

On "Labeling" in Actual Interaction: Delivering and Receiving Diagnoses of Developmental Disabilities*

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In order to deepen the understanding of labeling as a social activity, we propose that more attention be devoted to the actual activities of those involved in the process. Our research concerns professional-lay interaction in a clinic for developmental disabilities. Using videotapes of informing interviews involving clinicians and parents, we examine the delivery and receipt of diagnostic news. We show that clinicians proceed cautiously when presenting labels to parents, using devices such as the Perspective-Display Series, Incomplete Syllogism, Retrospective Perspective-Display, and Subordinating the Label, that allow parents' responses to enter into the news delivery and labeling process. We also find that participants invoke social outcomes in promoting and resisting labels.

Although labeling theory is a prominent tradition in the sociology of social problems, it has languished in recent decades. Indeed, Gove's (1980:27) assessment that the theory "... has not evolved but remains essentially where it was in 1974," may still apply today. This is not to ignore recent empirical investigations using labeling propositions, but it is to say that labeling *theory*, which purports to specify the socially constructed nature of "deviant" behavior, remains vague about how individuals acquire deviant labels in the first place.

Rather than considering deviant behavior to be a property of the individual, labeling theorists argue that officially recognized deviance is enacted through a social process. We fundamentally agree with this position and argue that there is more to this social process than the theory has identified. Advocates of labeling theory, whether working quantitatively with aggregate data or qualitatively by observation and interview, have largely overlooked practices of talk, action, and social interaction (Maynard 1988). Consequently, even in research arguing most fervently that labeling profoundly affects the lives of individuals, the acts of giving and acquiring labels appear as obscure, disembodied events.

In order to deepen the understanding of labeling as a social activity, we propose that more attention be devoted to the *actual activities* of those involved in the process. By referring to actual activities, we are not taking an ironic perspective on prior research and proposing that ours provides superior access to what is "real" in the production of a labeled individual. Rather, we invoke Garfinkel's (1988) proposal that ethnomethodological inquiry depends on inspection of unimaginable details that are impervious to capture by the generalizing and typifying statements inherent in theoretical propositions. Here, we examine labeling as an aspect of professional-lay conduct in a clinic for developmental disabilities. While we do not focus on label generation or how practitioners arrive at relevant labels in the first place, we do examine label application or how labeling is partly observable in the set of practices

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whereby clinic participants deliver and receive diagnostic news. Using videotapes and detailed transcriptions, we have preserved as much of the original interactions as is practically possible, recognizing that our video and transcript records are still not the events in their entirety. Still, they permit a close examination of phenomena that did "actually happen." In exploring the accessible detail of diagnostic informings, we not only gain insight into the local organization of the labeling process but ultimately find that in some aspects the process does not resemble customary glosses nor support existing assumptions. In particular, we find clinicians using diagnostic news delivery strategies that invite recipients' collaboration, as well as participants invoking social outcomes to promote and resist labels. These findings point to the need for readjustments in the way the theory views participants' participation in, and understanding of, the labeling process.

The Labeling Literature

General Literature

Most often, labeling theorists have addressed how social structural factors promote or inhibit labeling and have examined the consequences labels have once they have been applied. However, there is a longstanding concern with how the "societal reaction" (Kitsuse 1962) operates in interaction. When expressing this concern, labeling theorists have been vague about what that interactional process entails.

In its early stages, labeling theory said very little about labelers and in particular how they accomplish labeling. The theory has let nominal references, such as passive verb constructions, stand on behalf of complex social processes. Note how Tannenbaum (1938:19-20) uses the passive voice in his classic description of the "dramatization of evil" (emphasis is added):

The boy arrested . . . *is singled out* in specialized treatment . . . He *is questioned, examined, tested, investigated.* His history *is gone into*, his family is brought into court . . . He *has been tagged.* . . . The person becomes the things he *is described as being.*

To be sure, Tannenbaum (1938:21) refers to "factors," such as "the family, the gang, and the community," which prompt the dramatizing process. However, the overwhelming stress is on what happens to the targeted individual rather than the way in which group members enact practices, such as questioning, examining, tagging, defining, identifying, segregating, describing, emphasizing, and others that result in the purported deviant's isolation and stigmatization. Later statements about labeling are more systematic, but they still obscure both the labeling agent and the labeling process, as when Lemert (1951:77, emphasis added) employs the gerund to state that "a *stigmatizing* of the deviant occurs in the form of name calling, labeling, or stereotyping." Or consider Becker's (1963:32-3, emphasis added) assertions, which incorporate both passive voice and gerunds:

One of the most crucial steps in the process of building a stable pattern of deviant behavior is likely to be the experience of *being caught* and *publicly labeled as a deviant.* . . . He *has been revealed* as a different kind of person from the kind he was supposed to be. He *is labeled* a "fairy," "dope fiend," "nut" or "lunatic," and *treated* accordingly.

From this, we do not know *who* is doing the labeling, and the shorthand references—such as identifying, testing, tagging, defining, and stigmatizing—compress real social conduct and diminish the fullness of the activities surrounding labeling.

Some critics have called for more attention to actors' interpretations within the labeling process (Manning 1973; Matza 1969; Rock 1974), and observational studies (Black and Reiss 1970; Cicourel 1968; Werthman and Piliavin 1967) have helped to counter some of the

vagueness in labeling theory. However, these studies employ members' or observers' after-the-fact descriptions, thereby preventing analysis of labeling as a real-time sequence of actions. Spencer's (1983) research on how probation officers ascertain subjective orientations of defendants in assessing their propensity for recidivism does utilize recorded data but concerns *unofficial* labels such as "low risk" or "high risk." Our interest is in *official* labels and the details of language and social interaction as this occurs in actual, not recollected, conversation.¹

Just as we know little about how labelers actually perform their activities, the *targets* of labeling seem to have no independent agency at all (Davis 1975; Hagan 1973; Schur 1971). This is exhibited in passages above where authors depict the deviant as the mere *object* of various labeling acts (identifying, testing, etc.). The labeling "process" seems to have extraordinary powers to nominate and send individuals on the tracks of a deviant career, while labeled individuals appear to lack the capacity to respond or react except in ways the label would dictate. For instance, Becker (1963:14) argues that deviance "... is not a quality that lies in behavior itself, but in the interaction between the person who commits an act and those who respond to it," but this interaction is portrayed as highly unidirectional and non-contingent. Similarly, when Scheff (1966) discusses the "rewards" and "punishments" whereby residual rule-breaking becomes stabilized as "mental illness," it suggests that residual deviants, much like Pavlov's dog, are merely responding to conditioning.² In short, labeling theory has been overly deterministic (Gove 1980) and has an "oversocialized" conception of deviant behavior (Kitsuse 1980:5).

Empirical studies attempting to correct this problem have shown how polio victims and their families (Davis 1963), the chronically mentally ill (Estroff 1981), blind individuals (Scott 1969), and imputed members of other stigmatized categories (Goffman 1963), resist and counter labeling, or in the case of the "mad genius" (Becker 1978) and others, even use labels for their own ends. However, this line of investigation is almost entirely ethnographic and *typifies* the process rather than rendering its detail. For instance, in a general treatment of "fighting back phenomena," Rogers and Buffalo (1974:105) provide a *typology* of strategies, including "evasion," "modification," and "redefinition," much as (Goffman 1963) does in describing how individuals, through practices of "information control," defend themselves against stigma. In the end, although such studies do help unmask the labeling process, we are still left with the question of what these strategies comprise as real-time interactive productions.

Labeling theory is also vague in that it overlooks the social context in which labeling occurs *as that context is a concern for the participants*. Labeling theorists have largely directed their concerns toward the social variables that condition both the acquisition and social outcomes of labels. This is true even of social constructionists (Conrad and Schneider 1980; Holstein and Miller 1993; Spector and Kitsuse 1977) in their concern for the "politics" of deviance (Schur 1980) and questions of power and resistance (Kitsuse 1980; Piven 1981). That is, in bringing the activities of groups to the fore of inquiry, constructionists have nevertheless overlooked actors' local experience and knowledge (Marlaire and Maynard 1993). From our standpoint, labeling theory stands to gain from an appreciation of the way individuals display *their* knowledge of the social environment and act strategically within it in order to bring off labeling events.

Again, there are a few contemporary accounts of how actors define and negotiate social context. Consider Darrough's (1984) study which examines the interactional and rhetorical uses of juvenile court ideology, especially the notion of what is in "the best interests" of the

1. Our efforts are close to Meehan's (1989b) use of phone call and other data to study how "gangs" become constituted in the interactions among citizens, police operators and dispatchers, patrol officers, and youth.

2. For a recent review of the Scheff-Gove debate about the labeling of "mental illness" and how the terms of that debate take the reality of psychiatric illness for granted, see Holstein (1993).

youth. While illuminating the "micropolitics of placement," however, Darrough (1984, 1990) does not explore the implications of his studies for labeling theory. Gubrium (1988:32-3) does draw such implications, showing that "labeling talk" appears in the evaluative discourse of professionals inside a residential treatment facility, and that ". . . people appear to be more philosophically astute at labeling theory than labeling theorists warrant." Following this theme, we argue that professionals and others exhibit awareness of the social forces that affect label acquisition and labeling outcomes. Accordingly, rather than naively being compelled by "social facts," participants bring "social facts" into play in conversation as resources to advance and resist labels. Thus, social context and structure are analytically important in understanding the labeling process because they are observably of concern to participants during actual events such as the delivery and receipt of diagnostic news.³

Childhood Developmental Disabilities Literature

In the specific area of childhood developmental disabilities, a number of researchers take a labeling perspective and argue that mental retardation, autism, emotional disabilities, learning disabilities, and related conditions are products of the social system rather than inherent deficiencies. Many studies (Carrier 1986; Hagan 1973; Hargreaves, Hester, and Mellor 1975; Kugelmass 1987; Mehan 1983, 1991; Mehan, Hertweck, and Meihls 1986; Milofsky 1976; Rowitz 1974, 1981; Tomlinson 1981) seek to demonstrate that varying eligibility criteria, program availability, and personal discretion of teachers and parents — especially as decisions are based on race and ethnicity — systematically affect whether children are labeled developmentally disabled.

Labeling theory's vagueness surfaces in this body of research. When Milofsky (1976:37) contends that "statuses are affixed to people . . . as labels are affixed to packages" or Mercer (1973, emphasis added) says, "From a social system perspective, the term mental retardate does not describe individual pathology but rather refers to *the label applied* to a person because he occupies the position of mental retardate in some social system," we again see passive phraseology masking actual activity and portraying label recipients as pliant victims.

Finally, while Mehan (1983, 1991) and Mehan, Hertweck, and Meihls (1986) do examine transcripts of education team meetings with the parents of children who are diagnosed with learning disabilities, they nonetheless paint a picture of institutional determination. Documenting a number of asymmetries in the way a child's psychologist, nurse, mother, and teacher report on, assess, and define the child, Mehan and associates (1986:137) conclude that the child's placement ". . . was not negotiated; it was legislated;" the "institutionally sanctioned version" of the child was "superimposed" upon competing definitions. As Mehan (1991) has subsequently argued, fiscal and legal constraints influence the asymmetries and the superimposition of definitions; indeed, such constraints *determine* the ordering of certain events within the meeting. However, in our view it is unclear how the participants bring these factors into play in interaction so that they affect events. Mehan's (1983, 1991) otherwise close inspections of discourse in meetings provide little purchase on how the participants in these meetings, rather than responding mechanically to "distal" forces, display *their* analyses of and orientations to structural facets of the social environment in their interaction.⁴

3. This point harks back to early ethnomethodological discussions (Garfinkel 1967) about the lay theorizing of society's members (Cicourel 1973; Heritage 1974). For more contemporary treatments, see Gubrium and Wallace (1990) and Wilson (1991).

4. When discussing labeling, Mehan, Hertweck, and Meihls (1986:107), in a fashion consistent with previous literature, sometimes lapse into passive voice: "When a child in public school is officially labeled. . . the label becomes a social fact about the child." See also their discussion of labeling and how a classification ". . . seems to take on a life of its own" (1986:160). We do not necessarily disagree with this point; it is just that we wish to call attention to the actual social practices that are glossed by *is officially labeled, becomes a social fact, seems to take on a life of its own*, and so forth.

In sum, the traditional labeling literature lacks detailed examinations, descriptions, and analyses of the labeling process as it actually occurs in social interaction. Theorists present the process as a straightforward "naming" activity where labelers, who are largely naive to the social and historical contexts in which they operate, decisively attach labels to acquiescent and similarly naive individuals, and that is that. More recent critiques and investigations have addressed some of these shortcomings. However, contemporary empirical research largely relies on narrative, after-the fact accounts, and/or does not address the implications of their investigations for labeling theory. In his own critique of labeling theory, Becker (1973:190) argues how

. . . we often turn collective activity—people doing things together—into abstract nouns whose connection to people doing things together is tenuous. We then typically lose interest in the more mundane things people are actually doing. We ignore what we see because it is not abstract, and chase after the invisible "forces" and "conditions" we have learned to think sociology is all about.

In this paper, we urge attention to organized ways in which label acquisition is part of a complex of real-time, interactional activities, including those between professionals and laypersons in various institutional settings. We will specify how labeling occurs as part of the delivery and receipt of diagnostic news in clinics for developmental disabilities.⁵

Data and Methods

The data were collected by video- and audiotape at a clinic for developmental disabilities in a medium-sized Midwestern city.⁶ The purpose of the study was to follow the complete diagnostic process involving clinicians, children, and their families.⁷ Twelve children and their families were followed from the time of referral—when clinicians, at an "intake" meeting, discussed the children and decided on an appropriate sequence of examinations—until the testing, diagnostic, and informing process was complete. The evaluation may have included speech, psychological, psychiatric, pediatric, educational, and other kinds of examinations (Marlaire and Maynard 1990). After these, clinicians discussed findings in "pre-staffing" conferences, agreed on diagnostic categories and recommendations, and then presented the findings to parents in "staffings" or informing interviews.

The staffings with parents lasted from thirty minutes to two hours, and typically consisted of separate informings of the child's test results in each specialized clinic area (e.g., speech and language, occupational therapy). This was followed by a summary of the test results and presentation of a diagnosis, or label, although in some cases, the clinicians did not give a definitive diagnosis and recommended re-evaluation at a later time. The "staffing coordinator," who was the clinician most actively involved in the case or a clinician assigned on a rotating basis, delivered the general diagnostic news.

The staffings were recorded, with the participants' prior consent, on video and audiotape from behind an observational mirror. Each staffing was initially transcribed in a "normalized" or textual fashion. We scrutinized the transcripts and tapes for those segments of interviews when clinicians presented a child's main diagnosis. Next, we transcribed these segments in detail, using conventional transcription symbols (Jefferson 1974). Finally, we analyzed the

5. For a somewhat parallel investigation regarding labeling, see Holstein's (1993:5) discussion of the process ". . . of invoking and applying definitions, categories and practical interpretive procedures" in commitment hearings regarding the mentally ill.

6. Data were collected under Grant HD 17803-02 from the National Institutes of Health, Douglas W. Maynard, principal investigator.

7. This study was meant as an intensive follow-up to an earlier one, which used audiotapes of more than 50 informing interviews. In the earlier study, the researchers had not collected information about the overall diagnostic process. For publications from the earlier study, see Svarstad and Lipton (1977) and Maynard (1989).

segments according to procedures in conversation analysis. We attempted to identify and describe how the participants—clinicians and parents—organize the delivery and receipt of diagnostic news as a verbal (and often nonverbal but visible) exchange.⁸ The goal is to specify how labeling is accomplished in members' activities as a set of endogenously organized methods (Garfinkel 1967). Consequently, we do not seek to attribute labeling outcomes to the participants' social characteristics or attitudes, or to predict particular outcomes based on a set of exogenous social variables or internal states. Our focus is on the conversational methods participants use *in situ* to deliver and receive diagnoses of developmental disabilities. To provide background information on the staffings, we also utilize information collected ethnographically (through interview and observation) from the clinics.⁹ This includes notes from "intake" meetings and materials from case files.

Recipient Participation in News Delivery

Perspective-Display Series and Incomplete Syllogism

Labeling theorists have made labeling appear unproblematic for diagnostic clinicians and others who are professionally positioned to give the "bad news" and have cast recipients as objects who are acted upon; recipients appear to make no contributions to the process. In practice, clinicians mostly approach diagnostic news deliveries with caution,¹⁰ although they can and do deliver diagnostic news in a blunt, straightforward manner (Maynard 1989). Furthermore, in being cautious, clinicians allow for recipients' participation in the diagnostic informings. While this means that recipients can affect how the news delivery will proceed, it also provides clinicians with the opportunity to adroitly handle contingencies such as recipient resistance to the diagnosis.

For instance, in delivering diagnostic news, clinicians may employ a Perspective-Display Series (Maynard 1989), asking recipients for their view of a situation before presenting news about it, and then delivering the diagnostic assessment as a confirmation of the recipient's displayed perspective. The basic Perspective-Display Series (PDS) consists of these turns:

- 1) clinician's opinion-query, or perspective-display invitation;
- 2) recipient's reply or assessment;
- 3) clinician's report and assessment.

The cautiousness of the PDS lies in how it permits the clinician to assess the recipient's perspective before delivering the news. For instance, if in answering a query, recipients decline to present a complaint about the child, clinicians may work to elicit one before going forward with the news (Maynard 1992). Additionally, this cautiousness allows for *persuasion*. By delivering the news as a confirmation of the recipient's views, the clinician incorporates the recipient's perspective within the actual delivery, in effect transferring to them some of the "authorship" (Goffman 1981) of the news. The clinician's assessment thus appears to be less a unilateral assertion than a mutual agreement wherein the clinician modifies or adds to what the recipient already knows or believes (Maynard 1992).

Another way of delivering diagnostic news cautiously is through a device we term an *Incomplete Syllogism*. The clinician presents a series of related, general and particular premises that point to an implied diagnostic conclusion, allowing the recipients themselves to deduce

8. For a general discussion of conversation analytic methods, see Heritage (1984:237-44). See also Silverman's (1993) Chapter 6 on "Transcripts."

9. For discussions of combining ethnographic and conversation analytic methods, see Maynard (1984:17-24) and Goodwin (1990). For related discussions, see Corsaro (1982), Gubrium (1988), Silverman (1993), and Spencer (1983).

10. On the phenomenon of cautiousness in the talk of professionals operating in institutional settings, see Drew and Heritage (1992:45-47).

the upshot. In formal logic, a syllogism contains a general (major) premise followed by a particular (minor) premise and a conclusion, as in this example:

- 1) general premise: all children are funny;
- 2) particular premise: Jimmy is a child;
- 3) conclusion: Jimmy is funny.

However, when using the Incomplete Syllogism for delivering diagnostic news, clinicians proceed either from the general to the particular premise(s), or vice versa, while implying but not overtly stating the conclusion, which is left for the parents to draw.

In the following excerpts from an informing interview, a psychologist (Dr. M) delivers diagnostic information to five-year-old Ken's father and mother (Mr. and Mrs. D). A school psychologist referred Ken to the clinic because he was "nonverbal" and presented "severe behavior problems." The parents, as well, were concerned about Ken's delays in school, and wanted some definitive diagnostic advice. In this part of the informing, Dr. M provides a four-part assessment of Ken's developmental delays that constitutes the particular premise of the Incomplete Syllogism. The following excerpts occur in close proximity to one another. For reasons of space, we have eliminated the talk between excerpts that is not essential to our analysis. (See Appendix for transcription notations.)

SEGMENT 1A (40:19)

1. Dr. M: So the first question is are the delays significant. Ah::
2. the answer is yes.
3. (1.0)
4. Dr. M: >y'know< you have reason to be concerned.
5. Mrs. D: M hm
6. Dr. M: >Y'know< this isn't a mi:nor delay. This is- (.) a delay
7. which doesn't occur ver:y often.
8. (0.5)
9. Dr. M: In maybe: one kid in a- (.) or two kids in a hundred.
10. (1.0)
11. Mrs. D: *Mm* . . .

SEGMENT 1B (41:00)

1. Dr. M: The- the >question is,< is it o:nly talking (.) or are we
2. talking about a more general type of de[lay.]
3. Mrs. D: [Mm hm]
4. Dr. M: Tch uh: .hhh uh:: pt (1.5) an: I think the answer is fairly
5. clear that well- I- >actually it's a- it's a< co:mplicated
6. answer but thee (.) thee (0.5) .hh ah:: the most important
7. part of it is: is that- .h he's behind in all areas of
8. function[ing.
9. Mr. D: [M]hm
10. Mrs. D: [M hm . . .

SEGMENT 1C (42:28)

1. Dr. M: The third question is, .hh well okay there're del:ays, (.)
2. they're significant, they seem to be across the board .hh can
3. we identify a- a- a- cause. And ideally a treatable one. .hh
4. And (1.5) i- >y'know< these kind of cases are very (0.5)
5. funny because you can't pro:ve anythin:g but when you see
6. these findings where we kn::ow that something has happened to
7. the brain. That the messages aren't (.) .hhhh ah:- going to
8. the different parts of the bo:dy in a way which is normal.

9. .hh It see:ms likely that that's also the cause for these
 10. delays.
 11. (3.5)
 12. (Mrs.D): *Okay* . . .

SEGMENT 1D (43:50)

1. Dr. M: An the fourth one which is that the delays are not a recent
 2. kind of thing. That they seem to have been (0.5) .hh y' know
 3. right from the very beginnings [of life and they're=
 4. Mrs. D: [M hm[m]
 5. Mr. D: [M hm]
 6. Dr. M: =not going away. In fact .hh ahm: (.) .h ah it sou:nds like
 7. although this is a critical piece of (.) data which we don't
 8. ha:ve an:d (.) we'll need to follow a little bit over ti:me
 9. .hh uh- it looks like he's learning (.) but he's no:t
 10. catching up.
 11. (0.5)
 12. Mrs. D: M hm

In these excerpts, Dr. M has claimed that Ken has a significant (segment 1A), pervasive (1B), untreatable brain abnormality (1C), which is permanent (1D). Mr. and Mrs. D appear to at least minimally acknowledge these assessments (1A: lines 5, 11; 1B: lines 9-10; 1C: line 12; 1D: lines 4-5, 12).

Next, Dr. M presents the general premise (1E below): Problems that are significant, untreatable, of unclear causation, and long-term, are called mental retardation. This is the second part of the syllogism; together with the four-part particular premise it constitutes an implied proposal about Ken. Ken's mother deduces the upshot, completing the syllogism (see line 15), and Dr. M confirms her deduction (lines 17, 19):

SEGMENT 1E (45:17)

1. Dr. M: When:- when you put a:ll these things together. When there
 2. are [de:lay]s,=
 3. Mrs. D: [*M hm*]
 4. Dr. M: =When they're significant, and it looks like there's no:
 5. (0.8)
 6. (Mrs.D): *m*
 7. Dr. M: Clear treatable cau:se. .hhh uh- ta fix: (.) the problem up.
 8. .hh uh:: (.) a:n when it looks like this has been going on
 9. for a long period of ti::me, .hh (0.5) an:::d (0.5)
 10. projecting ahead you're:: not optimistic that the kid's going
 11. to catch up, [.hh uh] that's what=
 12. Mrs. D: [*M hm*]
 13. Dr. M: =we call mental retardation.
 14. (1.5)
 15. Mrs. D: And this is what it is.
 16. (0.5)
 17. Dr. M: *m hm*=
 18. Mrs. D: =*Okay*=
 19. Dr. M: =*yeah* Almost certainly.

There are three aspects to the cautiousness in the Incomplete Syllogism. First, after describing Ken's delays specifically in the particular premise (e.g., "he's behind in all areas of functioning," 1B lines 7-8) Dr. M moves to a more detached stance or footing in presenting (1E, lines 1-13) the diagnostic term, "mental retardation" in the general premise. The term itself occurs

in a description of how clinicians (referred to via the categorical "you" and "we" in 1E, lines 1, 10, and 13) define a generic "kid" (line 10) with a certain set of characteristics (lines 2-13). In short, our first point is that through the syllogistic delivery the clinician gives the diagnostic terms "special handling" (Clayman 1992:169-70); the general premise offers an abstract definition that only by implication applies to the child under consideration.¹¹

Second, as with the PDS, the syllogistic device allows the clinician to glimpse the recipient's reaction before fully committing to the diagnostic news. Recall here that the parents seemed to minimally acknowledge the clinician's claims (in 1A through 1D) about Ken's difficulties and impairments. Furthermore, if the recipients complete the syllogism in a way that conveys understanding or even acceptance of the conclusion, then the clinician can confirm what he has implied and the recipient has displayed as an inference. In this episode, the completion and confirmation are measured and protracted. First, Mrs. D gives a version of a conclusion to the syllogism (1E, line 15), which shows understanding of its implication, and Dr. M strongly acknowledges this (with head nods and "m hm", line 17). Next, Mrs. D says "okay" (line 18), which possibly indicates acceptance of the diagnosis, and Dr. M provides a marker of agreement ("yeah," line 19). While the clinician does show some uncertainty, going on (in talk not reproduced here) to explain that he "would hedge" some because of the need for further testing, he also proceeds to reaffirm what he has already said.

These first two aspects of syllogistic cautiousness imply a third. This strategy is built to handle the contingencies of recipient response. That is, while parents have the opportunity to complete the syllogism, it can happen that they do not publicly propose the conclusion—i.e., give no clue about whether they either can do so or are willing to do so. In such a circumstance, it is possible for the clinician to perform remedial work before actually going ahead with the news delivery. The following sections show further the interactional complexity of the labeling process, especially when clinicians meet parental resistance.¹²

News Receipt and its Effects on the Process

Retrospective Perspective-Display

Even when clinicians are cautious in delivering diagnostic news, they still encounter different kinds of recipient responses. Their use of devices such as the Perspective-Display Series and Incomplete Syllogism do not guarantee that the recipients will accept the clinician's implication about which label is appropriate. When recipients resist labels, clinicians may employ remedial strategies to encourage them to accept the clinic's position.

We consider the case of Ivan A., who was 4 years, 9 months old when his school psychologist referred him to the clinic for testing. School personnel thought he was "TMR or lower" (trainable mentally retarded or lower). There were some indications on his record, including a one month trial of Ritalin, that he had previously been diagnosed as hyperactive. Other difficulties included speech and hearing problems. Ivan's family, according to the school psychologist, was "difficult to deal with," and the clinic's intake secretary reported that Ivan's mother "minimized" Ivan's problems. The clinic scheduled Ivan for tests with the clinic psychologist, speech and language clinician, occupational therapist, and the special education clinician.

11. The clinician here presents the news without saying the exact upshot, such as "Ken is mentally retarded." For examples of this direct way of delivering a diagnosis, see excerpts (1) and (3a) in Maynard (1989).

12. In the written psychological evaluation later sent to Mr. and Mrs. D, the psychologist stated that test findings "all indicate the very high probability of mental retardation," although "a few more repeat testings" were necessary to establish this. During the informing interview and in this letter, the psychologist also indicated that "Attention Deficit Disorder with Hyperactivity" was a secondary diagnosis.

After Ivan was tested, the clinicians held a pre-staffing conference to discuss their findings and a diagnosis before meeting with Ivan's parents. In the pre-staffing, the psychologist expressed his "hunch" that "we're talking about a mildly retarded kid," but he added that he wanted to be cautious about that diagnosis because of Ivan's hearing problems and because he had made some significant intellectual progress in the past year.

In the meeting with Ivan's parents (Mr. and Mrs. A), the psychologist (Dr. M), uses an Incomplete Syllogism to imply that mental retardation is a potential diagnosis. This receives a very slight acknowledgement from Ivan's mother and no response from his father.

SEGMENT 2A (I:39:17)

1. Dr. M: .hh >you know< again .hh a:hm (.) the reason for going
2. through all this: ah- obviously when you have a kid who's
3. way behind you worry about mental retardation.
4. (0.4)
5. Dr. M: That's what we're y'know (.) discussing that issue. .hh A:hm
6. .h (2.0) you: do:n't and when y'talk about me:ntal
7. retardation what- (.) we usually mean is something- >y'know<
8. y- what parents are >a'ways saying y'know< ih- is the
9. permanence of this. Okay I know he's behind.
10. Mrs. A: ((nods very slightly))

As he moves from the general to the particular premise, Dr. M includes a proposal of the "reason" for their visiting the clinic (lines 1-3). The *general premise* is that when a child is "way behind," mental retardation is a "worry" (lines 2-3).¹³ Note the clinician's detached footing: He employs what Peyrot (1987) calls oblique reference — the indefinite "you:" he references "a kid" generically; and he pairs the term "mental retardation" with this generic reference. At a point of completion (line 4), the parents neither say nor do anything. Following this, the clinician provides a formulation of their joint activity (line 5): "we're y'know discussing that issue." Next, Dr. M starts to clarify what "we usually mean" (lines 5-7) and abandons the trajectory of that utterance in favor of a suggestion about how "parents" often view the problem (lines 8-9). It is within this still somewhat abstract suggestion that the *particular premise* arrives, stated from the parents' purported perspective: "Okay I know he's behind" (line 9). After this, the mother, Mrs. A, nods slightly, which may indicate that she aligns with this perspective—she may regard Ivan as "behind." According to the Incomplete Syllogism, there is a further implication, however, that Ivan may be mentally retarded. Throughout the psychologist's talk, indeed through most of the staffing interview, the parents sit silently; they are rigid and motionless, with blank, inscrutable expressions, and arms folded across their chests. As noted, they decline opportunities to acknowledge Dr. M's utterances, and Ivan's mother provides only the slightest nod after the psychologist's use of the term "behind." Overall, then, the parents' demeanor strongly suggests resistance or withheld disagreement (Pomerantz 1984).

Subsequently, the clinician resorts to another tactic, a Retrospective Perspective-Display (Teas 1989; cf. Maynard 1992) in what appears as a remedial bid to attain agreement on the particular premise that Ivan is "behind." That is, upon alluding to mental retardation in 2A, Dr. M now works in an *ex post facto* manner to exhibit that the parents support the clinic's

13. We have stated that use of the Incomplete Syllogism is a cautious maneuver on the clinician's part. Additionally, there may be degrees of cautiousness, according to whether the clinician starts with the particular premise (Example 1) or the general premise (Example 2). In that the particular premise involves reference to symptoms and test results and other specific findings, it appears less cautious, while the general premise, which poses the abstract and potentially stigmatizing label, appears more so.

view of Ivan. In the excerpt below, Dr. M refers to the parents having filled out a questionnaire that showed Ivan to have the skill level of a 2 or 3 year-old child (he is almost 5 years old). The first two lines in this excerpt reproduce the final two lines of Segment 2A:

SEGMENT 2B (I:39:17)

1. Dr. M: Okay I know he's behind
2. Mrs. A: ((nods very slightly))
3. Dr. M: .hh Fact you've done a better job (1.0) .hhh we didn't even
4. need to do our (test) ah Lyn reminded me ah (.) that (.)
5. horrendous fo:rm that you filled out.(0.6) You know(h)w-
6. (that-) >whatever it was< two three hundred item ah yn- can
7. 'e do this can 'e do that, .hhhh you're getting the same
8. numbers as we are.
9. (1.5)
10. Dr. M: A:h when you s:core the stuff that [you guys did]
11. Mrs. A: [(Yeah) that] I was
12. wonderin bout that.=
13. Lyn: =Yeah it's almost an iden[tical profile]
14. Mrs. A: [(You know) that three hundred]
15. twenty question (item) [I did
16. [(others laugh)]
17. Dr. M: That's a- yeah. And when you score all that ahm (.) y' yer
18. yer what chu in effect said was that in most areas of
19. development (.) .h he's looking like ah >somewhere<
20. between two ta three years. (0.5) In [skills.]
21. Mrs. A: [*M hm*] ((nod))
22. (0.4)
23. Dr. M: (More like) what you've said that you feel yer (1.5)
24. yer three year old is (1.0) >y'know< doing bout the same.

Here, Dr. M works to show that the clinic's assessment of Ivan as "behind" is consistent with what the parents had previously indicated in a questionnaire they completed about Ivan's skill levels. First, Dr. M compliments the parents by asserting the superiority of their assessment of Ivan over the clinic's assessment (lines 3-4); in filling out the questionnaire they performed a task that the clinic would normally do, and they did it so well they saved the clinic from having to perform one of their diagnostic tests. Then, in lines 5-8, Dr. M describes the questionnaire as "horrendous" and guesses at its length, possibly emphasizing its thorough, comprehensive nature. Finally, with "you're getting the same numbers as we are" (lines 7-8), he portrays the clinic's and the parents' evaluation of Ivan's skill level as consonant. He is proposing agreement on the particular premise, which is the prerequisite for the clinic's diagnosis.

At the same time, the psychologist's statement has an offhand quality when it comes to the details of the questionnaire. He professes ignorance of every aspect of the form but its result, claiming he was "reminded" the parents had filled it out (line 4), guessing at the exact number of items in the form, and describing the questions and the form itself in terms that are almost breezily indifferent: "can 'e do this can 'e do that" (lines 6-7). With this gloss of the details, he may be soliciting the parents' orientation to the *results* of the questionnaire, the "numbers" the parents obtained (lines 7-8).

During the ensuing silence (line 9), Mrs. A almost imperceptibly lifts and then slightly lowers her head, possibly acknowledging Dr. M's statement. Mr. A remains still. After the silence, Dr. M starts an elaboration (line 10) of his prior utterance, which Mrs. A interrupts (line 11) with a display of prior interest. At line 13, Lyn, a special education clinician, shows

agreement with Dr. M's characterization and may also propose that Mrs. A's utterance was an agreeing comment on Dr. M's characterization that their numbers were the same as the clinic's.

However, in the mother's next utterance (lines 14-15), which interrupts Lyn's, she refers to the form via its length ("that three hundred twenty question (item) I did"), referencing the very aspect of the form Dr. M had glossed over. She smiles as she says this, and obtains laughter from the others (including Ivan's father, who quickly regains his original inscrutable posture). Dr. M then provides a delayed and perfunctory acknowledgement of the preceding talk and laughter, appearing to break off from a new turn to do so (line 17). He goes on (lines 17-20) to reformulate the parents' assessment of Ivan as it was displayed in the questionnaire. At this point (line 21), Mrs. A produces a very soft acknowledgement, "M hm," and nods slightly, while her husband remains impassive. The psychologist next shifts his gaze to Mr. A (lines 22-24) and appears to address him directly with another aspect of the parents' assessment, their report that Ivan's skill level is equal to their other child's (who is three years old). Having been unsuccessful in achieving agreement from the parents on the general similarity between the two perspectives, he has stepped back to a recitation of part of the basis for that similarity, the specific details of what the parents reported.

In summary, the clinician invoked the parents' perspective as a resource subsequent to a cautious diagnostic news delivery. Dr. M had introduced the diagnostic term, "mental retardation," in a general premise concerning how "you" can "worry" when a child is "way behind." Then, he produced the particular premise about Ivan being behind. In contrast to example 1, where Dr. M was able to gauge Mr. and Mrs. D's reaction to his formulation of Ken's individual skill levels before delivering the diagnostic term, in the present case Dr. M delivered the overall diagnostic term first and encountered resistance. Then there was only minimal acknowledgement and certainly no agreement on the particular premise. Accordingly, the Retrospective Perspective-Display appears as a remedial bid for that acknowledgement and agreement. As in the Perspective-Display series, the clinician uses the parents' assessment of the child to cast their position as being consistent with the diagnostic news, albeit in a subsequent rather than prior elicitation of the parents' views.

Even so, he continues to face parental resistance. Mrs. A twice interrupts the clinicians' ensuing talk to ask about two questionnaire items where they had given Ivan higher scores. Dr. M responds by contending that the two higher scores actually represent only one area of functioning. However, he goes on to qualify the diagnosis:

SEGMENT 2C (I:41:42)

1. Dr. M: A:h (.) but at any rate .h a:hm (0.3) ptch I think you're
2. being very a:ccurate about how you're seeing him. A:h .h what
3. I'm >tryin tell you< is that there's reason to be concerned
4. .hh but a:lso (0.5) pt there's a .h a:h fortunately (.)
5. there's some uncertainty here. It's not a cut n' dried case
6. of a kid who's way behind.
7. (): *Mm*
9. Dr. M: Which (.) would likely mean mental *retardation*. He MAY: (.)
10. be retarded. .h But he may (.) not be.

In lines 1-2, Dr. M again reaffirms the parents' view of Ivan. He then produces a formulation of the prior talk, asserting there is "reason for concern" (lines 2-3). However, he proceeds to downgrade the particular premise and the probability of mental retardation by avowing "uncertainty" about Ivan's skill levels (lines 4-9). We argue that Dr. M's initial use of a cautious delivery method (the Incomplete Syllogism), which only implies a relevant diagnosis, allows him to back down if the parents were to resist. When they do, he mitigates the particular

premise, the extent of Ivan's delays, and backs away from or equivocates about mental retardation.

It is evident, then, that diagnostic news deliveries are not a uniformly easy naming or labeling process. Not only do clinicians approach this process carefully, but their use of cautious modes of news delivery allows for handling the contingencies of recipient resistance. As we have seen, recipients can facilitate or derail linkages in the Incomplete Syllogism through their responses to its component premises. Even the passive resistance that Mr. and Mrs. A exhibit is enough to prompt Dr. M to revise his presentation in order to obtain agreement on the particular premise that Ivan is behind, and further resistance leads him to qualify his certainty about that premise and thus, the overall diagnosis.¹⁴

Social Context

Subordinating the Label

We have argued that labeling theory, despite overt concerns with social structural determinants of labels, overlooks social context *as that context is a concern for participants*. In various theoretical statements, participants seem naive. Clinicians unwittingly, yet with conviction, classify targets in ways that reproduce structural and political conditions of the society. Targets of labeling appear to have no independent knowledge of these conditions except when their anger at repression turns to political activism (Kitsuse 1980).¹⁵ Contrary to labeling theory, and in line with what Gubrium (1988) finds in another institutional arena, our data show parents of developmentally disabled children, as well as clinicians, teachers, and other professionals, displaying acute awareness that the evidence for one diagnostic label over another is often ambiguous and that using any label profoundly influences the lives of children as well as those involved with them. Parents, often confronted with conflicting opinions, say they know that labels lead to differential social responses and treatment, and seek what they feel are suitable understandings of, and environments for, their children. Here, we focus on the way clinicians, faced with uncertainty, conflict, and resistance, strategically minimize the inherent meaning of labels and depict them as tools that will result in social outcomes the parents say they want.

Conflict and Uncertainty

Seven-year-old Michael B. was referred to the clinic by his school social worker for a comprehensive evaluation. Although the school was aware of a previous diagnosis of infantile autism, retardation, and hyperactivity, they were unsure of the degree of Michael's impairments and wanted recommendations for further educational placements. Michael's parents, Mr. and Mrs. B, agreed to the evaluation because different doctors had told them

14. Like Ken (example 1), Ivan was additionally diagnosed as having Attention Deficit Disorder with Hyperactivity. The written evaluation, which clinicians subsequently sent to the parents, found Ivan to be "functioning significantly below age level in all developmental areas." As with their evaluations of Ken, clinicians stopped short of saying Ivan was actually mentally retarded, and recommended re-evaluation in a year.

15. See the discussion in Waitzkin (1979) concerning the doctor-patient relationship as a micropolitical sphere in which physicians help maintain patterns of domination and subordination characteristic of advanced capitalist societies. They do so through control of information and discourse, using the Western scientific "medical model" to invalidate patients' folk explanations of problems. More recently, Waitzkin (1991:40-1) argues that professional social control is characterized by "unintentionality" — control operates at the edges and margins of discourse, and the analyst must explicate certain kinds of absences in doctor-patient interaction, for it is in these absences and their relation to spoken text that both doctors and their patients become subject to the "grip" of ideology and the consent that it engenders.

what they perceived to be contradictory diagnoses—that Michael was “organic” and that he was “autistic” (which is considered to be a “functional” as opposed to an organic disorder).

At this clinic, a variety of professionals saw and tested Michael and then met with his parents in the informing interview. At one point in the interview, Dr. O, a psychiatrist, says Michael is “well within the criteria” for an autistic diagnosis. While discussing this diagnosis, Mrs. B expresses her relief upon reading a book about autism and finding that Michael’s difficult behaviors were not a result of something she was “doing wrong.” Both Mr. and Mrs. B appear to accept the autistic diagnosis. However, when Dr. O mentions the term “organic,” Mrs. B informs her that another doctor has used this diagnosis, and she asks what it means. Dr. O answers that the guidelines for using the term “organic” are unclear, and then explains how she may decide to use that label:

SEGMENT 3A (II:59:16)

1. Dr. O: . . .if: there’s a really biggie (.) neurologic disease.
2. Ow:kay. And it looks as if the parents are gonna >absolutely<
3. f:reak if I say autistic. Huh HUH! .hh I’ll go organic
4. mental disorder?

Dr. O is portraying the label as variable, subject to parents’ anticipated reactions to the term “autistic.” At the same time, however, she is asserting that both disorders do involve “neurologic disease.” By employing lay terminology here (“really biggie,” line 1; “absolutely freak,” lines 2-3; “I’ll go. . .,” line 3), Dr. O may be working to affiliate with Mr. and Mrs. B. Her outburst of laughter (line 3) invites a light treatment of the depicted situation (“. . . parents are gonna absolutely freak”). It is as if Dr. O is letting Mr. and Mrs. B in on the “secret” that labels are socially constructed, and is thereby suggesting that they are not like those other parents who take labels seriously. Mr. and Mrs. B, however, do nothing that would acknowledge the proffered affiliation; they are silent throughout Dr. O’s turn and at its punchline (lines 3-4).

Dr. O elaborates, saying that the behavior problems involved in autism are “all secondary to what’s wrong with the brain.” Mrs. B offers a contrasting understanding that with autism, “brain waves are normal and there is nothing really wrong with the brain.” Dr. O disagrees with this position and goes on to elaborate Michael’s multiple problems: hypotonia, abnormal EEG, possible seizures, mental retardation, behavioral difficulties “that we call autism,” learning-processing problems, and “variability.” After this listing of symptoms, at a point where they might give some indication of receipt, neither parent does, and Dr. O moves to characterize this group of symptoms as an indication of a brain problem:

SEGMENT 3B (II:1:00:48)

1. Dr. O: All of those things are >symptoms of the fact there’s
2. something the matter with his brai[n].<
3. Mrs. B: [W’ you’re putting organic
4. and autism together aren’t you.
5. Dr. O: M hm.
6. Mrs. B: Well see now on the report doctor Kay said .h he didn’t feel
7. he was autistic he was an orGANic child.=
8. Mr. B: =Yeah zat they were two separate things.

In lines 3-4, Mrs. B produces a formulation of Dr. O’s line of talk, proposing that Dr. O is “putting organic and autism together.” After Dr. O appears to accept this formulation (line 5), Mrs. B again, and in a more insistent tone, cites the “report” in which another doctor submitted that Michael had an organic disorder rather than autism (lines 6-7), and Mr. B agrees with her statement (line 8).

Subsequently, Dr. O advises that the label is not important in itself; it will help Mrs. B fulfill two objectives she has indicated are important: understanding her son and getting him the services that will meet his special needs. Other clinicians present include Ms. L, a speech and language clinician, and Ms. T, from special education.

SEGMENT 3C (II 1:01:12)

1. Dr. O: Yes. .h but:- (.) what I would (.) s:ay go with this. Don't-
2. that's why >you shouldn't get hung up in this
3. [label business.<
4. Mrs. B: [Yeah
5. Dr. O: That's nuts.
6. Mrs. B: N:l[o
7. Dr. O: [It's obvious there's sompin the matter with Michael's
8. brai::n?
9. (1.6)
10. Mrs. B: Right.
11. (1.0)
12. Mrs. B: ((louder)) >That's why I said too. (I js)< let the word throw
13. me >I ws jus< .H read up on it so >like I said I was
14. relieved to know that this< is (.) normal and then I >quit
15. worrying about it really is< .H [if it was or=
16. Dr. O: [If::
17. Mrs. B: =wasn't: you kno[w
18. Dr. O: [Y:eah. >That's right.< So y:ou know there's
19. sompin the matter with his b:rain we try t' tell ya.
20. spec:ific:ally as we ca::n, (.) where his [levels] functions=
21. (Mr. B): [M hm]
22. Dr. O: =are, .hh The literatu::re that will help you get services.
23. (0.7) a-an the literature that will help you unders:ta::nd
24. how he looks (.) .h is the autistic literature.
25. Ms. L: (*quite*)
26. Dr. O: Oka[y?
27. Ms. L: [*That's right*=
28. Mr. B: =hm
29. Dr. O: S::o:: .h I wouldn't argue with do(h)ctor- I'm not >gonna
30. argue with anybody< because he obviously::
31. Mrs. B: We::ll. I [jus didn't know what or]ganic=
32. Dr. O: [It's confusing]
33. Mrs. B: =ya kno:w,
34. Dr. O: Yeah he i:s,
35. (1.0)
36. Mr. B: M[m
37. Mrs. B: [What he was referring to yea.
38. Dr. O: An if:- but if you use the autistic label:: (.) it'll get you
39. services?
40. (1.0)
41. (): Mmm.
42. Dr. O: You know.
43. Ms. T: (Ye:ah) more appropriate to me[et hi]s=
44. (Ms. L): [Mm]
45. Ms. T: =need[s:.
46. Dr. O: [Yes::

After playing down the importance of the label (lines 1-3, 5), Dr. O actively solicits agreement that Michael does have a brain problem. She does this by referring to Michael's problem as "obvious" (line 7), constructing a version of that problem using lay terminology ("sompin the matter with Michael's brai::n?"), and ending her utterance with questioning intonation (lines 7-8). In a variety of ways, this utterance "prefers" (Sacks 1987) an agreeing answer, which Mrs. B provides at line 10. Next, Mrs. B accounts for her reaction to the diagnosis (lines 12-17), saying that the term "organic" was troublesome to her. She references an earlier statement ("like I said," line 13) where she had reported that in her desire to learn more about Michael's problems, she had read some books on autism and discovered that Michael's behavior was "normal" for an autistic child. Dr. O accepts this explanation (line 18) before going on (lines 18-19) to re-reference Michael's problem (using the previous lay terminology). This reference plus a portrayal of the role of the clinic as doing its best to tell specifics about functioning (lines 19-22) reflexively exhibit both the lay-professional relationship in which the parents and clinician are embedded, and the relevance of the clinic's expertise for determining diagnosis and treatment (Maynard 1991a, b). In a typical manner, the clinician exploits this depiction to set up a hospitable environment for the delivery of diagnostic information. That information consists of a recommendation of the autism *literature* as a solution to two needs, getting appropriate services for Michael and helping the parents understand him (lines 22-24).

While another clinician (Ms. L) who is present quietly produces an utterance here (line 25), neither of the parents do, and Dr. O more strongly solicits some response from them (line 26). Ms. L shows agreement (line 27), whereupon Mr. B provides a minimal acknowledgement in line 28. Next, Dr. O refers to another doctor, presumably the doctor who gave the conflicting "organic" diagnosis, and portrays herself as unwilling to argue with him or anyone else (lines 29-30), while acknowledging that the "organic" term does apply (line 34).¹⁶ She does this with *provisional* intonation, elongating the word "is" in a way that suggests there is more to come. After a silence (line 35), a token from Mr. B (line 36), and Mrs. B's extension (line 37) of her prior utterances (lines 31, 33), Dr. O completes her own projected talk (from line 34) in lines 38-39. A gloss of Dr. O's talk might be this: While Michael fits the "organic" diagnosis, the autistic label will result in the appropriate services. This is subordinating a label to the seeking of help.

Thus, in an environment of uncertainty and possible conflict, clinicians may persuasively portray the appropriate label as one that will solve practical problems, not as one that is necessarily technically correct or that is a pristine, objective reflection of the child's abilities and their relation to diagnostic categories. This involves playing down the certainty of labels by revealing the social processes involved in labeling, as in Dr. O's attempts to show that labels are socially constructed and that diagnostic categories are confusing. In subsequently advocating the clinic's alternative "functional" label, the clinician capitalizes on what the parents have already established as a concern—the outcome of this labeling process. Thus, in a way similar to the Retrospective Perspective-Display, the clinician integrates the parents' contribution into a remedial bid for agreement on a label.

In addition, the label appears not only consonant with their perspective but as a *remedy* to their concerns about the outcomes of the diagnostic process. In advocating for outcomes that would help Mrs. B understand her son and get appropriate services, Dr. O advances reasons for selecting a label that are different from a reliance on diagnostic criteria. Again using social process as a resource, Dr. O claims that social outcomes can be manipulated by selecting the "right" label. The final label appears as the *relevant*, if not "correct," solution.

16. In the midst of this, Mrs. B (at lines 31-33) once more provides an account for her prior reaction to the discrepant diagnoses, which Dr. O affirms in line 32 ("It's confusing").

Recipient Resistance to Labels

In the final case we will consider, clinicians use the strategy of Subordinating the Label when a parent, who fears the consequences of any labeling, is resistant. Bea C. is an eight-year-old whose school was having difficulty knowing whether to place her in a class for learning disabled, mentally retarded, or emotionally disturbed children. On the basis of what an intake worker at the clinic summarized as "behavior problems," Bea was currently in a class for the emotionally disturbed. Recently, however, a seizure disorder was diagnosed and treated, and these problems were reported to have decreased substantially.

Additionally, according to the intake worker, Bea's cognitive functioning was at a kindergarten or early first grade level. By the time Bea came to the clinic, the options for her school placement seemed primarily between a class for mental retardation and one for learning disability. Based on their tests, the clinicians arrived at a firm diagnosis of learning disability rather than mental retardation. However, they felt that the learning disability was fairly severe *and* that the mental retardation class at Bea's school, which also had learning disabled students in it, was a good placement for Bea because it was taught by someone who was adept at giving individualized attention of the kind that she needed.

When the special education clinician (Ms. T) informed Mrs. C that they did not think Bea was retarded, Mrs. C also cited her strong opposition to both the "mentally retarded" and "disabled" categories. She reported her fears that any label would lead her to lower her expectations for Bea's performance. After the clinicians described Bea's learning problems, Mrs. C said,

I psyched myself into not accepting her as being retarded because I wanted to be able to keep going forward with her and keep expecting just a little more. And pushing her. So I would never allow myself to think of her as retarded, or disabled. I just felt this was her speed? And this is how fast she could go? So we'll just keep going from there.

The clinic's staff psychologist and Bea's school psychologist continued to pursue the idea that Bea did have problems in school requiring a special program. When Mrs. C readily agreed with this formulation, Ms. T moved toward the delivery of the clinic's diagnosis. As we see in segment 4A, Ms. T again discounts the mental retardation label and then proposes that the learning disabled (LD) diagnosis is a better "match" for Bea (Mr. P is the school psychologist):

SEGMENT 4A (II:15:24)

1. Ms. T: An- part of the reason: that I even (.) brought up (.) the
2. notion (.) that (.) she is not retarded an=
3. Mr. P: =M hm
4. (.)
5. Ms. T: Let's look at that, because unFOrtunately the way public
6. schools are set U::p .h is that tied in:to ge::ting the kind
7. of help that she's going to nee:d (.) from: (.) you know the
8. special classes y' have to go through::gh (.) y' have to call
9. it something.
10. Mrs. C: Khhhh [ha ha h .hhh ha ha h]
11. Ms. T: [Ok(h)a(h)a(h)ay? That's how it works]
12. Mrs. C: .hh Yeah.
13. Ms. T: That's the reality of the situation a[:n]
14. Mr. P: [Ye]ah
15. Ms. T: we fee:l strongly that she needs the extra help.
16. Mrs. C: M:hm?
17. Ms. T: Okay? But we do not think it's appropriate (at) this ti:me
18. (.) to u:se (.) thee: (.) mildly retarded label (.) to get
19. her that help. .h What WE:: s:ee comes cl:oser .h to fitting

20. the profile of a more .h learning (.) disabled (.) child.

21. Mrs. C: M hm

Ms. T presents the learning disabled diagnosis with a show of reluctance. This involves several pieces of her talk. At lines 5-9, she provides an account for having "brought up" the issue of Bea not being retarded: naming the problem is "tied into" getting help for Bea. The marker "unfortunately" (line 5) exhibits dissatisfaction with this state of affairs, and allows Ms. T to disclaim responsibility for the suggestion. Then, the truncated "y'have to go through. . ." (line 8) further portrays the naming process, to which she informally refers ("call it something," lines 8-9), as a requirement for getting help. In short, just as Mrs. C has indicated that she does not want to label Bea, Ms. T makes it sound as if she also would rather not, but is being forced to do so. This device is related to "identifying" (Maynard 1992:349-50), whereby a clinician construes the parents' feelings in regard to a diagnosis, and thereby appears to align with the parents by distancing herself from the very position she is at the same time espousing—i.e., that there is a diagnosis or label.

At this point, Mrs. C responds with laughter (line 10) and, in overlapping this laughter, Ms. T responds similarly, producing an extended "okay" with laughter particles within it (line 11). There is a collusive aspect to their laughing together; it suggests a joint understanding of "how it works" (line 11) and "the reality of the situation" (line 13), which could reinforce Ms. T's alignment with the mother. When Ms. T proceeds to reinvoké the need for help (line 15) and delivers the clinic's diagnosis (lines 17-20), then, it is against this proposed joint or collusive understanding of the situation, or the facts of social structure (Wilson 1991), so to speak. At line 16, Mrs. C acknowledges Ms. T's utterance regarding the need for help and allows for continuation into the news delivery (lines 17-20), which Ms. T forms through once more referencing the use of a label to get Bea special help, and offering "learning disabled" as the better diagnostic fit than "mildly retarded." While hedging about this label (Bea comes "closer" to being learning disabled), Ms. T is still less equivocal than Dr. O in example 3A. However, like Dr. O, Ms. T subordinates the label to the need for help. Together, examples 3 and 4 show this pattern:

- 1) clinician and parent display conflict and uncertainty over the appropriate label, in part because of its consequences for the child;
- 2) the clinician plays down the exactitude of diagnosis (portraying terms as subjective, confusing, or unwanted);
- 3) clinician solicits agreement on an outcome (appropriate help for the child);
- 4) the clinician proposes a label that will result in the desired outcome.

In response to the diagnostic news delivery, Mrs. C provides only a minimal utterance and says nothing beyond this. According to Heath's (1992) study of diagnostic presentations in general practice clinics, this is a regular pattern, as is the clinician then moving on to make recommendations. In this case, in talk not reproduced here, Ms. T claims that the learning disabled label would be justifiable to the school district, and Ms. T tells the school psychologist (Mr. P) that the clinic will write their final report in a way that will support the diagnosis. Mr. P follows with the placement recommendation, first noting the existence of a learning disabled classroom, and then suggesting that "most if not all" of the clinicians and school personnel ". . . agree that that would not provide her enough individual help." He suggests something different:

SEGMENT 4B (II:17:11)

1. Mr. P: So .hh what we have in [name of school] then like I explained
2. () the room is for (.) seVE:RE (.) learning disabled
3. children who ,h Do need more HELp wi[th learn]ing=
4. Mrs. C: [M hm?]
5. Mr. P: =like Bea does and there are some retarded children in there=

6. Mrs. C: =M hm=
 7. Mr. P: =Now she would have her own program just for her [Mrs. C
 8. Mrs. C: [Is thi::s
 9. go:ing [to] make her go backwards.
 10. Mr. P: [()]
 11. Mr. P: N:o. I think that's gonna make her go forward.

While the clinicians deny that this placement would make the child "go backwards," the mother's concern about the outcomes of the placement remains. After Segment 4B, when the clinicians go on to explain that the main feature of this placement would be the individualized attention, and that Bea would be mainstreamed or put in a regular classroom for a part of each day, Mrs. C expanded on her concern, by asking, "She won't go backwards in with the retarded children? She won't try and act like them? It won't go like a backwards step for her?" The clinicians continued in their attempts to reassure the mother that they didn't "see that happening," and stayed with their original recommendation. In the end, Mrs. C went along with the clinic's recommendation, apparently acceding to the argument that the individualized help Bea would receive overshadowed both the label of learning disabled and the placement in a class that contained mentally retarded children.

In previous sections of this paper, we examined diagnostic news deliveries in which clinicians use the fact that a child meets the diagnostic criteria for a developmental disability as an account for the suggested label (examples 1, 2). In this section, it is notable that clinicians also may take an almost opposite strategy. That is, instead of carefully listing symptoms of a diagnosis, submitting that they are characteristic of a child, and thereby implying the relevance of a particular diagnosis, as in the Incomplete Syllogism, clinicians may propose dissolving the relation between symptoms and label to highlight the obtaining of help and services (examples 3, 4). The label is simply a tool toward this end, and the outcome (understanding the disability, obtaining appropriate help) is one the parents have indicated is important to them. Therefore, the label appears to derive as much from the parents' interests and concerns as the clinic's.

Clinicians and parents in our data are as concerned as sociological theorists about the labeling process. They display awareness of the contingent nature of diagnoses and labels, and they recognize the social implications of labels—what they will actually mean for the day-to-day lives of children and their families. Moreover, they appear to enact this social awareness at strategic junctures, such as points where it is relevant to advance or resist the proposal of a label, in the delivery of diagnostic news. In the case of developmental disabilities, it is too strong to characterize clinicians and parents as responding to what they believe are objective stimuli that comprise deviance, and as "masking" this constitutive work (Pollner 1974). More to the point is Gubrium's (1988:32-3) proposal about the "label theorizing" of ordinary actors. As much as professional sociologists, actors in the everyday world can be, and are, labeling theorists in their own right. Put differently, "labeling theory" is a feature of the very circumstances its professional articulation purports to describe. Being aware of social determination and entertaining certain mundane beliefs in symptoms and the like, clinicians and parents appear to take a *strategic* ontological stance toward the reality of the diagnoses and labels they use.

With interview and observational data, ethnographic researchers, including Buckholdt and Gubrium (1985), Darrough (1984), Emerson (1969), Perrucci (1974), and others, have explored how labels are manipulated according to agents' desires to obtain particular treatments for their charges. Indeed, in plea bargaining, a long-recognized practice is that of criminal justice personnel deciding how an offender should be punished and then finding a label appropriate to that disposition (Rosett and Cressey 1976). In our view, however, the collaborative, organized nature of this label manipulation has not been fully appreciated, in part because of the distance even ethnographic research remains from interactional detail. We

find the social process of labeling, as evident in the details of clinician-parent interaction, to be complex and intricate, involving a pattern of conflict, clinicians' playing down the exactitude of diagnosis, their solicitation of agreement regarding the need for help, and in the environment of this agreement, proposing the label.

We do not wish to minimize that these interactional strategies are part of the process of *persuading* parents to allow a label to become part of their child's official record. First, in so carefully involving them in the delivery of a diagnosis, clinicians may be "cooling out" (Goffman 1952) the parents. For example, in using the Perspective-Display Series and discovering only partial agreement between the parents' and clinics' positions, clinicians may incorporate only *limited* aspects of the parents' expressed views in the actual news delivery (Maynard 1991b). Second, we have only alluded to the way in which clinicians help assemble a "documentary reality" (Smith 1974) as they generate their results and report them in letters to the parents and to the schools. An analysis of this "reality," along the lines of Frankel's (1989), Meehan's (1986, 1989a), and Whalen's (in press) studies of how participants assemble organizational records according to the contingencies of social and political contexts and of naturally developing actual interaction, is an avenue of important future research. Our contribution, an initial step in comprehending the overall labeling process, has been to examine actual interaction in the meeting between clinicians and parents, where we see different aspects of social organization than have been theorized or empirically typified. We attempt to analyze practices whereby clinicians deal with and use recipients' perspectives and whereby both participants enter the course of deciding on labels.

Conclusion

The major contribution of labeling theory, the recognition that labels are social constructions, was pivotal for sociology. However, a persistent and pervasive vagueness in propositions about labeling has meant that little is known of the actual process. Theoretical formulations, presuming that social organization lies in the mysterious "black box" relation between abstract categories and interactive products, have overlooked the organization that actors produce in the concreteness of their real, concerted activities (Garfinkel 1988).

It is time to put aside one-dimensional depictions of labelers and labelees, where diagnostic clinicians appear as staunch defenders of the medical model, unaware that labels are socially constructed (Mercer 1973) and in which targets and recipients of labels virtually disappear, as if they had no knowledge of what was happening and operated according to the dictates of those who diagnose. As our investigation shows, clinicians often proceed cautiously when delivering "bad news" to parents whose children are deemed to have developmental disabilities. In asking for parents' views and then confirming them, inviting parents to infer diagnoses rather than stating them outright, bringing their previously-expressed perspectives into current talk, or offering to fulfill their expressed needs for particular social outcomes through the use of labels, clinicians strategically involve parents in the task of labeling. That is, through devices such as the Perspective-Display Series, the Incomplete Syllogism, the Retrospective Perspective-Display, and Subordinating the Label, recipients' responses, in orderly ways, enter into labeling outcomes. Further research probing how this occurs, and to what extent, would correct a deep neglect of the collaboration involved in labeling and the role of recipients especially.¹⁷ Analyzing the social organization of events such as those involving diagnostic news demonstrates how participants, aware of both the

17. Our research concerns professionals working to label individuals who are not present in the interaction. Future research on the actuality of labeling should compare our setting with those in which the recipients of bad news are also the labelees. For examples of ethnographic research of this type in legal settings, see Charmaz (1975) and McClenahan and Lofland (1976).

uncertainties and the exigencies of social contexts, continually operate in concert to shape the trajectory of labeling and children's fates. Often, parents go along with what clinicians declare, but this hardly means that professionals impose something upon passive lay people. If either set of actors lacks anything, it is not sophistication, but rather naivete, with regard to what they are doing and its likely consequences for the child.

We have three final, interrelated points concerning our emphasis on actual interaction and participant-produced social organization. If our findings are empirically informative, they should urge and enable quantitative investigators using aggregate-level data to specify models more carefully, qualitative researchers employing observational techniques to examine interactive events more closely, and both to probe the local structuring of a wide variety of social environments in which "labeling" may be a moment. Second, when all is said and done, professionals and others do apply labels, and some individuals do acquire such labels. If investigators attend to local structuring, this process need not remain mysterious and need not be glossed through the grammar of theoretical statement. Rather, by attending to actual activity and socially organized actions, such as the giving and receiving of bad news in a variety of institutional settings, theorists may be able to formulate propositions that describe the exact mechanisms of label application and acquisition. Third, along lines suggested by Holstein (1993), attention to actual activity means that in addition to examining the effects labeling has on careers of deviance, we need to appreciate just how participants employ labels in orderly ways internal to lay and professional modes of commonsense reasoning and discourse.

Appendix: Transcription Notation

(Adapted from Jefferson 1974)

Yes::	Colons indicate stretching of preceding sound
[]	Square brackets show beginning and ending of overlap in speakers' utterances
(0.5)	Numbers in parentheses are silences in tenths of a second
(.)	Period in parentheses is a very brief silence (less than one-tenth of a second)
((quiet))	Transcriber's comments are enclosed in double parentheses
()	Empty parentheses denote indecipherable utterance
(text)	Text within parentheses is Transcriber's "best guess" as to a speaker's utterance
.	Period indicates downward intonation, not necessarily the end of a sentence
?	Question mark indicates upward intonation, not necessarily a question
.hh	h's with preceding period indicate audible inbreath; the more h's, the longer the inbreath
hh	h's with no preceding period indicate audible outbreath; the more h's, the longer the outbreath
> <	Talk within these symbols is spoken more quickly than surrounding talk
WORD	Upper case indicates especially loud sounds relative to the surrounding talk
<u>every</u>	Underlines indicate parts of words that are stressed
n-	Dash indicates a cut-off of a sound
=	Equal signs indicate no gap between two lines of talk
(h)	Parenthesized "h" indicates plosiveness, often associated with laughter, crying, breathlessness, etc.
Yes	Words, phrases, or utterances between asterisks are spoken softly or in a whisper

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