause can be identified. If no such cause can be identified the possibility of malingering may be entertained.

31. Despite her not expecting others to understand the problem of mental illness Mrs. R. was annoyed and confused by the conspiracy of silence which she perceived to surround the issue. As she said at one interview, "Why should it be like this?"

32. Atkinson, J. M., Discovering Suicide, op cit.

33. Beales, G., Social Relationships Among Health Centre Participants, in Stacey, M., (ed.), The Sociology of the NHS, Sociological Review Monograph, No.22.

34. Bloor, M. and Horobin, G., Conflict and Conflict Resolutions in Doctor-Patient Interactions, in Cox, C. and Meade, A., (eds.), A Sociology of Medical Practice, Collier-MacMillan, London, 1975.

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36. Douglas, J., American Social Order, Free Press, New York, 1971, p. 153.

37. Douglas, J., ibid, p. 153.

38. Zola, I., Medicine as an Institution of Social Control, The Sociological Review, 20, 1972, pp. 487-495.

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40. See the recent document, Prevention and Health: Everybody's Business, D.H.S.S., 1976.

CHAPTER 5

RECOGNISING DISORDER, LOCATING CAUSE AND ASSIGNING SIGNIFICANCE

In the last chapter I looked at the practical reasoning involved in the construction of definitions of health and illness. While I identified some of the rules employed in the imputation of these categories it is by no means the case that I described all the rules which members may employ. Nor is it the case that the women I interviewed used all the rules I identified on any occasion when definitions of health and illness were offered. Rather, features such as behaviours, biographies, motives and responsibility deemed relevant to the categorisation process were selectively invoked. Thus, componential analysis, recently recommended as the methodological way forward for the sociology of illness[1] misses an essential point. In aiming for descriptions of the features of an object to which a given name applies it fails to take account of the way in which such features are selectively employed in the interpretive work that constitutes things as social objects. It also assumes that the name applied to any particular object, indexing a collection of features, means exactly the same thing every time it is used. However, as the ethnomethodologists have pointed out, names and rules do not have a stable meaning but are constantly elaborated to fit the objects or events to which they are applied. The features of an object may be selectively invoked or elaborated to justify the application of a name to an object. Bloor has recently demonstrated how the abstract rules E.N.T. consultants used in deciding which cases to refer for surgery were elaborated by individual consultants to deal with the cases with which they were presented. Hence, the general lack of agreement between consultants as to the appropriate way of disposing of any case[2].

In this chapter I want to look at other problems which may figure in what I have termed a management sequence. I call this a sequence, not because I conceive of it as a kind of career, but because the events I assume it embodies exist in a temporal relationship. That is, some departure from a state considered to be usual or normal functioning must be noticed, subject to interpretive work so that it may be recognised as a disorder and defined as a disorder of a particular kind, prior to action to resolve it. This interpretive work may be successful or unsuccessful. An individual may or may not be able to make sense of an experience in the light of the knowledge available to him. He may not be sure that a given experience does in fact count as a disorder or normality, and if the former, he may not be able to make sense of it because it cannot be identified as a member of a known schema of things. Action, undertaken on the basis of the recognition of some disorder, may be as much directed towards identifying the nature of the disorder as seeking its resolution. Where an individual's knowledge is inadequate to make an experience consistent with a familiar world then he may resort to consulting others, including professional problem solvers who may offer solutions to the cognitive and practical problems with which the individual is faced. The importance of finding a solution to the cognitive problem is graphically illustrated by the case of Mrs. R. and her husband's depression, described in the last chapter. The apparent failure of any of the professionals with whom she came in contact, the GP and the psychiatrist, to offer her a causal theory of her husband's depression made it difficult to reconcile it with a known order of things. Cunningham has also documented the problems faced by MS sufferers prior to being offered a diagnosis which would enable them to make sense of their symptoms and organise an appropriate response. Such is the significance of a diagnosis that the majority remained angry over what they

identified as an unjustifiable delay in providing a label for their disorder(3).

This was also illustrated by Burton's study of families with chronically sick children(4). Many of the mothers of the children she studied had noticed a discrepancy between their baby's progress and what they assumed to be normal development. However, it was often many months before they finally acquired a diagnostic label for the child's condition despite consultations with their doctor and demands for paediatric referral. As one respondent said, "That was the worst time of the lot, knowing there was something wrong and not knowing what". The study also illustrates that answers to two questions have to be found to achieve a sense of order. The first, 'What is wrong?' was answered by the diagnosis of cystic fibrosis. The second, 'Why has it happened to us?' frequently went unanswered. Since cystic fibrosis is an inherited disease many of the parents felt a sense of responsibility and regarded it as a punishment for something they had done. Others explained it as a chance occurrence or 'one of those things' which on some occasions brought into question the meaning of life itself. Scientific medicine, while able to provide a diagnostic label to confirm the parents' interpretation that something was wrong was apparently unable to assist in finding an answer to the 'why us?' question. This may be contrasted with cognitive systems such as that of the Azande where all misfortune for which a reason cannot be found may be explained by witchcraft, as the product of some malevolent human agency. Accident as a category of explanation is unknown. Thus, a damaged foot may be attributed to stepping on a sharp stone, but some human agency will be seen to be responsible for that stone being in that particular position at that particular time(5).

It can also be illustrated by some of the data that I collected. One particularly graphic example was the case of Mrs. S. and her breathing problem. Mrs. S., as I have mentioned, was the mother of a disabled child. She had told me at the first interview of some of the problems she faced: "If I ever go to the doctor's it's my nerves, having Michael, you know." At the third interview she elaborated on this while describing a problem she had been having with her breathing:

S2.1 Mrs. S.: Well, I had to go to the doctor's cus I .... oh, yes that's what you want to know about probably, more than anything .... nerves, this is me. I went oh for about two weeks, I think about two, it was before Christmas I couldn't get my breath properly, you know, I was gasping for breath, it was a most horrible feeling. I've still got it and erm at least I know what it is now, it's not so bad, and erm I thought at first it didn't bother me too much and it gradually got worse so I thought I'd better go and see the doctor. I'd no idea what it was. Anyway, he took my blood pressure, that was alright, my heart was fine, so he said what he thought it was just nerves, you know, just a bad attack of bad nerves as he phrased it. So he just gave me some tablets and I took those which really didn't make any difference but at least I felt better because I knew what it was. You know, I mean I think you worry far more if you think it might be your heart or something like that, than if you do nerves, at least I do. I mean you might say well why have I got nerves, but I think it's because of having a handicapped child, you know.

Here, and in later exchanges, Mrs. S. says she was very worried about this breathing problem and went to the doctor after it had got gradually worse over a period of two weeks. The doctor's diagnosis not only labelled her experience but allowed her to make sense of it in terms of her biography as the mother of a handicapped child. For Mrs. S. suffering with her nerves was part of the routine order of things. She had had a variety of problems in the past and expected

that these would continue in the future and she would continue to be able to cope with them when they arose. Defining the breathing problem as a manifestation of her bad nerves not only ruled out a series of alternatives, "your heart or something like that", it routinised it as something a person in her life situation might reasonably expect. The diagnosis of bad nerves told her what was wrong and in this instance told her why she had it since a link had already been constructed between her nerves and relevant features of her biography. In this way something unknown, potentially dangerous and worrying became assimilated into a familiar order. As Mrs. S. put it later in the interview, "it was funny you know as soon as I talked to him (the doctor) about it and he told me what it was I felt better". Despite the fact that the tablets prescribed by the doctor had very little effect Mrs. S. did not return to the doctor with the problem during the period in which I continued to interview her.

When Mrs. R. was describing how bad she felt following a Caesarian section just prior to which she had been given "a massive dose" of corticosteroid she said, "it really was very nasty .... I think if I'd had it explained to me beforehand it would have been easier and I think, you know, the unknown is so much more frightening than the known". Mrs. R. had been taking corticosteroids throughout her pregnancy and because the Caesarian had been an emergency she had not been warned that she might not cope with the stress of the operation very well. Consequently, she was unable to understand why she was in such a "bad condition" afterwards. Because of this initial experience the second pregnancy, which was managed in a similar way, was "much easier". She had knowledge at her disposal to enable her to make sense of what was happening(6).

In this chapter I want to confine myself to the examination of the way in which interpretive work is conducted relative to the recognition of disorder, the location of causes and the determination of significance. Though these have implications for individual action I will deal with the problem of illness behaviour in the next chapter.

The problematic experiences upon which interpretive work is brought to bear and which may come to be defined as a disorder of some sort may not, as I have emphasised throughout this thesis, be defined as such by medical science or by medical practitioners on any one occasion. That is, what is regarded by the individual as a problematic experience may according to the premises of anatomy or physiology constitute normal function. In an earlier chapter I quoted the case of the ex-dental nurse who presented herself at an oral surgery clinic convinced that the indentations on the lateral aspect of her tongue, a normal anatomical feature, were the signs of cancer caused by years of exposure to x-rays(7). Similarly, at a given point in time health care professionals may define these experiences as normal when in fact they are the signs and symptoms of a medically legitimate disorder. Burton describes how the mothers of children who subsequently turned out to have cystic fibrosis were told they were "too fussy" or "over-protective" when they consulted the doctor about what they perceived to be problems with their babies' development. These differences in definition constitute what Coulter has referred to as interpretive asymmetries(8), where discrepant or competing accounts of a phenomenon or states of affairs are being proposed. They are not, of course, confined to lay/professional interaction for, as I have shown in the previous chapter, non-professional individuals may dispute the claims of others to the category ill and invoke evidence to discredit that claim. However,

one feature of interpretive asymmetries between lay and professional individuals is that the latter may discredit the account of the former by claiming access to special knowledge required to make an adequate definition. The social location of the lay individual concerned does not grant them access to this special knowledge. One implication of Burton's data is that doctors handle such asymmetries in this way(9). Not only is the mother's definition discredited, fault is also found with the mother. I will present further data to illustrate alternative ways in which perceptual conflicts of this kind may be managed.

Problematic experiences do not necessarily follow from changes in the structure or function of the body or person. As Dingwall points out, they may follow from a change in the stock of knowledge in terms of which normal structure and function is judged(10). He proposes "a general equilibrium between events in the biological sphere and events in the cognitive sphere .... Into this equilibrium we put some disruption of either the cognitive or the biological elements (so that) the usual attitude of familiarity that we take towards our bodies must be suspended. As a consequence some kind of interpretive work must be performed to resolve the discrepancy"(11). For example, reading a magazine article about malignant melanoma may lead one to see a darkly pigmented mole in a new light. From being a dark mole it becomes transformed into a potential cancer. Reinterpretations of this kind, brought about by a change in the stock of knowledge at hand, may occur retrospectively so that past events, which may or may not have been understood at the time, come to be defined in particular ways. One example of this is given in Mrs. S's account of her mother's death:

S2.2 Mrs. S.: She was very ill for about two years and gradually she lost a lot of weight er .... although nobody's ever said anything we

> think it might have been cancer you know, the way she went and what I've read and seen afterwards, but the day she was due to go into hospital to let them look at her sort of thing she died of a cerebral haemorrhage.

Alternatively, problematic experiences may follow from changes in the biological state of the body. These may be 'pathological' changes, such as those caused by disease, or they may be changes associated with normal physiological mechanisms such as aging or menopause. Whatever, these problems must manifest themselves in some way available to experience. Asymptomatic diseases such as hypertension go undiscovered because they do not intrude on the everyday experience of the body. To use Schutz's term, they do not constitute imposed relevancies(12).

As Dingwall goes on to suggest, the others with whom the sufferer interacts also play their part in this process during the general mutual monitoring of interactional competence and health status. Consequently, his model of a cognitive-biological equilibrium needs to be extended to include the social sphere. Although he hints at this he fails to accord formal status to changes in the social functioning of an individual. This may for others constitute a problematic experience which needs to be ordered by interpretive work. Judgements of mental illness, for example, hinge entirely on behavioural 'abnormalities' such as disordered action, perception or thought. In the following analysis I will extend what I indicated in the previous chapter, the way in which behavioural cues may be used to recognise disorder.

The extent to which others participate in the interpretive work that is brought to bear on problematic experiences is variable. It may depend upon the sufferer inviting their participation by making a complaint. Thus, it may be necessary for a sufferer to communicate a

problematic experience to others since that problematic experience may not always be directly available to them. Pain and emotional states, though sometimes having external indicators, may not be perceived by others until alerted by a verbal statement on the part of the sufferer.

As I have already indicated, the interpretive work necessary to order problematic experiences consists of several interwoven phases; recognising various manifestations which indicate disorder, attaching a label to the disorder and explaining that disorder. In examining and illustrating the processes involved I will make use of data which consists largely of the women I interviewed describing how they decided that something was wrong with themselves or a member of their family and how they attempted to make sense of the events with which they were faced. In analysing how they came to realise that something was not as it should be I will make use of the concept of a cue, first described by Davis in his classic study of polio victims and their families(13).

Recognising disorder: Types of cue

In Passage Through Crisis Davis describes some of the interpretive processes via which a diagnosis of polio was eventually reached. The children who were subsequently identified as polio victims initially complained of minor symptoms such as sore throat, stomach ache or fatigue. These complaints were attributed by the parents to common childhood ailments, minor mishaps or malingering. Davis uses the concept of cue to illustrate how this initial perception of the child's problem as simple or ordinary was challenged and revised. He classifies these warning cues as symptomatological, behavioural, environmental or authoritative. By symptomatological cues he meant those emanating from the child's physical condition as such, behavioural cues were those perceived as a

result of some striking discrepancy in the child's behaviour, environmental cues are those deriving from the time-place context of the child's illness and authoritative cues are those communicated by a doctor. These cues were used as indicators that something more serious than a common childhood ailment was wrong, led to professional consultation and the eventual diagnosis of polio. Similarly, Cowie has looked at the way in which cardiac patients perceived the symptoms of their heart attack(14). The symptoms were initially perceived as a common non-threatening ailment or the consequence of some previous illness and were only seen as something more serious following a 'critical incident'. This incident was usually a symptomatological cue, a sudden increase in the severity of pain in the chest. This would support an earlier comment I made about Zola's work on triggers. Zola claimed that symptoms act as a sort of constant such that medical consultation only takes place given the intervention of some non-physiological trigger. I would maintain, as Cowie's work would suggest, that changes in the nature of the symptoms may give rise to changes in the definitions applied either directly or because one of the triggers became operative as a result.

Here, I will use the concept of cue to look at an earlier stage of the interpretive process, the initial recognition of some departure from a state conceived of as normal, usual or routine. These cues may alert the sufferer himself or those around him to such a departure. They constitute the problematic experiences referred to above which disturb the taken-for-granted sense of order and intrude on the unnoticed every day functioning of the body and the person.

Three different types of cue are involved in this early stage of the interpretive process: symptomatological, behavioural and communi-

cative. The first two I conceive of in terms essentially similar to Davis. The third consists of a claim made by an individual to others or by others to the individual that something is wrong. Environmental and authoritative cues do not figure at this stage since according to Davis' definition they presuppose that an initial identification of a disorder has been made. I refer to these entities as cues rather than signs and symptoms since they are only constituted as signs and symptoms when they are interpreted as the indicators of an underlying organic or psychological problem.

These cues to the recognition of disorder may be used alone or together, although when only one cue is present others may be searched for to substantiate the definition of something wrong. In Davis' study cues were perceived cumulatively and eventually led to a redefinition: "typically, the perception of one cue triggered off others which fell into each other to produce pronounced strain on the normal outlook with which the child's illness had been viewed". To use McHugh's terminology(12), one cue may be used to locate a pattern of meaning which is then elaborated by locating it's particulars over a series of chronologically discrete events. Past events may come to be seen as cues pointing to that pattern of meaning and other cues may be sought in the present or anticipated in the future on the basis of that meaning. Where such instances do not correspond to the theme identified the incompatibility must be managed in some way to preserve the theme or the theme revised or abandoned. The way in which this occurs can be illustrated by some of the data presented in this and the previous chapter. For example, in data extract F2.13 below, the failure of Mrs. F's aunt to show the behavioural cues anticipated as following a 'bad fall' enable Mrs. F. to abandon her aunt's definition of the situation and to

construct an alternative. In P1 (Chapter 4), however, Mr. P's refusal to see a doctor was not employed to challenge his self-definition of depression but was managed by Mrs. P. who supplied a reasonable explanation for his refusal.

Symptomatological, behavioural and communicative cues are not only treated as the surface appearances of underlying disorders on any particular occasion of their use, they also become organised into what I will call cue inventories. These cue inventories consist of the typical ways in which disorders present themselves. They allow actors to monitor others by providing a limited range of surface appearances which may be used to anticipate the recognition of problems. These inventories may be category specific, applicable to a category of individuals such as men or children or, more usually, they are person specific, applicable to a given individual. The latter are derived from knowledge of the ways in which disorders have been recognised in the past with regard to that individual.

Symptomatological cues are those which pertain to the physical condition of an individual. They may be experienced by the sufferer as a change in the way he feels:

G2.1 Mrs. G.: If something hurt me or if I felt just perhaps shattered, tired or headache, something like that then I'd wonder what was wrong.

As far as others are concerned, symptomatological cues usually involve some change in external appearance. Mrs. G. talking about her husband:

G2.2 Mrs. G.: I would worry if I felt he looked tired in his facial expression, if he looked pale or tired or very flushed so that he looked .... something like that, or drawn.

Int.: Why would you worry about those things?

Mrs. G.: Well, obviously because there was a change .... just sort of a fact really isn't it?

Changes of this sort indicate that something is wrong and call for monitoring of the individual concerned or some action to clarify or resolve the suspected disorder. This is illustrated by the following two extracts:

S2.3 Mrs. S.: Sometimes Michael comes in from school and he's a bit pale, not because there's anything wrong with him but I think it's the journey home sometimes, they don't always sit him properly in his wheelchair, sometimes they tighten him up in his wheelchair, put the strap on and they probably have to keep stopping and starting cus they let other children off the coach, he comes in and you know he's as white as a sheet and oh, what's wrong with him you know, you know normally it's only the journey. I usually give him as I say his Junior Disprin, give him a drink .... I keep coming in and having a look at him and asking if he's O.K. and then I can see his colour coming back and then I know he's alright.

G2.3 Mrs. G.: The last time I took Daniel (respondent's baby son) to the doctor's he had a really bad, a really high temperature about five o'clock at night he was sat on my knee, been sort of mouldy all day you know, sleeping a lot of the time and he was burning .... he was just sat on my knee and you could see the glow coming off him, it was really bad so I rang the clinic.

For Mrs. S., the fact that Michael comes home looking "pale" or "white as a sheet" is a potential indicator that something is wrong. As she added subsequently, "he's a fit boy, he's usually got quite a good colour". However, she has an explanation at hand which, derived from past experience, enables her to routinise the problem, "nine times out of ten it's probably because he's had a bad journey home". Faced with these two alternatives she adopts a wait and see strategy and monitors his external appearance until she can see his colour coming

back, "then I know he's alright". The bad journey home hypothesis is then taken to be confirmed.

In the example given by Mrs. G. the problem of recognising that something is wrong is more clear cut. Although she says her son had been "sort of mouldy" and "sleeping a lot of the time" immediately she felt he was burning she realised there was a problem and rang the clinic.

On other occasions the respondents described cues which were typical of the way in which certain problems could be recognised:

N2.1 Mrs. N.: I know if I'm going to get a cold, I get this feeling at night, you know, that roof of your mouth smarting feeling.

Mrs. S. had just described in some detail the problems and worries of having a handicapped child:

S2.4 Int.: Do you find it sometimes gets on top of you?

Mrs. S.: Sometimes .... every so often. I know when I'm going to be like that because I start feeling all weepy, you know, and I generally feel as if I want to scream. I do sometimes, it does me good.

R2.1 Mrs. R.: My son will come down he sneezes like anything, he's a proper little sneezer and he'll probably sit there and he'll never stop sneezing and that's when I start dosing him up.

Behavioural cues involve some departure from a conception of an individual's normal activity. They constitute noticeable events which indicate and in turn are explained in terms of an underlying problem:

P2.1 Mrs. P.: We feel a bit worried about my father as he seemed a bit on the depressed side, I think, you know, he's gone very sort of quiet so we thought it was a good idea for him to see the doctor perhaps.

P2.2 Mrs. P.: Well, Lindsay said it .... she said she'd got this spot under her foot which hurt her and we looked at it and I took her along to the doctor because she came home limping from school. I had noticed it but, you know, I thought well maybe it's just something that's rubbed a little bit, maybe her shoe or her sock, you know, and when she started this limping, well, we'd better see what it is and I took her up to Dr. Z.

In the first example, Mrs. P. talks about her father who, following increasingly frequent falls, had been persuaded that he could no longer look after himself and moved in with one of his other daughters. Prior to the move I asked Mrs. P. if she thought he would be happy to leave his own flat. She said, "Well, this is the problem, one doesn't really know. I'm not too sure whether he will cus he does love it round there". Alert to the fact that his move may create problems Mrs. P. and her sister noticed that he had gone quiet, had attributed this to depression and decided to have the doctor to see him. The second example illustrates how a behavioural cue causes an initial interpretation of a problem to be redefined. When her daughter first complained about a sore spot on her foot Mrs. P. attributed it to "something that's rubbed a little bit, maybe her shoe or her sock". However, when her daughter came home limping it was seen to be something other than a simple abrasion and a doctor was consulted to "see what it is".

As with symptomatological cues, behavioural cues are seen in terms of typical patterns for given individuals:

N2.2 Mrs. N.: Well, you can generally tell if the girls (her daughters) are out of sorts really .... if they're kind of mooning around, they don't want to eat, that sort of thing.

F2.1 Mrs. F.: I think probably, yes, they sort of go fairly quiet .... we're a very chatty family, all extroverts but I think if they sort of go quiet .... you know.

P2.3 Mrs. P.: With Martin if he isn't sort of well he usually wants to be cuddled a lot and he gets a bit listless or something like that.

G2.4 Int.: Do you think you can tell when Daniel is not well?

Mrs. G.: Yes, mm .... he sleeps a lot, more than usual, you know, and he sucks his thumb. That's about it really, but I can tell.

These patterns form part of the stock of knowledge at hand which an individual can bring to bear on the situations with which he is faced. They are derived from a biography and provide a context in which cues may be situated such that they not only point to the fact that something is wrong they may also suggest a diagnosis. At the second interview I asked Mrs. P. if there was anything in particular she might notice that would make her think her husband was not well:

P2.4 Mrs. P.: Well, if he began to get unreasonably irritable I would watch that because I think I told you that some, oh a few years back now he did have a bit of a breakdown and he had to have treatment for it and that was one of the things the children couldn't understand why daddy was so irritable, so cross and would shout at them for no apparent reason. I would definitely keep an eye on that. Or if, you know, I occasionally I have noticed him rubbing his chest and I will definitely keep an eye on that because in his younger days he had pneumonia twice so I don't like to .... if he does get a cold and the cough goes on I will automatically make an appointment for him, you know, because I think that's something that should be watched with him.

Here, "unreasonable irritability", "rubbing his chest" and coughs that "go on" are seen in terms of Mr. P's diagnostic history. These cues are taken as potential indicators of past states of affairs that could reoccur. Hence, the necessity for them to be watched or managed in other ways such as making an appointment to see the doctor. Thus, although medically speaking the episodes of pneumonia and nervous break-

down are closed, that is, the patient was cured, socially speaking they remain open since they have implications for the future and are used in the cognitive organisation of the present. Mr. P. is then an ex-pneumonia patient and an ex-case of nervous breakdown and these facts may be taken into account in making judgements about his current health status.

In the fifth interview with Mrs. P. she described how her husband had recently had bronchitis which had taken so long to clear he had been sent by the doctor to a chest clinic for an X-ray. The same biographical information is invoked in her attempt to make sense of what is happening:

P2.5 Int.: So he was off work for ....

Mrs. P.: Two weeks.

Int.: Two weeks? That's quite unusual for him, isn't it?

Mrs. P.: Very unusual really, yes. I don't think I've ever known him .... well not since we got married. I know in his younger days he's had pneumonia twice and that's why it worried me so much, you know, I thought goodness me, is he perhaps going to really get something more serious and especially when he said about all this pain in his side as well as his back, I thought, goodness me, you know, I really did feel worried.

Again, Mr. P's bronchitis is taken to be a potential indicator of the more serious chest problems he has suffered in the past. His complaints of "pain in his side as well as in his back" reinforce her interpretation that this could signal another attack of pneumonia. This then is used to account for the fact that "I really did feel worried". The meaning of the symptoms is not inherent in the symptoms themselves, nor is it given by the doctor's diagnosis rather, it is imputed on the basis of his diagnostic biography. As it turned out, Mr. P's X-rays were clear and the bronchitis rapidly disappeared when the antibiotics he had been prescribed were changed.

These sign systems, consisting of indicators and an underlying state of affairs to which they point, in conjunction with the observation that what has happened in the past can happen again constitute the patterns which allow predictions about the future to be made. If on one occasion an event has been preceded by certain signs then it is assumed that if the event is to recur in the future it will also be preceded by the same signs. The following extract, taken from my fourth interview with Mrs. P. illustrates the expectation that the future can be so predicted and the consequences of a breach of that expectation. Mrs. P. had just told me that her husband was depressed:

P2.6 Int.: Is he? How does it show itself this depression, I mean ....

Mrs. P.: Irritability .... erm, oh sort of withdrawn a bit in a way, easily gets niggly with the children or things in general, you know.

Int.: Is he much different from his normal self?

Mrs. P.: Well, perhaps not .... it's very difficult, when he had the sort of the type of breakdown that he had before I knew it was sort of coming but this time I didn't so that was why it was a double shock in a way when he s he said about it, erm .... no, most people wouldn't know a thing was wrong really.

Int.: So did you notice it yourself or was it him just mentioned it to you?

Mrs. P.: Oh, he told me.

In this extract it is clear that Mrs. P. had anticipated that she would be able to recognise that something was wrong with her husband in much the same way as she had before. In this instance, however, the pattern his biography had led her to expect did not appear; last time "I knew it was sort of coming but this time I didn't". It was not until he told her he was depressed that she had any idea of what was happening. In fact, as she goes on to say, "most people wouldn't know a thing was wrong really". The sign system that she employs has here

broken down, it is inadequate to allow her to make the predictions she expected since the underlying disorder has appeared without its customary indicators. It is this breach of her sense of order that gives rise to what she describes as a double shock. First of all she was shocked that he had become depressed again and secondly, it was a shock that she had known nothing of it until he had told her.

I have already referred to the recurrent bronchitis suffered by Mrs. P's daughter during the study year. This usually began with a "rattly cough" which was particularly bad at night and signalled that a visit to the doctor might be necessary. At the sixth interview Mrs. P. described the following episode:

P2.7 Mrs. P.: About the middle of January it was, she said, on the Sunday she didn't feel too well and that night she woke up and said I'm so hot. The next morning she woke up and said oh I'm boiling hot and a terrific headache and of course my husband took her temperature and it was nearly 104 so of course I phoned the doctor. Dr. B. came and he sounded her chest and to my surprise he said she'd got the bronchitis but she hadn't been coughing a lot, that's what amazed me. I thought probably it was sort of flu cus it was the beginning of the epidemic.

In P2.6, Mrs. P's sense of order was breached because she had not known there was anything wrong with her husband until he told her. In this case the symptomatological cues did allow her to recognise that her daughter was unwell. However, she was unable to predict the correct diagnosis because the sign system she normally employed had broken down. Mrs. P. reports being surprised and amazed when the doctor diagnosed bronchitis since its usual precursor, "coughing a lot", had not been observed. She had seen the cues in terms of a current epidemic and thought her daughter had flu.

It was often the case that more than one type of cue was mentioned by the respondents in their descriptions of how they came to realise that something was wrong with themselves, or more usually, with one of the individuals with whom they interact. Faced with one type of cue an actor may wait for further cues to confirm the initial suspicion that something is wrong. In some cases these subsequent cues may not only confirm that suspicion, they may point to a diagnostic label or enable a choice to be made between alternative labels:

P2.8 Mrs. P.: Last Friday Lindsay ran a temperature for no apparent reason. When her father came home Colin came home from work and I said she's been a bit listless today, I said she's been out playing and she'd been out all day on Thursday playing with some friends around the corner but whenever she came in she just wanted to flop out on the settee. And Friday although she'd been out whenever she came in whether it was for a meal or for a drink or in general in and out, you know, she just sort of flopped on the settee and put a cushion and put her feet up you know and I felt her and she did feel a bit hot and by tea-time she looked a bit flushed for her. Colin took her temperature and it was nearly 103. So of course we put her to bed.

R2.2 Int.: How did it (the chicken pox) show on her, did she complain of anything or .....?

Mrs. R.: She had spots .... I noticed a few days prior to the spots she wasn't quite herself, she'd lost her appetite and er she was a bit irritable and I was a bit concerned because my husband hasn't been well and I wondered if this was reacting on her. So in fact when the spots came out I was very relieved that it was the reason, so I was quite happy about the chicken pox.

In the first case a series of cues are assembled over a period of time to arrive at a definition of disorder. Noticing that her daughter had been a bit listless for a couple of days Mrs. P. mentioned this to her husband who subsequently took her temperature because she felt hot and looked flushed "for her". Symptomatological cues were used to elaborate behavioural ones and led to action which revealed that

these were indicators of an underlying problem. In the second case Mrs. R. noticed similar behavioural cues with regard to her duaghter and applied a tentative diagnosis. Mr. R., who was being treated for depression, had recently spent two weeks as a patient in a psychiatric hospital. Consequently, Mrs. R. had had to provide her children with an explanation of why their father was going into hospital: "I haven't wanted to tell them exactly what was wrong because I think that could worry them very much". Nevertheless, Mrs. R. remained concerned about how this might affect her children and initially connected her daughter's irritability with her husband's illness, "I wondered if this was reacting on her". When the spots appeared, however, this interpretation was revised:

R2.3 Int.: Did you know it was chicken pox when the spots came out?

Mrs. R.: Yes, yes .... I checked it with Dr. Spock and the description tallied so I phoned Dr. M. and told him.

Here, a symptomatological cue not only confirms the definition that something is wrong, it brings about a revision of an earlier depiction by suggesting an alternative diagnosis and leads to action which substantiated that alternative. As Mrs. R. said a little later in the interview, "I was pleased when Alison developed spots because it explained her strange behaviour". I take it that Mrs. R. was relived because a diagnosis of chicken pox transformed what might have been a complex problem into a relatively routine childhood illness. I also take it that symptoms such as spots challenged the initial interpretation since it is assumed that problems of that kind would manifest as disorders of behaviour alone and not as changes in physical condition. Moreover, the initial interpretation of the problem presupposes a range of fairly

complex assumptions about children and their response to trouble in the family. Some of these I outlined in Chapter 3.

While symptomatic and behavioural cues may be noticed which are read as indicators that something is wrong it is frequently the case that nothing amiss is observed until the person concerned communicates some problematic experience to others. This is particularly the case with disorders which may not be directly available to them. Certain subjective experiences such as feeling sick, pain and a variety of emotional states may or may not have external manifestations. Where no such manifestations are apparent then a complaint is the first indicator that some disorder might exist. Though the person concerned may first become aware of the potential problem via a symptomatological cue it is via a statement or complaint that the problem is made public. Thus, though mothers, as part of the social role to which they orient, are expected to monitor and identify changes in the health status of members of their family, they must frequently rely on problematic experiences being communicated to them.

For example, in data fragment P2.6 examined previously, Mrs. P. knew nothing of her husband's depression until he told her, despite the fact that his biography had led her to expect certain behavioural cues which would alert her to a recurrence of the problem. These anticipated cues formed the basis of her monitoring of Mr. P. but on this occasion they did not appear. In fact, there were no external manifestations of his emotional state, "most people wouldn't know a thing was wrong" was how Mrs. P. expressed it. Consequently, a communicative cue was required to alert her to the problem. Data fragment R2 can be used to illustrate the same point. When Mrs. R's daughter caught chicken pox it was reasonable for Mrs. R. to expect that her son would get it

as well. The first indicator that he did have it was when "he just said he didn't feel well". This was confirmed later when a symptomatological cue, "spots", appeared. In this case the communicative cue was elaborated by the symptomatological cue and both elaborated by their context so that they not only indicated that there was a problem but pointed to a specific diagnosis. Occurring within a household where one member had already succumbed to a virus infection the cues confirm the expectation that other vulnerable members of the family would catch it as well. As the son is reputed to have said, "I've got <u>it</u> too" (my emphasis). A further example is given by the next extract taken from the same interview as S1 and S2. In these extracts Mrs. S. described how her daughter had gone to bed early one evening and had subsequently been sick. The following day she herself had gone to bed in the afternoon because she felt very sick:

S2.5 Mrs. S.: And, erm, that Saturday afternoon, that Saturday, the following one, we were supposed to be going to a party, just some friends we know and we were going to get a babysitter in for the children and that afternoon Michael had to go to a birthday party just a few doors down here, but meanwhile my husband said to me he said Oh, I hope we make it tonight, I don't feel very well, he said, I feel sick. I said, Oh dear, I think you've caught it, you just rest a bit while I take the children to this party in the afternoon.

Again, a communicative cue is the first indication that something is wrong with Mr. S. and this is subsequently elaborated by seeing it in terms of its context so that a judgement about the nature of the disorder can be made.

Communicative cues also function as triggers to action where a previously indentified problem is recurrent. Mrs. R's son, for example, had to visit the doctor frequently with ear trouble:

R2.4 Int.: What exactly happens when he has to go to the doctor with his ears?

Mrs. R.: He gets a lot of pain and Dr. M. has said that any time he has earache .... in fact I always carry some Pedipax, I always have it at home, which I can give to him immediately he complains. And then I take him along to the doctor and Dr. M. has a look and usually says carry on.

Here, a complaint of pain sets in motion a set of actions used routinely which involve both home medication and professional consultation. The communicative cue is the marker which calls forth such action.

Communicative cues may, then, be the first indication that something is wrong with an individual and these may be seen in context or elaborated by a search for other cues which confirm the original interpretation and, in some cases, allows a lay diagnosis to be made. That diagnosis may be as specific as "chicken pox" or it may consist only of the label "it", referring to an undiagnosed problem already experienced by an individual with whom the sufferer has been in contact.

In addition, there is an expectation on the part of the women I interviewed that sufferers will use communicative cues to indicate to others that some departure from normal exists. In the following extracts the respondents readily assert that these cues were used routinely by members of their families:

G2.5 Int.: Do you think your husband gets anything he doesn't bother complaining to you about?

Mrs. G.: No, I don't think so .... he'd let me know, yes, definitely.

Int.: Even though it was something he wouldn't bother going to the doctor with?

Mrs. G.: Yes, yes, he'd tell me. Well, he usually tells me .... more than likely he tells me about six times a day.

F2.2 Mrs. F.: If he (Mr. F.) isn't well I think he would say. Sometimes he comes home and says I've got a sick headache today which is usually following some big meeting he's had at work, he's had to do a lot of talking and, you know, probably sort of worrying about the job gives him a bit of a headache .... he always tells me.

S2.6 Mrs. S.: Oh, Mike (her husband) never complains. If he did .... you know, he's like most men, if there's anything wrong he'll have a moan about it but, you know, he doesn't really have anything wrong.

R2.5 Mrs. R.: I think whenever the children have not been well they have complained.

What past experience has shown to be routine or usual is often used to anticipate what will happen in the future. Any breach of the expectations based on past experience becomes a noticeable event that may call for an explanation. Alternatively, as shown by the next two extracts these events may be characterised as strange or funny:

Mrs. P. is talking about Martin, her younger child:

P2.9 Mrs. P.: Since I last saw you I have had him to the doctor, he did have a mild dose of tonsillitis, about the same time as Lindsay had her chest and throat infections so I presume the germ sort of passed on a bit really, but, er, he had just a shortish course of antibiotics and .... he wasn't ill with it, he just said one morning you know that .... he hadn't told me this was the strange thing he'd got this cough and cold and as I was taking Lindsay to the doctor, I thought well I'll ask him as well. And he said to the doctor, my throat's sore, he didn't tell me this and I didn't know, I hadn't a clue he hadn't complained about it and the doctor looked and he could see there was a bit of inflammation there and the tonsils infected. So, of course, he gave him a course of antibiotics. It quickly cleared him up with no bother at all.

S2.7 Int.: Anything wrong with the children over the last two or three weeks?

Mrs. S.: No, apart from her being bitten by a little boy at nursery school. She came home not long ago with big bites on her shoulder, really nasty ones they were. But the funny thing was she never complained, she didn't, you know .... in fact she was quite upset when I told her she mustn't let him bite her.

In both of these cases there is the expectation that problems of this kind would be mentioned. This expectation also means that in the absence of a complaint it may be reasonably assumed that nothing is wrong. The connection between no complaint and nothing wrong is implicit in S2.6 above. As Mrs. S. says of her husband, if there's anything wrong he'll complain but he never complains because he never really has anything wrong. Given this assumption, an actor cannot be held responsible for taking no action with regard to a sufferer who has not communicated a problematic experience. For example, Mrs. F's mother "suddenly had a very bad time" with her arthritis and was in such pain that she slept in a chair for two nights without telling anybody:

F2.3 Int.: She, she didn't phone you, she told you about this when you went to see her did she?

Mrs. F.: Well, the next door neighbour phoned me up and told me, did you know, you know aggressively, did you know your mother hasn't been to bed for two nights? I mean, I don't know if she doesn't tell me, I'm always phoning her up. Anyway .... so .... no, she hadn't told me personally so I had to make out the neighbour hadn't phoned me otherwise it would have looked as though we're spying on her, you see.

In this extract Mrs. F. invokes the assumption that all may be taken to be in order in the absence of a complaint to defeat a potential charge of neglect. Mrs. F. cannot be held responsible for not doing anything about her mother since she cannot possibly know that something is wrong if she is not told. Moreover, she presents her mother with

adequate opportunities for communicating any problems she might have, "I'm always phoning her up", in which case it is her mother who is to be seen to be at fault. As Mrs. F. said later in the interview, "she slept in a chair for two nights without telling anybody, silly old dear". Once she did know that her mother was in severe pain she arranged for a doctor to visit her at home. A similar rationale is presented by Mrs. S. in data extract S2 in the previous chapter. When her three year old daughter asked to be put to bed at five o'clock Mrs. S. "knew that something was wrong" but initially interpreted the request as a sign that "she was feeling a bit tired". Though she was subsequently "very sick" the initial interpretation is justified by the fact that "she didn't tell me what was wrong, she didn't say she felt sick". There was then no cue which would allow Mrs. S. to anticipate what would happen and, as a consequence, nothing on which to base preventive action(15).

Such is the importance of communicative cues that communicative incompetence poses problems for the recognition of disorder. Communicative cues may be required to recognise disorder per se or to elaborate symptomatological or behavioural cues so that judgements about the type or nature of the disorder may be made. In the absence of communicative competence communicative cues are not readily available, the assumption that no complaint means nothing is wrong is suspended and strategies adopted to acquire information which would usually be provided by the sufferer in the form of a complaint. Mrs. S's son, Michael, for example, was brain-damaged and unable to talk:

S2.8 Mrs. S.: With Michael he's very special, I mean, you know, he can't tell you when he's in pain unless I ask him different questions all about different parts of the body.

As reported above, Michael sometimes came home from school looking "a bit pale" or as "white as a sheet" which led Mrs. S. to suspect that something might be wrong:

S2.9 Mrs. S.: .... but then I say to him, is anything hurting you, Michael, you know, I go through all the different things and I just give him a Junior Disprin to be on the safe side.

Mrs. S. was very attentive to Michael and constantly on the lookout for indications that all might not be well. She had taught him to nod or shake his head in response to her questions about different parts of his body. During the time I interviewed her she was particularly concerned about his left hip which had been operated on some nine months previously to give him greater mobility. Since the success of the operation could only be determined in the long term she was constantly looking for signs, such as pain, which would tell her that he was not progressing as he should be. Whenever she noticed him looking a bit pale or if he drew his breath when she lifted him from his wheelchair her first question was always "Does your leg hurt, Michael?" Because he could not readily provide her with that information he was monitored closely and action taken "just to be on the safe side".

Michael represents a more extreme version of a problem that may be encountered with other non-competents such as children in general. Though children who can talk may be able to indicate verbally when they are in pain they may be seen to be incapable of giving descriptions of subjective experiences which would allow those responsible for them to make judgements about the type and nature of the problem:

P2.10 Int.: Erm .... one night Martin (respondent's six year old son) woke up with pains in his legs, didn't he?

Mrs. P.: Yes, that's right, yes, yes .... he does get this just now and again. I wonder really whether it is just a form of cramp, cus when they're little like that they can't really explain fully to you and he says, oh it's all in my legs.

Because Martin was only able to give Mrs. P. a vague description of his pain she was unable to decide what the problem might be. Mr. P. claimed that he was suffering from growing pains, a category of disorder which Mrs. P. did not accept. She suspected cramp, but was not altogether sure of that as a diagnosis since her son was too young to provide a more specific account. In the end she said "I just don't know really". Because the pains in his legs happened infrequently she had not taken him to the doctor for a professional opinion.

Each of the three types of cue may be elaborated by the other or, as I have indicated, may be elaborated by context. There are two types of context which are used in this way, biographical and time-place contexts. Both consist of a body of knowledge, either about a specific individual or a given time and place, which may be employed in recognising that something is wrong and constructing tentative diagnostic labels. Such contextual elaboration is of particular importance with respect to behavioural and communicative cues. Unlike symptomatological cues these are not necessarily independent of the person and may, as I described in the last chapter with regard to the way in which claims to illness are handled, be subject to a variety of discrediting interpretations. By contrast, symptomatological cues are their own verification.

In the following extracts, both taken from interviews with Mrs. S., biographical and time-place contexts are invoked in attempting to make sense of various observations with regard to her daughter:

S2.10 Mrs. S.: Well, with Joanna, I think I might have mentioned it before, she gets very flush, her face goes bright red and er she says I'm tired, I want to lay down and she lays down on the settee and she'll go off to sleep. And then I do worry because, well, erm, in fact I know now the doctor says she's got funny tonsils .... he said that her tonsils were a little bit funny and she might every so often have a little bit of trouble and we'll see what we're going to do about them a little later on when she's older.

S2.11 Mrs. S.: I keep thinking that she's going to get something cus at nursery school every child has practically got mumps, chicken pox or some measles or tonsillitis at the moment. You know, you go up there and there's three off with mumps today, you know, and another with tonsillitis, there's chicken pox and measles, but so far she seems to have kept free of it.

Int.: You've not noticed any signs or anything?

Mrs. S.: Well, this morning at nursery school I thought she was a bit pale and, erm, a couple of times she looked a little bit weepy but the first time was because they forgot to give her a biscuit cus it's not her regular morning and her name's not on the register and, erm, I thought it might be to do with, you know, at first because there's so many things round .... there was two or three children a bit nittery about different things so we all thought oh they're going to be down with something.

In the first case a variety of cues are situated within Joanna's biography as a child with "funny tonsils" to become potential indicators of trouble with her throat. Her biography, like that of Mr. P. referred to earlier, indicates a weak spot that may be expected to be bothersome from time to time. In the second example, cues are seen within a time-place context of "there's so many things round" to construct possible explanations of those cues. In this particular instance an alternative explanation was found to account for the cue which indicated that for the moment at least Joanna was free from disorder. However, the time-

place context establishes the possibility that Joanna will get something; consequently, any definition applied is for the here and now only and monitoring action is called for to locate symptomatological cues that may yet appear:

S2.12 Mrs. S.: I've been feeling around here (indicates Joanna's neck who was present at the interview) and I've looked at her back and tummy and chest but there's no spots or lumps yet, but it'll take a bit of time to come up.

The cues invoked by the respondents as indicators of disorder constitute theories about the typical ways in which disorders manifest themselves. These theories are culturally relative and socially sanctionable. That is, they are part of a culturally determined sign system that members are expected to employ in recognising disorder. Individuals may be held responsible if these cues are not interpreted adequately and appropriate action pursued. Conversely, they are also expected not to interpret 'normal variation' as signs of an underlying problem. Burton's data, for example, indicates the negative labels that may be attached to mothers who present as problematic babies falling within particular doctors' definitions of normality. Similarly, the ex-dental nurse I quoted earlier was publicly denounced as a cancer phobic when she presented features of normal anatomy as the signs of cancer, and many GP's complain that a large proportion of their workload is taken up with consultations which are inappropriate or for trivial reasons(16). It is via this process that doctors are involved in maintaining a particular version of the world by discrediting or substituting their own constructs for those of the patients who consult them. This does not mean that the professional version is always accepted as valid by lay members. As I will show later in the chapter, individuals may prefer their own version

of events and indulge in interpretive work to discredit the professional account. Consequently, they may ignore professional advice and pursue their own plans of action.

Explaining disorder: The location of cause

Symptomatological, behavioural and communicative cues not only point to a disorder they are, in turn, explained by that disorder. A definition of disorder may be only one among several alternatives which may be applied. Achieving a sense of order also requires that the disorder itself is explained. In some cases such an explanation contributes to the construction of a diagnosis or may allow a choice between alternative diagnoses to be made, while in others it occurs following a diagnosis. The former involves a search for a cause, the latter a search for a reason. The phases of the construction of a cognitive order that I described earlier, recognition of disorder, application of a label and the construction of an explanation are interwoven; they are not necessarily discrete events within an overall sequence.

The above distinction between cause and reason is, to a large extent, illegitimate. Beales notes that much of lay members' talk about the world consists of causal theorising in which members assume the existence of a social world independent of human reasoning and act on the basis of their identification of objects in the world and their allocation within a causal nexus as cause and caused(17). In a sense then, locating causes and reasons are part of this ubiquitous phenomenon causal theorising in which a given object or event is seen to precede and be responsible for another object or event. The difference I am attempting to convey in using this terminology is this: A disease such as polio may be explained in medical terms by a virus which invades the

body and damages the nerve pathways responsible for motor function. Lay versions of this explanation might not look very different from the professional one. In fact, "it's a virus" was often invoked as a cause by the women I interviewed to explain disorders of various kinds. However, actors may also ask a different order of question requiring a different type of explanation. That is, 'Why has this happened'? Recurrent tonsillitis in a child may be known to be caused by an infective agent but may also be accounted for in terms of a familial trait or features of the environment that predispose a child to infection. The parents of children suffering from polio or cystic fibrosis may ask a third question, "Why has this happened to us?" As the father of one of the polio victims studied by Davis asked, "What is God's purpose in singling out our child for so dreadful a disease?"(18). And one of Burton's respondents, the mother of a child diagnosed as having cystic fibrosis asked "What have I done to deserve this?"(19). Davis, using a stage conception referred to the seeking of answers to these questions as the inventory stage, a post-diagnostic attempt to make sense of events. This was achieved via a process of redefinition, re-evaluation and retrospective reconstruction:

> "Through this process the past was made to fit the present. This realignment then set the stage for a subjectively more congruent response to what in the actual past had been but no longer was a wholly unanticipated future"(20).

Cardiac patients also attempted to render their heart attacks intelligible by the selective invocation of biography. They assumed their attacks were not sudden, unanticipated events but something which can be seen to have causal antecedents. Appropriate causes located within their biographies were derived from the accounts presented by doctors and other patients or what was already known about types of

individuals and/or lifestyles which predispose to heart attacks[21]. In some cases, however, presumed causes could not be discovered within the individual's biography; consequently, the patient was left with no explanation of its occurrence.

In this study respondents generally constructed explanations to answer the first two questions only; "Why has this happened to us?" did not appear as the basis for the construction of explanatory accounts. This may be because most of the problems I discussed with my respondents were defined by them as trivial rather than the catastrophe presented by a child with polio. Voysey, however, also noted that this was a question that her respondents, mothers of disabled children, did not ask themselves. The questions one asks in attempting to make sense of events presuppose a world view just as much as the answers that may be provided. Where serious illness is interpreted as punishment for moral fault then "What have I done to deserve this?" is a relevant question. Just as God's purpose may be questioned if the world is seen as a product of the purposes of a Higher Being. Consequently, the extent to which phenomena can and therefore need to be explained is influenced by the assumptions one makes about those phenomena in the first place.

In this section I want to look in some detail at the way in which the respondents constructed explanations of the disorders they, or those around them experienced. I will proceed by examining the features of one case and expanding each point by reference to other data. The case I will consider first is that of Mrs. S. and her breathing problem, some aspects of which I presented at the beginning of the chapter:

S2.13 Int.: Can you remember when you first noticed this shortness of breath?

Mrs. S.: I think it was er .... the beginning of November .... I just suddenly, you know, I just couldn't take a deep breath. I thought at first, I thought it was cus I always, I mean I'm always rushing around, you know, I don't have much time for sitting down, you know, dashing here, there and everywhere. I do seem to do a lot of things, you know, and when that happened I thought at first that this is what it was, you know, just rushing round. And then I thought well maybe it's because it's too warm .... we've got central heating but it's not because of that, you know, I'm too warm sort of thing, and erm .... opening all the windows to get some fresh air, you know, ridiculous. But erm, when it got really bad I thought well I must go to the doctor and I think I had it a couple of weeks before I went up there. It just suddenly came, you know, one minute I was perfectly alright and the next minute I couldn't breath.

Int.: There was nothing that happened that you thought might have brought it on was there?

Mrs. S.: Not specifically, no, this is it, you know, now if I ever get these various things, I mean sometimes I get it that I can't sleep and I lay there worrying about different things and it's so stupid because really and truly there's nothing specific apart from when my little boy has to have anything done. I mean he's had this operation and every time he had to go back to the hospital or anything like that then I did get worked up about that, you know, but er .... there was nothing particular at that particular, you know, at this time, you know, I hadn't to go with Michael for any appointments so .... It always seemed to start when I was getting the washing machine out and I used to hang over that washing machine and, you know, just kind of gasp for breath. And I still do. I've done the washing this morning and it's just the strangest thing. I will probably not think about it sometimes and then as soon as I've got the washing machine I suddenly start taking deep breaths. It's the strangest thing. Whether it's just coincidence or what I don't know or just psychological.

This extract immediately followed that presented in S2.1 in which Mrs. S. described how she had seen her doctor about her problem and had it diagnosed as "nerves". This allowed her to construct a causal pathway linking her situation as the mother of a handicapped child with

this and other disorders. As I shall describe in more detail later, this involved positing "worry" and "nerves" as intervening variables. Here, Mrs. S. gives some indication of other causes she claims to have considered prior to consulting the doctor. This illustrates what is a common feature of the construction of explanations. Various causal mechanisms may be identified as potentially responsible for an object or event. Subsequently, evidence may be assembled to allow a choice between these alternatives to be made, and licensed problem solvers may be canvassed to confirm the choice or be given the responsibility for making the choice in the first place. Mrs. S. rejected what she initially identified as probable causes on the basis of her doctor's definition. Had she rejected that choice, as some of the women I interviewed did on some occasions, then she would have assembled evidence to demonstrate the superiority of her own choice and discredit the professional construction of the situation.

The factors that Mrs. S. invokes as potential causes of her breathing problem are chosen from a range that are available within a particular culture. Moreover, those that are considered on any given occasion are probably influenced by the nature of the problem to be explained. That is, a culture will not only recognise certain phenomena as causal agents while rejecting others, it also specifies sets of causal nexii in which objects and events are linked together as cause and effect. Consequently, Mrs. S. is unlikely to identify witchcraft as the cause of her breathing problem since that is not recognised as an entity in the real world in modern cosmologies. She is also unlikely to invoke "a virus" as the cause of shortness of breath since these are not expected to exist in a cause/effect relationship. Rather, she identifies such factors as her life-style, "I'm always rushing around",

or her environment, "maybe it's because I'm too warm", as possible causes, although these are subsequently rejected. The explanation couched in terms of the environment does seem to have been considered sufficiently plausible for Mrs. S. to have acted upon it, "opening all the windows to get some fresh air, you know", though at the time of the exchange she characterised this as ridiculous. Different causes are invoked to account for the "strange" connection between Mrs. S's breathing difficulties and her getting the washing machine out. This, I think, substantiates the point I have just made. Mrs. S. does not attempt to account for this observation by referring to lifestyle or environment since it is difficult to see how they could act as causal agents. Commonsense knowledge is inadequate to allow a pathway to be constructed between these factors as causes and the observation as effect. The observed connection between the onset of her breathing problem and getting out the washing machine is so bizarre that Mrs. S. is not really able to account for it. Two tentative explanations are advanced however. One is "coincidence", in which two events may occur together but are not connected in any way, the other is "psychological". The latter does constitute an explanation whereas the former explains away and renders an explanation unnecessary. No attempt was made by Mrs. S. to link this observation with the cause of the overall problem, nerves.

In some cases, new facts which appear may challenge an explanation and call for the construction of a new one. Recall how Mrs. R. came to change her interpretation of her daughter's strange behaviour from a response to her husband's psychological problems to the start of chicken pox when spots appeared. In other cases new facts may be seen to support an explanation, as expected if the explanation is valid, or

they have to be managed in some way and assimilated into an explanation. Where the new facts do not quite fit, as in this case, judgements about them may be suspended. Atkinson describes several cases in which coroners characterised deaths as suicides on the basis of evidence about the location and mode of death although the "psychological autopsy" did not reveal a mental state usually taken to be the antecedent of suicide(22).

Although Mrs. S. accepts the diagnosis of nerves as the cause of her problem she is not really able to use this to account for the onset of her breathing difficulty. She had learnt from past experience that she suffered with her nerves just prior to an imminent event such as a hospital appointment for her handicapped child. This she attributed to worry about the outcome of these appointments since they were used to monitor her son's progress and report on the success of his recent leg operation. Consequently, she anticipated being "a nervous wreck" prior to these appointments or "anything like that" and expected a variety of problems to appear some of which might require her to consult Dr. M. However, she was not able to identify the onset of her breathing problem as preceding or being preceded by an event of this kind. This discrepancy is not taken as a challenge to the diagnosis, rather, as the following data taken from subsequent interviews shows, the facts of the matter are presented in a way to fit the diagnosis:

S2.14 Int.: Er .... shall we start off talking about your breathing cus that ....?

Mrs. S.: Er, yes, well that's still with me, sometimes .... today it hasn't been so bad but er yesterday it wasn't too good .... it's odd this, you know, some days I don't feel too bad, I mean most days I feel fine but I think I probably worry more one day than another day about what's going to happen the following day, you know, or something like that and I think this is when my breathing starts getting bad. It's definitely nerves.

S2.15 Int.: Do you think there's anything you can do for it?

Mrs. S.: Well apart from going up there again and getting some more tablets I don't think so, I think it's mainly me, I think if I can which is very hard to is to stop worrying, I mean you can't, you just don't turn off like that, I don't anyway. I mean I'm not worrying as such but I think it's subconsciously you do worry, I mean as I've said before I think, erm, probably Michael, although really and truly he's not as bad as probably, you know, but I suppose it's there all the time, you just can't forget you've got a handicapped child and although he's doing quite well he's doing a lot better than he ever did do there's still the future. I think that's mainly the cause of it because I don't really worry about much else you know.

In the first extract the intermittent character of her breathing problem is presented by Mrs. S. as a product of the intermittent character of her worrying. Her breathing is worse on some days than on others, therefore she must worry more on some days than others. The breathing problem is taken to be the surface appearance of an underlying pattern which is assumed to exist and is embodied in the causal connection she has already constructed. Note that Mrs. S. does not say she worried more on a given day and consequently her breathing problem was particularly bad, rather she assumes that she must worry more on some days than others because that is what the fluctuating nature of her problem indicates. The conclusion is derived from her theorising on the topic and not from empirical observation. The main point, however, is that the facts are presented in a way that fits the pre-existent explanation and as a consequence reinforce that explanation.

In the second extract Mrs. S. makes statements about the nature of her worrying which allows her to continue to present it as a cause in the face of evidence which might reasonably be taken to indicate that it was not responsible for her difficulty in breathing. As I mentioned

earlier, Mrs. S. was not able to locate the kind of incident which usually caused her to worry to account for the onset of her respiratory problem and in this extract she states that she does not worry all the time, "I mean I'm not worrying as such". Consequently, in order to continue to present this as the cause of her difficulty which is present all the time it is relegated to her subconscious, "it's subconsciously you do worry". Her situation as the mother of a handicapped child is, moreover, a source of continual stress, "it's there all the time, you just can't forget you've got a handicapped child". Aspects of the theory Mrs. S. employs to make sense of these events are elaborated so that the explanation continues to fit.

Types of causal agent

Common-sense theorising about suicide, as revealed by an examination of newspaper reports, consists of a relatively limited number of causes and causal mechanisms presumed to lead to suicidal behaviour. These theories provide confirmation of the definition of any death as suicide by offering reasons why it occurred. As Anderson has shown, the theories employed are lay versions of psychiatric and sociological theorising about suicide in which the suicide is seen to be the product of a state of mind brought about by illness or worries over illness or a low level of domestic integration. By contrast, common-sense theorising about the origins of the sorts of disorders in which I am interested identifies a more diverse range of causal agents. It is common for more than one agent to be considered as the cause of a given problem and also for a given agent to be the cause of a variety of problems. As I have already mentioned identifying a cause involves selecting appropriate agents from a culturally limited range and fitting them to the problem in question. In this section I am not so much interested

in demonstrating a relationship between lay and professional theorising about these matters but with describing some of the causes invoked as explanations of disorder.

Seven different types of cause were mentioned by the women I interviewed to account for their own problems or those of others around them. These I will call environmental, noxious agent, biographical, person type, psychological states, familial and esoteric. Explanations were frequently constructed from more than one type of cause, or several causes were assembled into a causal sequence consisting of cause, effect and intervening variables. Consequently, it is difficult to illustrate each of the types in its pure form so where a type does not appear as the sole agent responsible for a problem I have attempted to select cases where it appears as the major precursor.

Explanations invoking environmental causes can be illustrated by the following examples:

G2.6 Int.: I've had a look at some of the things you put in your diary and I'm going to ask you about some of them. Er .... now about these ulcers, do you get them very often?

Mrs. G.: No, only when I go up to Derbyshire. I think it might be a change of water. I used to get them when I lived in Leeds and I used to go back home to Derbyshire then at weekends, sometimes I got them then. I think it could be a change of water.

F2.4 Mrs. F.: I get a touch of rheumatism in my arm, but as I say, I don't worry, I ignore it and perhaps it'll go away. I think it's caused from driving with the window down.

P2.11 Mrs. P.: My husband did have rather a .... well, he did have a stiff neck, but as I say, erm, I think again we'd been out in the car and the children had had the windows open at the back and I wonder whether driving he didn't notice the draught, cus he'd got his window down so there'd be a fair amount of draught going by .... we put it down to that really, that's what caused it.

P2.12 Mrs. P.: My daughter at the moment they do seem to think she suffers from a sort of hay fever or allergy .... they're not too sure .... as I say I have been noticing for some time now that she's been getting this cough, it seems whenever there's a wind, a certain direction of wind and again I do notice her eyes seem to be a bit puffy.

Int.: Did the doctor actually diagnose it as an allergy?

Mrs. P.: Well, not definitiely, he said and he was a bit streamy Dr. S. was himself, he said it's quite likely he said that she's like me he said, it is when the weather changes, one day you get it warm and then you get it the wind gets up and erm I had noticed, you know, that it does seem that when the wind gets up that she'll start coughing or perhaps get a runny nose a bit you know.

Environmental causes such as those contained above are imputed on the basis of observed changes in an individual's environment preceding a problem of one kind or another. As in P2.12, this environmental theory of causation may be legitimised during consultations with professionals. Though many of the disorders explained in this way were respiratory or involved pain in joints or bones many problems were seen to be the result of environmental factors. For example, Mrs. P. claimed that her daughter's nose bleeds and her own swollen ankles were due to warm weather. However, one of the most common connections to appear in lay talk on these topics is the association between cold and cold weather and problems with the chest or musculo-skeletal system. When Mr. P. complained of pain down the back of one of his legs Mrs. P. said, "I don't know what it was with his leg trouble, he had been doing some gardening I think and er .... more often than not, well, I don't think he ever takes anything out to sort of kneel on and if we've had buckets of rain he's kneeling on the damp grass and I know myself I've had my knees play up terribly if you kneel on anything damp for any length of time". Explanations such as this may be used to inform

actions undertaken to manage the problems to which they refer. Following one bout of chest trouble Mrs. P's daughter had been kept at home:

P2.13 Mrs. P.: Yesterday it was so lovely she sat out in the garden a bit, you know, and played around in general. I thought, well, it can't hurt her. And erm, she wanted to go out today a bit but it's cooler and it's very damp so I wasn't over keen. Cus all I, p'raps it sounds silly but I don't want her to have a sudden change of temperature and get the cough really bad again.

Where this common-sense association does not hold additional factors may be introduced to account for the discrepancy. For example, at one interview Mrs. S. expressed concern that her daughter appeared to get recurrent "bad throats" and she got them more in the summer than the winter. This apparent contradiction of what the common-sense version of events would have us anticipate is managed by introducing "children's behaviour" as an intervening variable:

S2.16 Int.: Do you think it's unusual to get these throat infections in the summer?

Mrs. S.: I would have thought so, yes. But when you think that children run around with not many clothes on. You know, they run around without shoes on and things like that. I mean Michael can't do that so I often think anything like a summer infection is due to the fact that they are running around, they get hot I think rushing around, they play very hectically, don't they, children, they get a bit hot, I know she does and then probably she gets a bit cool when she's not rushing around and then I think this is the sort of thing when things do happen. That's what I've found with her. With Michael I can't tell cus he can't run around. I mean he sits outside but it's not as if he's running around with bare feet and things like that.

When noxious agents are introduced as causes they usually take one of two possible forms, either something that has been ingested or

something that has been caught. They tend to be invoked to account for symptoms such as vomiting, diarrhoea and high temperature. In both instances confirmatory evidence is routinely sought in the form of other cases, either individuals who have eaten the same thing or have been in contact and show the same symptoms. When Mrs. P's son, Martin, had tonsillitis following her daughter's chest infection she said, "I presume the germ sort of passed on a bit really". Even where individuals have not been in contact a noxious agent such as a virus may be invoked to account for similar symptoms in which case it is identified as "something going around".

Where familial causes figure in the construction of explanations they may also take one of two forms. Problems may be seen to be the product of particular relationships within the family, or they may be seen to be the product of inherited tendencies. Mrs. P., for example, offered an explanation of her husband's depression in terms of the former:

P2.14 Mrs. P.: It's all really to do with, the psychiatrists that he saw said it was childhood, goes right back, you see, he had such an unhappy time, his parents were divorced and when he sort of needed a dad he hadn't got one and then his mother married again but stepfather when he was smaller never had any time for him, it was all his sister cus she was the sort of baby of the family and he was er kind of pushed aside and this is the trouble, it kind of something for some unknown reason can trigger off all the unhappy memories and he does literally go down and down and then hits rock bottom but erm it's all sort of to do with that.

Mrs. R. and Mrs. G. both identified problems which stemmed from a family tendency:

R2.6 Mrs. R.: My son had problems very early on in life, he suffered from tonsillitis very severely from the age of three months, it fizzled out when he was about four, just before we changed to Dr. M. In fact, my husband had to have his tonsils out when he was an adult, like my son, you know, it seems to be from there.

G2.7 Mrs. G.: I've got high blood pressure, but we're all blood pressurey, definitiely, my sister, myself and me dad, we've all got high blood pressure.

Where specific aspects of biographies are invoked as causes reference may be made to life situations, life events or life stages. Mrs. S., as I have already mentioned, explained her problem with her "nerves" in terms of her situation as the mother of a handicapped child:

S2.17 Int.: You told me last time you sometimes get a touch of nervous problems.

Mrs. S.: Ah yes, well I think this is mostly Michael. I've never suffered with nerves in my life before I had Michael. I mean, you can appreciate that, you've seen him, he's in a wheelchair, he's spastic, he can't walk, he can't talk, he's just recently had an operation and I worry over that. I worry because I think how's he going to be in the future.

It is the special worries associated with having a handicapped child, which Mrs. S. assumes anyone would recognise, that lead to her problems:

S2.18 Mrs. S.: Every time I lift him up and he goes uuh, he goes like that, I think it's just sheer habit with him now, I have to scoop him up to get him to sit in his wheelchair, you know, cus he doesn't sit in his chair all day long, it's too uncomfy for him and he might go uuh, like that, and I think what's the matter, is it his hip, has it come out of its socket, you know. I suppose it's things like this that I have daily that make me like I am.

The ordinary everyday routine of child care can then become a source of worry to the mother of a brain-damaged child. It is the numerous events associated with the care of such a child that cause concern and are responsible for Mrs. S. suffering with her nerves. In turn, as other data extracts dealing with this case have shown, "nerves" can also be used to explain a variety of other problematic experiences which Mrs. S. encounters. Her biography offers and consists in causal chains of this kind.

Specific life events may also be identified as the precursor of particular difficulties. Mr. R., for example, claimed at an interview with his wife where he was present that his "normally depressive state" had been "exacerbated by overwork" to the extent that he required professional treatment. And Mrs. R. in a prolonged discussion I had with her about depression offered life events as causes for cases of depression she knew among her friends and acquaintances:

R2.7 Mrs. R.: With one woman I know it followed the death of her mother after a little time, she was alright for a bit and it happened after that that erm which I believe is very frequent, the death of someone and then after a time people get depressed.

(Later in the same interview.)

I mean there's another woman I know who had a sort of breakdown after her husband ran off with another woman. But then this is almost to be expected I suppose you've got to react in some way. I mean, not everybody has a breakdown but there must be a reaction.

As I will describe later, Mrs. R. did not subscribe to a life events theory to account for her husband's depression, nor did she entirely agree with his diagnosis that it had been caused by overwork. This is part of the cognitive problem under which she laboured and which

I described in the preceding chapter. Clearly, where life events can be seen to be the origins of a psychiatric problem then they are understandable to the extent that they could almost be predicted.

Life events are not only invoked to account for psychiatric disorders, they may also be seen as the causes of more mundane conditions. Mrs. F. suffered from recurrent and often prolonged swelling and irritation of the eyes and eyelids which had been diagnosed by her doctor as an allergy. However, numerous tests at an allergy clinic had failed to identify any substance which could be causing it. Consequently, each allergic attack led Mrs. F. to a retrospective examination of events which might have brought her into contact with a potential allergen:

F2.5 Mrs. F.: I had a very bad do with it just before we went to a dramatic conference at Chester and, you know, I looked dreadful the whole time. Er we decided after talking to someone at the conference, an architect chap, he tied it down for me, he said it's the paint, this particular time it was the paint, cus Pete was painting the kitchen and we got this special white paint that never goes yellow and he said ... and it wasn't until .... I mean I didn't personally tie it down with that, it was alright while everything was being done, undercoat and so on, it wasn't until Pete came to put the top coat on .... and I did some top coat as well and funnily enough, I mean now it's been said I can say, oh yes, that must be it because my eyes started stinging as I actually started putting this white stuff on the pipes by the boiler. He said there's something in it and he gave it a name, being in the trade he would know, some chemical in it which obviously I must be allergic to and I'm pretty sure he must be right cus since you know the smell has gone and we've finished painting the kitchen I've been alright. I wouldn't use it again just in case.

Although Mrs. F. thought that the special chemical in the paint was responsible for her allergic attack, "I'm pretty positive that was

it this particular time", she thought that she was sensitive to several substances, "I mean we're not always painting, it can't always be that". This arose because she was unable to connect a given event with every outbreak of her allergy. At the next interview Mrs. F. was also in the throes of an attack:

F2.6 Mrs. F.: Erm, I thought it could have started with detergent powder cus I'm always very careful to keep off detergents and for some reason I had a mental blackout you know, I was in Sainsbury's and I saw own brand and I thought that's bound to be cheaper and it wasn't till I was halfway through the packet that I read Sainsbury's detergent powder, not Sainsbury's soap powder, and I thought that might have started it. But obviously I haven't touched that since, I mean I've thrown it away and that's it but it still hasn't cleared up ....

Int.: Yeah.

Mrs. F.: and it tends to come back a little bit and go away a little bit and come back a bit and go away again. So I wondered whether it was Handy Andy which is something I've always used but not frequently.

Here, Mrs. F. is able to identify a possible causal agent in the detergent she unwittingly used just prior to the onset of the problem. When the problem did not resolve after she had thrown the detergent away this explanation was rejected. Subsequently, she attempted to find an agent that would fit the character of the attack; since the attack was intermittent then it was likely to be caused by something with which she had intermittent contact. Another household cleanser was then identified as a possible cause. A similar reasoning was offered by Mrs. F. to explain why she had never bothered to have her stage make-up tested at the allergy clinic: "I use that so seldomly and I couldn't directly associate the allergy with stage make-up at any time". At the same interview, Mrs. F. was also able to find a life event to explain her younger daughter's "bad throat":

F2.7 Mrs. F.: My younger daughter has a bad throat, but I suspect it's because she's been, they've been rehearsing at school an awful lot for this Orpheus, she's singing Venus which really is too high for her, I think it's just strained.

Int.: And how is she today?

Mrs. F.: She thinks she might have a bit of a cold but there's nothing visible so whether it's just sort of nerves or as I say whether the throat because she's been singing all these high notes which are a bit out of her range really ....

Int.: It would be a bit of a disaster for her to have a cold ....?

Mrs. F.: Well, it would, yes, this is it. So whether it's psychological or not I don't know but we'll dose her up until we get her on stage, you know.

In this case Mrs. F. rejects her daughter's explanation for the event because there is no observable evidence to support it. She substitutes her own life events theory which may be connected to the problem in two ways. It may result from the physical strain of singing a role which is too high, or it may be psychological, the product of pre-performance nerves(23).

Some disorders are seen to be the consequence of the life stages which an individual progressively occupies. Childhood, adolescence, the menopause and old age were all allocated an aetiological role by the women I interviewed. In so doing they made reference to common-sense conceptions of the typical characteristics of individuals occupying those life stages. Mrs. G., in attempting to identify a reason for her son being unwell is aware of such a conception: "I thought at first it could be teething couldn't it with a baby. Obviously, everybody puts everything down to teething with a baby. But it could have been". Thus, though teething can lead to a baby being unwell and may be legitimately invoked as cause, "it could have been", it's use is frequently

unwarranted judging by the fact that it is seen as the cause of "everything" wrong with a child at that life stage. A similar conception of problems associated with childhood is involved in the notion of "growing pains" and the often expressed hope that children will "grow out of" their problems. Mrs. F., for example, said "I used to get hay fever as a child but I've gradually grown out of that, I don't get it any more". Mrs. G. said she was told by her doctor that she would "grow out of" her recurrent tonsillitis; Mrs. S. said "I feel sure she's growing out of it" when referring to her 3 years old daugher's frequent colds, and Mrs. R. said she hoped her son would "grow out of" the problems with his ears.

Other life stages are also seen to embody weaknesses that may predispose an individual to particular kinds of disorder. Adolescence, for example, is seen as a difficult emotional stage, such that when I mentioned people I had known who had been depressed or prescribed psychotropics in their "late teens" Mrs. R. commented, "Ah, yes, well that's a very vulnerable age, isn't it?" Similarly, the menopause is often taken to be a difficult period in which problems may arise. Consequently, it may be used as a device to explain disorders that appear at that stage of life:

G2.8 Mrs. G.: My mother used to get .... oh dear, what did my dad call them .... lurgy bouts.

Int.: What?

Mrs. G.: Lurgy bouts, well just sort of sickness .... she used to get them a lot on a Sunday, sort of headache and sickness, whether it was the change that caused it, you know, the menopause.

Old age is the stage of life at which a wide variety of disorders may be experienced. It is also the stage of life when those disorders are expected. Mrs. F. said of her mother, "She's got something to com-

plain about, I mean to say at 84 you expect to get all sorts of things". And Mrs. P., speaking of her 85 year old father said, "He's very fit for his age" (my emphasis). While general level of health is seen to be age-related, specific problems are also associated with aging. Though she pronounced him "very fit" Mrs. P's father did have hardening of the arteries in his legs which made walking difficult, "Well, at his age you've got to expect it really", and he often sounded so wheezy that she had encouraged him to see the doctor about it, "there again, it's one of the problems of old age, their breathing gets a bit that way, you know". At a later interview, after he had begun to get muddled and confused, his doctor is reported as saying, "Oh well, of course, it is to be expected, he is 86". Aging may also be used as an explanatory device by the not so old. Mrs. P., herself only 46, thought an episode of swollen ankles was due to the warm weather although she did also comment, "I suppose my age has got something to do with it".

Some explanations locate the origins of disorders within the individual concerned by identifying them as a particular type. The problem is seen as one of their response to events or situations. Mrs. S., although having a fairly well defined biographical explanation of her "nerves" was able to see how this could be exacerbated by the way in which she reacted to her situation as the mother of a handicapped child. Though she often remarked upon the worry that this caused her she said more than once, "It's silly really, because there's nothing specific to be worried about". At one interview she continued, "I think I do worry needlessly when I think about it. But then I'm like that. You just can't change yourself, can you, I mean if that's the way you are?" The same sort of influence was seen to operate in preventing her from sleeping:

S2.19 Mrs. S.: My husband's work is hard and I think if anything he comes home quite tired in the evening, more mental strain than anything, but it doesn't seem to worry his nerves. For instance, last night I went to bed and I couldn't sleep and lying there, I'd had a hectic day, and I lie there thinking of all the happenings over the day and all the things that are going to happen the next day and Mike, although he's probably had a very busy day he can, he's said he can just close his mind off like that and go to sleep. I can't do that, this is my problem. Once again, it's nerves.

Though both herself and her husband have busy, hectic days he has the capacity to close his mind off to the events of the day and go to sleep. In contrast, Mrs. S. responds by thinking over the events of the day because she is not the kind of person who can close her mind off in that way. Consequently, she has difficulty in sleeping and he does not. While her life situation is at the root of the problem, as she went on "probably if I led a bit quieter life", her reaction to it, imposed on her because of the type of person she is, is a contributary etiological factor. In comparison, though her husband's work is hard, his days busy and he is subject to mental strain, "it doesn't seem to worry his nerves".

Mrs. R., in attempting to make sense of her husband's depression, also indulged in theorising about the aetiological role of his person type. While he preferred to see his current mental state as the product of hard work, she was more inclined to emphasise that it was his response to the pressure of work that was the important factor. In the following lengthy extract Mrs. R. attempts to assess the contribution made by work and his person type to his problem. She had just described how he was very keyed up about a forthcoming meeting at work:

R2.8 Int.: Did he use to worry about this sort of thing before he started getting the depression?

Mrs. R.: Yes, but not to that extent. He used to get very keyed up about things, he's always had this tendency to get keyed up about things but of course this has become vastly worse since he got more and more depressed.

Int.: Obviously, his work's very important to him.

Mrs. R.: Yes, erm .... yes, but erm .... well I, and this is my own personal opinion, I think if you're the kind of person who gets into a state about things you'll always find something to get into a state about, which in fact he has done, I mean if it hasn't been one thing it's been another so I think the bit about work is a little bit of an excuse although there is a lot .... I happen to know from talking to other people who work there there is a lot of pressure and sometimes it is difficult to cope there. Another friend of ours used to work in the same office and he had a breakdown, a bad breakdown and he was in hospital for two months. Again I don't think that was the reason for the breakdown but it didn't help and since he's left he's very much happier and he's a different person. So I think that the work isn't altogether although I said it's an excuse it is .... I'm not making sense am I?

Int.: Well, you think it's contributary?

Mrs. R.: Yes, this is what I think. But I know where he works there is a lot of pressure but then of course maybe at other places there is also a lot of pressure, I don't know, I think it's largely a matter of how you react to it, to what's going on around you.

Mrs. R. does then see the problem in terms of internal tendencies and individual reactions to situations. This construction led her to a pessimistic view of his prognosis:

R2.9 Mrs. R.: I do have worries and reservations about, you know, will he always be inclined to depression because in fact, er, he says, and I'm sure this is true, that he's been depressed ever since he remembers really without altogether realising it. This goes back a very long way and of course I wonder how far can this be cured if it's of such long-standing.

Mrs. R. also offered a person type explanation to account for the fact that he lost weight while treated as a psychiatric in-patient:

Mrs. R.: He lost a lot of weight in hospital even though he said he was eating but the tendency for him I think under stress will be for him to lose weight whereas I'll put it on under stress, he'll lose it.

It is not only problems of a psychological nature that may be subject to person type explanations. Mrs. F., because she could not definitely identify the substances to which she was allergic began to see it in these terms:

F2.8 Mrs. F.: I'm allergic, you know, I'm just one of those people who get allergies and put up with them.

Tension, stress, depression and worry are psychological states frequently identified as the causes of certain disorders, either directly or, as in the case of Mrs. S., as an intervening factor between some more basic cause and an effect. Mrs. R., for example, claimed that her husband's complaints of stomach ache and indigestion were psychosomatic, and invoked a common-sense connection between being nervous and alimentary problems to justify that claim:

R2.10 Mrs. R.: Well, he does complain of stomach ache and indigestion which I'm convinced is psychosomatic, absolutely convinced it is because when he's relaxed he doesn't get it and when he's tense he tends to get indigestion and so forth so I am .... and after all, it's one of the first things to be affected if you're nervous.

One of the most common connections made was that between tension and pain of various sorts. Mrs. N. attributed her husband's headaches to nervous tension, "he just gets terribly tied up and knotted that's all, I mean it's just complete tension on his part", and her own and her husband's backaches were similarly explained, "I have backaches, my husband has backaches, it's from being tense, we're a very tense family". Both Mrs. P. and Mrs. S. said they had headaches from being "tensed up" and Mrs. P. found the same cause for the intermittent pain from her

duodenal ulcer, "I find it plagues me if I ever get wound up or worried". On the last occasion on which it bothered her, "it was probably the upset of, you know, all his problems and that", referring to her husband's recent confession that he had become depressed. Despite a doctor's diagnosis to the contrary, Mrs. F. claimed that her mother's "shakes" was due to worry:

F2.9 Mrs. F.: She calls it the shakes, I've got the shakes you see. It's in one arm. The doctor says it's old age, the muscles get weak. I don't know. I think possibly it's worry's got a lot to do with it. My mother worries so much about anyone in the family it seems to start .... the fact that she was worried about her sister seemed to start her shakes quite honestly. But then that's just my diagnosis.

A final category of causes I have, for want of a better label, called esoteric. These are frequently invoked to account for the otherwise inexplicable. Mrs. R. for example asked, following an exchange about someone I knew who had been depressed for a number of years, "Did anything precipitate it or was it just one of those things?" That is, either a specific causal agent must be located or the event is relegated to that category in which phenomena happen for no apparent reason. The particular entity invoked in this category seems to be related to the severity of the disorder in question. Parents of children with life-threatening or crippling diseases may refer to God's will or purpose, while my respondents, considering less catastrophic disorders were more likely to accept them as one of those things. Since their impact was only temporary the need for an explanation was less. Mrs. S., whose handicapped son might reasonably be expected to constitue a catastrophe, did refer to fortune when she talked about how fit and well he was, "We're lucky that Michael is as normal as he ever could be as a brain-damaged child, we're very fortunate, you know".

Similarly, fortune may be invoked to explain why an unwelcome event, expected to be the consequences of some prior event, did not happen. Mrs. P., in answer to my question about her father who only had the use of one leg and had recently had several sudden falls said, "Fortunately, he hasn't hurt himself. This has been the thing that's so well miraculous in a way, he hasn't hurt himself at all". However, even with regard to relatively trivial matters apparently sophisticated explanations may be constructed. For example, in the following extract Mrs. N. invokes a conception of a natural order of things which is not to be tampered with to account for the increased frequency with which her husband caught colds after a course of injections:

N2.3 Mrs. N.: My husband is very susceptible to colds. After all his cold injections. I've stopped him having them now. A waste of time. They'd come up with the flu jabs in his office and I'd say to him you're not having one this time. He had a cold and that was that. But they were more recurring when he was having the jabs. Sometimes you can't interfere with nature, it's got to take its course.

Mrs. F., describing her recipe for avoiding colds, tentatively attributed its success to faith:

F2.10 Mrs. F.: The whole of the time I was doing this pantomime I was surrounded by colds, so from about the fortnight before the show and for the week of the show every night before I went to bed I put a little TCP up each nostril. And that's all I did for that three weeks because it was important for me to be well. I don't know whether there's anything in it but it does seem to .... as I say, they had colds all round me all of the cast and the minute the curtain came down three of them went down with flu, you know, they were practically in bed, but I didn't get it. Maybe it works because I believe in it.

The choice of alternatives

It is often the case that more than one explanation can be con-

structed to account for any particular disorder. One individual may select from a variety of causal agents to produce two or more explanatory hypotheses or alternatives may be offered by others, including professional problem solvers. Where this happens the evidence may be reviewed so that one explanation may be seen to be the more likely. In the next two data extracts two of the respondents offer accounts of problems which have also been presented for professional diagnosis. In the first, Mrs. G. describes what happened following her decision to consult the doctor when she noticed her young son had a high temperature:

G2.9 Mrs. G.: Anyway, I thought he ought to see a doctor so I rang the clinic and he had an appointment at twenty five past six. By the time we saw the doctor it was seven, by that time he'd been asleep in my arms for about twenty minutes and he'd got his clothes on and it's always hot up there and we got in and undressed him so he could listen to his chest and he'd got a great big red rash all over him and he thought he had measles. So, you know, he gave me penicillin, came back and by the time we got him undressed and ready for bed there was no rash at all. It was just a heat rash, that's all. And that was it.

Int.: And did you bother giving him the penicillin?

Mrs. G.: I did, yes. But it was a virus I'm sure because within .... I had Nathan (a neighbour's child) that day and within two days he'd got exactly the same thing, but he just got over his within 24 hours. And Darren (a friend's child) got it as well and he'd been with us the day before so, you know, it must have been a virus.

Here, Mrs. G. challenges the doctor's explanation of her son's high temperature, his diagnosis of measles, and presents facts to substantiate her alternative. The doctor's diagnosis rests upon the observation of a red rash. Mrs. G. is able to demonstrate that this is not a symptomatological cue indicative of an underlying disorder, but the product of temporary environmental circumstances. Her depic-

tion of the rash as a heat rash unconnected with the problem for which she had consulted the doctor, is based upon the fact that conditions which might create a heat rash were present, and the rash disappeared following a change of environment. The assumption is that a rash due to measles would not have disappeared in this manner. The doctor is therefore depicted as misreading the facts although no criticism is necessarily implied because at the time the diagnosis was made he had no way of knowing of later developments which point to a different interpretation. This disposal of the professional definition of the situation is subtantiated by her presentation of a feasible alternative; that is, the high temperature was due to a virus. This is indicated by facts of which Mrs. G. subsequently became aware. Thus, since two children who had recently been in contact with her son developed the same symptoms "sort of tiredness and this really high temperature", a theory of contagion is invoked and a causal agent identified which is known to be contagious.

In the second extract Mrs. F. describes how her daughter consulted the doctor about a dermatological problem:

F2.11 Mrs. F.: My eldest daughter, Madge, has been to the doctor because she started getting very spotty .... but only when she got hot. You know, she could sit in the kitchen having her tea by the boiler and she'd get well just sort of flushing all hot and coming out in little spots under the skin .... only as I say when she got hot. He gave her some pills which didn't do her any good so she went back again, he gave her some sort of ointment to put on it but it's not that type of thing, it's not an acne thing and it practically took a layer of her skin off and still did no good. So she bought herself some sulphur tablets and I think she's cured. So anyway she's better, whether it would have gone away on its own anyway or whether the sulphur tablets have done any good I don't know. Someone said to me that sulphur is an old fashioned remedy for overheated blood and so on which seemed to be more like she'd got, you know, we

> felt it was overheated blood. It seemed to coincide with sitting by the boiler but she did get it other times when she sort of got overheated like. They just came up on her face and they'd gradually go away. So every time she went to the doctor's she got nothing to show him, see, cus she wasn't having one of her hot flushes at the time. I don't blame him for not sort of diagnosing it cus he never saw it. It wasn't an infection, not pussy spots or anything like that.

In this case Mrs. F. rejects the doctor's depiction of events on the grounds that the action to which it gives rise does not in fact resolve the problem. Again, he is not to be held responsible for his misdiagnosis since he was not in possession of the full facts. That is, owing to the circumstances under which the problem appeared the doctor was not in a position to make a proper diagnosis, "I don't blame him .... cus he never saw it". The alternative, "overheated blood" is constructed by Mrs. F. on the basis of the events which are depicted as always preceding the problem. This explanation is reinforced by the success of the home remedy, despite Mrs. F's reticence, since an explanation is available which fits the situation. Thus, if sulphur is a remedy for overheated blood and the problem resolved following a course of sulphur tablets then it is not unreasonable to assume that the problem was caused by overheated blood. Though it may have gone away on its own anyway, the facts point to this as the likely cause. In both of these cases lay definitions are taken to be superior to professional ones since they are based upon a consideration of all the facts and not a partial scrutiny of the evidence. Consequently, they are definitions which fit the known facts of the matter.

Discrediting one explanation of events does not always require the elaborate theorising that is a feature of the above two cases.

Mrs. P., for example, simply denied her husband's characterisation of the pains in her son's legs as growing pains by denying the existence of such an entity, "That's ridiculous, there's no such thing". In other cases, two explanations were constructed without a choice between them being made. This usually occurred when the problem resolved itself, a common outcome of many trivial disorders which are self-limiting. The problem does not then constitute an imposed relevance, it is transformed from a practical problem into a theoretical one. Unless preventive action is to be a consequence of the experience two causal theories can be entertained simultaneously.

Diagnosis as outcome of the explanatory process

The above two cases illustrate other features of the construction of an explanation of disorder. Firstly, that the labelling of a disorder, its diagnosis, is the outcome of the way in which that disorder is explained. As Mrs. G. put it, "You get diarrhoea and sickness with a lot of things, don't you?" Though diarrhoea and sickness may always be taken as indicative of disorder interpretive work is necessary to determine the specific disorder they signify.

The following extract reinforces the view that lay diagnoses depend upon the location of a cause for any disorder under scrutiny. It also shows how lay diagnoses are not based solely on signs and symptoms but derive from a process in which other knowledge is employed to arrive at a decision. Since any sign or symptom may point to more than one diagnosis this other knowledge may be the evidence upon which one, rather than another is selected. This extract follows that presented in S2 in which Mrs. S. descibed how her daughter had asked to be put to bed one evening and had subsequently been sick:

S2.20 Int.: You don't know what it was that made her sick, do you?"

Mrs. S.: I haven't a clue. I tried, you know, how you do to think back now what has she eaten during the day, did she have anything different. As far as I could see she had what she would normally have, what we had as well. So I just don't know what it was. Yet funnily enough, I heard two or three children had this afterwards so whether she'd picked something up from nursery school, one of those quick things, because the girl next door, her two little girls had got it. I usually put it down to something they might have just eaten, I mean children aren't terribly fussy are they when they go to school or anything like that, they're not. I mean, she'd gone to nursery school so it's quite possible she might have had something there. I think it was just something going around because so many children had it.

In this case two diagnoses of the symptom are considered and the final choice is made on the basis of information about aspects of the case other than its overt manifestations. The two diagnoses are varieties of noxious agents, either "something she's eaten" or "something going round". The facts indicating one or other diagnosis are assessed and a choice made. Although Mrs. S. had not given her daughter anything unusual to eat or anything that other members of her family had eaten it is a possibility that she could have had something at nursery school that had been responsible for her being sick. While this would account for her daughter's symptoms it would not explain why "so many other children" had had the same complaint. "I think it was just something going round" thus emerges as the diagnosis because it fits not only the symptoms but other observations assumed to be connected to it.

The reinterpretation of cause

Cases F2.9 and F2.11 also illustrate a feature of many of the data extracts I have presented here, the way in which interpretations

are reconstructed following the appearance of new evidence. In fact, judgements about the meaning of events is often suspended under the assumption that there will be future developments pointing to a particular interpretation of those events. Whatever, a new theory is called for which accommodates old and new observations. At my first interview with Mrs. N. her younger daughter was at home having left school with what she described as a very bad head. Just prior to my arrival Mr. N. had telephoned to say that he had a very bad headache and Mrs. N., while waiting for him to come home had got in touch with her doctor:

N2.4 Int.: Why did you decide to telephone the doctor?

Mrs. N.: Well, because I thought to myself, she had it, O.K., it was tiredness or a migraine. Now my husband has gone down with it, it must be a virus. So I just thought I'd confirm with one of the doctors that it may be or not.

Tiredness and migraine are, in Mrs. N's terms, explanations which may be applied to individual cases of headache. Two cases in the same family, however, require a theory that is not couched in individualistic terms since two people within the same family would not usually be expected to have migraines at the same time. Rather, the two cases are assumed to be connected and an agent identified which would reasonably account for both. In many of the extracts in which they are mentioned as agents viruses are depicted as things which "go around", striking suddenly and affecting more than one individual. Given these characteristics a virus may reasonably be seen to be causing the headaches of members of Mrs. N's family. This, however, only became a possibility when the situation developed, showed the original interpretation to be incorrect and demanded a new theory.

Similarly, diagnoses may be revised when new facts appear. Mrs. F. had taken her mother to the doctor after she developed a tremor in one arm. Mrs. F. thought it was caused by worry but the doctor said it was due to old age and weakening of the muscles:

F2.12 Mrs. F.: Even now I wonder whether .... you see she's a funny old thing, it wasn't until we came home from the doctor's the second time that she said, cus the doctor couldn't understand why it's only in one arm you see if it's the old age shakes one assumes it should be ....

Int.: Yes.

Mrs. F.: it wasn't until we got home from the doctor's that she said to me cus it's since I banged it you know, I gave it a nasty bang. So maybe it's not old age tremors after all, maybe she's actually damaged the muscle or the elbow.

The information provided by Mrs. F's mother is used to construct another diagnosis which will fit the newly emerged facts. At the same time it resolves the discrepancy between the original diagnosis and the facts on which it was based. That the tremor is due to injury rather than old age explains why it affects one arm only[24].

Selecting the evidence to fit the explanation

In some of the extracts above the respondents were able to reject causal theories offered them by others by demonstrating that the explanation did not fit the facts. In some cases, however, explanations may be accepted although some of the facts cannot be accounted for in its terms. For example, Mrs. G. had recently been to the doctor with her young son who had diarrhoea and vomiting:

G2.10 Int.: And did you find out what was wrong with him?

Mrs. G.: Well, the doctor said it was a virus because I went up to when we got the prescription the chemist said you're lucky, you know, I've just got some of this stomach medicine left, he said there'd been a run on it so, you know,

it was just something that was about. I think there's been a lot of it this year, you know. I know families who've had it four or five times.

Int.: Mm ....

Mrs. G.: But we didn't get it. That's funny isn't it?

Int.: Why?

Mrs. G.: Well, you would have imagined if it was a virus we would have got it.

Although Mrs. G. accepts that her son's symptoms were due to a virus, the doctor's diagnosis seems to be supported by the chemist's evidence, she is able to note an anomaly in the fact that she and her husband "didn't get it". Clearly, this is expected to be the outcome of a virus infection for, as she points out, "I know families who've had it four or five times". This, however, does not seriously challenge the interpretation that it was "just something that was about".

Evidence which does not fit an accepted explanation may be selectively disregarded. Alternatively, the theory may be elaborated by the introduction of new facts which remove the anomaly by deeming it irrelevant. In the next extract Mrs. R. tries to find what it was that caused her to be very sick one night, an event which for her is very unusual:

R2.11 Mrs. R.: Well, I suspect but I may be wrong, I took my son out for a treat to the Wimpy bar and we each had .... well, he hardly touched his but I ate mine. I suspect it was that but there was another lady with me and she ate hers and she was alright cus I phoned her up and she was fine so whether it was the Wimpy or whether it was my reaction, I don't like them anyway and perhaps because I don't like them very much, perhaps that's why it didn't agree with me. I couldn't think of any other reason.

In looking for an explanation of her symptoms Mrs. R. attempts to locate a causal antecedent and finds one in something that she ate. However, because she assumes that anyone eating the same things should

also show the same symptoms the explanation is rendered suspect by her discovery that the person with her at the time was alright. Her son who was also present does not figure in this theorising since "he hardly touched his" and would not be expected to show symptoms as a result. In order to maintain the theory that the food she ate was responsible the theory is elaborated by the selective presentation of other facts. This modified version can then be seen to apply independently of the health status of the others involved. This new theory still allocates a causal role to the food that was eaten but Mrs. S. personalises the explanation by introducing as an intervener her reaction to it. In this explanation the food itself is not to be found at fault; this would account for the lack of symptoms in those who ate the same thing. Rather, the fault lies with Mrs. S., "because I don't like them .... it didn't agree with me".

The explanations which individuals offer for the problematic experiences which they and others face must articulate with common-sense ideas about typical causes, typical effects and the sorts of mechanisms which typically link them. Though the data I have collected is insufficient to be definitive it does suggest that the common-sense conception of the structure of the world makes available to members a series of routine explanations for a variety of problems that others may legitimately expect them to employ. In some instances these explanations are reinforced by the opinions of those professionals with whom members come into contact. Part of the way in which an individual may demonstrate his competence as a member of a social order is by invoking socially appropriate causes to explain given events. It does not seem likely that anyone would attempt to explain psychological problems such as depression in terms of environmental causes such as a

change of water or a change in the direction of the wind. Those who do interpret the world in inappropriate ways are likely to be subject to sanctions in the form of derogatory labels, ranging from "stupid" to "mentally ill", which challenge their cognitive competence. Similarly, the only supernatural entity that may be accorded a causal role in the material world is, for members of Western societies, God. Spiritualist and faith healers are usually treated with suspicion, if not derision, and the idea that disease, illness and death can be brought about through magic or witchcraft is usually confined to story books. The thesis that any given problem is likely to be explained by a limited set of causes could be substantiated if I were to count the frequency with which any cause is invoked to account for a given problem such as headache. I have, however, been more concerned with describing the types of cause that the women I interviewed employed and expected me to see the sense of in describing the problems that formed the content of my interviews.

The way in which explanations of disorders are constructed is not of interest only as an example of the cognitive ordering of the world. Different explanations may have different implications. For example, the way an event is defined may depend upon an explanation of the way that event was brought about. The theories that coroners employ to account for deaths lead those deaths to be characterised as suicide, homicide or whatever. Similarly, actors may account for their actions towards an object or event in terms of the way they explain that object or event. Conversely, where an explanation cannot be found for an event action towards that event may be suspended. As I will show in the next chapter, doctors may advise patients that there is nothing they can do when they are presented with disorders for which they cannot account.

Causal theorising not only allows members to account for past or present problems it also allows the future to be made predictable. Under the assumption that what has happened before can happen again an effect may be reasonably expected given the occurrence of a cause. Mrs. S., for example, was able to predict when she was likely to suffer from her nervous problem by employing the causal theory she had constructed prospectively:

S2.21 Mrs. S.: As soon as it comes near a time when Michael has to go to a hospital I mean again in May, you'll probably find if you see me I shall probably be a nervous wreck in May because he's got to go back for his yearly appointment after having his leg operation and I shall be dreading it when he has to go I'll be thinking suppose something happened in that year because I would dread him to go through that operation again.

And Mr. F., knowing that an allergic response was due to cats, was able to take antihistamine prior to going to see friends who had cats to prevent the reaction he would otherwise expect to occur.

As I have already demonstrated, new developments may bring about a revision in the way events are defined. However, explanations may be found for those new developments which allows the original definition to be maintained. For example, Mrs. P. described how her daughter, Lindsay, woke up late one night and coughed violently for several hours:

P2.15 Mrs. P.: And then she was sick, but, erm, really it was only because I'd probably given her, I didn't know what to give her to stop her coughing and ease her throat really, I had some cough stuff which I usually keep because it's got no drugs in it and you can give it every hour, well her cough was so hard and dry and I thought I must loosen it so almost every hour I gave her a dose of this and in between I gave her lemon and honey. And erm, she said I think I'm going to be sick mum and she was but as I say, it was really just the cough medicine and the lemon and that.

Here, Mrs. P. is able to account for her daughter being sick in a way which makes it independent of her cough. It is seen to be a product of the treatment that Mrs. P. has provided rather than a product of the disorder of which the cough is a symptom. Consequently, the diagnosis does not need to be revised to take account of this new symptom nor its severity reassessed since the two are not connected. Actors may use a similar procedure to avoid the implications an act they have committed may have for the way in which they are defined by others. Coulter discusses the case of an Air Force psychiatrist dealing with a man who got drunk and made a sexual advance to another member of his crew. The status that may be attributed by others on the basis of this one act was denied by the psychiatrist who argued that the behaviour stemmed from the amount of alcohol the man had drunk and was not an indicator that he was a homosexual. By explaining the act in this way a definition of the man as normal could be maintained(25).

The way in which a disorder is explained may have implications for the extent to which the individual concerned or others connected with him may be held responsible. Explanations may, then, constitute a denial of responsibility. As Coulter, discussing McHugh's work, puts it "poor biographical experiences (as explanations of insanity) are more admissible for ascription to a stranger than to one's own son, daughter or spouse on the grounds that one's own responsibilities are implicated in the latter cases"(26). And as Atkinson suggests, offering ill health or worries about ill health as accounts of suicide "ties the suicide personally and exclusively to the deceased: no-one else is involved and no blame is due to them"(27). Similarly, it has been suggested that the relatives of a suicide often claim that the person seemed "better" or "more normal" just prior to death so that they cannot

reasonably be held responsible for not taking action to prevent it[28]. In this context it is easy to see that explaining a child's dermatological condition as a product of a virus infection has different implications for the public status of it's mother than if it were seen to be the product of malnutrition. Mrs. R's problem in responding to her husband's depression stemmed from the absence of an indentifiable cause which would allow her to fully accept lack of responsibility on his part and also from her interpretation of his problems deriving to some extent from his personal tendencies. Consequently, when he became very keyed up about a big meeting at work "I said to him maybe a bit cruelly, I said, well when that's over there'll be the next thing to worry about, you know". Thus, constructing explanations may provide opportunities for criticising others, demonstrating their incompetence or otherwise manipulating definitions of situations for particular ends.

The assignation of severity and significance

In the foregoing sections I have given some idea of how lay members recognise disorder and give meaning to that recognition in the way that they seek to explain the problematic experiences to which they are subject. I have also described some of the resources, the procedures and practices, that members employ in constructing social meanings. A further important aspect of conferring meaning on those events I have variously labelled problematic experiences or disorders or merely problems is assigning them to categories of severity and significance. Talk about these matters frequently contains references to how "bad" particular symptom episodes have been and in the course of the interviewing the respondents described disorders in such a way, either spontaneously or in response to my questions, which demonstrated their severity and/or significance. In deciding such matters members must draw on a stock of

knowledge which they assume is shared and socially accredited so that their judgements can be accorded the status of descriptions of the way things really are and not exaggerations or misrepresentations. I make a distinction between severity and significance since a disorder may not be severe according to medical or lay criteria yet may be seen to be significant in context. For example, catching a cold in summer constitutes a noticeable event and may be accounted for as especially bad luck whereas in winter a cold does not seem to be so remarkable. This judgement is based on common-sense notions of typical associations between certain sorts of problems and the seasons. Similarly, being ill on holiday is viewed differently than being ill during the course of one's usual working life since its implications are very different, independently of its severity.

In demonstrating severity and significance members may appeal to features of the disorder itself, its consequences and/or the contexts in which it occurs. Where respondents' descriptions appealed to features of the disorder itself reference was almost always made to time. That is, the longer a disorder lasted the more likely it was, in retrospect, to be characterised as "bad" or severe:

R2.12 Mrs. R.: I've had a very bad cold which lasted for about five or six weeks and it was really very unpleasant.

Mrs. F. is describing an allergic episode in which her eyes had been swollen and irritated:

F2.13 Mrs. F.: Well, it has been very bad, I've had it sort of over a month or six weeks.

In both of these cases no reference was made to any other aspect of the disorder. In the former the expectation is that reference will be made either to experience or knowledge derived from other sources about the

typical course of a cold to see the categorisation as warranted. Mrs. F. in the latter example supplied her own standard for judging the severity of the problem. Whenever she talked about her allergy she referred to this temporal dimension. Experience had shown her that the condition usually cleared up within two weeks and any episode which extended beyond this normal period was seen to be correspondingly more severe although the symptoms themselves were not any different.

Mrs. R. in monitoring her husband's psychiatric condition used this notion of time as a resource to chart his progress:

R2.13 Mrs. R.: By about November he'd got considerably worse, he was getting more and more depressed. His bouts of depression became more frequent and lasting much longer, in fact, they were with him most of the time .... erm .... the periods in between when he was for want of a better word normal were getting fewer.

In defining her husband's condition as "worse" Mrs. R. refers to the fact that his episodes of depression were becoming more frequent, that is, there were more of them in a given time, and were lasting much longer such that he was depressed "for most of the time". In many ways this is similar to what Zola has called temporalising of symptomatology in his discussions of triggers to the seeking of medical care. That is, where a symptom reoccurs or lasts, its significance may be reassessed and professional advice sought. A similar procedure may be used for assigning significance to the cessation of normal body function:

G2.11 Mrs. G.: (Talking about a friend with constipation) I sometimes get it but not chronic constipation which is hers, hers is chronic, she couldn't go at all unless she had laxatives, she wouldn't go for weeks unless she had laxatives.

Conversely, the assumed connection between time and severity can be used to depict problems as relatively inconsequential:

Mrs. G. is talking about her oral ulcers which she has described as trivial:

G2.12 Mrs. G.: They're just little spots on your tongue, that's all, in a couple of days they just go.

S2.22 Mrs. S.: At the moment I have no problems but, erm, probably in about a month I'll start feeling nervy again.

Int.: Does it concern you .... I mean does the fact that you get like this worry you at all?

Mrs. S.: No, not really because I know it's not going to last very long.

R2.14 Mrs. R.: (Referring to her son and daughter who had both recently recovered from chicken pox) His wasn't quite as severe, erm, it was only a couple of days really that it caused any problems.

In each of the above examples the respondents may be said to be engaged in the activity of trivialising, that is, of minimising the significance of an event(29). This is accomplished by reference to the aforementioned interpretive scheme in which the length of time a lesion or condition lasts is an indicator of its seriousness.

On occasions other features may be appealed to to provide for judgements about severity. Mrs. R. described in one interview how she periodically suffered from migraine in which she would have a "very bad headache" and "feel sick". She went on, "my brother has them but a little bit worse than mine .... when he gets them he is sick and he has felt .... he gets double vision with his I think". Thus, the number and type of symptoms associated with a condition may be invoked to compare cases and define one as worse than the other. Mrs. F. in discussing her husband's allergy minimised it in comparison to her own, "He gets sort of something that is similar to hay fever although he's never had proper hay fever that I've caught, cus I've had hay fever

really badly, you know. I think it's something in the garden which affects him, if he does gardening that's when he gets it but normally just to go out and have a picnic in a field or something whereas I would have been sneezing my head off it doesn't take him like that".

In constructing definitions of severity and significance members may also point to the consequences of disorders. These consequences may be offered alone or, as will be shown by further discussion of some of the above cases, in conjunction with other aspects of the problem such as those just described. As far as the consequences of the disorder are concerned an appeal may be made to the actions that were undertaken as a direct result of the disorder. Mrs. R., for example, indicated the severity of a migraine attack in the following way:

R2.15 Int.: Do you usually take anything for them?

Mrs. R.: Not usually .... I did this time because my head was so bad I took some pain killers.

Here, the severity of the attack is given by the fact that something had to be done about it in comparison with other attacks which do not usually call for action of this kind. Mrs. G. also refers to actions as consequences in the next extract:

G2.13 Mrs. G.: I had this real sort of bad pain in my stomach and it was just after I'd eaten, you know, it got really bad.

Int.: How bad was it?

Mrs. G.: Well, it got to the state where after I'd had something to eat I'd be lying, you know, I'd have to lie down, you know, the pain would be quite severe.

The assumption that a disorder which is at all severe imposes some limitation on action or other consequences for function is implicit in many of the descriptions I was given by the respondents. Mrs. P's father, for example, had had a series of falls over the year or so in

which I visited Mrs. P. which became progressively worse:

P2.16 Mrs. P.: He had this one bad fall just before Christmas and this is what made us go round night and morning because up to then he was getting himself to bed and I think he must have fallen getting his trousers off and he was on the floor all night and he couldn't get up. He crawled sort of round the bed clawing at the bed trying to get up and he just couldn't, you see.

Following this one bad fall Mrs. P. arranged for him to have a telephone installed and began the process of persuasion which ended with him moving in with one of his other daughters.

The way in which a disorder affects function is then to be read as an indicator as the severity of the disorder. Mrs. R. described how her husband, following a psychiatric consultation, had been referred for group therapy and while waiting for notification to attend his condition had deteriorated:

R2.16 Mrs. R.: He'd been recommended in September and no word came that he could join. Well, by November he'd got considerably worse and then one day he felt he just couldn't go to work, that's all he just couldn't face work. So I phoned up the hospital and, er, said he had got worse and what about the group therapy and in fact they put him in within a few days. He then went back to work for odd days but he wasn't really coping well and then he just stopped going to work, you know, it had got worse and he just couldn't face work.

Mr. R. then returned to his GP and asked to see the psychiatrist again. After a wait of four weeks he saw the psychiatrist who, on learning that Mr. R. had not been working, suggested treatment as an in-patient. The following day Mr. R. was admitted to hospital.

In subsequent interviews Mrs. R. again made reference to the connection between severity and function to demonstrate how bad other cases of depression that she knew had been:

R2.17 Mrs. R.: She wasn't very bad to begin with, she didn't get to the stage where my husband got to where he just couldn't face work any more and he couldn't face people and he couldn't answer the telephone and this kind of thing.

As this extract illustrates, the connection may be used to deny the severity of a disorder. At one interview Mrs. R. had just recovered from an infection in the maxillary sinus which had been causing her some pain. When I asked her if the pain had been severe she said, "No, just a nagging pain, it was uncomfortable but I was able to carry on as normal".

This procedure may be used to cast doubt on claims made by others that they are suffering or have suffered a disorder of some severity. Mrs. F., while talking about her mother gave the following account:

F2.13 Mrs. F.: She's been worried about her sister who is seventy something and also lives alone in Harrow. She had a fall, had a bad .... well the sister called it a bad fall in the bath... well, that's all, a, well you know, the big scene, but she would .... I mean it didn't incapacitate her, she didn't stop <u>home</u> or anything, but my mother worries so much about anyone in the family. (Respondent's emphasis.)

Here, Mrs. F. provides reasons for challenging the way in which an event has been characterised. Essentially, that characterisation provides for consequences which do not follow. Thus, there is a contradiction between Mrs. F's aunt's claim to have had a bad fall and the fact that it 'didn't incapacitate her' and she 'didn't stop home or anything'. For this to constitute a successful challenge it is necessary to assume that anyone having a bad fall would have had their activity limited in some way. This assumption takes the form of what Smith has recently called a formation rule[11]. This rule allows for the prediction of a sequence of events given that an event early in the

sequence has been seen to occur. In this case the rule would suggest that anyone, and an elderly person in particular, having a bad fall would have been injured in some way and been subject to some degree of temporary or permanent incapacity. The absence of the final stage of this sequence in this instance shows that the rule is not operative and casts doubt on whether the earlier stages can have occurred. This allows Mrs. F. to provide an alternative definition; the claim by her aunt to have had a bad fall is an exaggeration, merely her creating a big scene. Thus, the nature of this event is interpreted in terms of its consequences for the pattern of activity of the individual concerned(30).

Finally, with respect to pain, a variety of consequences may be mentioned such as being woken up in the middle of the night, crying or fainting to indicate its intensity:

P2.11 Mrs. P.: (talking about severe headaches she used to get for which she had tests in hospital but which were never diagnosed). They were intense, they would wake me up in the middle of the night and I would quite frankly, they were so bad I almost wished I could die then the pain was so intense I cried with it.

S2.23 Mrs. S.: I pull muscles quite regularly (lifting Michael in and out of his wheelchair). I had one go in my stomach here and one go in my back and one in my neck. And in fact, when I had this tummy muscle one I couldn't stand up. In fact I fainted with the pain it was so bad, that's another thing I've never done in my life before.

P2.18 Mrs. P.: (talking of her son, Martin, who woke up one night with pains in his legs). Oh, it's all in my legs he said and he really cried with it, you know, it was genuine it wasn't, er, something put on, cus as I say it really woke him up so it must have been pretty intense I should think.

The women I interviewed invoked a variety of contextual matters to substantiate their characterisation of the significance of symptom episodes. They frequently made references to age in managing problematic experiences and claimed that a disorder in a child caused more concern and was more likely to lead to remedial action than a similar disorder in an adult. That disorders in young children are to be treated with some degree of urgency because they are in themselves of significance was invoked as a principle by the respondents in dealing with others such as practice receptionists who were seen to be reluctant to grant G.P. appointments:

G2.14 Mrs. G.: When Daniel had this high temperature I thought he ought to see a doctor so I rang the clinic and she said must he see the doctor tonight so I explained that he was only 11 months old and that, yes, I thought he ought to.

S2.24 Mrs. S.: I mean my friend's got a baby of 18 months old and she's had awful chest trouble with the baby and she coughs and has a permanent cold and all the rest of it and when she phoned the doctor the receptionist said, oh, well, you know I'm sorry but we can't fit you in and Pam said, well it is a baby you know and they said well alright perhaps we can.

Symptom episodes may also be situated within the context of a person type. Mrs. R. described how her mother who has high blood pressure was sitting watching television one evening when her leg "suddenly swelled up and was exceedingly painful":

R2.18 Mrs. R.: Well, when I saw it the next day it was still a bit swollen but not very much but it had been exceedingly painful. Erm .... er .... the kind of person she is then if she says is exceedingly painful then it really is because she's not one to complain, she'll always minimise everything.

R2.19 Mr. R., who was present at one of the interviews with his wife was talking about his daughter who had recurrent lower abdominal pain:

Mr. R.: It actually was quite nasty, she was in quite a lot of pain with it. She would try and throw herself all over the place and she's not too much of a fusspot in that direction, is she?

Here, typifications of individuals are used to show that their response to pain can be taken as a valid indicator of its severity since it rules out the possibility that they are exaggerating, lying or otherwise misrepresenting an experience. At a subsequent interview I discussed the latter case again with Mrs. R. She had taken the child to the doctor who had been unable to find any cause for the pain and had decided not to refer her for further examination. When I asked Mrs. R. if she thought it was serious she offered the professional definition, "Well, the doctor couldn't find anything", to indicate that it probably wasn't.

Time-place contexts may also be used to situate symptom episodes and accord them a degree of significance. Mrs. G. had a fairly long history of tonsillitis and throat infections and to indicate her susceptibility to this problem said, "But even when I was living in Bahrain I had to go to the American Mission for stuff for it there, in that climate, you know". This derives its force from the assumption that certain problems do not ordinarily appear in certain climatic or seasonal conditions; hence the fact that summer colds usually receive special mention in everyday discourse. Mrs. S. also mentioned seasonal factors as the reason why she was worried when her daughter went through a period of refusing to eat:

S2.25 Mrs. S.: Joanna went through this dreadful stage of not eating, she wouldn't you know, bits and pieces and that sort of thing but she would not sit down and eat a proper meal. That was a worry to me.

Int.: Did it go on for a particularly long period?

Mrs. S.: A couple of months .... through the winter time which of course made it worse.

Mrs. S. often spoke of her belief that eating well and eating the right kind of food was essential to good health. She thought that the success of her handicapped son's hip operation was due to the fact that "he eats like a horse". Others whose operation had been a failure showed the tongue thrusting characteristic of some brain damaged children with consequent difficulties in eating. As a result, they were weak and frail in comparison to her son who she described as healthy and strong boned. In conjunction with the assumption that the winter is a time of increased susceptibility not eating takes on particular significance.

Finally, disorders may be seen in the context of life interests which make them a matter of concern to one individual whereas to another they may be ignored. Mrs. F's eye allergy had signficant implications for her life interests which meant that she found it difficult to accept the problem and live with it:

F2.15 Mrs. F.: I mean, I must wear eye make-up, I know my mother says, oh, you don't need to and the rest of it but the crowd I mix with everybody does, I mean, we're doing a show er, we're doing Lilac Time at the end of May, I mean you can't go on a stage without eye make-up because everybody's got to wear it, it's a big hall so you've got to wear make-up if my eyes are poorly to start with they're going to get worse if I put all this muck on. I've got to be able to use it or give up my hobby, so it bothers me personally very much more so than someone else who doesn't do that type of thing.

Similarly, when her daughter developed spots on the face, an apparently trivial problem, Mrs. F. appealed to her current life interests to account for the fact that she was worried about it, "But as she's doing modelling at the moment, photographic modelling, she was particu-

larly worried about this and that's why she went to the doctor". Relatively minor problems can then take on significance when viewed within a social context. It could be suggested that the interpretive asymmetries involved when doctors complain of patients who present with trivial disorders arise because those disorders are not seen in their proper context. Medical judgements are made according to a different set of criteria although they may, as Hughes has indicated, involve the use of everyday, rather than specifically medical, knowledge(31).

A note on normal disorders

Some of the data presented in this and the previous chapter suggests a common-sense conception of what may be termed normal disorders. Although "abnormal" they are disorders which are taken to be part of the routine experience of everyday life. As such the concept of normal disorders is distinct from the concept of normalisation. The former in no way involves the idea that the disorders in question are normalised. Normalisation refers to that process whereby what is perceived as potentially problematic is explained in ways which show it to be normal, typical or unworthy of further comment. For example, Yarrow and colleagues have described how the wives of the psychiatrically ill initially normalised their husbands' apparently bizarre behaviour by seeing it in themselves, in others who were not defined as mentally ill or as a product of their personality, subculture or what have you(32). In data extract S2.11, Mrs. S. normalises her daughter's behaviour at nursery school by seeing it as the product of particular circumstances, "they forget to give her a biscuit", rather than as a symptom of an underlying disorder. Other problems such as tiredness may be normalised by showing that they are normal responses to normal life situations:

S2.26 Mrs. S.: Well, I'm always dead tired but after a day it's bound to be, you know. I mean, it's nothing to see my husband nodding over the television but, erm, we all do that, I do at the end of a day. I find that life is so hectic there's always plenty to do. As I say if Mike wants to nod off, fair enough, cus I know he's had a busy day. I suppose like everybody else he gets tired.

Normalisation may also be achieved by claiming that a potential problem is normal for a member of a given social category. When Mrs. G. told me that her son had recently had a very high temperature I asked if she had a thermometer and used it to determine how high his temperature had been.

G2.15 Mrs. G.: No .... I haven't got a thermometer, I don't know if it's a good thing really, I mean with a baby the temperature can go up and down constantly you know, you could be panic stricken or something like that.

In offering this rationale as to why she does not keep a thermometer so she can check her son's temperature Mrs. G. claims that it is normal for there to be variation in a baby's temperature. Consequently, keeping and using a thermometer could lead to this normal variation being incorrectly interpreted as a symptom with undesirable results, "you could be panic stricken". Thus, changes in a baby's temperature are not always pathological but can be a normal feature of an individual in that category.

In contrast, the concept of normal disorders does not involve the idea that certain problematic experiences are in themselves normal, merely that their occurrence in given categories of individuals is. For example, it was common for the respondents to speak of "normal childhood complaints" or "children's ailments" to which it is expected all children to be subject. As Mrs. S. said of her husband, "He's had no

serious illnesses apart from the normal childhood ones". And Mrs. R., during a general discussion of the kind of circumstances in which she would consult a doctor about her children, said:

R2.20 Mrs. R.: I know that I expect the normal childhood illnesses. If they had anything that I didn't recognise as a childhood ailment which was bothering them then I'd take them to the doctor. Yes, I'm sure I would because one doesn't expect children to be ill, not <u>ill</u>, other than the childhood things. (Respondent's emphasis.)

Thus, what are referred to as childhood illnesses are normal disorders because they are expected and as a result do not give rise to a great deal of concern. When Mrs. R's two children went down with chicken pox she telephoned the doctor to let him know but did not ask him to visit as "there was no point". The same kind of disorders appearing in an adult give rise to greater concern because they are not expected as the routine experience of adulthood. Mr. R. had had his tonsils removed eight years previously which Mrs. R. said was "very unpleasant for an adult" and Mrs. P. having told me that mumps had "been going round" said:

P2.19 Mrs. P.: Cus I feel sorry for a girl friend of mine .... all three of her children have got it, the baby included and neither her or her husband have had it and I thought, oh my godfathers if you get it now .... I keep hoping she won't poor thing.

While particular ailments are seen as normal in childhood the quote from Mrs. R. above would suggest that any complaints apart from these are not seen as part of the usual pattern of things.

As well as this general class of phenomena 'childhood illnesses' specific complaints may also be expected to occur in members of that category:

S2.27 Mrs. S.: I think with children, I mean they are sick at times most of them, my friends often say one of the girls has been sick for a night or something like that, you know, but they're alright the next day.

P2.20 Mrs. P.: Lindsay had a very bad nose bleed once when we were on holiday and Dr. M. said, oh, it's nothing really to worry about, some children do. I have a friend over the road and her children get nose bleeds quite a lot in warm weather, apparently they say the membranes in the nose are a bit thin.

Certain disorders are also seen as normal for individuals at the other end of the age continuum. Mrs. F., for example, said of her mother, "she's got all the aches and pains that go with old age". Some disorders may also be seen to be typical of members of a given sex category. Mrs. G., during a discussion of constipation in pregnancy, claimed that abnormal bowel function was a characteristic of many women:

G2.16 Int.: Had you been constipated before you got pregnant?

Mrs. G.: Oh yes, you know, I've asked lots of women about this and I'd say that a fantastic percentage say that they are constipated, they don't want to go to the toilet every day and yet most men seem to, you know, with a man it seems to be a certain, you know, you could almost time it, put it down to a time but with a woman it's not at all.

Normal disorders are then disorders that are routinised rather than normalised. This routinisation may have its basis in common conceptions of what is typical or knowledge of what is typical derived from an individual's own experience. Both of these are illustrated above. Professional definitions may also be sources of routinisation and doctors may deliberately or unwittingly influence patients' conceptions of their problems. During the year in which I interviewed her, Mrs. P. repeatedly expressed concern about her daughter who seemed

to be very susceptible to respiratory infections. At one stage she had been prescribed four courses of antibiotics for bronchitis within a period of five months. Finally, Mrs. P. had demanded that they "get to the root of the problem" and had been referred by Dr. S. to the local General Hospital for blood tests and X-rays. Subsequently, Mrs. S. said, "maybe Lindsay is a bit on the weaker side you know in comparison to other children". However, while waiting for her hospital appointment Mrs. P. took Lindsay to a national children's hospital for a routine yearly check on a heart murmur discovered at birth:

P2.21 Mrs. P.: And I told them about the bronchitis and the doctor said tell me someone who hasn't had bronchitis so I presume the weather we've had this winter has been bad weather for bronchitis.

Int.: So you don't think Lindsay's abnormal in that respect?

Mrs. P.: I guess not by what the doctor said.

The doctor's statement, "tell me someone who hasn't had bronchitis" is read by Mrs. P. as routinising her daughter's chest infections by indicating that it is a problem common to everyone. Mrs. P. is then able to supply an explanation which locates the weather as cause and revises her initial conception of her daughter from one of "a bit on the weaker side" to one of "not particularly abnormal". Given this interpretation, bronchitis becomes a normal disorder one might reasonably expect given prevailing climatic conditions.

The concept of normal disorders also encompasses a notion of the form in which disorders appear. In many respects this is similar to Sudnow's concept of normal crimes[33]. This notion was usually employed when some departure from this normal form was noticed. This can be discerned in the following extract in which I had asked Mrs. F. what factors might lead her to consult a doctor:

F2.16 Mrs. F.: Well, say it was a cough, it would depend on the cough.

Int.: How do you mean, depend on the cough?

Mrs. F.: Well, if it was just a normal sort of cough that you've experienced before, fair enough, but if it wasn't .... obviously, if you were spitting blood or anything like that then obviously you would go.

Given that categories of individuals are expected to present with certain disorders members may be faced with the problem of deciding when that disorder does signify something other than a routine state of affairs. How do mothers, for example, go about seeing an episode of sickness in a child as something worthy of special attention rather than part of normal experience? The limited data I have would suggest that this is accomplished by appealing to the form the sickness takes. Mrs. G. had no problem in defining her son as ill and in need of medical attention after he had been sick even though she had told me in an earlier interview that he was sick quite often:

Int.: When he was ill with his sickness .... I mean you said he was sick a lot as a baby ....

Mrs. G.: Yes, but this was violent.

Int.: How do you mean?

Mrs. G.: Well, you know, he just pumped it all up .... it wasn't like a normal .... a sickness where, you know, sort of like with wind when the sickness comes up, but this was a pump, two or three .... it was all down Roger (her husband), all over the carry cot, Daniel was covered in it as well.

The recognition that her son was ill did not depend upon his being sick, rather it was the manner in which he was sick that alerted Mrs. G. to the fact that all was not well. The way in which he vomited on this occasion constituted such a clear departure from the normal form that the alternative interpretation, that this was a routine case of vomiting, was not entertained. Similarly, Mrs. S. described a case in

which the normal form was breached:

S2.18 Mrs. S.: My friend, she gets bad headaches, at the moment she's got to go to the General Hospital, she's been getting these headaches, apart from her normal headaches she was beginning to feel a bit sick and dizzy at the same time and the doctor at first told her she had a touch of migraine but anyway, she's got high blood pressure and she's got to go to the hypertension clinic.

While it is tempting to suggest that the departure from the normal form led to the friend's entry into hospital care it is perhaps better to restrict this piece of data to an illustration of the use of the idea of a normal form. What it does demonstrate is that there are normal headaches and abnormal headaches. Talking about her own headaches Mrs. S. said, "It's not migraine or anything like that, just a straightforward headache". Categories of individuals such as mothers may expect normal headaches as a consequence of their life situation while abnormal headaches require special attention because they are not part of the routine order of things. In the next chapter I will re-examine the ideas of normal form when I look at the way in which recurrent problems are handled. The normal form in which these problems present is offered as the rationale for their management by recipes that have proved to be effective in the past.

Conclusion

In this chapter I have presented an analysis of lay descriptions of how disorders are recognised, explained and assigned significance. The meanings imputed as a result of practical investigations into these topics is vital to an understanding of the way in which problematic experiences come to be labelled. According to the principles of conversational analysis, what is offered here is the methods the analyst,

i.e. the author used to make sense of the accounts presented by six women in the context of a series of research interviews. The procedures and practices revealed may not have been those that went into the production of those accounts since all that is required of coparticipants in a conversation is that they employ some methods for seeing some sense in what the other is saying. Given that each can impart coherence to what the other is saying or otherwise communicating interaction is unproblematic. I would suggest, however, that what I have described here are a set of resources supplied by a common-sense understanding of the way in which the world works that may be used on other occasions by other people in making sense of what is going on.

Given the above, what I have described are the cues that sensibly indicate that an underlying order may be present and the way in which these cues are elaborated by other cues or the context in which they appear. I have described the causes the women invoked to sensibly explain the problems with which they were faced and some of the procedures involved in constructing and maintaining their explanations. Finally, I have suggested some of the ways in which disorders come to be seen as severe or significant and have tried to illustrate the concept of normal disorders. In the next chapter I will look at the rationales offered by the respondents to account for their actions with regard to the disorders they and their co-interactants experienced.

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23. Note that the respondent does not say this but takes it for granted that the assumed connections will be filled in by a hearer.

24. At the next interview Mrs. F. reports a further consultation at which she mentioned possible damage to the muscle. The doctor said that was nothing to do with it and mentioned that "it's quite common to have it in one arm". The tablets prescribed at the previous consultation were also reported to be having an effect.

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29. In Turner's terms they are doing trivialising. See Turner, R., Wards, Utterances and Activities, in Douglas, J. (ed.), Understanding Everyday Life, R.K.P., London, 1973.

30. Also contained in this extract is a further device used by Mrs. F. to undermine her aunt's claim. This is performed by the words "well the sister called it a bad fall". The work that this does is to demonstrate that the claim is not independent of the claimer. Consequently, it cannot be accorded the status of fact but remains as a subjective interpretation on the part of a potentially interested party. While Mrs. F. does not offer any evidence that the claim was motivated by particular interests, we are oriented to this as a possibility. This can be compared with the data presented by Smith in which a respondent giving an account of how she came to define a friend as mentally ill goes to great lengths to demonstrate that this definition was arrived at simultaneously and independently by several individuals, some socially remote from the friend concerned. The factual character of the definition is thereby reinforced by this concensus and the alternative depiction,

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CHAPTER 6

ILLNESS BEHAVIOUR: THE IDENTIFICATION OF RATIONAL ACTION

In the previous two chapters I examined some of the presuppositions and practices involved in the ascription of meanings to various events and situations. In this chapter I want to use the same theoretical and methodological approach in an analysis of social action, specifically illness behaviour.

The analysis of what is conventionally referred to as illness behaviour using semi-structured interview data requires consideration of two problems: firstly, the theoretical issue of what sort of sociological understanding of social action is possible; and secondly, the methodological issue of how that understanding may be developed via the use of interview talk. These two issues are, of course, interrelated.

There are two distinct ways in which an understanding of social action may be achieved. For current purposes these can be termed the antecedent and the non-antecedent approaches. The former, as the name suggests, attempts to identify what are taken to be the antecedents of action. There are two versions of this; a causal version which locates factors prior to and causative of action; typically, sociodemographic characteristics, norms, values, attitudes, expectations and a whole range of other psychological and/or social structural variables; and a non-causal version which sees action grounded in meanings, reasons and intentions. The former sees man as a passive organism responding to 'external' or 'internal' influences, the latter as an active agent constructing his action towards the world according to the way he defines

the situation and his own intentions or purposes in that situation. Both of these schemes are explanatory. Mechanic, while he expouses the latter view in his theoretical writings resorts to the former in his research practice where he has investigated the influence of a variety of social and social-psychological factors on utilisation of medical care. Parsons, however, falls within the causal antecedent approach although system needs, socialisation and occupancy of social roles are identified as the precursors of action rather than a range of atomistic variables. The non-antecedent approach, however, does not attempt to explain social action in terms of antecedents but describes the process whereby social action is constituted. Behaviour, and its consequences, take on social and sociological relevance only when subject to interpretation by actors in society. Understanding social action takes the form of describing the interpretive process via which it is constituted as a social object.

A symbolic interactionist position on interaction involves a non-causal antecedent approach and an interpretive non-antecedent approach. As Blumer suggests,

> "(In interaction) the participants fit their acts together, first by identifying the social act in which they are about to engage and, second, by interpreting and defining each other's acts in forming the joint action. By identifying the joint action or the social act, the participant is able to orient himself; he has a key to interpreting the acts of others and a guide for directing his action with regard to them .... (The participants) have to ascertain what the others are doing and plan to do and make indications to one another of what to do"(1).

Here, the behaviour of others is continually subject to interpretation and redefinition. The context, itself defined as a particular type of social act, is used as a scheme for the interpretation of the

actions of individual participants. The meanings imputed to the joint act and to individual actions are the basis on which actors construct their own actions. Thus, actors constitute joint acts and the acts of individuals as social objects through this interpretive process and the meanings become the antecedents of their own reactions. The symbolic interactionists, however, have not provided a theory of meaning which describes this interpretive process, nor have they specified how meanings as antecedents give rise to action.

Zimmerman and Wieder have provided a critique of the view that meanings are the basis upon which action is built. Meanings are viewed in much the same way as norms and other imputed attributes, as analysts' resources for accounting for action. Instead, they suggest that meanings should become topics for study. This involves the suspension of the assumption that social conduct is based in meanings and its substitution by the study of the way in which members go about seeing, describing and explaining, i.e. creating the order of, the world in which they live:

> "The ethnomethodologist is not concerned with providing causal explanations of observably regular, patterned, repetitive actions by some kind of analysis of the actor's point of view. He is concerned with how members of society go about the task of seeing, describing and explaining order"(2).

The concern here is with the procedures individuals use in recognising, making sense of, and thereby producing the regularity of, their social and physical environment. One implication of this position is that there can be no sociological explanation of social action; ethnomethodology sees man as a skilled cognitian but not, as recent writers have pointed out, an actor(3). What this means is that ethnomethodologists do not theorise about social action, they investigate the

practical reasoning presupposed in members' theorising about social action. Sociological accounts of social action are not taken to be qualitatively different from or superior to common-sense accounts. Sociology merely comprises one set of resources for creating order and regularity in social life; sociological concepts and tacit assumptions are the means by which these regularities are identified and explained.

These two positions have implications for the way in which interview talk can be used in the analysis of social action. In the former, respondents' statements are taken to be descriptions of the actor's point of view within which meanings, the precursors of action, can be located. The latter approach treats respondents' statements as phenomena in their own right to be used to investigate the resources employed in the creation and communication of experience. This is the position that has been adopted in the analysis of the data so far. To the extent that both theoretical perspectives accord some degree of significance to the interpretive process an analysis of the production of meanings contributes to both. As far as the first approach is concerned this is the first step in the analysis of social action(4), while the second approach would take a description of the interpretive process as all there is to say.

However, the problem posed by interview talk for the non-causal antecedent position is what of substance can be said about social action from accounts which are interpretive reconstructions of past events. As I have emphasised throughout, the interview is one context in which respondents may be called upon to give accounts of their own actions or the actions of others. It is not necessarily the case that the characterisation of and rationale for those actions is the same across contexts or time. It is this which makes for difficulties in using

respondents' statements as indicators of meanings imputed at given points in time. However, in order to provide an explanation of social action based on meanings it is necessary to be able to say what meanings were imputed to given objects at given points in time and to show how these gave rise to the action to be explained. This demands the possibility of literal descriptions(5). Or it requires the sociologist to make inferences about what happened and how it happened from respondents' interpretive accounts. For example, Brown and colleagues, studying the onset of depression in women, solve this problem of the reconstruction of events in accounts by having the researcher impute meanings to the life events their respondents describe. That is, the researcher determines the severity of the life event in question by seeing it in the context of the respondent's life(6). This judgement is then substituted for that of the respondent which cannot be treated with confidence since it may be biased by retrospective reinterpretation. The researcher's judgement becomes the facts on which the analysis is based. The validity of this procedure is determined by rater agreement; social reality is thereby measured by consensus. The interpreted leaps involved in this process have been the target of the ethnomethodological critique of conventional methodologies for they are founded upon unexplicated assumptions about social life(7). Given that the non-causal antecedent perspective does hold out the possibility of an explanation of social action there still remains the problem of what kind of data can be validly used to construct that explanation(8).

As far as the non-antecedent approach is concerned the problem is not methodological but theoretical. While interview talk can be used to describe the processes whereby actions are constituted as social objects the approach can take us no further. As I have mentioned, it

presents a theory of the cognitive organisation of social order but denies the possibility of a sociological theory of social action. As Wilson points out, action involves more than the interpretive process[9]. In addition, the theory of meaning it offers is only partial; it may tell us how particular interpretations of utterances or behaviours were arrived at but not why those interpretations rather than others. As a recent critic has observed, ethnomethodology offers a sophisticated critique of positivist sociology but it cannot account for the fact that a positivistic interpretation of the world is acceptable to sociologists and others[10]. In many ways the problem is similar to that contained within the labelling perspective. While labelling theory can show how acts are constituted as deviance in the societal reaction to them it cannot explain the origins of the act that becomes so constituted.

Whichever of these positions is adopted, and it is not necessarily the case that they cannot be reconciled[11], an analysis of the cognitive and interpretive processes involved in accounts of actions can be achieved using interview talk and does make a contribution to the study of social action. It poses less complex theoretical and methodological problems that an attempt to get at the genesis of action via the same data.

Respondent accounts of actions can, then, be examined "for the techniques men use to make visible for themselves and others the orderliness and rationality of the actions they perform"[12], irrespective of whether the meanings involved were the basis for those actions on the occasions on which they were performed. Thus, the analysis involves "the explication and clarification of the actor's rationality

for his actions"[13]. For example, Moore has shown how radical clergyment talk about the Church and the community in ways which identifies problems for them to solve. This provides a rationale for their actions and, by showing how their role qualifies them to assist in the solution of those problems, legitimates their occupation[14]. Stimson and Webb have also described how members talk about their encounters with doctors in ways which allows others to see them as sensible and rational actors[15]. In this process members assume that their actions are rational and they also assume that others will be able to see the rationality of those actions. In so characterising their acts members are able to defeat potential charges that they are deviant, odd or otherwise abnormal.

During the course of the conversations I had with my respondents they frequently made general statements about how and when they would use the doctor:

N3.1 Mrs. N.: I don't go to the doctor very often .... it's only when I have to .... I don't like to worry him too much these days anyway.

S3.1 Mrs. S.: I only go when I think it's something I ought to go about. If I know what it is then I don't because I'd rather not.

R3.1 Mrs. R.: I don't like to dash up at the slightest thing, you know.

P3.1 Mrs. P.: I don't go unless I can help it. I'm more prone to take the children, you know, than myself or my husband, sort of thing.

F3.1 Mrs. F.: I think somehow we look on the doctor more or less as a last resort. I mean for other people I always say go, but if it's me I think ignore it, it'll go away.

G3.1 Mrs. G.: If it's something that I can treat myself rather than go up and see the doctor I'll buy something, you know, cough mixture or something like that.

These statements, while they do not contain clearly articulated decision rules which guide social action, do specify some conditions under which the respondents would or would not act in a certain way. These statements, however, should not be used to infer actual behaviour patterns or be taken as descriptions of the strategies the respondents employ in decision-making situations where consulting the doctor or other forms of action are available options. Rather they should be seen as indicative of the fact that respondents take for granted the rationality of their actions and assume that their use of the doctor is 'appropriate' and 'responsible'. Mrs. G. and Mrs. S., for example, emphasised that they would only consult the doctor if it was something serious that they could not handle themselves:

G3.2 Mrs. G.: If it was something trivial, just minor that made me feel under the weather I'd try and buy something to ease or correct it; if it was something worse then I'd go to the doctor's and see what he could do for me.

S3.2 Mrs. S.: I don't take the children or ourselves to the doctor unless I think it's something, it's serious enough to go.

In statements made at other points in the interviews the respondents claimed that they were competent to make decisions about when to see the doctor:

F3.2 Mrs. F.: I was talking to my daughter about this, I was saying, you know, animals you take because you don't know how bad they are, but when it's you, you sort of know whether you're ill or not.

G3.3 Mrs. G.: Surely most people know, don't they? I suppose with a child you wouldn't take any chances but, I mean, sort of, an adult, surely you know if you ought to see a doctor.

R3.2 Mrs. R.: I don't think I would be neglectful with the children, erm, with my husband, well, you know, he's an adult, I could only say to him if I were worried about him you ought to go to the doctor and nag him a bit if I think he ought to go .... I .... I might be like I am with myself, I might feel, you know, if he doesn't feel he ought to go maybe he needn't .... with the children I think I would be more careful because I know I've got to make the decision not they and I wouldn't take any undue risks there. I mean, I wouldn't run them round to the doctor every time they sneezed or something, er, but if I thought there were cause for concern then I would.

In these extracts an adult is depicted as knowing whether he is ill and whether he ought to see the doctor. Consequently, any visit to the doctor can be seen to be for good and proper reasons. The only exceptions to this rule are with animals and other communicative incompetents such as children. The former you "take because you don't know how bad they are" and with the latter "you don't take chances" or "undue risks" because, as I have previously suggested, any disorder in a child which is not immediately recognisable as a childhood ailment is a legitimate cause for concern and because children as communicative incompetents cannot always explain fully what is wrong with them. That this may create something of a dilemma was recognised by Mrs. R. when she said, "you often don't know what to do for the best". Refusing to take chances and consulting the doctor in situations where the issue is not clear-cut is one way in which the respondents were able to resolve the issue and demonstrate responsible parenthood.

Not only did the respondents assert that they would not visit the doctor other than for problems which were serious or troubles they could not resolve by their own actions, they also offered good reasons for this course of action by depicting their doctors as busy individuals who were not to be bothered with trivial matters:

G3.4 Mrs. G.: If I did get a slight ailment I wouldn't go unless I thought it was really worth it .... probably because you think they're hallowed and you shouldn't waste their time.

S3.3 Mrs. S.: I always try and sort it out myself before I go to the doctor because I find that, you know, he is pretty busy.

S3.3 Mrs. S.: If I find they get really bad coughs and colds then I'll go to the doctor but if I can get rid of them by myself then I will. I think they've got enough worries without them having minor coughs and colds.

Respondents' descriptions of when and why they visited the doctor or took an alternative course of action are justifications. They constitute the materials which an observer can use, and is expected to use, to identify what they did as situationally appropriate and themselves as responsible patients and mothers. This is not to assert that these women indulged in some form of impression management, presenting distorted accounts of events that they know did not happen that way. Rather, it reflects their own belief in themselves as competent actors and decision-makers. It is the breach of this assumption of their own competence which gives rise to annoyance when the appropriateness of their actions is challenged.

Some of the points made above can be illustrated by the analysis of the following extract taken from an interview with Mrs. G. In this account she describes a series of events which led her to telephone the doctor about her eight month old son:

G3.5 Int.: Well, tell me about Daniel then. What did you say he'd been to the doctor for?

Mrs. G.: Well, he went, erm .... I rang the doctor on a Saturday lunchtime about one o'clock because he'd been violently sick. He'd had diarrhoea for a couple of days but then with a baby you sort of think, you know, diarrhoea can be caused through anything, can't it, too much fruit or something like that?

Int.: Why, is it common in babies?

Mrs. G.: And then he was really sick, it was while we were out up in Clifton and he was sick all over Habitat's front doorstep, really ill, bad. Came straight back, I rang the doctor but he was at home cus surgery finishes up here at twelve o'clock on a Saturday, it was Dr. C. .... and I rang him at home and he was sort of ever so funny with me until he said to me, mm .... you know, he was mad because I hadn't rung before you see but it wasn't obvious that he was ill until then ...

Int.: Is that why you say he was funny with you?

Mrs. G.: Yes, because it was after surgery hours .... and he changed the, oh .... he changed his tune as soon as he said to me, mm "Have I seen this baby before?", so I said yes once at a three month check-up, by this time he was eight months old and that was the first time, you know, that he'd been ill and I'd rung the doctor, and he said "Oh, been remarkably healthy up to now then?" and he changed his tune completely, he realised that I didn't ring every Saturday afternoon.

Int.: Yes ....

Mrs. G.: But it put me off, it did ....

Int.: Off the doctor?

Mrs. G.: Yes, it did, yes.

Mrs. G. begins by describing how her son had diarrhoea for two days and it was only when he was "violently sick" that she contacted the doctor. She implies that at the time the diarrhoea was not viewed as being anything out of the ordinary and provides an interpretive scheme by which this conclusion can be reached. Here, she invokes her son's life stage and some typical features associated with that life stage to construct the meaning of the event. Thus, "in a baby" diarrhoea can be caused by a range of things and therefore does not always signify illness or call for medical attention. It can point to more than one underlying theme, it could be due to "too much fruit or something like that". Given this context and the absence of any evidence to the contrary the interpretation of the event as routine, as something

which happens to babies, is as good as any other. I take "can't it" not as a question but as an appeal to an observer to see the reasonableness of this judgement. When later called upon to justify her delay in phoning the doctor she makes recourse to the ambiguity of the situation, "it wasn't obvious that he was ill", at the time. What is more, there were no grounds for defining him that way since the diarrhoea could equally have been a routine state of affairs. It was only when her son was sick that she redefined him as ill and the diarrhoea as an earlier indicator of that. This illustrates what McHugh refers to as revelation; two events are seen to be connected and the first reinterpreted according to the theme that the second signifies. Seen in terms of this new meaning the diarrhoea is transformed from a potentially routine event into a symptom because of what it is now seen to signify. More than one interpretive procedure is involved here:

1. developments over time bring about a reinterpretation of an event or make an interpretation possible where none could be made previously;
2. the meaning of some events can be determined only if they can be seen to be related to other events;
3. the documentary method is used in reverse in which an underlying pattern is discovered from some source and used to give meaning to an event by identifying that event as an indicator of the underlying pattern.

As I indicated in the previous chapter these are common procedures in the recognition and interpretation of disorder.

In these accounts Mrs. G. describes how she interpreted certain events and provides a rationale which allows those interpretations to be seen as reasonable under the circumstances. Though her initial interpretation turned out to be inadequate it cannot be deemed incom-

petent given the facts at her disposal. Though the diarrhoea subsequently proved to be an early manifestation of illness the normal form in which it presented means that she cannot be expected to have known it for what it was at that time. Once some clear indicator was available she had no trouble in imputing an appropriate definition. In this way she is able to present herself as a good mother providing adequate care for a child for whom she is responsible. The account is then a justification of her seeing things in the way that she did and, as I shall now indicate, a justification of acting in the way she did. Such justifications are necessary lest her actions are subject to the same kind of challenge she reports in her encounter with the doctor. They allow her to maintain an appearance of what Voysey refers to as "adequate parenthood"(16).

Mrs. G's account of her actions grounds those actions in the definitions that she constructs to make sense of observed events. The meanings she imputes to various states of affairs are offered as explanations of what she subsequently did. Thus, once she had identified her son as being ill she "came straight back" and "rang the doctor". Conversely, her rationale for not contacting the doctor before was that she had not know, and had no way of knowing, that the child was ill. Given these definitions her actions are to be seen to be appropriate. However, the connection between her identification of her son as ill and her subsequent action is not made explicit. An observer is expected to be competent to make the connection by supplying situationally appropriate motives to link "what I did" with "why I did it". In elaborating this connection recourse must be made to common-sense knowledge about social categories such as mothers, children and doctors, their functions and typical relationships between them and the socially

sanctioned and technically efficient ways of coping with various problems. To someone so competent no enquiry as to reason is necessary.

Mrs. G. not only describes and explains her own behaviour she is also able to describe and explain the doctor's behaviour as he responds to her telephone call. His initial reaction, "he was ever so funny with me" is taken to be the result of her phoning him at home outside surgery hours and seen to imply that she should have acted in a different way, "he was mad because I hadn't rung before". It is her perception of his initial characterisation of her action as illegitimate that calls for her to construct an explanation of her delay to show she could not have acted otherwise. It is this violation of her assumption that her actions are reasonable that makes her indignant and leads her to see the doctor in a different light; "it put me off, it did". However, during the course of their conversation Mrs. G. is able to detect a change in the way the doctor defines her behaviour. His response to her is cited as evidence of this redefinition and this redefinition identified as the cause of his change in response. This redefinition is brought about by information that he seeks and is provided with. Upon learning that he has only seen an eight month old baby once before for a routine check-up "he changed his tune completely". As she concludes, he was then able to see her as someone who "didn't ring every Saturday afternoon", that is, as someone who did not make frequent or unnecessary demands for medical attention. This information about her past consultation behaviour is seen by Mrs. G. to be incongruent with his initial definition, leads him to see her as a different type and to interpret her action accordingly. His original characterisation of her action as irresponsible is transformed due to the lack of fit between that characterisation and other facts that he then learns;

the initial pattern imputed is replaced and his response modified in line with the new meaning her behaviour holds for him.

I take it then that the central feature of this account is the respondent's explanation of her delay called for by the doctor challenging her actions. The research interview is one opportunity for her to reformulate her explanation and demonstrate the sense of her actions and reaffirm the competence of her performance as mother and patient. This is accomplished by her ability to show that what she did was reasonable in context and that any attempt to categorise her as irresponsible or neglectful is unfounded since it presupposes her to be a type her previous conduct shows that she is not.

This extract also illustrates what seems to be a typical dilemma in the lay management of trivial disorder and the kind of interactional problems this may engender. Where problematic experiences are ambiguous within the context of the knowledge at an individual's disposal decisions as to meaning may be difficult to make. It may not be apparent whether they signify 'normality' or 'illness'. Where such manifestations are seen as indicating that something is wrong it may not be clear that the condition is sufficiently severe to warrant medical attention. Individuals may then be caught between the alternatives of going to the doctor with a disorder that may be medically insignificant or waiting for future developments with the potential risk that this entails. In both cases charges of incompetence or irresponsibility may result and create conflict in doctor-patient and patient-other interactions. The kind of accounts presented above are integral to the management of these interactions. As I shall describe later, patients often invoke the anticipated reactions of the doctor and the more general decision rules presented above in explaining their failure to seek medical

treatment. They also develop strategies for influencing the doctor's reaction when they do present. These represent some of the methods people use for coping with ambiguity and the interactional problems to which it may give rise.

The critical incident

The account given above by Mrs. G. contains what Cowie has referred to as a critical incident, a physiologic version of Zola's non-physiologic triggers. The cardiac patients' Cowie studied identified this critical incident, an increase in the severity of chest pain or the development of other symptoms such as breathlessness or sweating, as the reason for deciding to call in the G.P.:

> "The symptoms before, or at the initial stage of the critical incident were normalised in a variety of ways. They were regarded as indigestion which everybody knows is a non-serious, non-threatening ailment treated by a variety of home remedies, or they were regarded as indicating the occurrence of yet another bout of a previously experienced illness which although it may be serious need not cause alarm as recipes for action in the past had proved successful.(17)

This initial interpretation, as in the example I gave above, constitutes the justification for delay in seeking professional help just as the critical incident is offered as a justification for reinterpreting the situation as serious and calling in the G.P. In constructing the justification for the initial delay individuals point to the reasonableness of the interpretation by showing that it fits the available facts. Any moral condemnation or charge of incompetence is then unwarranted since this initial definition is not to be seen as inappropriate.

In previous chapters I have presented cases which can also be used to illustrate this general process, although in these cases the

conditions of concern to the respondents were relatively trivial. The interpretive procedure seems to be independent of the nature of the biological disorder. For example, in data extract N3 (Chapter 4), Mrs. N. initially interprets her daughter's claim to have hurt her back as malingering though this is revised when her daughter began to complain of pain in the neck and professional help was sought. Similarly, when her daughter was sent home from school with a severe headache, data extract N2.4 (Chapter 6), Mrs. N. saw it as a consequence of the glandular fever from which she had recently recovered. However, when her husband came home with the same complaint the problem was redefined and the doctor contacted. Mrs. P., in data extract P2.2 (Chapter 6), initially thought her daughter's complaints of a sore spot on her foot were due to a minor abrasion and it was only when the girl came home limping that she thought she had better have it looked at. In all these cases the original interpretation was such that the problem was routinised and was only seen to be something else following a critical incident. In the following example, a critical incident brought about a reinterpretation of a problem that had been present for some months:

P3.2 Mrs. P.: Didn't I tell you I'd slipped a disc? That was at the beginning of this year. Erm, for months the doctor thought I'd had sciatica, I had the pain low down and right through my seat and down this part of the leg and, er, it came and went, I had it for quite a long spell and then it started to clear and it seemed to be better and a couple of mornings I had it again and on this particular morning when I went to get up .... we'd over-slept a bit and I had this sort of nagging pain low down in my back and down my leg and I thought, oh golly, you know, it's going to be a nuisance today, let's get out of bed quick and I sort of put my hand on the bed and sort of shot myself forward like that which I shouldn't have done and, er, I went into the bathroom and all of a sudden I just screamed with pain, I couldn't move, I've never experienced anything like it in my life. My husband was shaving, it's a wonder he didn't cut his throat.

> I just felt I've got to scream and I couldn't stop and I just sort of grabbed the towel rail, I sort of turned round against the wall and hung on to this and I just went on screaming and screaming. He said whatever's the matter, oh, I said, my back. I've never had a pain like it in my life before, I really haven't and as I say I know it sounds stupid but I felt I've got to scream to do something, you know. As I say, it's a wonder the lady next door didn't come flying in thinking murder was being done, but the poor kids they came flying into the bathroom, they looked at me shattered, and they sort of helped me back to bed, he sort of gripped me under the elbows and I shuffled cus I couldn't walk, I didn't know what had hit me for a minute, and of course I let go of him and I literally fell on the bed and he picked my legs up and of course I screamed again, he flattened me out, covered me up and then he phoned the doctor.

In this extended account Mrs. P. tells how the pain in her back when she woke one morning was taken to be a reoccurrence of her sciatica for which she had been treated for some months: "It's going to be a nuisance today" (my emphasis). Within minutes a critical incident had occurred which in and of itself led to the doctor being called and subsequently brought about a revision of the original diagnosis. As Mrs. P. says, the doctor "thought" she had sciatica. The character of the symptoms Mrs. P. describes is sufficient justification for the decision to telephone the doctor. The intensity of the pain, demonstrated by her response, "I just went on screaming and screaming", and her subsequent inability to walk, was so unlike anything she had experienced before that it could not be routinised by reference to the original interpretation.

As in other accounts, the interpretations applied at any given point in time establish a context in which the respondent's action vis-a-vis the doctor is demonstrably rational. However, the connection between the interpretation and subsequent action is not made explicit.

An observer must and is expected to refer to a stock of knowledge to make the assumed connection. This involves recognising the problem as described by the respondent as falling within or outside of that range of situations in which it is appropriate to consult a doctor since he is in a position to offer a solution. The motives of the respondents in seeking professional help are assumed to be apparent. The point can be emphasised by considering the likely response of Mrs. P. had I followed her account with the question, "But why did your husband bother to phone the doctor?" Such a question may have brought forth the kind of response shown by Mrs. G. when her consulting behaviour was criticised and create a breach in the interview rapport.

Critical incidents were not reported in all the cases in which the respondents sought medical help. Such incidents seem to be the precursor of consultations in those situations in which a feasible alternative explanation is available. In others, in the absence of an explanation which would routinise the problem, the character of the symptoms suggested that something serious was wrong. At one interview Mrs. F. had just taken her mother to see the doctor "because of this pain when she swallowed":

F3.3 Mrs. F.: When she swallowed she got this bad pain, so of course she was worried she immediately thought she'd got this terrible blockage or something dreadful so I took her round to her doctor.

Int.: So there was none of her usual resistance to seeing the doctor?

Mrs. F.: No, no cus she was really worried that there was something really wrong.

At another interview Mrs. N's husband had recently been to the doctor to see about a pain in his arm:

N3.2 Mrs. N.: My husband went to see Dr. Z. because he had a pain in his arm and he thought, God, I'm going to have a heart attack, that's where it starts and I suppose the doctor realised he was the worrying kind and though he couldn't find anything wrong with him he sent him to a specialist for tests who said there's nothing wrong.

In both of these cases the respondents present the interpretations others apply to their problems as the basis for subsequent actions. The tentative diagnoses applied to the symptoms indicate a potentially serious disorder and constitute the rational for those individuals behaving in those particular ways. The recognition of this as rational action involves accepting that those diagnoses were reasonable under the circumstances, as it turned out Mrs. F's mother had a small oesophageal ulcer which rapidly healed and the doctor could find nothing wrong with Mrs. F's husband, and that the individuals concerned were acting prudently in presenting themselves for professional diagnosis. As Mrs. R. says in a similar context I will describe later, "I just wanted to make sure". One of the perceived functions of the doctor is that he alleviates worry by providing proper diagnoses.

In some cases, the character of the symptoms immediately ruled out an explanation which could otherwise have been used to define a problem as routine. Mrs. S., as I have described, periodically pulled muscles in her neck, stomach or back while lifting her handicapped son in and out of his wheelchair. These gave rise to pain and some limitation of movement. Because these were a routine feature of Mrs. S's life, something she expected to happen, 'pulled muscles' was available to explain pain or stiffness in any of these locations. At one interview Mrs. S. described how, contrary to her usual practice, she had consulted the doctor about what turned out to be a pulled muscle in her stomach:

S3.4 Mrs. S.: I had to go to the doctor with it because it was really nasty and I was a bit frightened it might be something else.

Int.: Was that just painful?

Mrs. S.: Oh no, I couldn't stand up. I was frightened it might be appendix or something like that. I was practically bent double with it, it was really very bad.

In this instance the severity of the symptoms, unusual for that condition, suggested something more serious such as appendicitis and the doctor was consulted. Again, the rationale for seeing the doctor lies in the tentative diagnosis and not in desire to relieve symptoms.

The construction of these tentative diagnoses frequently involves the use of knowledge about the typical ways in which certain disorders manifest themselves. When Mrs. R. was told by her mother that her leg had suddenly become very swollen and painful the previous evening Mrs. R. advised her to "go down to the doctor immediately because she has very high blood pressure". As Mrs. R. said later, "I thought it might have been a thrombosis, you know, with high blood pressure this is always a risk". As it turned out the pain and swelling had gone when her mother saw the doctor and the problem was never definitely diagnosed. However, the sensible character of the action is taken for granted given what the symptoms, in the context of other knowledge, might have indicated. Similarly, Mrs. G., who was pregnant at the first interview, thought that a show of blood was the onset of a miscarriage:

G3.6 Mrs. G.: At first I thought it was a miscarriage, you know, the first thing I thought of when I saw the bleeding, it was that .... then I realised the blood wasn't coming from the vagina.

This first diagnosis was derived from seeing the symptom, bleeding from the region of the lower abdomen, in the context of pregnancy. Subsequently, when Mrs. G. decided that the blood was coming from the "back passage" she thought she had piles and went to the doctor. When I asked her why she had sought professional help Mrs. G. again invoked the fact of her pregnancy:

G3.7 Mrs. G.: Well, I wouldn't try and treat those .... I wouldn't try and treat that myself.

Int.: Why not?

Mrs. G.: Well, because I was pregnant. Probably if I hadn't been pregnant I probably would have done, I would have bought something, you know, a suppository or some kind of, er, cream and tried it first before I went. But the fact that I was pregnant made me go and get something which was medically safe to use and effective and also in a leaflet they give out it says that you should let your doctor know if you are susceptible to piles. That was the first time in my life that I'd ever had them.

By invoking pregnancy and the medically defined relevance of piles for pregnancy Mrs. G. is able to show that consulting the doctor about what might ordinarily be a trivial complaint to be handled by self-medication was a reasonable thing to do. In this way she establishes that her consulting the doctor on a specific occasion is consistent with her general statements on the same issue. That is, she only consults for conditions which are not trivial and which she cannot be expected to treat herself.

In constructing initial diagnoses of their symptoms the respondents also made use of a notion of time. That is, both the character and the duration of the symptoms contributed to their definition that something potentially serious was wrong which needed medical attention. When Mrs. G. had a "real sort of bad pain in my stomach" the duration

of the symptoms ruled out routine diagnoses:

G3.8 Mrs. G.: So after a couple of days it was obvious that it wasn't something I'd just eaten or indigestion so I went to the doctor's and he gave me .... he examined me and apparently it was wind, that's all. But it was something I hadn't experienced before that obviously wasn't just indigestion so I felt I ought to go and see him.

And Mrs. R., when her daughter complained of stomach ache over a period of two days took her to the doctor to rule out potentially serious conditions:

R3.4 Mrs. R.: Alison was complaining of stomach ache for a couple of days, really complaining and I made an appointment and took her to the doctor in case it was appendicitis or something like that. I didn't really think it was but I wanted to make sure.

As I noted in the previous chapter, the duration of symptoms is often used by the respondents to assert that a condition is severe or trivial irrespective of whether that condition is taken to the doctor. Under the assumption that trivial conditions are of short duration any symptoms which last for a few days or more can be seen to be of a more serious nature. Mrs. G. used this assumption in deciding that her stomach pains were not an ordinary problem such as indigestion but a complaint that required medical attention. This assumption is frequently used prospectively in mapping future courses of action. At one interview Mrs. P's ankles had been swollen and painful for a few days although she had not been to the doctor, but said, "You know, if it does continue I obviously will". When Mr. P. complained of pain and stiffness of his neck and shoulders it was attributed to draught from driving with the window down and resolved itself without recourse to medical attention. Mrs. P., however, went on to say, "If it had persisted I think possibly

he would have gone to the doctor cus I said to him, well, you know, if you'd have lifted the children or messing about with them you can hurt yourself without realising". Here, persistence of the symptoms would have called for a different explanation and a different strategy of action. This wait and see attitude was presented by some of the respondents as a general strategy they adopted when faced with any problematic experience. Mrs. F. said, "If there's anything wrong I ignore it and hope it'll go away and it usually does". And when I asked Mrs. N. if the backaches she reported caused her or her husband any problems she said:

N3.3 Mrs. N.: Well, not really. I mean, obviously if it's something that keeps on then we'd go to the doctor. But I think one always waits and waits and waits and then one has to go to the doctor but that applies to anything that you have.

This general strategy may also be applied to specific symptom episodes and a period of time may be established after which professional attention becomes an appropriate course of action:

G3.9 Mrs. G.: I had this irritation at the opening of my vagina but I gave it a week and it went otherwise I would have gone (to the doctor). But it was sort of at the end of the week, by Saturday Roger said to me that I ought to go to the doctor's and I said I would go by Monday if it hadn't gone but it had gone.

In this case the symptoms had disappeared within the time period set and the doctor was not consulted. Not only did the resolution of the symptoms remove the need for professional attention it also meant that a definite explanation of the problem was unnecessary. When I asked her if she knew what had caused the irritation Mrs. G. said, "No, not really, I just wondered if it might have been the fact that I'd stopped taking the pill".

This wait and see strategy provides an opportunity to see if the symptoms will resolve themselves or get worse. Mrs. S. had her breathing problem for two weeks before she went to see the doctor. I asked her what it was that made her decide to go:

S3.5 Mrs. S.: Well, it just got worse, when it got really bad I thought well I must go to the doctor. That first week or so it wasn't bad enough and by the second week .... and not only that, I was worried. At first I wasn't too worried about it, I thought maybe it's something that'll go away. It didn't so I made an appointment and went to see him.

Mrs. R. used a similar procedure in the following account:

R3.5 Mrs. R.: I had an infection in my face which started with what looked like a spot and it spread and spread and eventually as I saw it was just spreading I went to the doctor. I waited a few days because at first I thought it was just a spot which would go away and then I got another one and another one and I ended up with about four. And more recently I got a boil under my arm which I take to be a similar sort of thing. By the time I went to the doctor I realised what it was and realised it wasn't going to get better.

Both of these accounts contain implicit notions of when it is appropriate to consult a doctor, and these provide the rationale for the initial delay and the subsequent consultation. The delay is accounted for by the fact that the symptoms were first seen to be trivial and likely to resolve themselves. The gradual realisation that this was not the case is presented as leading to a redefinition of the situation and the formulation of a new plan of action. Nothing resembling what has been called a critical incident can be detected in these accounts.

The legitimacy of this notion of duration of a problem as an interpretive procedure may be affirmed when it is seen to feature in

professional decision-making. If it is used by doctors in planning courses of action then it may reasonably be used by lay actors in determining when and how to act. Mrs. P. reported taking her daughter to the doctor with bronchitis:

P3.4 Mrs. P.: And, erm, well it took so long to really clear, I was taking her to the doctor every few days for him to sound her chest and he said to me, she'd finished the antibiotic and he said it's at last clearing but if it had gone on we'd have had her chest X-rayed.

As it happened the bronchitis reappeared a few weeks later and Mrs. P., deciding that it had not in fact really cleared asked that they "get to the root of the problem" and her daughter was referred to hospital for X-ray.

These accounts are not just descriptions of 'what I did' but can be read as explanations of 'why I did it'. Consequently, they provide a rationale for and, therefore, a legitimation of actions that were undertaken at particular points in time.

In these accounts the respondents ground their actions in the interpretations they placed on various observed or experienced events. Their ability to make sense of the actions of others also requires that they can discover the interpretations those others placed on the events with which they were faced. Similarly, their advice to others on how to manage given problems is justified in terms of the way those problems are defined. This highlights the fact that interpretations and actions involve interpersonal work. Consequently, the interpretations that others place on events may provide actors with a rationale for acting in the ways that they do. In data extract S8 (Chapter 4), Mrs. S. reports that she was worried when her daughter began walking

with her foot turned in and consulted the doctor although she claims to have already diagnosed the problem and instituted a plan of action later ratified by the doctor. The consultation is presented as a response to the definitions of others, "everybody was noticing it and talking about it so we had to ....". Social pressure thus legitimates an action which was arguably unnecessary and the performance of that action is a public demonstration of proper concern for the welfare of a child and integral to adequate parenthood.

Good reasons for not seeing the doctor

During the course of the interviews the respondents not only provided rationales of why they consulted the doctor about some problems they also, in response to my questions, offered reasons why on some occasions the problems they described had not been subject to professional attention. The answers they gave to my questions provided them with yet another opportunity for showing that their help-seeking behaviour conformed to the general criteria which defined appropriate consultations. Though the respondents assumed that I would identify their actions as reasonable they were sometimes able to fault the rationales presented to them by others who refused to seek medical attention even though those rationales may be formulated in terms essentially similar to ones the respondents had themselves used.

Given the general statements about visiting the doctor I quoted at the beginning of the chapter the respondents have at hand a ready-made rationale for not seeking professional treatment. That is, they may only need assert that an experience falls outside that range of problems for which a visit to the doctor is appropriate. Having established that responsible action consists in visiting the doctor

"only when it's necessary", "only when I need to" or "only if it's something serious" failure to consult may be legitimised by defining the problem at hand as trivial or a condition which does not require expert advice. The latter would consist of a problem that any lay person might be expected to treat. The following examples contain rationales of this type:

R3.6 Int.: Can you remember any incidents or complaints that you haven't bothered taking to the doctor?

Mrs. R.: Lee has had a cold but I didn't take him to the doctor, it wasn't, it didn't warrant it.

R3.7 Mrs. R. had told me that she had recently had a migraine:

Int.: Do you have migraines? I don't remember you mentioning them before.

Mrs. R.: I have had them .... not as well not a lot. It happens very occasionally. It's never troubled me to any great extent but I have had them. Erm .... but again I've never done anything about it because it's never been serious enough.

R3.8 Mrs. R. had been violently sick one evening in the week prior to an interview:

Int.: Did you bother going to the doctor's with it?

Mrs. R.: Oh no, because I wouldn't have been able to go to the doctor's, I felt far too ill and I wouldn't dream of calling him in for a thing like that because I don't, you know, unless it continues I don't think it merits calling a doctor in and by next morning I was alright.

In these three examples taken from interviews with Mrs. R. the character of the problems described is such that professional attention is unnecessary. In the last extract Mrs. R. distinguishes two routes via which professional attention may be obtained and shows how the nature of the complaint was such that it was ruled out in both. She felt too ill to be able to go and see the doctor and the complaint was not sufficiently severe to justify asking him to make a home visit.

Similarly, Mrs. P. said that her husband had not been to the doctor with his stiff neck because "It was such a trifling thing to go about probably, you know", and when her son woke up one night with pains in the legs, a complaint which he gets "now and again", she said "I haven't had him to the doctor cus it's such a spasmodic thing that I've never really bothered much about it, you know". Mrs. G. had not consulted the doctor about a sore throat "because I wouldn't have gone until it got worse than it was" nor had she been about her constipation "because it's never really upset me". The respondents not only claimed that they had not been to the doctor because their problems were trivial or inconsequential they legitimated this strategy by invoking professional definitions of the situation:

G3.10 Mrs. G. had reported in her health diary that she had recently had oral ulcers:

Int.: Have you been to see the doctor?

Mrs. G.: Oh no.

Int.: Why not?

Mrs. G.: Well, he'd think I'm a nut case, it's so trivial.

G3.11 Int.: If you remember last time (i.e. as reported in health diary) you had a cold you went to get some medicine, why didn't you go to the doctor this time, why didn't you go and see him about it?

Mrs. G.: It's too trivial, a waste of his time, if I could buy something.

Int.: Well, why do you think a cold is trivial? What makes a cold trivial?

Mrs. G.: A doctor.

Int.: Makes it trivial?

Mrs. G.: Yes, they'd treat it as trivial, if you went with a cold they'd treat it as trivial, they'd treat you as if you were wasting their time. They wouldn't be particularly pleased. I don't know whether he'd say he wasn't pleased but I don't think he'd treat me sympathetically. They haven't got time for people with colds.

Here, Mrs. G. is able to demonstrate that her action with regard to various problems is in line with professional definitions of what is appropriate. These definitions are indicated by the way the doctor is expected to respond to patients who consult with the type of disorders she describes. Although the doctor may not convey these definitions directly, "I don't know whether he'd say", they can be read by means of their external expression in the way the doctor treats the patient. The conflict between doctor and patient to which this may give rise can be avoided by attempts to conform to professional definitions of the situation. This involves presenting only with complaints that the doctor will view as worthy of his attention. That this strategy is not always successful can be seen by Mrs. G's complaint in G3.5. In constructing this legitimation Mrs. G. draws on commonsense knowledge about the ways in which doctors typically react to problems of a given type. This is a product of doctors' public statements on the matter(18), direct experience and the stories of medical encounters that are a feature of everyday discourse(19).

Though the criteria of seriousness that doctors are assumed to employ in judging appropriate consulting behaviour may be invoked by patients in legitimating their own actions the definitions which inform doctors' actions are not always acceptable to lay members. Following her telephone call to the doctor in G3.5 Mrs. G. was given instructions on how to feed her son and told to take him up to the surgery on the Monday following the Saturday on which the incident occurred:

G3.12 Mrs. G.: Anyway, he wouldn't come he just took my diagnosis as being correct and that was it. He wouldn't .... I mean they would never, I mean the only time he would ever come out, you know, to a baby even a baby would be, oh it would have to be something really serious.

Formulations such as this may be read as complaints, as instances where professional definitions and the practices they inform determine outcomes such as lack of home visits but where lay definitions should have formed the basis for action. Mrs. G. clearly regards it as unacceptable that the doctor took her diagnosis as correct rather than make the home visit she thought necessary. However, interactional problems such as this may be invoked to legitimate failure to consult since they are presented as barriers preventing the respondents acting in ways they think appropriate.

If rational action may be defined as action which serves an actor's purposes or interests then failure to consult a doctor may be deemed rational if it can be shown that to consult would be in conflict with these purposes or interests. The respondents frequently asserted that they or individuals known to them would suffer pain or discomfort in preference to the consequences they anticipated following from seeing the doctor. Mr. P., for example, refused to see the doctor because he was afraid he would be again referred for ECT. In contrast, Mrs. R. was only too pleased for her husband to be treated as a psychiatric in-patient, despite protests from his family who were worried about the stigma attached to such treatment, because "my feeling was if he could get better more quickly by going into hospital then please go into hospital immediately". Mrs. R. was then able to present her in-laws' response as irrational since their desire to have him treated at home was seen to be designed to protect the family's good name rather than serving the interests of her husband's health.

Mrs. P. periodically suffered pains from a duodenal ulcer which usually woke her in the middle of the night and continued to be a problem

for a week or more. At one interview she described a development of the problem which, contrary to my expectations that this would act as a trigger, she had not taken to the doctor:

P3.5 Mrs. P.: This last time I found that I had the most terrible sort of sensation in my mouth, I felt as if I was almost going to be sick really. I sort of sat on the edge of my bed and thought, gosh, am I going to be sick and I sat there and I thought, oh blimey, not at this time of the night when you're only half with it and then it passed off.

Int.: And has that happened before, can you remember?

Mrs. P.: I don't think it has, no, I can't remember that it has, you know. Usually it's just this terrible gnawing sensation in my stomach and I'll either reach for tablets or something, you know.

Int.: Did you go and see the doctor this time?

Mrs. P.: No, I didn't. Well, as I say, it's just that I've got the things, I know sort of what to do really. I mean if I went whether he'd send me for a barium meal or again, I don't know, erm, because I had all those originally you know and they're not exactly something I relish the thought of again because when it is troubling you like that you see if you're going to have a barium meal you have to go for hours without any food and the pain builds up and it gets really grim, you know. I'm not being funny, it's utter misery and so as I sort of know what to do really I sort of do it and after a week or so it starts to die down and fades out completely.

Past experience had taught Mrs. P. a routine which could be used to manage the pains from her ulcer relatively successfully. In general this meant that it was usually unnecessary for her to see the doctor because she knew exactly what to do. Her reason for avoiding going back with this new development resides in her evaluation of the likely consequences of such a consultation. The diagnostic procedures involved, because they require a radical alteration in her management routine,

cause her discomfort in the extreme. One of her methods of pain control, and incidentally one of the methods she used to prevent the problem occurring in the first place, was to make sure that she did not go for long periods of time without food while one of the requirements of the anticipated diagnostic procedure was that the patient did not eat for several hours. Respondents who had developed routines for dealing with recurring problems of this kind sometimes claimed that they had been to see the doctor following the breakdown of their routine. It does then seem feasible that Mrs. P. would have viewed this new development differently had it threatened the success of her normal management of the problem.

Using a similar rationale, Mrs. R. had avoided returning to the doctor with pain in her maxillary sinus because she feared it would necessitate another operation. A year prior to the first interview she had had the root of a tooth removed from the sinus where it had caused an infection. The operation was not entirely successful and she had been warned that it might have to be repeated. However, Mrs. R. preferred to tolerate the discomfort although occasionally it became quite painful. "I feel if I go, if I really go back and pursue the matter it will probably necessitate another operation which I want to avoid if I can." Presumably, Mrs. R. would accept another operation if the pain became frequent or severe: "it doesn't happen very often, I don't feel it warrants going back to repeat the whole process." Recall that in data extract R6 (Chapter 4), Mrs. R. refused to accept a similar rationale offered by her husband as the reason for not consulting the doctor about his stomach pains. The acceptability of any rationale may then depend upon the circumstances in which it is given.

In the general statements quoted in the early part of the chapter children were regarded as occupying a special status with regard to deciding whether or not to visit the doctor. As I have indicated in other parts of the analysis that special status stems from their inability to communicate accurately any problematic experience to which they are subject. It also stems from the assumption that any problem to which a child is subject is to be viewed with more concern than its equivalent in an adult. Whereas a problem in an adult may be ignored, with a child "you wouldn't take any chances" or "you'd be more careful". The failure to take a child for medical attention thus calls for justification if the public presentation of responsible parenthood is to be maintained. Mrs. P. and Mrs. R. invoked versions of the conflict of interests rationale to account for failure to consult the doctor about their children. Following a course of treatment for bronchitis Mrs. P. reported that her daughter started coughing "badly again and at nights" which she had treated herself with medicine previously supplied by the doctor:

P3.6 Mrs. P.: She still sounds wheezy but I haven't taken her so far, but I'm sort of keeping an eye. Well, you know, you sort of feel it's such a nuisance really for the kid herself to keep backwards and forwards, you know, and I'm not keen on too much antibiotic in massive doses, I sort of feel that they'll, you know, it won't have the desired effect if she keeps on she'll get sort of immune, won't she?

And Mrs. R. reporting that she had not taken her son to the doctor although she thought he was likely to get an ear infection said, "I don't want him to spend half his life at the doctor's". Mothers may also disregard doctor's orders on the grounds that the consequences of following those orders are not in a child's best interests. Mrs. P.

stopped giving her daughter anti-histamines which had been prescribed for an allergy because she thought it was responsible for drying out her nose making it bleed quite severely.

Rational action is not merely action which serves an individual's interests. As McHugh suggests, members frequently assert that some means are more efficient than others in achieving certain ends and characterise behaviour as appropriate or inappropriate depending upon how it facilitates those objectives(20). Rational action is technically efficient action. Members may then legitimate courses of action by pointing to their viability in bringing about desired ends. Conversely, they may legitimate the non-performance of certain actions on the grounds that they are irrelevant to the attainment of their objectives. One good reason for not going to the doctor is that the cognitive and material resources at his disposal are ineffective in bringing about the resolution of a given problem. Mrs. G. had not been to the doctor with a cold because "there's not a great deal he can do for me, is there?". And when Mrs. R's daughter caught chicken pox she phoned the doctor and told him but "didn't bother to take her up there because there's nothing he can do". Mrs. F. used a similar rationale to explain why she hadn't been to the doctor when her eyes were swollen with what she assumed was an allergy:

F3.4 Mrs. F.: I've had .... I .... this is something which I get fairly regularly, my eyes get all puffy and it happens about this time of the year, so we, the doctor and I assume that it's all connected with the hay fever which I don't get any more, but it does affect my eyes. This one particularly has been itchy and all sort of swollen but I haven't bothered to go to him because in the past I've been to .... I've had all the tests that you can think of for what I'm supposed to be allergic to at the allergy clinic and the doctor said he'd met his Waterloo. Another time when my eyes were

> particularly puffy I went to the hospital and they gave me some cream and I've still got a tiny bit in the tube so I shall put that on and hope it goes away. But, as I say, I don't feel it's worth going to the doctor for because he doesn't know what to give me.

At a subsequent interview Mrs. F. reported that following a prolonged episode of the allergy she had been to the doctor who had suggested referral to a specialist:

F3.5 Mrs. F.: Quite honestly, I don't think I shall bother, I think it's a waste of time because I've been through the pipeline before. I went through one pipeline to a specialist, an eye specialist, and he didn't put his finger on anything and another time I went and had all the allergy tests, I took all my make-up and I had bits of plaster all over my back with all their little bottles they tried and I wasn't allergic to anything except the plaster they stuck them all on with and the doctor said I've met my Waterloo, go home and live with it. So I really don't think there's an awful lot of point going through that lot again.

Past experience had shown Mrs. F. that neither the G.P. nor the specialists to whom she had been referred had been successful in treating what was supposed to be an allergy. Because they were unable to identify any substance to which she was allergic they were unable to formulate effective remedial action. Consequently, going to the doctor about this problem was pointless and a waste of time because it produced no better results than Mrs. F's own method of managing the problem.

As I described in Chapter 5 women may invoke the obligations imposed on them by their occupancy of the roles of wife and mother to manage the discrepancy between a definition of illness and the non-performance of illness-relevant behaviours. The same rationale may be invoked to account for failure to go to the doctor. Mrs. S., for example, had not been back to see the doctor although the tablets he prescribed for her breathing problem didn't seem to work:

S3.6 Mrs. S.: I keep saying I will go back but I never have. It's just getting there, you know, finding time in between. I was going to go back when I'd finished the tablets, you know, and say to him, well I've taken them and I don't really feel much better, erm, you know, what do you think now, but, erm, I haven't really had the time to go up there.

Later in the interview Mrs. S. provided a detailed description of how her responsibilities as a mother prevented her from finding the time to make an appointment and from getting to see the doctor:

S3.7 Mrs. S.: I find it's far more difficult to even find time sometimes, say in the morning, I find that the best time to ring up is half past eight in the morning and then you can make sure of getting through immediately because after that the phone is permanently engaged. Well, I haven't got time when I'm getting the children ready for school to keep trying to ring the doctor up so it's impossible. Sometimes I might think to myself I ought to make an appointment to go and see the doctor and I haven't got the time honestly, it's impossible. And then after the children have gone to school it's either too late and the phone's permanently engaged or it's too late to make an appointment for that day. I don't know what's going to be happening the following day so really it's very difficult. I can't go up in the evenings because the children they come home from school so I think it's half of the thing why I don't always get in touch with the doctor. Once again it's the time factor as far as I'm concerned. And then again in the holidays when I'm not rushing it means traipsing the children up there. I prefer to go without if it's for me. If it's a child, obviously it's a different thing, you've got to take them anyway.

Mrs. S. thus presents her duties as a mother as a barrier preventing her gaining access to the doctor because these conflict with certain features of the way access to the doctor is organised. At one interview Mrs. P. described how she had been unable to go into hospital for tests because of her responsibilities as a mother:

P3.7 Mrs. P.: Some years ago I had these very bad heads and I was under a doctor at the hospital and I had X-rays, head X-rays from all angles and also a chest X-ray and they never discovered anything. They said they would have liked me to go in for further tests but they realised that the children were young at the time and it wasn't very convenient for me to go in.

Entry into medical care may be viewed as desirable, Mrs. S. for example, recognised that she ought to go back to the doctor about her breathing problem, but may not occur because of constraints imposed upon the individual. That constraints such as role responsibilities are legitimate barriers to seeing the doctor can only be seen if reference is made to knowledge about the role concerned and typical ways in which it is performed. Mothers are expected to put the interests of their children before their own and in so doing may be identified as good mothers. Consequently, they cannot be identified as irresponsible in failing to find time to seek medical help. There seemed to be a consensus of opinion between Mrs. P. and her doctors that her duties as a mother came before the investigations they would have liked to have performed. In defining the outcome as consensus opinion Mrs. P. underlines the fact that her choice of action was socially and professionally sanctioned. As a result, her action is difficult to fault.

Interactional and organisational barriers to seeing the doctor

In the account given by Mrs. S. above, she not only refers to the way in which her responsibilities as a mother create difficulties in gaining access to medical care, she also cites the way in which access is organised as a contributory source of problems. During the course of the interviews the respondents described a variety of inter-

actional and organisational barriers which they claimed had an influence on their help-seeking behaviour. The extent to which these problems did act as barriers to prevent them from seeing the doctor is, given the methodological approach, problematic. I prefer to take the view that our discussions of illness behaviour provided them with opportunities to construct complaints about doctors and medical practice. Consequently, their identification of organisational and interactional barriers preventing access to the doctor shifted the responsibility for their failure to seek professional help to those involved in the provision of medical care. At the same time they gave some indication of the strategies they found it necessary to adopt to circumvent these barriers.

The interactional problems experienced in consultations that the respondents described consisted of the ways in which doctors deliberately or unwittingly challenged their competence or otherwise failed to conform to their definitions of the situation. In the case presented at the beginning of the chapter, data extract G3.5, Mrs. G. interpreted the doctor's response to the telephone call about her son as an attempt to fault the appropriateness of her actions. As a result, she reports being "put off" the doctor. Mrs. G. continued her account by formulating a further complaint:

G3.13 Mrs. G.: I was told to take him up to the surgery on the Monday morning. Even then, it put me off that. I took him then and he was all wrapped up because it was a freezing cold morning and he said, he said to Daniel and what are you going to wear when the winter comes, you know?

In any encounter, statements by one party may be read by the other as criticisms or attempts to fault performance. I take it that the statement by the doctor to Mrs. G's son was read by her as a challenge to her competence(21). One formulation of the statement

as such a challenge would be to read it as a claim that the child was over-dressed and by implication Mrs. G. an over-protective mother. Mrs. G., however, provides for her own competence and the appropriateness of her actions when she says "it was a freezing cold day".

That there is a power differential in doctor-patient interactions whereby the doctor, because of his control of cognitive and material resources and a whole host of other factors, is able to impose his definitions of the situation on the patient and comment on their rationality has often been described in the medical sociological literature on the doctor-patient relationship(22). That the reverse is more difficult because of the imbalance of power has also been recognised(23). Patients are also aware that there is a power differential in the relationship so that they are relatively disadvantaged. As Mrs. F. remarked when a doctor diagnosed and treated her eye problem as an infection although she knew it was an allergy said, "I knew it was an allergy but he insisted it was an infection, but you can't argue, can you?". And Mrs. R. commenting on a visit during her second pregnancy to the endocrinologist who had prescribed corticosteroids for the first said, "He said haven't you been taking it all along and I said no, whatever for, and he said, oh I would have expected you to take it all the time and, er.... I didn't argue with him, a very well-known man who's not to be argued with".

These kind of conflicts, usually covert, which may occur when patients consult doctors may be invoked by patients as barriers to entering into consultations. At the same time they present strategies which they claim to use to influence the doctor's evaluation of them and the appropriateness of their consultation and thereby minimise conflict:

G3.14 Mrs. G.: The next time I went up because Daniel had got a very bad cold. I was reluctant to go because of the way that he'd treated me the first time and sort of when I went in I made it sort of quite obvious, I said to him, well I thought I'd better come up now rather than have you out in the middle of the night, I didn't think, you know, that you'd find that very pleasant.

Stimson and Webb have suggested that patients' accounts of their encounters with doctors are formulated in such a way that the activity and integrity of the patient are stressed and the inequality between the doctor and patient is redressed. They also suggest that the reconstruction of the encounters depends as much on the shared opinions and assumptions of the teller and the audience about the social world of doctors and patients as it does on the recall of the details of the original exchange(21). In this account Mrs. G. presents herself as managing the encounter with a doctor who in the past had proved difficult by offering a good reason for her visit at the opening of their interaction. Stimson and Webb would probably claim that it is unlikely that the encounter happened in the way the respondent describes. However, irrespective of the way in which an observer would have characterised the scene, Mrs. G. must present an account in a way that makes it clear what she was up to. That is, a listener or reader must be able to make sense of what she claims to have done in the situation in which she claims to have done it. I take it that her statement at the opening of their encounter was an attempt to influence the doctor's definition of the appropriateness of her visit for a disorder that might otherwise be characterised as trivial. One reading of what she claims to have said is that it is preferable from the doctor's point of view for her to consult with a complaint that might be relatively trivial rather than wait for her son's condition to deteriorate which might have involved the doctor in a night call. To the extent that strategies

of this kind are employed by patients, they are made necessary by the ambiguity with which many disorders present. Lay knowledge is not always sufficient to allow an unambiguous definition to be constructed. Mothers then may often decide to err on the side of caution. They are also necessitated by the patient's awareness, either derived from direct experience or indirectly from the accounts of others, of the way in which doctors may respond to consultations they see as unnecessary. Mrs. P., unsure of whether or not to consult the doctor when her daughter began coughing again following the completion of a course of antibiotics left the decision to the doctor:

P3.8 Mrs. P.: Over the week-end she's been coughing a lot and I thought, I don't know, she sounds really rattly there again and I phoned the doctor on the Monday and I said I don't want to bring her up if you don't think it's necessary but I said she does sound rather wheezy on her chest again. Oh, he said, bring her up.

At a later interview Mrs. G. complained about the same doctor on the grounds that he had an unreasonable disregard for her status. This she saw as a manifestation of a general attitude towards mothers:

G3.15 Mrs. G.: I don't like him, he hasn't got time for the mothers, he treats you as if you're not there. Well, fair enough, he probably thinks a child ought to learn to think for itself but at a year old obviously they can't, but he treats you as if sort of it's a shame that you've got to be there.

Here, Mrs. G. feels and is concerned about being excluded from an encounter of which she has a right to be a part. Although this may be warranted in certain cases, "fair enough, he probably thinks a child ought to learn to think for itself", it is unwarranted in her case since her son is only one year old and incapable of conducting the interview in his own right. His attitude is then to be seen as a challenge to

her right to speak for her child. These sorts of criticisms of the way doctors act towards their patients may, as in data extract G3.5, be presented as barriers which make patients reluctant to consult the doctor.

Another way in which doctors are seen to challenge patients' competence is in what patients perceive as their refusal to impart information. Mrs. S. and Mrs. R. complained bitterly about the difficulty of finding out what is going on:

S3.6 Mrs. S.: I'm so worried about Michael going to hospital for his next check-up. I know it's stupid but I just tremble now I can feel myself just going all funny, you know. It's stupid, he's doing so well now but I just can't help myself. Mr. B. I think as much as anything, he frightens me to death. He's the surgeon, he did the operation. Well, I mean he's a very good surgeon, he's marvellous but it's just .... when we first went up there I suppose they did it for our sake they said he'd only be in plaster for about six weeks and we thought six weeks that's not too bad and it turned out to be six months. I mean, it's a heck of a difference from six weeks. And I felt oh I think that's rotten saying things like that, I'd rather be told the truth from the beginning, you know, if they say it's going to be six months you accept it but from six weeks suddenly to go into that long time that annoyed me tremendously. I thought, well, what do they think us parents are, sort of thing, you know, I'd rather be told the truth about things. This is what I think is wrong with doctors they don't tell you anything, I think they think you're a load of kids or something and can't accept the truth so it does make me feel nervous about it.

R3.9 Mrs. R.: I do feel there is a lack of information given. It's very much up to the individual doctor some doctors will discuss fully whatever it is wrong with you and others won't. I feel our present practice don't discuss fully enough although I must make one exception when my husband went to Dr. M. he did discuss the thing with us very freely but, erm, at other times I think he doesn't, I think he tends to treat the patient as a bit of an idiot who's not going to understand anyway, I think this is quite general to a lot of doctors, you know, don't bother to tell them cus they're not going to understand,

> just give them their prescription and they can go away like good children and take it which I object to very strongly.

In both of these cases part of the respondent's indignation stems from the way in which doctors are assumed to characterise patients. It is the doctor's characterisation of patients as "children" or "idiots" incapable of understanding what is wrong with them or accepting the truth that is seen to underlie doctors' unwillingness to discuss matters fully or otherwise give an accurate picture of the situation(24). That doctors see patients in such terms is a source of annoyance since it defines them as incompetents and challenges their taken for granted status as responsible adults. It is not without its other consequences. Mrs. S. claimed that part of her nervous problem prior to hospital visits originated in this lack of information and Mrs. R. went on to describe the effects of ignorance:

R3.10 Mrs. R.: If you don't know you worry about it, or at least I do, if I know what's happening I can say right well, you know, I, this, that and the other, but if I don't know then I start thinking well I wonder what's wrong and I wonder what I'm taking and I wonder what effect it can have and I do start worrying although I don't generally worry much about my health. I don't like the unknown and, er, I can get very indignant about it because then I feel very unhappy, once it's explained to me then I'm much more at ease about it.

In this extract Mrs. R. reaffirms a point I made at the beginning of Chapter 5. Without the relevant knowledge at her disposal Mrs. R. is unable to achieve a sense of order and is consequently unhappy. Given that the problem is presented in this way it suggests a rational course of action. "I always ask, I mean I just insist and if they don't explain I just go on asking or I'll ask the chemist who's prescribing as well so that I know what I'm taking". That this contravenes

what Mrs. R. imagines is a doctor's conception of a good patient is recognised when she says, "I must be a doctor's nightmare". That this is a typical experience of patients was indicated by Mrs. S. when she said, "It happens to the majority (of people she knew), they just don't tell you anything".

Doctors were also seen to challenge the respondent's competence by not acquiescing to patient defined needs. Mrs. G., for example, told me that she had a long history of tonsillitis and past experience had taught her its typical course and the most efficient way of managing it:

G3.16 Mrs. G.: Well, sometimes it starts off as a cold. This has, you know, been the only thing that I've ever suffered with, I've ever gone to the doctor's with, my medical card's just covered with sore throats and tonsillitis from when I was about seven or eight until now. Perhaps starts as a cold and then I just get a sore throat and it, if I don't go and get some antibiotics from the doctor it turns into tonsillitis. So when I've had a sore throat, rather than let it get hold of me, I'd say go up there I'd go to the doctor's and ask him if he'd give me some penicillin or some kind of antibiotic because I knew that if I took them it would go within a matter of a couple of days, but if I'd waited say a week and then went it would have got hold of me and I'd have to have a fortnight at home off work. And I went a couple of times like that and he sort of, I mean he gave it to me but he was er .... I don't know, a bit annoyed.

Mrs. G. had a proven recipe at hand for dealing with sore throats which was designed to prevent it turning into tonsillitis with consequent absence from work. That involved presenting early on in its course and requesting antibiotics from the doctor. The doctor is presented as defining the situation differently; although he granted Mrs. G's request he was perceived to be "a bit annoyed". That Mrs. G's strategy was a reasonable one is given by its technical efficiency:

G3.17 Mrs. G.: And yet it did, you know, that was true, that within, I didn't have any time off in those eighteen months, I didn't have a day off at all. And yet I could probably have had a month off with those couple of bad throats.

Mrs. F. reported how both she and her daughter had experienced problems when they went to one doctor for the renewal of their prescriptions for the pill:

F3.6 Mrs. F.: There's something about some of these doctors, one really put my back up and, you know, I'm quite a sort of mild person, he really upset me and he upset my daughter who went for the pill. O.K., so he was anti-pill but it's there and it's available and .... I don't know, the argument seemed to be, what at your age, at my advanced age, I went to him in the January and I was forty-six and I was only just forty-six, the attitude was you're forty-seven you should be thinking about facing, you know, old age and the rest of it embracing, you know...

Int.: Mm.

Mrs. F.: the menopause, what do you want with the pill at forty-seven, and I said to him mildly, forty-six, and anyway he managed to bring back into the conversation forty-seven again, you see, and anyway he then gives it me for six months and then he says you've got to think about giving up and I thought I'm damned if I'm seeing you again mate so I made quite sure I went on a morning when Dr. M. was there ....

Int.: Yes.

Mrs. F.: .... and the attitude was so different. I said, you know, almost apologetically, please may I have another and he said, well, of course, we don't want you pregnant at thirty-two, do we? Now what a different attitude, totally different and as I say he upset my daughter so much that she left the place in floods of tears and went straight to another doctor and said can I come as a private patient and he said, yes.

Int.: Did he refuse to give her a prescription?

Mrs. F.: No, he didn't really, but he was going to argue about it and he wanted her to have a smear test which she thought was somewhat unnecessary at the age of seventeen and he insists, you know, that she has this smear test and she said, well, Dr. Z. or Dr. M. have never gone into this at my age .... at my age, O.K., but I don't think it's necessary

> at her age and there was an attitude that, er, he said, well perhaps you think I want to look at you undressed or something, you know.

In both of the instances described by Mrs. F. the doctor is seen to be imposing his definition of the situation on Mrs. F. and her daughter, a definition which conflicts with their own self-perceived needs. The account is constructed in such a way that the doctor's attitude may be interpreted as unreasonable, evidence of an underlying "anti-pill" stance, rather than the alternative formulation that he was practising good medicine. Given this perceived underlying attitude the doctor's specific recommendations may be taken to be attempts on his part to erect barriers preventing access to the goods and services they desire. Advising Mrs. F. to think about giving up the pill and recommending that her daughter have a smear test may fall within what is medically defined as good practice, serving the interests of the patient. However, that these actions are to be read as evidence of the doctor being unreasonably difficult in the consultation is given by the facts that Mrs. F. presents. The doctor's definition of Mrs. F. as too old is a product of his consistent and deliberate over-estimation of her age. This, and his general attitude are contrasted with that of Dr. M. who not only under-estimates her age but willingly prescribes the pill. The doctor's insistence that Mrs. F's daughter have a smear test is also to be seen to be unreasonable given her age and given the fact that two other doctors have never thought it necessary that she submit to these investigations. The interpretation that the doctor's behaviour was unreasonable is reinforced by Mrs. F's response given her person type: "he really put my back up and, you know, I'm quite a sort of mild person". Mrs. F. and her daughter managed these difficult interactions by avoiding that doctor in the future.

In a subsequent interview Mrs. F. described recent changes in her doctor's practice that had changed the nature of medical care and created barriers between a doctor and his patient. This influenced when she would choose a consultation as the way of dealing with certain problems:

F3.7 Mrs. F.: I think somehow we look on the doctor more or less as a last resort. I mean for other people I always say go, but if it's for me I think ignore it, it'll go away. You know, somehow it's too much .... I don't know .... it's not the same going to the doctor as it used to be. It somehow used to be a pleasure. When Dr. M. was on his own and we all knew him really well and he had this one receptionist who was a sweet woman and lived on the premises we really felt we were one of his family. And it's the same with everything these days, everything expands, there are now three of them practising there you know you never know who you're going to see and when you go he's got three receptionists and it seems to me they are there to stop you seeing him if possible, they want to know what your symptoms are when you phone up and if they don't think you're ill you don't get transferred to the doctor, you don't get an appointment, you know, they .... I'm resentful somehow over doctors and their practices. I'm just a number, just an address on a card. I'm not me any more that the doctor knows and the receptionist knows. This is basically why under the old set-up I would have gone to Dr. M. and said, well, look my eyes have come up again this year, anything fresh we can try? But now as I say there are three receptionists to get past first and then you're lucky to see who you want to see. Erm, this is something I don't want to know about, I'd rather stay away unless it's really desperate.

For Mrs. F. the essence of good medical practice involves personal knowledge of the patient and his family on the part of those involved in medical care. Recent changes in the way the practice is organised, its expansion to three doctors and the introduction of receptionists, have resulted in an impersonal service in which the doctor no longer knows his patients as individuals. In addition, the function of the receptionists appears to to be one of keeping patients from seeing the

doctor since they, by their control of the appointment book, are able to question the appropriateness of the patient's decision to see the doctor and impose their own judgements where they think necessary. The problems involved in negotiating access and the patients' lack of control over outcome in terms of which doctor they see are presented by Mrs. F. as sufficient reasons for staying away from the doctor "unless it's really desperate".

That the system is impersonal and prevents the exercise of knowledge of the patient by those involved in controlling access, which would otherwise allow them to make adequate judgements about the appropriateness of requests for consultations or home visits, is evidenced by the case Mrs. F. described and which I presented in Chapter 4 (data extract F4). When her husband had flu Mrs. F. telephoned the practice to request a home visit and "all I got was the receptionist fending me off". Had the system involved the exercise of personal knowledge those controlling access "would have known this man must be ill if he's asking for a doctor because he's never been near us, never bothered us" and would then have been in a position to make an adequate decision. While this would have been possible under the old set-up, under the new set-up "who knows the individual any more?".

Experiences such as this led to the conclusion that the practice no longer cares, "who cares any more?", and may then act as a legitimation for not visiting the doctor when it might have otherwise been thought necessary. Just prior to the last interview with his wife, Mr. F. had a very bad cold and a temperature and had to stay in bed for two days. When I asked Mrs. F. why she had not had the doctor round to see him she said, "Well, because last time he had flu the doctor didn't want to know. I went round and I was given a piece of paper

how to treat influenza so as far as I'm concerned, you know, that's it. I've gone off doctors, I have really, I'm very disillusioned".

Similar points were made by Mrs. S. in discussing the difficulties of getting appointments with the doctor of her choice:

S3.7 Mrs. S.: Actually it's a hell of a job trying to get an appointment always you know with him because Dr. M. is pretty busy up there and I do like to see him rather than any others cus I've known him since I was eleven years old, you know, as far as I'm concerned he's my doctor, he knows me, he knows what makes me tick and sometimes you phone through and the receptionists are, you know, stupid, you try, it's ridiculous, you know, you'd think they were Mafia or something trying to get past to see Dr. M. and It's so stupid and I get mad. You know, I think who the hell are they to talk to me like that? I know they have a certain amount of job to do but they're like little Hitlers and that's another thing that puts me off.

Int.: You always ask to see Dr. M?

Mrs. S.: Yes, he knows me, er, I must say I don't know if Dr. Z's even there any more, somebody said he'd retired, now I liked him he's very nice but he just didn't seem to know me and there's another little man up there I've only seen Dr. S., I've only seen him once a long time ago and he was very nice but once again I just felt that they didn't know me. Dr. M. is very good and he's very kind, you know, he's very good. He knows I have Michael, he understands my problems so therefore I like to see him and if I can get an appointment with him then I'm happy. If I can't get one the same day I'll wait, I'll wait for him. The thing is, you see, the receptionist probably thinks why sort of thing when there's other doctors, but obviously they don't know that I've been going to see him for, you know, I just feel it's as if, well, that's it, I want to go and see Dr. M. They do put you off though some of these women, they're ogres they really are and I'm not the only one to say that, the majority of people do. It's most off-putting really, I don't think they have a right to talk to people the way they do talk to them.

Int.: Yes.

Mrs. S.: One lady up there, she's very nice. If I ring in a morning sometimes I get her but she doesn't always answer the phone. But there is another

she's most unpleasant and it puts me off, otherwise I might, you know, have made my appointment sooner.

In this extract Mrs. S. describes how she prefers to see Dr. M. since he knows her, her family situation and her problems in a way that makes other doctors unacceptable. The receptionists constitute a barrier between her and the doctor. Because they do not know her history and her relationship with Dr. M. they are not in a position to understand her desire to see only him, they "probably think why .... when there's other doctors". Like Mrs. F., Mrs. S. invokes the problems involved in gaining access as a good reason for delaying visiting the doctor or avoiding seeing him at all. If she were not "put off" by the receptionists who she sees as having no right to talk to her in the way that they do she claims she would already have made an appointment to see the doctor about her breathing problem. Because of the difficulties of negotiating access to the doctor of her choice Mrs. S. chooses to take care of most disorders herself:

S3.8 Mrs. S.: If I ring through and say to them I'd like to make an appointment to see Dr. M. I'll probably get one of them saying you can't see him, he's not here or something like this, you know. So if I can we dose ourselves up unless it's really urgent and if I think it is then I'll have to go and see him. But if I could look after everything myself then I'd do that. It's much quicker and much easier and no bad results yet, everything's, you know, sorted itself out.

That these barriers were seen by Mrs. S. as the product of the actions of the receptionists rather than the doctors is evident in the following account:

S3.9 Mrs. S.: This is a thing that'll give you an idea. I pulled a muscle in my neck just at the back here and I went to Dr. Z. and he gave me a pain killer, Distalgesic I think it was. I started taking them and they were good so I

finished those and I had about four left and I thought well I'll phone through rather than come out cus it's a bit difficult getting out sometimes, you know, so I phoned through and oh I'm sorry Mrs. S., it was this dreadful one again, we don't take prescriptions on the phone any more, you'll have to come up and get it, you see, but this once she said this once we'll, she was going to do me such a favour, we'll make up the prescription for you and, erm, mustn't do it any more, you just feel like a child ....

Int.: Yes.

Mrs. S.: you know, and this is the sort of thing that gets me, so I said oh I'm sorry I won't do it again, you know, and that was it. So I went up there and Dr. M. was in and he was so nice you know, although she was there he said, oh hello, Shirley, you know, it's been Shirley ....

Int.: Yes.

Mrs. S.: you know, and it's so nice, well how are you and what have you been doing? I've got your prescription here, do you want to come in and collect it and he signed it for me and there was no comment from him, well I shouldn't have gone up, I shouldn't have phoned through and all the rest of it and it just makes you wonder if it's just them lot that say it. But there you are, I got my tablets, he didn't query it, he didn't even, you know, worry that I was getting them and not coming up to see him.

In contrasting the response of the receptionist and the doctor Mrs. S. demonstrates that her request for a repeat prescription was not unreasonable. The doctor is certainly presented as being happy to accept that state of affairs and willingly granted Mrs. S's request. Consequently, it may be concluded that the receptionist was not acting on the doctor's authority, "it just makes you wonder if it's them lot that say it". This absolves the doctor from any responsibility for the presence of this particular barrier, for it is the receptionist alone who is seen to be at fault.

The respondents not only presented receptionists as routinely questioning the necessity of a visit to the doctor, they also described

some of the methods they used in persuading the receptionists that an appointment was necessary. This largely consisted of invoking features of the case concerned to demonstrate the severity of the problem. In the last chapter I described how Mrs. G. and Mrs. S. (G2.14 and S2.24) reported instances in which the age of children was invoked when receptionists queried whether there was any need for the doctor to be seen. Mrs. P. described how she had gone up to the surgery with her husband only to find that there had been a mistake in the appointment and he had been incorrectly booked in for the next day. "So I explained, well look he really does feel ill, he's got up out of bed to come, isn't there a chance that the doctor will see him?" And when she phoned the surgery to request a home visit for her daughter the receptionist said "can't you bring her up and I said not with a temperature of 104". Here the respondents attempt to trade on common-sense knowledge that they assume the receptionists will use in deciding how to allocate the doctor's time. In attempting to demonstrate the severity of the problem in this way they assume the receptionist will see the sense of the matter and grant their requests. Where this does not happen the respondents report being annoyed and disillusioned. They also clearly resent the fact that barriers such as this exist which require time and energy to negotiate. These barriers constitute an organisational challenge to patients' competence to decide when it is necessary to see the doctor whereby actual need is judged according to the common-sense and unexplicated rules receptionists employ to judge matters of this kind. Respondents' accounts are then critiques of the organisation of medical practice and a reaffirmation of their competence and rationality.

Alternatives to seeing the doctor

As numerous social and epidemiological surveys have shown the majority of symptom episodes are managed independently of formal medical agencies[25]. Where doctors are not consulted, or where professional attention fails to produce a satisfactory outcome individuals resort to alternative methods of coping with the disorders that arise. The options available for them to pursue are fairly limited; they may do nothing, they may self-medicate or they may consult one or more non-licensed practitioners such as chemists or spiritualists. Where disorders are recurrent individuals may develop routine ways of dealing with them without recourse to professional attention. These routines may be developed in consultation with doctors who provide the cognitive and material resources on which the routine is based, or they may develop routines through self-experimentation. The extent to which such routines can be developed and maintained independently of doctors depends upon whether the resources a doctor controls are necessary to the routine. As Mrs. G. said, "In this country you can't obtain antibiotics can you and that kind of thing so therefore you've got to go to the doctor in order to, if it's something that needs that kind of treatment then you've got to in order to get them, haven't you?"

The routines that the respondents constructed and employed involved a recipe for action that in the past had proved successful and was assumed would be successful in the future and a notion of the typical course of a problem which defined what action was to be taken at what point in time. As I have shown, these notions of the typical course of a problem were also employed in characterising any particular occurrence of it as severe or otherwise. Departures from this typical course may then be offered as the rationale for new methods of management

or they may call for interpretations such that the problem is no longer seen to be an instance of what it was originally supposed to be.

Management routines may be legitimated as professional constructs or derive their legitimacy from their ability to produce successful outcomes. That is, the routines may be seen to be successful irrespective of whether that success has any foundation in medical fact. Mrs. S., whose daughter had "funny tonsils" that troubled her from time to time, described a management routine the doctor recommended she use while judgement on how to resolve the problem was deferred:

S3.10 Mrs. S.: We'll see what we're going to do about them later on when she gets a bit older. But, er .... I give her a couple of Junior Disprins every so often, you know, and it goes and she's alright. I've taken her temperature, I never had one but I went to Dr. Z. when Dr. M. was away and he gave me a thermometer because I'd never had one in the house before, you know, and I took her temperature and it was a bit high and he said every time it happens I should take her temperature and just give her Junior Disprin and don't do anything more than that.

Mrs. P. and Mrs. F. both described routines for managing problems which, while not recommended by the doctor, depended upon material resources supplied by him:

P3.9 Mrs. P. suffered periodically with pain from a duodenal ulcer:

Mrs. P.: Er, usually it'll wake me in the middle of the night or something like that, er, the only way I can describe it is as if something's eating my inside away and I usually have to get up although sometimes I take a glass of milk and some plain biscuits up to bed with me. I've got Nulacin tablets which the doctor gave me and I always keep some of those handy, you know, to suck .... if I suck one or sometimes two if it's been bad as I'm sort of dropping off to sleep and they sort of dissolve in my mouth through the night that keeps it down cus I presume they coat your stomach and that gives it something to work on, you know ....

Int.: Mm.

Mrs. P.: through the night hours. But, erm, I did have a bit of a bad spell this last time, you know, it was rather uncomfortable but, er, I know what I've got to do when it does flare up so I just sort of plod on, you know. The thing is you see, never to go without food, something inside, erm, if I'm going shopping and I sort of stop and think now it's sometime since I had breakfast or something I'll have something quick before I go out because I know it's fatal once I get that terribly empty feeling because it starts paining again, you see, so the thing is to keep having something every couple of hours and then I'm O.K.

Int.: Did the doctor advise you to do that sort of ...?

Mrs. P.: Well, erm, not exactly, but the thing is my brother along the road he had ulcer trouble for years and eventually he had the operation and he said I wish I'd had it years ago cus now of course he can eat everything and anything. But I don't watch what I eat, perhaps I should but, as I say, it doesn't flare up all that often and so, you know, I go merrily on. But if I have trouble with it, you know, I'm very, very careful.

F3.8 Mrs. F.: I do get allergies, my eyes swell, my face swells. I take antihistamines for most of the summer. There again it doesn't necessitate a visit, just a phone call for a prescription cus I know what I need. I just take an occasional Piriton in case it's an allergy and I use a little bit of the cream I was given at the hospital which I have left and it seems to keep it down until the season or whatever it is affecting me goes away, you know, it'll probably be for only a few weeks and I shall be alright. I'm sure it'll go away on its own without having to go to the doctor.

In both of these cases, Mrs. P. and Mrs. F. had acquired a body of knowledge about problems which occurred periodically and had developed routines for dealing with them. Mrs. P's method of managing the pain from her ulcer involved diet control and the use of drugs previously supplied by the doctor. The control of diet derived from her knowledge of the consequences of going without food for any period of time.

Because her brother had suffered from a similar problem she was able to draw on his experience as a resource in understanding and dealing with her own. Mrs. F. had not been provided with a medically defined method of management but had learnt through experience how to treat what she supposed was an allergy. She had been told by a specialist that there was nothing that could be done since the source of her problem could not be identified; consequently she only rarely went to the doctor when the allergy occurred. Her management routine involved taking anti-allergic drugs "in case it's an allergy" and using cream that she was prescribed on one of her visits to a specialist. Because they knew what to do and had the resources to do it these management routines constitute feasible alternatives to visiting the doctor. At subsequent interviews both of these respondents reported that they had recently been to the doctor because their methods of management had broken down. At one interview Mrs. F. said, "I've run out of the ointment so I don't know what I shall do" and at the next interview she explained why she had recently been back to the doctor, "Well, I didn't have any cream left and I didn't have any antihistamines so I more or less had to go". And Mrs. P. said, "This time I went to the doctor because I didn't have the sort of tablet, you know, the Nulacin and he gave me those".

Where conditions have been treated in the past by a doctor individuals may acquire resources which may be used in the future given any reoccurrence of the problem. This may take the form of self-medication with medically prescribed drugs. When Mrs. S. pulled a muscle in her neck she took some of the tablets she had previously been prescribed. "The first time I went to see the doctor he gave me these pain killers and he said take those and I had some left and I've been taking them for my neck and it's much better". Similarly, having been

prescribed drugs for her nerves she had the resources at hand for dealing with any future problem herself. "If I start feeling depressed again I have got some tablets which the doctor gave me last time I went and I only took a few and I've got them so I'll take them." Experience of what has proved effective in the past is used to construct future courses of action under the assumption that it will again prove to be effective. At another interview Mrs. S. was able to use this assumption and knowledge of the typical outcomes to plan alternative methods of dealing with a problem:

S3.11 Mrs. S.: I've got a headache now but I suppose that's because I've been rushing around. But that will go. I won't take anything for it unless it gets nasty. I find that now I'm having a bit of a sit down it will probably go and if I find it doesn't I'll take an aspirin and probably in about half an hour it's gone.

Knowledge about the typical pattern of onset of a disorder may also be used as the basis for preventive action. Mrs. R's son suffered fairly frequently with ear trouble and just prior to the first interview he had been to the doctor several times with infections. Because these ear infections had been seen to follow coughs and colds they were the signal for Mrs. R. to act:

R3.11 Mrs. R.: He's got a cold at the moment and then we're a little bit careful with him in case he gets an ear infection, you know, we dress him up warmly and that sort of thing which is about all you can do, I think.

Similarly, Mrs. P. said of her daughter, "She might say, oh, my throat hurts and I immediately look and get her to stick her tongue out so I can look down her throat and if there is any inflammation there I usually straight away .... I don't hang about knowing the throat is troublesome with her".

As I described in Chapter 3, mothers often asserted the value of dressing children warmly in maintaining good health. The theory that the two are connected thus provides them with a rationale for actions of this type. Other respondents provided more explicit theoretical justifications for their actions.

Mrs. F., for example, invoked a germ theory of disease when explaining the action she or members of her family followed if they had reason to suspect they might get a cold:

F3.9 Mrs. F.: Before we go to bed we put a little bit of TCP up each nostril, because I think if there's any germs up there, kill them off, mate, before they get any bigger and I will suck a TCP pastille, you know, if there are any germs down there, you know, it's got all night to work on them. As I say, my husband, he'll sniff up TCP if he's been in contact with anyone with a cold or if anybody in the family's got a cold, we say, come on, TCP bottle, you know. Now I wouldn't gargle with it, you see, it's just a case of sniffing a bit up because that's where I feel the germs are probably, you see, up there and down there, that's where they start and if you can knock them out for a bit or weaken them or something with TCP, do so. I hate gargling, I don't think it does you any good quite honestly, you make lovely noises but I feel it probably never gets the water only wiggles about in the space, it never actually touches anywhere to stay long enough to do anything. I think it's a waste of time.

This theory of the cause of disease is used to provide a detailed rationale for the most mundane activities and allows some action to be characterised as appropriate and others inappropriate. While this theory is incorrect in scientific terms, in Mrs. F's experience it is correct. The success of the remedy, "it does seem to work", justifies the theory from which it is derived. By contrast, Mrs. S. was unable to provide an explanation of the success of her preventive remedy:

S3.12 Mrs. S.: If I'm getting a cold I just, sort of, always got oranges and honey in and I just have that and I never seem to get that cold. Now maybe this is just sheer coincidence, you know.

The legitimacy of Mrs. S's procedure derives from its effectiveness although she does not offer a reason as to why the remedy might work other than to speculate that it is "coincidence".

The management routines that the respondents reported do not only break down as a result of a lack of the material resources involved, they may also prove to be ineffective following changes in the nature of the problematic experience. That is, a departure from the course a disorder typically takes may call for new courses of action. Mrs. F., for example, usually ignored the rheumatism that occasionally affected her arm but did go to the doctor once "when it was particularly painful". When Mrs. R. got a headache she didn't usually take anything for it, "I just have to sleep it off, it's the only way", although she did resort to pain killers on one occasion "because my head was so bad".

Departures from the typical course of a problem may not result in the adoption of new courses of action but they may call for new interpretations of the problem. Mrs. F. described how her husband had had a cold which had not run its normal course:

F3.10 Mrs. F.: He's had a cold and he's a bit annoyed about it cus he hasn't shaken it off. Normally, two days and it's gone, you know, marvellous, me, all I ever get is a runny nose and in two days it's gone. Well, you see, this time it's sort of catarrh and it's been hanging on and he's quite annoyed to think he hasn't shaken it off with his usual .... I think there are different colds going around this time.

Mrs. P. also described a case in which her husband's illness had not run its typical course. He had developed a chest infection over

the week-end and initially refused to see a doctor because "he thought he'd dose up and shake it off like he's done before". He eventually did see the doctor and was off work for two weeks with bronchitis. In describing this as "very unusual for him" Mrs. P. gave the following information:

P3.10 Mrs. P.: A couple of times he was sick, two different nights. But it still didn't unfortunately make any difference. Now normally, if he is sick it will often clear him of anything if he doesn't feel well, you know, he seems to be fine but he wasn't this time at all.

The respondents frequently asserted that the remedies they used were successful in resolving the problems for which they were designed even though there was no medical basis for their being successful. Under the assumption that if A precedes B then A may reasonably be seen to be causing B the resolution of a problem may be attributed to the remedy that precedes it. Where a theory is available to connect the two the conclusion that the remedy is an effective cure is reinforced. Where particular methods of dealing with problems do not bring about the desired results then alternative methods may be tried. When Mrs. N's daughter fell and cut her leg Mrs. N. attempted to treat the wound herself until it became clear that she was not competent to do so and professional help was sought:

N3.3 Mrs. N.: She got oil and tar in the wound and we couldn't clean it. At first we tried to clean it up ourselves, we thought we could, when we realised this wasn't getting anywhere we just took her straight to the hospital.

When the antibiotics Mrs. R. was prescribed for the boil under her arm did not prove to be a success Mrs. R. tried a remedy of her own:

R3.12 Mrs. R.: I did a bit of home treatment on that eventually because I was told not to put anything on it just to use the antibiotic which I did and after finishing the antibiotic the thing was about three times as large as when I started so I went back and Dr. M. said not to worry it will shrink. So I waited another few days and if anything it was getting larger so I put some magnesium sulphate on it and that's what cleared it up. I don't think Dr. M's a great believer in it but I've found it very good.

Mrs. R's action in contravention of doctor's orders was justified by the lack of success of the medically prescribed treatment. That the antibiotic was a failure is obvious given that the lesion for which it was prescribed did not behave as the doctor predicted, it got worse judging by its increase in size, rather than better. Consequently, Mrs. R. resorted to a remedy she had tried in the past and which she had found to be "very good".

As Schutz has pointed out in his analysis of the natural attitude, the common-sense actor has a pragmatic rather than a theoretical orientation to the world. His stock of knowledge at hand and the projects to which it gives rise are only as good as they need to be in bringing about desired ends. As these cases illustrate, the common-sense actor is not concerned with the preservation of a set of theoretical ideas but will draw on contradictory notions of the way the world works or ideas drawn from conflicting sources in finding solutions, defined as successful according to his own criteria, to the problems with which he is faced.

At the last interview I conducted with Mrs. F. she was suffering from a "bad attack" of her allergy. She had been to the doctor for fresh supplies of the drugs she normally used to control the problem

and despite "various ointments and drops and what have you it's not really better". All the doctor could suggest is that Mrs. F. went back to see a specialist which, as I have described, she thought was a waste of time. However, there was a further option available to Mrs. F.:

F3.11 Mrs. F.: Quite honestly, I'll tell you what I'm going to do, I shall go to the spiritualist's and say what can you do for me because I have been before and I think it's one of those things, they might possibly clear up for me whereas medical science can't.

In the discussion that followed Mrs. F. elaborated on the reasons for her trying spiritual healing:

F3.12 Mrs. F.: I always used to go quite a lot actually, I used to take my mother to, erm, a dear lady who had, er, a room in Wembley cus we had a healer in the family ....

Int.: Yes.

Mrs. F.: you know, my aunt is a spiritual healer and therefore one tends to think, well, you know, there might be something in it. But I wouldn't go to my aunt cus we're sort of incompatible, you know, like relations sometimes are. But we did go, my mum and I, to this lady in Wembley and she was a great help to both of us, you know, I sort of had, I first went to her when I had a very bad bout of bronchitis which is something I never get, I think it was sort of a virus bronchitis thing ....

Int.: Mm.

Mrs. F.: and I was singing in a show and, you know, I'd coughed so much my voice had practically gone. Anyway, within two days she had me singing again.

Int.: Really?

Mrs. F.: So I went to her just to keep well. Quite honestly, it was more or less a social occasion, she used to hold a sort of open clinic, you know, everybody sort of walked in all sat down and had a little chat and you went up to have your treatment, you know, in turn and it was really quite pleasant. As I say, I used to take my mother. She cured me of warts, I also, you know, I used to be susceptible, I had a lot of warts and I had them burned off at the hospital

and then I had another batch coming and I said to her, well, I said, look here we go again and she said we'll see if we can do that and she sort of put the fluence on and I sort of forgot about it, she forgot about it and a couple of weeks afterwards I thought my warts have gone. I mean, I know people can ....

Int.: Yes.

Mrs. F.: warts are funny things they might have gone away on their own anyway but, er, she got rid of those for me. So I think this is what I shall do. I might possibly take my mum as well because she used to get a lot of, seemed to get a lot of relief with her back aches from this lady we used to go to. So quite honestly, I might as well just go there as go through the hospital pipeline again.

Spiritual healers may, like other "fringe" practitioners, be viewed as cranks, frauds or persons of dubious moral character. They may be condemned for believing in and basing their practices in a system of healing which is ritualistic, magical and without scientific foundation(26). This belief in the supernatural may be taken as an indicator of the person's incompetence. Or they may be viewed as individuals who practise a system of medicine which they know is ineffective for financial or other gains. The persons who consult fringe practitioners may, by implication, be similarly viewed. In this extended extract Mrs. F. elaborates on the value of spiritual healing to justify her decision to seek this type of help. Ultimately, that justification rests upon the fact that spiritual healing is just as likely to produce results as medical science. That Mrs. F. is able to maintain a belief in both systems of healing requires that problems are conceived of as falling into one of two types depending upon the type of treatment to which they respond. Medical science cannot help as far as her allergy is concerned; consequently it may be a disorder which falls outside the sphere of competence of orthodox medicine as "one of those things"

that spiritual healing "might possibly clear up". The contradictions in the systems of thought embodied in the two types of healing are not a problem for Mrs. F. From within the natural attitude practical problem solving is of more relevance than matters of theoretical purity.

Mrs. F's past experience with spiritual healing has shown her that it can in some circumstances be effective. Following a bad bout of bronchitis in which her voice had practically gone Mrs. F. went to a spiritual healer who "had me singing again within two days". That this should be recognised as an achievement is emphasised when Mrs. F. says that bronchitis "is something I never get". Mrs. F. also claims to have been cured of warts which reoccurred after treatment at the hospital, although she does recognise that alternative formulations are possible, "warts are funny things they might have gone away on their own anyway", and Mrs. F's mother at least seemed to get a lot of relief from back aches. In addition, the family connection with spiritual healing encourages the view that it may have some validity and apart from that the healing sessions are of value in themselves as a pleasant social occasion. Mrs. F's use of spiritual healing for preventive purposes, "I went to her just to keep well", was motivated as much by the social as the health gains. In this way Mrs. F. constructs a definition of spiritual healing such that it may reasonably be seen to be worth a try.

Later in the interview I asked Mrs. F. why she had suddenly decided to try spiritual healing she said, "Well, I haven't had it bad enough for it to worry me and not clear up". The decision to try a different form of healing was prompted by an episode of her allergy which lasted six weeks in comparison to its normal course of one to two weeks. The failure of her own management routine and the inability of

medical science to help meant that her options were limited once it became necessary for something to be done. Spiritual healing was then a last resort.

Unlicenced problem solvers may be consulted when formal medical care systems fail to provide solutions to problems or they may be consulted in preference to those systems. Pharmacists are partially licensed in the sense that they are able to offer potential solutions to a limited range of problems by means of the proprietary medicines that they sell. This may be extended when they supply preparations normally available only on prescription. The respondents' efforts to manage the disorders they experienced themselves frequently involved the purchase and use of proprietary medicines or asking pharmacists for advice on the best course of action. Mrs. S. said that she often asked the chemist to make up medicines for her children or asked his advice:

S3.12 Mrs. S.: At Christmas I had this really bad cold and it wasn't just a cold it was a sore throat as well, it was, you know, more like a laryngitis sort of thing but I didn't bother to go to the doctor's, I just got, you know, some cough mixture, I went to, you know, the chemist himself and asked him what was the best thing and he gave me this ....

Int.: Do you often do that?

Mrs. S.: Oh yes, I often do. The man in the chemist's, you know, I've known him quite a long time, he's nice and friendly, sometimes he'll make up a cough mixture for the youngsters if necessary and if I need any advice sort of thing I'll always ask him. If he can make something up for them he always will. I've always done this cus I used to work in a chemist's so I think you know although it wasn't actually behind that particular part we had a lot of people kept asking this sort of thing and I've found they're quite knowledgeable things that they could prescribe, you know, without a doctor then they would do it so, erm, that sort of thing, I've always done since working in there from the age of seventeen.

Mrs. S's biography included experience of working in a chemist's shop and although it "wasn't actually behind that particular part" it does impart some legitimacy to her actions. She is able to assert that her actions are typical, "a lot of people kept asking this sort of thing", and reasonable since pharmacists are competent to prescribe, "I've found they're quite knowledgeable", and willing to do so within the limits of their licence.

Mrs. G. claimed that she would often attempt to buy things to deal with any problems she or her children might have even though consulting a doctor would allow her to obtain the medicines she would otherwise buy free of charge. Again, Mrs. G. claimed that this sort of action is typical:

G3.18 Mrs. G.: And yet when you think about it a lot of people do that. In fact, when I bought that cough mixture I was speaking to another woman who's got twins and she'd been buying things for those kids that had this sort of a cold and yet she could get free prescriptions for those children and yet she spent a lot of money, you know, whereas, and the same with me, I went and bought that cough mixture when in fact I could have got it free because I get free National Health prescriptions but I just wouldn't waste his (the doctor's) time.

Not only is the action typical it is also defensible. Mrs. G. asserts that it is preferable to spend her own money buying preparations rather than wasting the doctor's time to have them supplied free of charge. In a later interview Mrs. G. enlarged upon the same point by providing other good reasons for this type of action:

G3.19 Mrs. G.: I know that say, rather than go to the doctor I've bought things, you know, say if it's only cough mixture or something like that. And yet at the same time I've got a National Health Service exemption card which is stupid, isn't it?

Int.: Mm.

Mrs. G.: But I've done it rather than spend time and effort waiting to see the doctor and coming out with a prescription cus there's a chemist up here that'll prescribe something for you that's not on the shelf.

Int.: What that's only supposed to be on prescription?

Mrs. G.: Can only be prescribed, yes.

One possible characterisation of Mrs. G's purchase of medicines that she could obtain free of charge from the doctor is, as she herself recognises, stupidity. Here, she asserts that it is preferable to spending other resources such as time and effort in getting to see the doctor. In addition, the two courses of action are not very different in terms of outcome since she knew of a chemist who would supply drugs normally only available on prescription. When I asked Mrs. G. why she would prefer to go to the chemist rather than see the doctor she invoked possible undesirable consequences of going to the doctor which stemmed from the size and nature of the practice:

G3.20 Int.: Why would you see him rather than go to the doctor?

Mrs. G.: I don't know .... probably the fact that with it being a clinic it's such a big practice and there's always so many people to see, you go up there with a cough and you come back with German measles, you go up there with a cold and you come back with a sore throat, if you go up for an injection, you know, you come back with somebody else's infections.

This represents a common-sense expression of the professional view that medical care facilities are high risk areas in terms of the transmission of infection. It is given here as the possible outcome of going to see the doctor. A visit to the chemist, by contrast, carries no such risk.

There is, however, an element of risk in allowing a pharmacist to prescribe drugs that should be dispensed only with a doctor's authorisation. Consequently, I asked Mrs. G. if she thought it a wise thing to do. In response to the implied criticism she said, "I wouldn't do it for anything where pills or anything were concerned but this was just a very mild .... they didn't sell anything suitable for a young baby's cough, you know, and he gave me something that a doctor would prescribe". Thus, Mrs. G. claims that she would follow this course of action only for problems which required "mild" solutions; moreover, her allowing the pharmacist to provide something a doctor would normally be required to prescribe was in part a product of circumstance, there was no alternative proprietary preparation available.

At the end of the interview, Mrs. G. reviewed the situation, possibly as a result of my questioning:

G3.21 Mrs. G.: When you think about things you look at them in a different light, don't you? You say things like, you know, getting things from the chemist that really you know darned well that you ought to go and see a doctor that his advice is more professional yet you don't. I wouldn't say I make a general practice of it, I would say I've only been once and that was this linctus stuff.

One further option open to individuals faced with disorders of various kinds is to do nothing. Mrs. F. claimed that doing nothing was her general strategy for coping with signs and symptoms, she ignored them and hoped they would go away. That such rules of procedure may be modified by circumstance is evidenced by some of the data that I have already presented. The time-place contexts in which signs and symptoms are situated may alter their meaning and their implications for action as may the way in which signs and symptoms develop over time. Mrs. F's daughter was "particularly worried" about the heat rash on her

face "because at the moment she's doing photographic modelling" and went to see the doctor. For Mrs. F. and her family whether or not they were currently involved in an amateur dramatic production formed a context in which health matters were of some concern. When her daughter began to complain of a sore throat just prior to singing the lead in a school production Mrs. F. "dosed her up last night with Lemsip, Vick on the chest, TCP up her nose, cough mixture and what have you, I think come on if you think you're getting a cold cus the show's on Tuesday ....". When Mrs. F. told me her husband had a cold I asked if he were doing anything about it:

F3.13 Mrs. F.: Nothing at all. If he were doing a show he would if it were vital for him to be well. But it's not vital, all he's got to do is go to work, he's not bothered.

Individuals may also assert that they did nothing about problematic experiences affecting themselves or those for whom they are responsible because there was nothing that could be done. When Mrs. S's daughter was sick one night Mrs. S. "didn't do a thing for her" because "I really don't think there's much you can do when they're being sick".

As with all health and illness related actions doing nothing may be legitimated by reference to professional definitions of the situation. Parents may point to such definitions to account for their apparent lack of action with regard to a disorder in one of their children:

R3.13 Mrs. R.: She started getting these pains usually at night and I took her to our previous doctor who said it's probably from cold, ignore it, and it happened quite a few times so I took her back and in fact our previous doctor was away at the time and her locum, I thought it was quite good to get another opinion on it, and her locum said just leave it alone, so you know we tend to ignore it.

The lower abdominal pains about which Mrs. R's daughter complained periodically had received the attention of two doctors who advised Mrs. R. to ignore it or leave it alone. Neither of the doctors felt it was in the child's interests to pursue the matter by subjecting her to internal examination and the origin of the pain was never definitely diagnosed. Though Mr. R. said, "It's an odd one, I've never heard of it before", the doctor's tentative explanation was accepted. Mrs. R. thought "it seems to be her age" and hoped she'd grow out of it. In line with the doctor's advice the problem was ignored and as the pain appeared to be lessening nothing further was done about it.

Other data would suggest that professional advice that nothing can be done may stem from the failure to diagnose, that is produce an explanation of, the disorders which may present. While the failure of a lay person to diagnose a problem is not the end of the explanatory line since consulting licensed problem-solvers is always a possibility, where medical science is not able to produce an explanation the individual may have to accept that the source of the trouble is unknown and nothing can be done. Because the cause of Mrs. F's allergic response could not be identified her doctors were unable to suggest any definitive treatment, "here we are fighting in the dark again", and she decided to seek help outside the formal medical care system. When Mrs. R's mother's leg suddenly became swollen and painful no diagnosis was forthcoming because of the atypical course which the problem followed. Consequently, nothing was done apart from hoping that it would resolve itself:

R3.14 Mrs. R.: She went down to the doctor who said it sounded like all the symptoms of a thrombosis except that it was strange that it had gone so quickly and

> she was able to walk. The following day she had an appointment for her normal check-up at the hospital and again the doctor said the same thing, sounds like a thrombosis except it disappeared too quickly and really he couldn't suggest any treatment, erm, you know, take it easy for a week and if you're alright carry on as normal and hope it doesn't recurr or that the thing the clot, if it was a clot, doesn't come up somewhere else. Erm, but he couldn't do much for her because he didn't know quite what to do. But it appears to be alright so far so we just hope for the best.

Conclusion

In this chapter I have examined respondents' accounts of actions they and others undertook as a result of the problematic experiences to which they were subject. Rather than treating those accounts as the materials within which precursors of action such as motives, intentions, meanings or what have you can be located I have attempted to describe what the respondents themselves identified as the precursors of their actions and the assumptions contained therein. Taking the account in data extract G3.5 as an example, the analysis was concerned with the methods Mrs. G. used to make sense of her own actions and those of the doctor on an occasion when she telephoned him about her son. In presenting an account of what was going on Mrs. G. is also able to present a definition of herself as a competent actor and definitions of the doctor's actions which shows him to be at fault. What is striking about her account is the complexity of her explanation of action and the nature of the resources she uses to construct those explanations. With regard to her own behaviour 'definitions of the situation' are identified as the basis of what she did at particular points in time. Similarly, her explanation of the doctor's response to her telephone call are seen by her to be the result of the way in which he defines

her and her actions; changes in his response are seen to be the product of changes in these definitions. The knowledge that he seeks about her past pattern of activity and which she provides account for the development of new definitions. This then involves her in making assumptions about his interpretations.

Not all respondent accounts of action are as complex as this. For example, some explain their failure to go to the doctor when they recognise some departure from health by a lack of material resources such as time, others by particular social circumstances such as the social responsibilities associated with a category that they occupy. Mothers frequently carry on as normal when they are not well because "you can't afford to be ill when you've got children to look after". But whatever the complexity of the explanations offered the devices employed do not seem to differ radically from those used by sociologists in their explanations of action. Lay individuals are constantly involved in a search for the causes of and reasons for their own actions and the actions of others. This is an integral part of the way in which they understand, categorise and order the world around them. Their descriptions of action are then always interpretive descriptions; moreover, they are only one version of events and situations that can be adequately described in other ways. Conventional sociological procedure would, however, treat these as literal descriptions of more or less adequate validity within which facts independent of subjective human experience may be located. The problem with this is that the analysis that results is likely to differ according to which version of the world is accepted as valid data. Here, I have chosen to analyse common-sense interpretations of action and the construction of culturally adequate accounts. This does not require that an analyst makes

assumptions about what 'really happened' or about the validity of respondents' accounts, for what 'really happened' and what is or is not a valid account are matters that individuals decide for themselves. It could be argued that this is methodologically more sound since it involves less judgements on the part of the sociologist about matters which cannot be directly known. Rather than assuming these matters the analytic task has been to render problematic and thereby describe the assumptions respondents employ in describing the world in ways that is sensible and rational.

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7. Cicourel's remedy is for the researcher to make known these tacit assumptions by specifying the rules on which the allocation of events to categories is based.

8. Such data may be acquired through observation and the study of naturally occurring talk. However, I suspect that the premise that social action is based on meaning is not a theoretical postulate that can be verified or demonstrated by data but a philosophical assumption of the same order as the idea that social reality is a member's construct.

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CHAPTER 7

CONCLUSIONS

The underlying theme of the early part of this report concerned the problem of social reality and the most appropriate way to proceed when studying it. In a critique of the approaches adopted by Parsons and Mechanic, I attempted to show how they were inadequate in their own terms and inadequate in their conception of social phenomena. I suggested that both saw these as objective entities having an existence independent of the subjective experience of members of society. Ideas drawn from the labelling perspective and symbolic interactionism were used to present an alternative view; social reality is the outcome of the interpretive work whereby members of society assign events to culturally defined categories in order to make sense of and manage their everyday experience. Consequently, the analysis presented in Chapters 4 to 6 was not concerned with verifying or producing generalisations to explain an order assumed to be there, it was concerned with the identification and description of the ways in which members of a society create and sustain social order.

The descriptions offered in the preceding chapters contain a relatively superficial explication of the practices and procedures integral to the cognitive organisation of one aspect of experience, that of health and illness. I say superficial since every extract presented could be subject to a more detailed and extensive analysis. Much more is involved in the accounts I have analysed than has been described so far. However, at this stage of the game a wide ranging, though somewhat elementary, analysis is probably more valuable than a

more intensive analysis of a more limited set of issues. Chapters 4, 5 and 6 should be seen as mapping out a field of enquiry and providing some guide as to what issues need to be considered when providing a sociological account of illness and its related phenomena.

The particular issues investigated in these chapters were selected on the basis of the theoretical argument outlined in Chapter 1 and as a result of an initial scrutiny of the data. In many ways, the theories I employed and the statements I made about illness and illness behaviour provided a scheme of orientation which allowed me to identify areas that might benefit from empirical analysis. The situational construction of meanings and the role of common-sense knowledge in the organisation of experience were deemed key areas for empirical elaboration. As a result of reading and rereading the transcripts of the interviews I conducted, a precise division of the field into topics was possible. I did not rewrite the theoretical chapter in the light of this more precise specification for that would obscure the extent to which the subsequent analysis was rooted in the data. Moreover, there is no logical connection between the theoretical propositions used as an orientation to illness and illness behaviour and the particular issues elaborated in Chapters 4, 5 and 6. That is, a definition of illness as a social construct constituted by the meanings actors employ to make sense of a variety of experiences directs attention to meanings but does not, in and of itself, lead to an identification of the interpretive processes involved. That is an empirical matter. As I mentioned in Chapter 1, theory can take us only so far; empirical research is necessary for clarification and further elaboration. In this way, the research reported here is grounded in both theory and data.

The division of the analysis into topic areas is, in some ways, illegitimate. It was pursued because it was one way of making the data and its analysis more manageable rather than because the events described are naturally well demarcated issues. Reading the extracts from the interviews should give an impression of the extent to which these events are interconnected. The analysis will have been successful if a reader is able to see the interconnections in the data. An alternative method of presentation of the material, though I consider it the next stage of the analysis, would be to take individual management sequences and analyse them from start to finish using accounts collected at all the interviews in which they were described. Here, I make a start by documenting recurrent themes within the data to provide the foundation for such an analysis.

The above-mentioned themes broadly consist of the construction of definitions of health and illness, the way in which various types of disorders are recognised and explained and the methods used to render given responses to given problems as rational under the circumstances. Within each of these broad categories a number of sub-themes have been pursued. All have been concerned with the common understandings that members of a society can use to make sense of what is going on or what is being talked about. These understandings are part of a culturally defined and socially sanctioned world view consisting of categories of events and the relationships between them that provides the resources for practical reasoning about everyday experience. The thrust of the ethnomethodological critique of much conventional sociology is that the professional sociologist, like the man in the street, uses and takes for granted, these resources in producing explanations of what is perceived to be a real world.

The common understandings employed by the women I interviewed to make sense of events located within the realm of health, illness and its associated behaviours broadly consists of knowledge of two types. Firstly, there is knowledge about matters of health and illness per se. This may include such things as typifications of the conduct of people who are ill, the typical ways in which given disorders manifest themselves and their typical courses and the causal connections between events in the world and problems of various kinds. Secondly, they also had at their disposal more general knowledge about such contextual matters as typical experiences of family life, the nature of children and their particular needs and the motives and conduct of particular types of people. All these may be involved in making inferences about and managing problematic experiences. It is by means of the skilful use of these common understandings that the women were able to display their status as moral persons and competent members. Moreover, by showing that their inferences and actions were reasonable given the resources at their disposal they were able to defeat potential charges of incompetence and demonstrate adequate performance as mothers and patients. Accounts given in interviews are then to be read as such and not as more or less adequate descriptions of some independent reality.

In Chapter 4 I described the way in which ideas not too dissimilar from those outlined by Parsons in his discussion of sick role expectations were used as an interpretive device in talk about health and illness. They were used in the construction of definitions of health and illness and as prescriptions for action. I argued that illness is one explanation of patterns of action I called illness relevant behaviours. Actions such as staying in bed, not going to work, going to see the doctor are

typical of people who are ill. Consequently, anyone who undertakes these actions may be allocated to that category. Conversely, anyone who claims to be ill can be expected to pursue action of this kind. Failure to do so may result in the definition ill being denied unless acceptable reasons can be offered to justify that failure. Because actions of this kind may be motivated by a desire for the benefits they are assumed to involve a definition of illness assumes and may only be applied where they are the unavoidable outcome of some underlying disorder or the subjective experiences to which it gives rise. Where no underlying cause can be identified or where its presence is ambiguous then alternative formulations such as malingering may be considered. This is particularly the case with mental illness and other problems involving subjective states where the disorder has no externally available manifestations other than the claims of the sufferer. Even where some disorder is present the location of motives may be used to construe the response of the individual concerned as an attempt to manipulate the definition of the situation for their own ends. This highlights the distinction between the presence of disorder and the imputation illness. Not all disorders have as their unavoidable outcome the kind of patterns of action covered by the term illness behaviour. Thus, an individual may be subject to some disorder without being defined as ill.

In order to justify the imputation of illness actions such as staying in bed or staying away from work may be situated within a biographical context. These biographies provide for the meaning of the action concerned by showing that the individual in question is of a type unlikely to malinger or make exaggerated or illegitimate claims. Anyone in possession of biographical information of this order is

expected to use it to interpret illness relevant behaviours as indicators of illness. This requires the use of an interpretive scheme which links actions with the motives assumed to inform the actions of given types. Defining an individual as ill means that their actions are not the product of motives but have their origin elsewhere. Motives and illness are, however, linked in more than one way. Firstly, claims to be ill may be denied if they are seen to be informed by anticipated gains of one sort or another. Dependency, sympathy and social support are potential outcomes of occupying the status ill. Secondly, the problems offered as the basis of a claim to illness may be interpreted as the product of an individual's wilful actions and thirdly, a lack of motivation to maintain an active life may lead to attempts to use problems which have their origins elsewhere as the grounds on which to claim legitimate occupancy of a dependent state. In all of these instances the individual making the claim may be subject to moral condemnation. Because imputations of illness always involve judgements about responsibility illness is essentially a moral category. In this way deviance and illness are mutually exclusive categories, alternative explanations of given states of affairs, such that it is not possible to talk of illness as deviance per se. Imputations of deviance involve a judgement about the origins of an actor's conduct in terms of motives and goals while imputations of illness locate the origins of that conduct in an underlying biological disorder. As Morgan has argued, behaviours which cannot be rationalised in terms of assumed motives or goals are likely to be characterised as the symptoms of mental illness. By contrast, rule-breaking behaviours which do appear reasonable in terms of assumed motives are more likely to be characterised as deviance(1). Illness constitutes an explanation for behaviours which otherwise can-

not be explained by reference to common-sense ideas about typical motives and typical actions. These remarks apply not just to mental illness but also to the relatively minor physical disorders described by my respondents. For notions about motivated conduct and appropriate responses to given types of disorder figure in their judgements about illness and the moral status of the persons concerned. Because the labelling of someone as ill necessarily involves such judgements it is a social phenomenon quite distinct from the biological abnormalities with which it is sometimes associated.

The women I interviewed were alerted to the possibility that something was wrong with themselves or someone they knew by a number of types of event. Prominent among these were what I have termed symptomatological, behavioural and communicative cues. These cues were sometimes seen to be the external manifestations of an underlying disorder or some other explanation was found whereby they were normalised. In some cases these cues were sufficient in themselves to indicate the presence of a health disorder; more usually, a cue was seen in the context of other cues which preceded or followed to confirm the suspicion that something was wrong. Hence the search of the immediate past or the "wait and see" strategy employed when one cue did not provide sufficient evidence for a meaning to be located. Not only were given cues elaborated by others in the search for meaning they were also seen in terms of biographical and time-place contexts so that the individual concerned was construed as unwell and tentative diagnostic labels applied. This elaboration was of some importance where behavioural and communicative cues were concerned since the experiences they document may not be directly available to persons other than the sufferer.

These cues both indicate and are explained by the categories of phenomena to which they are allocated. Where they are seen as pointing to some disorder an explanation of that disorder may, in turn, be sought. Such explanations typically take the form of "causal theories" whereby some antecedent agent or event is selected from a culturally prescribed range and fitted to the problem in question. Where a causal explanation could not be constructed the women were often unable to make sense of what was or had happened. While this may be of limited significance in the case of relatively short-lived experiences, it would seem to have some consequence where the disorder in question is more threatening or long-term. The cultural resources available to make sense of these experiences do occasionally fail, leaving an individual bewildered or confused. In a secular industrial society witchcraft and God's will can no longer be employed to render the otherwise unexplainable explained. As a result, the assumption of a stable orderly world in which things happen for a reason is sometimes challenged. Because this sense of order not only provides for an explanation of the past but makes the future predictable the natural attitude which defines the common-sense actor's orientation to the everyday world may be thrown into doubt.

Numerous interpretive devices were employed in the construction of these causal explanations and their maintenance in the face of conflicting evidence. Evidence was accumulated over time to enable a choice between competing explanations to be made or later developments used to revise an already accepted explanation. A causal sequence is sought which fits all the known facts. The women I interviewed often revised versions of events offered by professional problem solvers because they did not account for these later developments. Alternatively,

where an explanation could not account for all the known facts, evidence which did not fit was selectively disregarded or the explanation elaborated in ways which rendered the discrepancy irrelevant. In this way, explanations were produced which conformed to common-sense ideas about typical causes and typical effects and the sorts of mechanisms which typically link them.

One further categorisation procedure to make sense of disorders is to assign them to categories of severity and significance. This was achieved by appealing to the characteristics of the disorder itself, its consequences or the circumstances in which it appeared. Reference was often made to time, the number and type of symptoms, the actions undertaken as a result of the symptoms or a variety of contextual matters to substantiate a particular characterisation of the severity and significance of episodes of disorder. The significance of some problems was denied because they fell within a category I called normal disorders. These are disorders that are expected to occur at given stages of life or under certain environmental or social conditions. Consequently, they lie within a known and routine order.

The accounts on which these analyses are based demonstrate something of the emergent and transient character of social reality. The objects attended to by man in everyday life are fluid and ambiguous. They change over time as new evidence is accumulated and events subject to retrospective re-interpretation. This accounts for much of the tentative character of lay theorising and such general interpretive strategies as waiting for future developments under the assumption that these will allow a more certain allocation of experience to socially available categories. That these objects are ambiguous and common-

sense theorising about them tentative is evidenced by the tendency for the respondents to preface many of their remarks with statements such as "I don't really know but ...." and the like. Such ambiguity may arise because the cultural resources available at any given point in time are not adequate for the interpretive task at hand or because those resources offer alternative characterisations or explanations of experienced events. Consequently, this means that any characterisation or explanation that is offered is defeasible and may be shown to be inadequate in the light of subsequent experience. However, although events and experiences are essentially ambiguous they are not necessarily experienced as such by the participants in everyday life. They are frequently able to fit a description to a scene and make sense of what is going on in much the same way as they are able to understand what people say, even though their utterances could be taken to mean more than one thing. This highlights the extent to which social order is an accomplishment, "a construction of and constituted by the activities of people's minds"(2). Perhaps one of the most striking illustrations of this is the way the subjects of Garfinkel's experiments were able to draw on a stock of knowledge to make sense of conversations which, owing to the random nature of one of the participant's replies, were senseless(3). These experiments, and the analysis here, also illustrate the point that participants in everyday life assume that objects and events are meaningful and, further, an inability to locate such meanings is a sign of incompetence and failure. Moreover, not just any meaning will do; members are constrained to provide characterisations and explanations that are acceptable to general or specific audiences otherwise interpretive asymmetries may arise with negative consequences for the individuals concerned. Interpretive activity,

like practical activity, is subject to normative boundaries which define adequate and inadequate performance(4).

While interview talk may lend itself to an investigation of the interpretive procedures involved in the construction of definitions of illness and the recognition and explanation of disorder, it is subject to certain limitations when used for the study of illness behaviour. For if accounts of the actions undertaken to manage problematic experiences are interpretive rather than literal descriptions, then it is not possible to use these accounts to say what meanings were imputed to given events at past points in time or to show how they gave rise to the action in question. They can only be used to show how these actions are constituted as rational acts. Some of the ethnomethodologists would claim that this is all that can be said about social action, that any attempt to explain action, whether in terms of meanings, intentions or antecedent causal factors, is essentially a common-sense explanation. Others, such as Cicourel, adopt a position more in line with that I have outlined. Cicourel talks of the actor using interpretive procedures to negotiate and construct courses of action and to evaluate the results of completed action(5). While the analysis in Chapter 6 has described something of what is involved in the latter, it says little about the former because of the methodological problems involved. Whether the assumption that actions emerge out of meanings can be verified is something of a problem, for in order to know what meanings were operative at any point in time the researcher has to make judgements about meaning himself or rely on the accounts presented by the actors concerned. The first is illegitimate, and for the second to have any currency, those accounts must be collected at the time the actions being studied

are constructed. This, of course, is likely to produce methodological problems of its own. Since it is not possible to get inside someone else's head it may not be possible to show a direct connection between meaning and action no matter how and when the data is collected. Consequently, the proposition that actors act towards objects on the basis of the meanings those objects hold for them has the status of a philosophical assumption that is no more open to verification than the idea that social reality is a social construct. What this means is that while an appreciation of social action is possible the production of a distinctly sociological explanation of that action is much more problematic.

Sociological naturalists such as Becker(6) and Matza(7) attempt such an appreciation by an analysis of the actor's point of view and a description of the subjective meanings this entails. More ethnomethodologically inclined sociologists have been more concerned with how those meanings are possible in the first place. In fact, much of the debate within sociological naturalism has been about this very point(8). These two positions are not as far apart as it may at first seem, for a discussion of how meanings are possible suggests that some judgement about meaning is necessary in the first place. The conversation analysts, for example, while not specifying how an utterance was heard on any given occasion specify one or more potential meanings and describe the interpretive procedures necessary to hear the utterance in a given way. Similarly, I have assumed that respondents' accounts are constructed in ways whereby their actions may be seen to be instances of reasonable conduct and have begun the analysis of the procedures that justify their depiction as such.

That the women I interviewed took for granted the reasonableness of their actions was inherent in much of what they said. They depicted their doctors as busy men who did not ought to be bothered with trivial disorders that anyone might be expected to treat themselves. They claimed that they only consulted the doctor with problems which were significant or warranted special attention, since these could have indicated a serious disorder or fallen outside a lay person's competence. Moreover, they presented themselves as competent to judge when such professional attention was necessary. Only children were exempt from this general rule and they were frequently taken to see the doctor "just to be on the safe side". Consequently, any challenge to this assumption of competence and rationality often brought forth a complaint on their part.

In explaining their own actions or the actions of others the respondents often made reference to the way in which the object of those actions was interpreted. When called to account for any delay in visiting the doctor they pointed to the triviality of the problem in question or the fact that it had not been seen as a problem at all. These interpretations were justified on the grounds that they were reasonable given the facts that were available at the time. Subsequent visits to the doctor were presented as following a reinterpretation of the problem brought about by the advent of a critical incident. These critical incidents figured in cases where alternative meanings could have been applied to the problem being reviewed. They were absent from those cases in which the only available meaning to make sense of the problem indicated a potentially serious disorder. Here, going to see the doctor was motivated by a desire to have the tentative diagnosis confirmed or denied. Because problematic experiences were often ambiguous

and could not always be unequivocably deemed to require medical attention, a "wait and see" strategy was adopted and decisions suspended pending future developments. In this respect the respondents made use of assumptions about the typical course of given types of problems in order to assign meaning and plan action.

The failure to take a given problem to the doctor was not only justified by allocating it to a category where such action was unnecessary, it was also legitimated by invoking the reaction of doctors to patients who consulted with such complaints. In so doing the respondents were able to demonstrate conformity with professional definitions of the situation. When more significant problems were not subject to professional attention the women pointed to the likely outcome of a consultation. Past experience had shown that the treatment would involve more suffering than the problem itself or that professional methods of management were no more effective than their own. For these reasons self-medication was preferred and well-tried recipes followed until the problem resolved.

Two types of external constraint were presented as being relevant to the decision to seek medical attention. Firstly, constraints on resources such as time were imposed by the responsibilities associated with the statuses the women occupied. As wives and mothers they were expected to put the interests of family first so gave preference to their household duties rather than their own needs for medical attention. Secondly, they identified a number of interactional and organisational barriers which they claimed had an influence on their help-seeking behaviour. Some negotiation was required to circumvent these barriers so that access could be gained to a consultation and their self-defined needs fulfilled. These barriers not only constitute the rationale for

not seeing the doctor, they provide the grounds on which criticisms of medical care may be constructed. However, they are only good reasons for acting in particular ways, and cause for complaint, if recognised as such by reference to a stock of knowledge which includes typifications of patients' experiences with medical practice. That they are typical is to be read from the respondents' assertions that "they happen to the majority". One method of coping with these barriers is not to attempt to circumvent them but to seek alternative methods of managing problems and other sources of help.

The broadly phenomenological approach I have adopted here has been subject to a number of criticisms. Ethnomethodology, in particular, has given rise to a lively debate within the literature, probably because of its programmatic claims. Some of these criticisms rest on a misunderstanding of its recommendations(9). The two most commonly advanced are that ethnomethodology allows for no general statements about social life and that it ignores macrostructural phenomena such as social class, power and inequality. The latter has, of course, given rise to the view that a phenomenological sociology is deeply conservative in character(10). As I indicated in the discussion of the work of the conversational analysts in Chapter 2, ethnomethodology does allow for generalisation. What it does not provide and what it sees as being no business of sociology to provide, is explanation of whatever kind. Similarly, the claim that a phenomenological sociology neglects social structure also rests on a misunderstanding. Rather, it has its own version of social structure, albeit a structure "which does not exist independently of the social meanings its members use to account it and hence, constitute it"(11). From a phenomenological point of view "social structure cannot refer to anything more than a

member's sense of social structure since it has no identity which is independent of that sense"[12]. As Rock points out, this means that some attention is paid to the common-sense ideas about social structure held and employed by the subjects of sociological investigation. This enables the exploration of "the import of such phenomena as social class without a commitment to the belief that social class is an autonomous or real entity"[13]. Recent attempts within the sociology of deviance to marry a naturalist orientation to social phenomena to a "quasi-determinist structural sociology" with its conventional view of social structure must inevitably fail because of the irremediable conflicts in ontological assumptions they entail[14].

However, it would be true to say that this version of social structure has not been pursued with any vigour by its proponents. The ethnomethodologists have, for the most part, diverted their energies to the investigation of the rules presupposed in conversation. That this does constitute something of a diversion is evidenced by the fallacy contained within Garfinkel's statement that to "recognise what is said means to recognise <u>how</u> a person is speaking"[15]. It is this statement that provides the foundation for the analysis of conversations and the description of the machinery involved in interpreting utterances as complaints, questions and the like. For, to make sense of what people are saying requires more than a mere recognition of what they are doing with talk, it requires a recognition of what they are talking about. That is, when a man complains that the vegetables in his garden do not grow because they have been bewitched by the wife of his neighbour the categorisation of his statements as complaints is of less relevance than the public status of what he is complaining about, the categorisation procedures this involves and its likely implications. What this

means is that social phenomena are not limited to speech acts. Because of this narrowing of the ethnomethodological focus the development of a notion of social structure within the framework of a sociology which accords significance to the social construction of reality has been left to others. The work of Berger and Luckmann[16] and Giddens'[17] more recent exposition of the idea of the production and reproduction of social life are noteworthy, although not entirely satisfactory attempts. Many ethnomethodologists would be indifferent to work of this kind, viewing it as an attempt to remedy conventional sociology by means of concepts drawn from a cognitive sociology. On the other hand, many conventional sociologists would also view such remedies as unnecessary. Goldthorpe, for example, argues that sociologists should be ontologically pluralistic, accepting that there are different forms of sociological knowledge each of which must be judged in its own terms. While this view is superficially attractive, since it allows sociology to retain both traditional and more phenomenological approaches, it does mean that the criticisms of each by the other remain unresolved. Moreover, it implies a view of sociology as a collection of social philosophies, or more properly ideologies, rather than a corpus of knowledge that will ultimately provide an independent, objective description of society.

Whichever of these positions is adopted and whether or not it can produce a viable version of what are commonly called macro-phenomena, the contribution of a phenomenological orientation to sociological analysis cannot be denied. That contribution has been both theoretical and methodological. As Wootton points out, the theoretical schemes that have been developed over the last ten years or so have made increasing use of cognitive concepts[18]. The sociology of deviance in particular has been characterised by studies owing much to symbolic

interactionism and phenomenology. These have stimulated a change in the way in which deviance, social action, social processes and society itself is conceptualised by emphasising meaning as the key element in human affairs. While these early positions gave rise to stimulating theoretical debate the empirical relevance of these conceptual schemes was not worked out in detail. That is, they offered few systematic guidelines as to how meaning was to be handled empirically. Even Schutz's programmatic sociology of common-sense knowledge is essentially a theoretical enquiry. Consequently, naturalistic sociologies were only marginally more successful than survey research in sorting out the meaning of people's descriptions of their experiences(19). Ethnomethodology's specific contribution has been, as Wootton also notes, the specification of the connection between meanings, their problematic character and the nature of language use. They have also offered the beginnings of a methodological strategy whereby the connection between language use and meaning can be investigated. This strategy is not acceptable to all simply because it is based on the premise that meanings cannot be determined in any objective way. Consequently, it offers little to those who wish to attempt some kind of measurement of meaning. Here its contribution has been to force a more critical awareness of what is involved in the study and description of social life(20).

In the discussion of Mechanic's work in the Introduction I was somewhat critical of developments in medical sociology which tend towards what Fay has called a policy science(21). This was not a critique of the use of sociology for practical purposes. Rather, it was critical of a particular conception of social practice and its attendent view of social science. This view of theory and practice is organised

around the notion of technical control and presupposes a reality available for intervention in this way. To some extent the distinction I drew in the context of this discussion between a pragmatically oriented sociology and a theoretically oriented sociology is false. For all social practice is based, albeit implicitly, on some theory and all theory has some implication for practice, although that practice may not be recognised or realised. Consequently, an interpretive social science also has its uses although these are far removed from positivistic ideas of manipulation and control. As Fay says, an interpretive social science "reveals to people what it is that they and others are doing when they act and speak as they do. It does this by articulating the symbolic structures in accordance with which people in a particular social setting act, by making clear the criteria of rationality in virtue of which certain alternatives were chosen rather than others, and by revealing the basic assumptions which pattern the world in distinct ways"(22). The outcome of this is that an interpretive social science "increases the possibility of communication" by "creating the conditions for mutual understanding between members of the same or different social orders"(23).

Research has recently been reported which suggests that consultations for minor complaints can be reduced by the education of patients by the general practitioner. That is, by providing patients with the cognitive resources necessary for the interpretation and management of problems more in line with professional definitions of the situation. I make no such claims here. I merely suggest that this analysis offers one method of understanding the way in which others see and act towards the world. While this may not necessarily result in differences in the way in which patients are diagnosed and treated or in a change in their

help-seeking behaviour it may result in a change in the way in which patients are managed by those involved in providing health care.

The foregoing analysis would suggest that doctors' complaints about the number of trivial problems that present in general practice stem from their tendency to view patients and their problems from the perspective of an inappropriate model of rationality. Here judgements about the clinical significance of problematic experiences provide for judgements about the appropriateness of help-seeking behaviour. The data in Chapters 4, 5 and 6 contains a different model of rationality and a different way of viewing such behaviour. Significance and rationality are not labels that can be legitimately employed without specification of an interpretive context. Consequently, what are irrational or inappropriate consultations from one position may not be so from another; that is, if they are seen in terms of the knowledge, resources, interests and responsibilities of the individual concerned. By employing devices of this kind the respondents were able to provide for the reasonableness of the way in which they interpreted the world and what they subsequently did. By employing a similar set of devices, those involved in the delivery of medical care may be better able to understand the conduct of those with whom they come into contact and may, as a result, treat them and their problems more seriously.

By conveying something of the complexity of social life in general and social interaction in particular, the analysis may also stimulate an awareness of how statements and actions on the part of those who provide or control access to medical care can often be interpreted as challenges to the patient's status as a competent member and responsible person. This not only creates covert conflict, it also

exacerbates the dilemma that individuals face in their attempts to make sense of and cope with their problems, for it highlights the fact that their interpretations and actions are subject to the critical scrutiny of, and can be faulted by, health care staff. Consequently, acting according to their own definitions of what is necessary to solve their problems, whether these are practical or cognitive, may be inconsistent with professional ideas of what constitutes a good patient. Children are a particular problem in this respect since they are not always able to provide detailed descriptions of their subjective experiences and because it is assumed that symptoms of any kind may be indicative of relatively serious disorders. Seeking professional advice not only provides a solution to these diagnostic uncertainties it also has a symbolic value by indicating parental concern and proper care of the child. It is because such behaviour can be faulted and labelled as the action of an over-protective or fussy mother that patients may develop strategies for defusing or circumventing these interpretive differences. However, an understanding of help-seeking behaviour and its potential for avoiding these kinds of interactional difficulties is only likely to be of importance if medicine is taken to be a body of knowledge applied to people's problems rather than their biological abnormalities.

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16. Berger, P. and Luckmann, T., The Social Construction of Reality, Allen Lane, London, 1967.

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19. I say marginally more successful in that naturalistic methodologies do not force lay descriptions of experience into rigid preformed categories.

20. The ethnomethodologists have, for example, forcefully argued that the sociologists' descriptions of actions or scenes are interpretive and not literal and are accomplished by reference to the sociologists' own stock of knowledge.

21. Fay, B., op cit.

22. Fay, B., ibid, p.79.

23. Fay, B., ibid, p.80.

APPENDIX

PRACTICAL PROBLEMS IN QUALITATIVE RESEARCH

Doing sociological research involves solving a variety of problems, theoretical, methodological and practical. Chapter 1 consists of my attempts to solve the theoretical problems posed by illness and illness behaviour. The theoretical position articulated in this chapter led to the formulation of issues to be clarified and developed in the analysis of data. This theoretical work was drafted prior to any consideration of the practical and methodological problems posed by the collection and analysis of that data. The practical problems had to be solved prior to entry into the field; in fact, data collection could not proceed until they were solved. The methodological problems did not come to the fore until I was faced with the data and beginning the analysis. The problem here largely revolved around the nature and status of the data I had at my disposal. Decisions regarding these matters and the theories on which they were based have been documented in Chapter 2.

In this Appendix I want to present an account of the more practical aspects of the research. Broadly speaking, the main decision which I faced was the choice of settings in which to pursue my empirical interests and the main problem was how to gain access to them. The critique of positivist sociology outlined in the Introduction had already led me to reject quantitative in favour of qualitative methodologies. Consequently, some decisions regarding data collection techniques had already been made. In a sense the decisions I made and the strategies I employed created the methodological problems I describe in

Chapter 2, since the nature and status of the data I acquired is very much a product of those decisions and strategies. In turn, an understanding of the nature and status of the data I had at my disposal forced me to be more precise about the kind of issues it could be used to pursue. The theoretical, methodological and practical aspects of the research were, then, inter-related.

The issues that are investigated in this research were derived from the application of particular sociological perspectives to an area of interest, illness and illness behaviour. This contrasts with other approaches within the qualitative tradition in which the specific research interests are formulated on the basis of a period of participant observation of a social setting. This approach conforms more closely to that advocated by Glaser and Strauss in The Discovery of Grounded Theory where it is suggested that in order to generate better theories the researcher should allow the concepts, categories and theories to emerge out of the phenomena themselves(1). Basically they are arguing against approaching any area with the intention of verifying or clarifying existing theory. However, as Irwin indicates, this seems to suggest that concepts, categories and theories are intrinsic to phenomena and will be revealed if a researcher looks closely enough(2). It ignores the common-sense and sociological perspectives the researcher must use to make general and abstract sense of those settings. Concepts, categories and theories are the product of the interpretive activities of the researcher and are not intrinsic to phenomena themselves. In fact, those phenomena are constituted by this interpretive activity and cannot be seen in isolation from it. The formulation and specification of theory means that some of the assumptions employed to judge phenomena may be made known.

The extent to which theoretical ideas are formulated prior to entry into the research field is one decision that has to be made in the process of gaining some knowledge about a social setting or phenomenon. Structured research methodologies require that all such decisions are taken prior to contact with the subjects of the research(3), while qualitative methodologies allow for the making of decisions prior to and during the fieldwork. While the former requires that any theorising results in a testable hypothesis the latter employs theory as a scheme of orientation to an area or setting such that issues requiring empirical clarification can be identified.

Decisions determining the research strategy

Since the research began as an interest in illness and illness behaviour rather than in types of individuals, e.g. criminals, homosexuals, or organisations, e.g. deviant subcultures or hospital wards, the first decision that had to be made was in the choice of setting in which illness and its related phenomena could be studied. Commonsense would indicate that there are many settings in which people defined as ill could be located; the home, the doctor's surgery, the outpatient clinic, the hospital ward and what have you. The choice of setting was, however, limited by those aspects of illness and illness behaviour deemed relevant for study by the theoretical work of Chapter 1. Thus, I was initially concerned to demonstrate that illness is a social phenomenon, a product of interpretive work, and to illustrate the theory that illness behaviour is a product of situationally constructed definitions applied to the problematic experiences with which individuals are faced. Hence, the emphasis on the categories that individuals employ to order their experiences and the conditions under which they are used. This meant that the focus of the research was the construction of lay

definitions. Because the processes by means of which lay definitions are constructed occur prior to contact with medical personnel (though the diagnoses supplied by medical personnel may subsequently be taken into account in the formulation of definitions) medical settings did not provide a suitable research field since that would presuppose much of what I was wanting to study. Consequently, the family was chosen as the setting for the study since I considered that the events in which I was interested had their expression in the context of family interaction. Of course, the construction of definitions of problematic experiences may occur in other interactional contexts, as a result of a variety of encounters. However, I assumed that an important part of such definitional work would occur within the family or that events relevant to the interpretation of problematic experiences would be reported within that setting in an attempt to legitimate the definitions applied. From a purely practical point of view the family is a well demarcated and, therefore, a convenient unit to study compared to the other contexts such as work, recreational activity or those contacts with friends, relatives or strangers during which definitions may also be constructed.

Having chosen the setting it was then necessary to determine the nature and extent of involvement in the field, i.e. whether an overt or covert approach was preferable, and whether participant observation, depth interviewing or a combination of both was to be the technique employed. As might be expected, there has been considerable argument among sociologists over the issue of covert or secret research. As Douglas indicates(4), there are two fundamental questions involved: i) the question of effectiveness - Which provides the more reliable evidence, secret or non-secret involvement? and ii) the question of

morality - Is secret research immoral given the invasion of privacy that it necessitates, and if so, should it be rejected by sociologists? Both of these have been discussed to some extent in the limited literature on qualitative research methods and varying and opposing standpoints recommended. Thus, Henslin(5) contends that information can best be obtained by working "secretly from the inside" since members of a group share a certain amount of information which would not be revealed to an outsider or overt researcher for fear of harming the group as a whole. This barrier can only be overcome by the investigator being accepted as a bona fide member of the group. Conversely, there is also the opinion that there are things that members might be willing to reveal to a trusted outsider because he will not use the information against any other member to advance his position within the group. Defining himself as a member and trying to do secret research may thus make some things unobservable to the researcher. In most cases, these recommendations are justifications of procedures that have been employed by their adherents in past research. In fact, it would seem that there is no way that the relative effectiveness of either strategy can be assessed, for this would require the assumption of a stable underlying reality that can be known in some way to allow for the possibility of judging how this reality is differentially revealed by covert and overt methods. It is then difficult to choose between the two approaches on the basic of objective criteria such as effectiveness. Hence, the exhortation to remain flexible(6).

In many cases, and perhaps fortunately so, the research strategy is imposed by the nature of the setting under study. For example, the types of activities that constitute the setting and the structure of the interaction within the setting may determine whether overt or

covert research is a practical possibility. Humphreys' study of tacit communication in sexual encounters in public conveniences[7] would probably have been impossible to accomplish by means of an overt approach for the following reasons. Firstly, it is unlikely that the participants would have wished their activities to become known to, let alone observed by, persons other than their co-participants. Secondly, since the participants remain anonymous and are known to each other only as co-participants it would have been difficult to secure consensual agreement to be studied. Thirdly, and perhaps most importantly, since the absence of talk is a feature of the setting it would have been difficult for Humphreys to communicate his presence as a researcher. Other features of the setting facilitated a covert approach; thus, the presence as part of the setting of the role of "watch-queen" or "look-out" enabled Humphreys to be in on the action without having to be part of the sexual activity itself. Other social situations are not so rigidly structured and either approach is possible. Covert and overt approaches can be used in studies of deviant subcultures such as the gay community where alternative roles other than member homosexual exist for the researcher to occupy and an entry can be made to a setting which, if not public, is relatively open[8].

In the present study, however, it seemed self-evident that a covert approach was not a possibility given the absence of any legitimate means of gaining access to the family unit for periods of time long enough to acquire the necessary data. Since membership of a family group is usually determined by marriage or descent it is not possible for an investigator to pass as a member. Nor did there appear to be any viable alternative roles that could be occupied to gain access to the setting. Additionally, given the status of the home as the

ultimate in 'private' settings it is unlikely that a covert approach could be justified on ethical grounds. Even Douglas who warns against a "methodological puritanism"(9) would probably view such a strategy as lying outside any "situational morality of research activity". Apart from that, it was just too risky. On these grounds no alternative to an overt approach was considered.

Having chosen the research setting and an overt approach it was then necessary to decide on an appropriate technique for gathering 'data'. As many writers have mentioned(10), participant observation is, in fact, a collection of methods which may involve participation, observation, formal and informal interviewing, and the analysis of records, letters, notes and diaries. As William Whyte remarked, "the method used should depend on the nature of the field situation and the research problem"(11). Thus, the particular combination of techniques that is employed is largely determined by the types of phenomena under study. For example, Cicourel, in his study of the organisational processing of juvenile offenders, was able to make use of written reports prepared by probation officers regarding individual cases(12). This would not be a possibility in settings in which written communications are not part of the interaction. Material of this sort is largely restricted to formal organisations. The collection of techniques that are available can, however, be resolved into two separate, though inter-related approaches; participant observation and intensive or depth interviewing. Obviously, both involve participation of some sort with the individuals taking part in the study, and the former often includes the latter, at least in overt research(13). It seems generally accepted by most writers that participation in and observation of the action is the preferred strategy given the closer relationship of

the researcher and the phenomena he investigates that this entails. Intensive interviewing as an approach in itself being best reserved for those events in which the researcher cannot be directly involved given their infrequency, e.g. earthquakes, their privacy, e.g. sexual intercourse, or the privacy of the setting in which they occur, e.g. it would not be possible to study 'ordinary' activities such as non-verbal communication in a Cabinet meeting. Participant observation requires that the phenomenon is relatively frequent, public and accessible. Additionally, it requires that the researcher either resides with his subjects or is able to commute to and spend periods of time in the relevant action scenes.

Owing to the particular nature of the family, I decided that access to the setting was too restricted to allow the long-term participation required to observe the interpretation and management of problematic experiences within family interaction. Like Voysey(14), I assumed it would be difficult to find families willing and able to tolerate the presence of a stranger in their home or that the research could be undertaken without considerable disruption of family activities. It also seemed to me to involve a considerable waste of time; after all, coping with illness is only a small part of family activity. When it was pointed out to me that some had undertaken participant observation of family life my motives became clear; like others faced with the same decision "I was not prepared to commit myself that much to the project, I preferred to stay at home"(15).

Because of the considerations outlined above, intensive interviewing was chosen as the preferred data gathering technique. This means that I was limited to obtaining informants' accounts of problem-

atic experiences, their cognitive organisation and practical management. Consequently, information was collected in two ways: tape recorded semi-structured interviews and health diaries which were completed by the respondents. I also decided to interview the mother of the family since I assumed that she would be more closely involved in the health and illness experience of members of the family than any other individual and would be more likely to be willing to spend time talking about 'women's work'. This of course presupposes a theory of the sexual division of labour within the family(16).

Making contact

Problems here revolved around two key issues: identifying the relevant settings to study, and gaining access to them. Though there is some discussion of these issues in the methodological literature, the majority of the writing on such problems and how to solve them consists of reports of what other workers did and how they did it. In the absence of a theory or set of principles to act as a guide there is no alternative other than to use one's common-sense.

The family settings that I wished to study I conceived of as 'ordinary' families. That is, I did not require them to be any more extraordinary than to consist of one or more adults and one or more children. I had some idea that there would be some variation in the matters I wanted to investigate according to such factors as sex and age so that when I had to stipulate the sort of families in which I was interested I asked for one adult of each sex and at least two children. It could be argued that the family settings to which I gained access were far from ordinary, but they are families just the same. At the outset I did not require that the families were special in any

way but nor did the fact that they might be said to be special lead me to exclude them from the study. Their special characteristics were not irrelevant to the study, far from it. They were of interest insofar as they formed the context within which meanings were constructed but they were no better or worse than any other context I might have encountered for illustrating and elaborating the issues outlined in Chapter 1.

Though 'ordinary' families are everywhere, there is a sense in which they are nowhere. That is, their ordinariness did not mean they were any easier to locate than a given type of deviant or what have you. Other than knocking on doors at random there are no immediately obvious ways of contacting families. As Bott discovered(17), though there appear to be many ways in which such contact can be made for the most part the apparent ease with which the end may be achieved is illusory. Like Bott, I employed the referral method contacting subjects through an intermediary known to us both. Intermediaries may be a friend or acquaintance, even a subject, or an individual in some kind of formal agency. Both of these types were used. Two women were contacted via acquaintances to take part in a short pilot study and the women in the main study were contacted via their G.P. The referral method has the advantage that it confers legitimacy on the researcher and the study.

I was introduced to a G.P. who was interested in social research and willing to co-operate by a fellow medical sociologist who was well-known for research in this field. I saw him at his surgery and we decided that he would make the first approach to respondents whose families fulfilled the research criteria. Within ten days he supplied me with a list of five women who had agreed to be interviewed. Follow-

ing a brief telephone call I wrote to them explaining that I was interested in the kind of health problems they encountered and how they coped with them and that I would like to interview them three times over a period of 6 months. I telephoned them again to confirm that they were willing to co-operate and to arrange an appointment for the first interview. All agreed to participate.

My original intention was to interview two groups of five women over periods of six months. The first five respondents were interviewed between May and October 1974. At the end of that time I decided to interview the same women for a further six months, rather than selecting a new cohort of cases, to take advantage of the relationship which had developed over time. I also continued to interview one of the pilot cases and subsequently analysed the data along with that I obtained from the five.

Unlike quantitative methodologies, qualitative approaches have no equivalent of the statistical and sampling theory the former employs to determine matters such as the number of cases to be studied. There are recommendations in the literature which suggest that between 20 and 50 interviews is the standard caseload though the number of interviews that can be managed is dependent upon the back-up facilities available. As a PhD student with nothing but a tape recorder and a box of tapes I aimed to acquire 25 to 30 interviews since I felt that this was roughly about the number that I could comfortably transcribe and analyse. Too much data is no less a problem than too little. Since I wanted to interview the respondents several times then their number had to be reduced accordingly.

I do not conceive of the women I interviewed as cases. They are not the unit of analysis. Nor are the 30 or so individuals about whom I collected information the unit of analysis. The unit of analysis is what I originally thought of as a symptom episode and I have since come to call a management sequence[18]. By limiting myself to six respondents I merely reduced the number of contexts that I was able to study. However, my aim was to use the data on symptom episodes to demonstrate the way in which context figured in the construction of meanings rather than the study of a wide variety of contexts. A longitudinal design, because it allowed me to follow the "career" of the problems the respondents reported and provided the opportunity for showing how the past functions as an interpretive context for the present and future, I judged to be more important than increasing the size of my "population". Like any quantitative study that does not investigate a large sample from a defined population, it might be claimed that the results are limited in the extent to which they are generalisable. It could be argued that what I have described is nothing more than the experiences of six women. However, on the basis of the reasoning presented towards the end of Chapter 3 I would claim that what I have described are some constituents of a stock of knowledge at hand that is available to members of a culture to organise and make sense of their experience. This does not mean to say that it <u>is</u> used, merely that it is <u>available</u> to use. What is described then is a common frame of reference. Consequently, one could argue that one woman would have done equally as well[19].

<u>The interview and the health diary</u>

The interviews were conducted between May 1974 and June 1975. They took place in the respondents' homes during the late morning or

early afternoon. These times proved to be the most convenient for these women who worked as housewives and usually allowed up to two hours for the interview to proceed uninterrupted. I preferred to interview the respondents alone, though the husband of one respondent was present at one of the interviews and at interviews with two others the children were sometimes present. At the first interview I asked the respondents if they minded the conversation being taped, explaining that it made recording of what was said much easier for me. At the second interview I mentioned the tape recorder again but at subsequent interviews I took the matter for granted. None of the respondents objected to, or seemed worried by, the use of the tape recorder. I gradually learned from experience that much valuable data could be obtained from the pre- and post-interview talk so I made a practice of having the tape running as I knocked on the door and switched it off only after I had left. The respondents frequently took the opportunity during the post-interview talk to elaborate on topics they had discussed in the interview and before I became wise some of this was lost.

In all, I conducted 26 interviews. Each respondent was interviewed between 3 and 6 times, the differential reflecting the ease with which the respondents could fit me into their busy daily routines. One of the interviews was accidentally taped over, one was lost due to a fault in the tape recorder and another went when the recorder and the tape it contained was stolen from my office. The analysis in Chapters 3-6 is based on the remaining 23 interviews. The interviews lasted from three-quarters of an hour to 2 hours and provided approximately 40 hours of taped conversation. These 40 hours were transcribed verbatim and fragments are reproduced in Chapters 3-6 with the minimum of editing. I terminated the interviewing rather reluctantly unsure of

whether I had gathered adequate material. At that time I had not worked out a method of analysing the data and I was somewhat troubled by the apparent triviality of what I had so far collected. With qualitative research where the interviewing is open-ended in more than one sense of the word there is always the temptation to believe that one more interview will furnish the key to the problems with which one is faced and will invariably provide better data. Fortunately, I was forced to complete the interviewing stage of the research by practical considerations - my studentship came to an end.

Though I planned to conduct unstructured interviews they necessarily turned out to be semi-structured. They were organised around the idea of a symptom episode or management sequence and my questions were designed to prompt the respondents to talk about the problematic experiences they, members of their family or others known to them had encountered and how they had been managed. Over time the women became accomplished respondents. They were able to provide me with detailed accounts of their everyday affairs such that my participation in the exchanges was reduced to a minimum. Much of what they said was, then, spontaneous.

Prior to the second and the fourth interviews I asked the respondents to keep health diaries. These were simple records of symptom experiences and actions taken and though they were originally intended as data collection devices I used them only as aids to interviewing. They were sent to the respondents through the post, kept over a period of two weeks, returned to me through the post and formed the basis of an interview which was conducted as soon as possible after the diary was completed. I used them in an attempt to build on the

work of Robinson and others[20] although I did feel and wished to avoid their manifest tendency to impose a structure upon the respondents' experiences. As it turned out the diaries were inadequate as sources of data simply because they did not contain sufficient detail. However, they were successful as devices to facilitate recall and provided a systematic record of events which I used in formulating questions and probes. In fact, the difficulty of remembering the exact sequence and timing of events led one respondent to suggest that she keep a diary before I had chance to suggest it myself. I also noticed a diary effect which needs to be taken into account in studies which do use diaries for the collection of data. That is, without exception, the first week of the diary had an entry for every day whereas there would be a noticeable tail-off during the second week. This problem may be overcome by a visit halfway through the diary keeping period[21]. However, given that my respondents felt it necessary to apologise for the absence of symptom experiences there may also be a tendency for them to record experiences that are not usually categorised as symptoms in order to demonstrate that they are fulfilling the task of respondent adequately. While the problem of the reliability of the diary is not an issue in this study it is where diaries are taken to be objective records. Though some of my interviews used diaries as a guide they were not in fact constrained by them and I attempted to clarify the status of the events recorded in the diaries in terms of the respondents' own categories and also to locate instances of events which were not recorded in the diaries since they were not seen by the respondents as falling within the categories the diary demanded. What the respondents said at interview was then used as data and not what they had written in their diaries.

Throughout the period during which I interviewed the respondents I deliberately tried to keep by status vague. I had been introduced to them via their doctor and though I did point out that I was an independent researcher it was evident that they were unsure of my relationship with the practice. At that time my concern was to preserve my legitimacy by maintaining a link with their doctors while wishing to avoid so close an identification so that complaints and criticisms would not be forthcoming. There is no way of telling whether I got it right, except my belief that my relationship with them as individuals developed over time so that it became independent of the initial source of contact. In the early stages it seemed difficult for some to accept that I was interested in what they had to say about their "ordinary" problems, so I had to point out that I would not have come back if what they had to tell me had not proved to be of value.

To some extent, their view of me as a representative of some authority and their assumptions about my purposes and interests in coming to interview them, had an effect on what they said in the interview. Certainly, I believe that common-sense notions about what it is appropriate for mature women to discuss with young men influenced the topics they talked about. I have very little evidence for this, except to point out that none of them talked about menstruation and what Mrs. R. discussed as a pain in her daughter's abdomen was later described by her husband as a pain in the vagina(22). It is for these reasons that I have argued that interview data is a situational construct; my presentation of self and the respondents' interpretation of it are part of the complex process whereby the interview as a social encounter is accomplished(23).

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