Doing Staffings

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HUMAN SERVICE PROFESSIONALS are trained and certified to diagnose and treat a wide variety of "troubles" (Emerson and Messinger 1977). Their ranks include psychiatrists, psychologists, counselors, social workers, nurses, and educational specialists. Their work is the subject of volumes of literature dealing with matters such as the causes of select human disturbances, techniques of helping clients, programs for training professionals, and evaluation procedures. This paper takes a look at the work that a variety of human service professionals in two institutions do together in what are called "staffings." Staffings are conferences, common to human service institutions, where professional staff members deliberate over particular aspects of their clients' troubles. The working question deals with how staffers manage the business of making diagnostic and treatment decisions on particular clients and, by so doing, come to have a sense of and orientation to their clients' troubles.

In staffings, different types of service providers attempt to work out their differences concerning what is wrong with clients and to arrive at some reasonable solutions about what to do for them. This, of course, is not an altogether perfunctory task since client troubles are encountered by a variety of professionals who review clients from different perspectives. The differences in perspective are of at least two kinds. One has to do with professional training and commitments. Background assumptions and theoretical preferences vary among disciplines. For example, a psychiatrist may look for deep disturbances in basic personality structures caused by traumas in early family life. A behavioral psychologist, on the other hand, may seek more immediate sources of difficulty such as improper reinforcement, lack of positive feedback, or conflicting expectations for behavior. There are also differences related to the varied organizational contexts in which the staff encounters the client. A special education teacher may report problems in control or discipline in the classroom while a social worker may be more concerned with a deteriorating family or deviant peer group. In a nursing home, a charge nurse may be concerned with managing a difficult patient on the floor while the social worker is interested in how to work the "disoriented" patient into one of her group therapy sessions. A group case worker may be more concerned than a psychiatrist with matters such as kids fighting in residential cottages, their inability to use leisure time constructively, poor eating habits, and other dimensions of group living. Given these differences in professional organizational concerns, the ways in which diverse human service professionals manage the business of meeting together and arriving at some consensus concerning treatment and care becomes an important question.

The Institutions

Fieldwork centering on the social organization of care

and professional practice, respectively, was conducted in two institutions: a nursing home called "Murray Manor" (Gubrium 1975) and a residential treatment center for emotionally disturbed children called "Cedarview" (Buckholdt and Gubrium 1979). Murray Manor is a 360-bed, non-profit, church-related nursing home offering both residential and skilled nursing care. Cedarview is a nonprofit, non-sectarian, residential treatment center that cares for and treats about 60 emotionally disturbed children. The Murray Manor data were gathered over a period of several months of full-time observation in 1973; the Cedarview observations were completed in 1976 after a year of fieldwork. As part of the participant observation undertaken in both settings, numerous patient care conferences or staffings were attended. In the nursing home, regular participants at staffings included nurses, social workers, activity workers, occupational therapists, a pastoral counselor, a dietitian, and the administrator. On occasion, a physician, psychiatrist, physical therapist, or other interested party participated in patient care conferences. Social workers, a psychiatrist, psychologists, teachers, childcare workers, and representatives of the county welfare department regularly attended staffings at the residential treatment center.

Much of the data reported here are excerpts from conversations that took place between participants in the course of staffing a client. Conversations concerning related matters, such as occurred in discussions during breaks in the staffings, were also transcribed. At Murray Manor, staffing conversations were transcribed both by hand and with a tape recorder. At Cedarview, conversations were transcribed by hand, usually by both of us simultaneously. The written transcriptions from Cedarview were later analyzed for consistency and completeness. Comparisons showed that key phrases and conversational themes were being recorded in much the same way. There were, of course, some differences in exact wording in the notes but there was agreement on such matters as the identity of speakers, the order in which they spoke, key phrases, and the major themes and rationales presented in the discussions. The data from staffings at both institutions were supplemented with observations of staffing participants in other settings such as classrooms, cottages (dormitories), individual counseling sessions, recreation, and nursing floors.

Two Images of Staffings

Consider two contrasting images of the work done in staffings. The first, the professional image, represents the formal perspective of those who conduct staffings. While there are obviously many subtle differences of opinion among professional workers along disciplinary, organizational, and more personal lines, we found that they generally agreed on the basic substance and processes which con-

stitute staffings. In attempting to answer the question of how staffings are done by professional participants, however, a second, rather different image of staffings comes through—a constructive image. Both images are integral parts of the ongoing business of conducting staffings, but enter into it in different ways.

THE PROFESSIONAL IMAGE. It is a commonly accepted belief that problems of human deficiency exist within and/or for clients and that these problems can be identified, and more or less successfully treated once they are known. For the aged, the problems involve both declining physical ability and the deterioration of mental capacity, generally referred to as chronic brain syndrome or senility (see Gubrium 1978). For some children, problems may stem from a condition known as emotional disturbance. The symptoms of disturbance are numerous, including lack of impulse control, inability to distinguish right from wrong, aggression against other children, and other behaviors seen as bizarre in varied ways (see Buckholdt and Gubrium 1979). Human service professionals may raise questions, from time to time, over whether a client should really be in the institution when there are few, if any, apparent physical, cognitive, or emotional signs of trouble. In most cases, however, the presence of the person is routinely taken to be an indication of some variety of real, if perhaps hidden problem.

The identification of the precise nature of the problem and the design of remedial intervention is, of course, the job of the professional care provider. Since the problems to be dealt with are complex and multifaceted, it is often considered necessary to employ the skills of several professionals, each of whom works on one or several aspects of the difficulty. For example, certified teachers work to develop the academic skills of emotionally disturbed children. Psychologists devote most of their time to emotional troubles, using clinical interviews and a variety of tests to locate the nature and source of difficulty in areas like self-concept, peer relations, and impulse control. They may be asked to consult on a case of chronic combativeness in an elderly patient in a nursing home. Social workers may concentrate more on the linkages between home and institutional environments as they affect kids and adults. They rely on their training in human dynamics and human relations both to understand how clients and those with whom they associate feel about one another and to intervene in order to establish more positive, healthy relationships.

While the various professionals who work with a client claim some degree of expertise in one or more problem areas, they also recognize and rely on a certain amount of interdependence. A teacher, for example, must deal with more than just academic skills since emotions are presumed to interact with cognitive learning. The teacher relies on the psychologist for understanding the dynamics of emotion and for practical advice on intervention. Social workers ap-

proach teachers and nurses for useful information on the nature and extent of problems and for periodic data concerning positive or negative change. One reason for this interdependence is the common institutional claim for total care. Not only do individual staff members work on problems for which they have specialized training and skills, but they also work together to provide a comprehensive package of care and treatment. Part of this is provided through staffings at which the various staff members who work with a particular client meet together in the service of coordinating care, treatment, assessment, and the like.

While staffing participants recognize problems in their collective work stemming from the variety of professional differences and organizational interests among them, they remain optimistic about the value of staffings. The basic difficulty is believed to be the complexity of the real troubles they face. Complexity justifies teamwork. Each profession possesses one or several pieces of a diagnostic and treatment puzzle. They must work together to arrive at, as they say, "the whole picture" or "the entire story." Collective deliberations, of course, sometimes break down and little of value seems to result. Yet these problems are believed to be rectifiable, in principle, since each participant in a staffing is seen as confronting the same set of concrete troubles. In the professional image, problems in collective deliberation are seen as technical shortcomings. With more experience together in staffings and advances in each of the participating disciplines, collective efforts should become better coordinated and more effective in treating client troubles.

THE CONSTRUCTIVE IMAGE. The focus of the constructive image is quite different. Client troubles as such are secondary to the practical problem of the staff's knowing when and how to treat people, whether kids or adults, as troubled in the first place. Staff itself is center stage in this image—an image that, most tacitly, recognizes that troubles are as much a feature of the practice of providing care as a condition of clients' behavior.

The constructive image is one in which staff on occasion see, but do not commonly notice, that they work as hard at sustaining the realities of troubles and treatments as they do at providing care and therapy to clients. By orienting their routine attention in staffings to the everyday business of diagnosing and treating clients, staff ignore their own contributions to the ostensible realities discovered there. Staff members continually work at making troubles and their varied features available to themselves for consideration in staffings and then deliberate over the troubles as entities in their own right. In the actions and interactions of staffers, the image organizes and makes available to the very same people a wide-ranging, indeed never-ending, body of facts from possible sources of trouble to the progress of clients in treatment.

It is important to note that the constructive image is not merely a sociological observer's image of people. It is people—staff members—themselves who adhere to the view. They show evidence of this in two ways, one tacit and the other explicit. They become exasperated with each other, as well as sociological observers (cf. Garfinkel 1967), when their taken for granted contributions to the world of troubles are unduly opened to question. The constructive image of trouble is, in effect, so obvious a view as to be trivial and without relevance in the business routinely taken to be at hand. The image, in this regard, is a tacit one. On occasion, such as in well-contained asides in the course of an ongoing staffing, the constructive image becomes explicit. For example, in a moment of jest (and insight), a staffer may suggest to other participants that the problem he and his colleagues have "discovered" is really there just because of the way they are choosing to read a kid's or elder's behavior. Such an insight into the dialectical complexity of what is usually accepted as a separation, in principle, between the world of troubles and the world of care and treatment, may be appreciated and agonized over, but then is routinely passed over as the press of business is called into consideration.

The missions of the images are quite different in practice. The professional image makes reasonable the ability of a group of professionals to accurately diagnose and treat human troubles. The merit of professional work is ultimately told in improvements in client condition. The obvious, mostly tacit quality of an ongoing, constructive image of the world generates the everyday affairs of staffings which, in turn, become the obvious objects (troubles, care, and treatment) of business at hand. By means of a kind of ongoing, practical subterfuge, a world of troubled objects is available for deliberation and treatment by people who speak of themselves as knowledgeable in such matters.

Describing Construction

There are two ways in which the general problem of how social life is constructed may be dealt with. One is to focus on the methods that people use to accomplish their everyday affairs, with the aim of ultimately specifying general procedures such as Cicourel's (1970) consideration of "basic rules." (See Chapter Five, "Staffing Children," in Buckholdt and Gubrium 1979, for this approach to doing staffings.) The other is to describe the way the concrete stuff of people's affairs emerges as such (see Douglas and Johnson 1977). In the remainder of this paper, we take the second strategy and describe how staffers construct the various objects of their collective concern in staffings.

In describing the concrete processes by which staff members select aspects of staffings, we trace the ongoing interpretations and negotiations that take place as participants arrive at practical solutions to the varied issues that crop up. Through interpretation and negotiation, they

construct the momentary realities of a staffing. Consider, for example, the definitional problem posed by a boy who has run away from Cedarview. One staffer sees this as an act of defiance while another discovers a hint of developing independence. Running may indicate a reversal in treatment progress or an advance which should be encouraged, but in some less disruptive way. On the other hand, running may be said to have no real relevance to the boy's treatment program since it was simply a spontaneous but foolish act that is not unusual in early adolescence. The real meaning of running, or of any other behavior, is not clear. It remains to be discovered by staffers as they interpret the meaning of the various alternatives offered by participants and negotiate their relative acceptability. One interpretation may be momentarily accepted and then later rejected as new evidence is introduced. In some cases, radical shifts in client status occur in the same staffing as, for example, when a client is said to be making "remarkable progress" at the beginning of a staffing but turns out to be a "hopeless case" at the end.

A wide variety of client matters are available for deliberation. Three rather general concerns about clients that arise in staffings are: locating the source of trouble, determining whether problem behaviors are intentional or inadvertent, and deciding whether a client is making progress in treatment.

Locating the Source of Trouble

Staffers entertain a wide variety of possible sources or causes of client troubles. Sources are often suggested in intake files but, in practice, these are not necessarily accepted as accurate without review or further consideration. They have the status of options, which are evaluated as staff work with clients and carry out their own schemes of testing and review. For emotionally disturbed children, some possible sources of trouble include early childhood trauma, current family problems, neurological or emotional disorders, genetic defects, poor perception, deficient academic skills, and bad social relations. For the aged, senility and other problems generally associated with the aging process may be included with many of the same sources identified for children.

When staffers meet, each may contribute his or her theory of source or cause along with supporting evidence. The group then reviews each suggestion and further arguments are made in defense or opposition. Eventually some decision is made, even if only the decision to not decide on a source at that time, but to gather further evidence. Even when decisions are made, they have an "until further notice" quality (Garfinkel 1967). At the next staffing of the same client, a different source may become the major theme of discussion and, for the moment, may be the real cause. Such shifts may even occur in the same staffing, with one source being accepted for a time, only to be displaced by one or more competitors. In this give and take it is impossible to disentangle the client and whatever problems he or she may have from the practical work of staffers in identifying or discovering problems and their sources. Locating the source of trouble is as much a matter of weighing the facts as a construct of the practice involved.

Consider the location of the source of trouble in the following example taken from Cedarview. The occasion is a special staffing to consider a 13-year-old boy who has become overly aggressive. In attendance are a consulting psychologist, a social worker, a childcare worker, the principal, and the childcare supervisor. The social worker speaks first, after reminding the group that at the last staffing of this boy it was decided that his trouble stemmed from "severe nurturant problems at home and the resulting personality deterioration."

| Social Worker: | He has intense anger which is manifested through withdrawal. |
| Psychologist: | I remember. We figured he was like this because of his punitive background. |

The social worker now describes some of the aggressive episodes which have led to this special meeting.

| Psychologist: | We anticipated that he would come out at some point. Paul Millikin [another psychologist] gave him a complete psychological in 1975 and he reported verbally to me that he is a classic borderline psychotic. |
| Social Worker: | Now that he's entering adolescence his aggression is really coming out. His first year here was a honeymoon but now he's really coming out. |

The social worker describes additional aggressive episodes. He suggests that another reason for their emergence might be a desire to stay at the institution over the weekend since he has heard about how much fun the boys have.

| Psychologist: | Do you think he'd be better off here? |
| Social Worker: | I think not. Peer relations are a problem for him and these relationships are just starting to improve in the neighborhood. |

The childcare supervisor now argues that the mother is the real source of the problem and that if the boy stays in the institution over the weekend, she will never learn to deal with him. The psychologist then asks the boy's childcare worker what she thinks about his going home or staying for the weekend.

| Childcare Worker: | I don't see him ever going home. I think he should be institutionalized. |

Psychologist:	But an institution doesn't teach him much!
Childcare Worker:	What he really needs is structure and an institution can provide that.
Psychologist:	I see . . . but he's been in one since first grade.
Social Worker:	Another problem is his bizarre and aggressive sadomasochistic sexual fantasy.
Psychologist:	Be more specific!

The social worker proceeds to describe the boy's tales about sexual intercourse with his teacher and a horse. He traces the problem to a sexual encounter the boy had with a babysitter when he was nine or ten. Others also comment on some "weird" behavior they have observed.

Psychologist:	It may be that he hasn't learned to be discrete or he may use this to intimidate people.
Principal:	I don't agree. I think he's a real sickie. He can't distinguish reality from fantasy. That's his basic problem, you know.

Participants now engage in an extended discussion about the boy's sexual behavior. Lurid details are requested and presented. Some see it as "not too unusual" for a boy of this age and background while others see it as a sign of real disturbance. The latter maintain that the fantasies will eventually lead to completely maladaptive behavior. Finally, the psychologist offers a brief concluding remark and then introduces a new topic.

Psychologist:	There's no question that his deep structures have been damaged by the early deprivation and violence. How about his classroom work?

The teacher now reports that he has the ability to do good work but his behavior is very disruptive for the class. She describes how he has gotten worse and that old control strategies no longer work.

Social Worker:	I think he is feeling more of a need for security. The control room is the last place he can be secure, so he wants to be there.
Childcare Worker:	He tries to avoid the consequences. He is constantly testing us. That's his problem.

The psychologist now argues that both interpretations may be accurate, depending on the particular situation. He also suggests another source of recent problems, namely, an impending change in social workers. The boy may see this as another rejection in his life and he may be reacting against it. Discussion ensues on whether or not the change should be made. The topic eventually turns to the boy's need for basic nurturance and how this need

has been created from past experiences in the home and at another institution where the boy was locked up for 28 days. The psychologist then concludes the staffing by telling the participants that whatever the source and nature of his problems, the staff can only help by being sensitive to the meaning of particular situations as they encounter the boy on a daily basis. He claims that any or all of these problem sources may operate at one time or another.

At this staffing, held because of recent behavioral problems, several conflicting views are presented on the immediate source of the boy's behavior. At one point the psychologist reports that the boy is a "borderline psychotic." This claim is embellished by the social worker who describes the boy as having "sadomasochistic sexual fantasies" and by the principal who describes him as "a real sickie." Later it is suggested, however, that much of this behavior is really "not too unusual" for an adolescent boy and that the behavior might actually be intended to "test" the staff rather than a direct result of some emotional disturbance. The recent behavior may even be traced to a change in social workers. The psychologist concludes that any or all of these factors may be operating in particular circumstances.

Throughout this particular staffing, there is basic agreement that whatever the immediate sources of current problems, underlying all was early childhood trauma. But even this is questioned at a later staffing. A social worker later claims that the mother is "not so bad once you get to know her" and suggests that the boy's difficulty might be better traced to some neurological difficulty which causes problems in learning and peer relations. Those present agree with this, even though neurological tests had shown no impairment.

Regardless of what the outcome of deliberation over the source of a client's trouble, its practical status is imbedded in two images of what staffers believe they are doing. On the one hand, they see themselves as involved in the very serious business—lighthearted at times, but nonetheless serious—of trying to make sense of what precisely is causing some form of troublesome behavior. They organize the effort around varied bodies of concrete evidence and a gamut of treatment and assessment skills. On the other hand, they also tacitly (but sometimes expressly) see themselves *doing* the business that is reasonable for professionals working with disturbed children. Their task in staffings is to take the business at hand seriously, and not to question the existence of troubles as something real and objectively available to them in their professional capacities. The two images, of course, intertwine in the course of the staffing as one or the other—in the varied attentions and inattentions of the participants—push the proceedings along.

Negotiating Intention

Suspicions about the intentionality of disruptive behavior frequently emerge in staffings. While problems may indeed be the products of emotional disturbance in children or senility among the elderly, it is also suspected that they may be conscious subversions. There was a hint of this in the foregoing staffing when the childcare worker suggested that the boy may be "testing" the staff. Below we present two further examples of the negotiation of intention, the first from the residential treatment center and the second from the nursing home.

A ten-year-old boy had been diagnosed by a pediatric neurologist as having a rare neurological disorder. Its symptoms are facial and other tics, stuttering, uncontrollable throat sounds, and spontaneous swearing. The causes of and treatment for this problem are unknown. However, the condition generally tends to subside in mid-adolescence. Staffers discussed the condition shortly after it was diagnosed. The following is an excerpt from the discussion.

Social Worker:	It's comforting to actually find a real neurological problem. We suspect this sort of thing in a lot of our kids but they [physicians] usually don't find anything.
Childcare Worker:	I only wish there was some cure. Those noises he makes are really irritating. He gets going with the shrieks and swearing and you can't stop it.
Psychologist:	I'm not doubting the doctor but there may be a lot more here than just a neurological problem.
Social Worker:	What do you mean?
Psychologist:	Some of these behaviors may be . . . well . . . sort of planned. He may be using his sickness to control us. I don't doubt that he has some sort of problem, but some of this behavior may not be simply spontaneous or uncontrollable. You know what I mean?
Principal:	I think the same thing. He seems to turn those weird behaviors on and off, you know. If things go his way, he's fine. But when a teacher makes him finish his work or another kid stands up to him, he starts being weird. Really up the wall . . . and he knows it. It scares the kids, even some of the staff, and he knows it.
Childcare Worker:	Yeah. I agree. You can pretty well tell when he's gonna start up. He puts on a lot of it.

Psychologist:	Good. I'm glad you agree. Let's talk about what we can do to control some of these inappropriate behaviors.

As the social worker mentioned, there is no firm diagnosis of neurological impairment in most of the kids, though staff often suspect it. Staffings are replete with speculation about whether a child's behavior is a by-product of a neurological (or emotional) disorder or a deliberate attempt to test or annoy staff and others. However, even when a neurological disorder is firmly diagnosed by a specialist, staff must still work to interpret the meaning of specific behaviors in relation to the diagnosis. Is a specific behavior a consequence of the disorder or is it something else, possibly a calculated strategy used to control others? The "real" meaning of select activities emerges out of the meaning assigned to them on the varied occasions when they become a topic for consideration. Staffers have available to them a large stock of "reasons" for making sense of select actions, only one of which is, in this case, the neurological disorder. That diagnosis does not in any way close the issue of whether a kid is to be considered responsible for his behavior. Such determination is not causal, but practical—sensitive to the acknowledged relevancies referenced by those whose business is currently the intentionality of the kid's actions. While staffers professionally appreciate data about the neurological impairment in the kid being staffed, at the same time they must construct links between the data and "other things to be taken into consideration." Thus, in this sense, the neurological impairment enters staffers' deliberations as both fact and artifact.

Now consider a brief excerpt from a staffing at Murray Manor. Thelma Folsom, an 89-year-old patient, is being staffed to formulate a care plan for dealing with her epilepsy. In attendance are the charge nurse and an LPN from Thelma's floor, the director and assistant director of nursing, the activity director, the pastoral counselor, the occupational therapist, the dietitian, and a social worker.

Thelma's chart has been reviewed and it has been noted that she has a history of epilepsy and occasional minor seizures. Considerable discussion has followed this in which each participant contributed accounts of how the epilepsy affects Thelma's participation in most areas of daily living at the Manor. At one point, however, the LPN takes issue with the pervasiveness of the epilepsy as a cause for Thelma's behavior.

LPN:	Well . . . you know, I'm not so sure about all that . . . I mean about the seizure thing. You all know—you'd all agree, wouldn't you—that Thelma is a very clever little lady? You just can't say "no" to that . . .

No one disagrees.

LPN: I mean, if you remember, Thelma's pretty good at using the seizure thing to get around us. I mean . . . that's the only way I can read it lots of times. She just has her seizure and snaps right out of it when it's convenient.

Activity
Director: Now that you mention it, I guess I've thought that a number of times when I tried to get her to come up for Bingo. I just never paid that much attention to it though.

Pastoral
Counselor: I've seen that sort of thing in a number of patients, here and at other places . . . so, what can we do about it? She does have a history of epilepsy. When do you know it's that [the epilepsy] or just her?

LPN: If you ask me, it's mostly her. I see her on the floor everyday and I think I know her in and out.

For the remainder of the staffing, participants reconsider many of the behaviors discussed earlier and, this time, frame them as possible outcomes of Thelma's clever way of "working the system." The epilepsy is seen in an entirely different way than before. The staffing ends with everyone's agreement to take up a strategy for "dealing" with Thelma at the next staffing.

The staffing as a whole shows that the thrust of the work of evaluating Thelma's behavior is not simply a straightforward matter of considering the information available to participants. Staffers' ability to frame and reframe the intentionality of Thelma's behavior, in practice, serves to reconstitute the relevance of facts about her behavior. Indeed, the new reading of Thelma's seizures contains two different interpretations of the history of Thelma's epilepsy. At the close of the staffing, the director of nursing suggests that the epilepsy is possibly, "all along, just a big con." The assistant director of nursing is more generous in her interpetation of the seizures, as she states, "in the light of what we now know." As she puts it, "The epilepsy is probably in some sort of remission and now Thelma's using it to her advantage."

Negotiating Progress

There are frequent references to improvement or regression in the status of client troubles. Some clients change for the better while others remain the same or even deteriorate. One of the major functions of staffings is to assess change. For those who are doing well, current programming can be maintained, but some modification in treatment may be required for those who are lagging. What this fails to make clear, however, is that there is considerable practical work involved in construing the meaning of progress or regress in individual clients.

Consider the following three examples of the construction of client progress in staffings. The first one occurs at Cedarview. The social worker opens the staffing by describing the circumstances surrounding a boy's admission to the center. He then portrays what he sees as considerable progress in the child since admission. The kid runs away from the center much less frequently, he is in better control of his aggression, his bed-wetting has ceased, he has less anxiety and is in closer touch with reality, he has developed more self-control and trust, he is more patient in difficult situations, and he is better able to express his inner feelings. The consulting psychologist enters the conversation.

Psychologist: How can you tell if his trust is shallow or deep?

Social Worker: He tells you about some problems now. He used to keep in problems, then explode, and then forget it. He was mute. But now he will give you some indication of a problem. Uh . . he'll . . .

Psychologist: Is that good? Of what utility is it to be able to talk about problems?

Social Worker: He's more aware of them.

Psychologist: O.K., as a kind of substitute for exploding. He has learned to pinpoint his problems better. Then others can help him. So it is a progression.

Social Worker: Yes it is!

Psychologist: One problem may be his language difficulty. He is in the slow learner category in language. It's hard to express yourself if you have these verbal problems. [Elaborates]

Principal: We haven't seen much improvement in school. He can't express his reasons for being angry. He still explodes and runs. He doesn't always comprehend what you want from him. He explodes, screams, kicks, but then forgets it ten minutes later. He blocks out the whole thing.

The principal then reports that the boy has been attending a special class in the public schools in the morning. The boy seems to enjoy it and to be doing well. The psychologist asks if that means that the boy can go home soon. The conversation now turns to the mother and her many inadequacies. She is depicted as uncooperative, ineffective, impulsive, seductive, and sexually promiscuous. Several participants now claim that the boy will never make any real progress until the mother cooperates with them.

Psychologist: Has he really made any significant gains here [Cedarview]?

Negative head-shaking all around.

Psychologist: Then why are we thinking of sending him home?

Social Worker: Because we've reached the limits of what we can do.

Principal: I disagree. The outside class will be good for him, but what about the rest of the day? He'll really regress if he goes home. I'm convinced that the only reason we see any progress now is that he's gone part of the day and we don't see him as much.

An extended discussion follows about how they might help the mother and what they might do for the boy in order to achieve "at least some" improvement.

Has this boy improved or not? Notice how this judgment changes as the conversation shifts in context. At the beginning, he is said to have made considerable progress but at the end this is said to be illusory, a function of the staff seeing less of him. Progress or regress takes on its meaning in relation to a shifting background of meanings. As part of both staff's professional and constructive images of their affairs, it is reasonable and obvious that they, of course, attend to the varied contexts of their business together.

The second example is taken from a Murray Manor staffing. In this particular gathering, the patient's progress is construed in the context of at least two different agendas: a physician's assessment of the patient's behavior during examinations, and the nurses' concern with the manageability of the patient. Note how varied accounts are used to make reasonable the disparity of views.

The patient is Cora Kilpatrick, who is being staffed specifically to decide whether she should be transferred from residential care to skilled nursing. The usual complement of professional staff members is in attendance. In addition, a concerned nurse's aide and Cora's private physician have been invited to the staffing. The staffing is more or less aimed at the physician, for he will write the order for whatever action is warranted in Cora's further care.

The staffing begins with the medical review of the patient by one of the nurses. A number of comments are made about specific points in the review, questions and answers concerning Cora's current health, her physical complaints, the medications that she takes, their relative effectiveness, and so on. Her behavioral status then becomes the topic of discussion. According to the charge nurse, Cora has had an unusual number of incidents recently such as falling, sudden lack of steadiness, and bursts of combativeness harmful to others. As a result of the incidents and her general behavior of late, the charge nurse concludes, "We just can't handle her on first [the residential floor] anymore. We just don't have the manpower."

Cora's physician asks to see the incident reports. The director of nursing leaves the room to get them. While she is out, the physician states that he finds it strange that Cora is causing the staff so much trouble since it has been his observation that she is quite steady on her feet, in fact, is comparatively nimble, adding that his observation is based on recent contacts with Cora. Several staff members then respectfully respond that he does not really know what Cora is like in matters of day-to-day living. The aide adds, "Yeah. She's just awful . . . impossible to deal with. She's always runnin' and fallin' all over the place and she really don't know what she's doin' most of the time." The physician listens attentively, accepting the useful information.

Meanwhile, the director of nursing has returned with two incident reports. Taking them, the physician questions in jest, "Only two? From what everyone was saying, I expected to see a stack three feet high." They all laugh, including the director of nursing, who responds, "Oh, there's more. There's more. You better believe it. You can't record everything. You know how it is." The aide confirms this, "We're just too darn busy to fill out one of those forms every time something happens." Cora's physician assures them, "Yeah. I know what you mean."

The physician then reads through the two reports and notes that, in both instances, Cora's "condition before incident" is marked "senile" (rather than "normal," "disoriented," "sedated," or "other"). As before, he asks why she has been diagnosed senile, because his recent observations stand in contrast. Again, several staff members add that Cora is indeed, as they put it, "really confused" and "unrealistic." The aide even suggests that the physician's observations are invalid when she informs him, "I'm not sure if you can count that, doctor, because she really puts on a straight show when someone like you comes around. That's not the real Cora we all know 95% of the time." Again, the physician concludes, "Yes, I see." The director of nursing, in turn, suggests, "Those two incident reports, when you think about it, are just a very small sample of all the things that've been happening with Cora."

As the staffing comes to a close, the administrator addresses the physician, "So we recommend, doctor, that Cora be moved to a skilled nursing floor . . . for her own welfare. What is your opinion on the matter?" The physician answers, "Yes. I think we can do that for the good of all concerned."

Accepting the data recorded on the reports simply as *the* data, it is suggested that what little data available about Cora's mental condition are a small sample representative of a large number of incidents that went unrecorded. The real fact of the matter becomes, as an aide remarked and everyone accepted, Cora is senile "95% of the time."

Subsequent references to Cora's mental condition, in talk and in writing, mention the 95% figure and the incident report data as representative cases. The 95% figure comes to be spoken of as *the* data on Cora and what *the* data show. The general reference takes on a life of its own.

Underpinning the professional perspective on client data is the use, creation, and/or reconstitution of data in practice. The validity of data on clients is subject to considerable negotiation among staffers. For example, staffers may debate the accuracy of a psychological report completed by someone at a consulting clinic. In one case, at Cedarview, a psychological report stated that a boy had normal psychological functioning but that his parents were disturbed. After considerable debate on this report, staffers concluded that the clever boy had fooled the psychologist. His cleverness was then used as evidence for his severe disturbance. In another case, staffers agreed with the conclusion of an intake report that described a client as a borderline psychotic, but they dismissed the evidence used to support this conclusion. The evidence for this diagnosis actually lay elsewhere, according to them.

The validity of data is not self-evident in numbers, charts, graphs, or whatever, but is negotiated and construed in the context of staff discussions. For example, at Cedarview, there is a heavy emphasis on behavior modification. Teachers, social workers, childcare workers, and others are constantly taking counts of one behavior or another. The counts serve as so-called baseline or follow-up measures of a problem prior to, during, and after treatment. The measures are taken to assess treatment effectiveness during and after intervention. In principle, they are believed to be objective measures. Yet during staffings, when counts are reported, this objectivity is often questioned, as seen in the following excerpt from a staffing.

The staffers have been discussing recent changes in a child's behavior. The consulting psychologist asks the teacher to report her counts on fighting.

Teacher:	If you look at this [chart], he is doing pretty well. I've only gotten two fighting episodes each of the past three days. His baseline was twelve, twelve, and fifteen.
Psychologist:	He does seem to be doing better.
Assistant Teacher:	I don't really see the change. He still seems to be fighting a lot. I think he knows when you're counting and lays off. He's really sneaky, ya' know. He punches kids on his way by and we don't see it.
Childcare Worker:	He's still fighting in the cottage. I'm not counting that but I know he's still causing a lot of problems with the rest of the kids. [Elaborates]
Teacher:	Should I change my counts?
Psychologist:	Well, if he hasn't changed much your data should show that.
Teacher:	What should I put, 12 or 15 or so?

Assistant Teacher:	I think 15 would be pretty close for a day.
Teacher:	O.K. 15. [Changes her measures]
Psychologist:	Watch him more closely, when he isn't aware of what you're doing. See if 15 is about right. It may be even higher. The actual number isn't so important as long as we have some reading on changes or trends.

Of course, staffers view discussions like this as part of the process of establishing sound data. It makes good sense to compare data on clients with what staff know from daily experience rather than simply accepting data blindly. If the data are believed to be flawed, staff renew their efforts and revise their procedures for getting at the truth. What they do not routinely recognize is that there are multiple truths or several reasonable ways to interpret data on the progress of each client. Which of these truths wins out, at least temporarily, is as much dependent on sound data as on the dynamics of discussions in staffings. Staffers may literally talk themselves into or out of the validity of one or another set of conclusions despite the balance of data available about a client and the progress in treating his troubles.

Doing Staffings

We have distinguished between two images of the work of staffings; one professional and the other constructive. Both are staffers' images, albeit they are images of different quality. The professional image of the work of staffings is one that portrays staffers as professionals involved in the serious business of deliberating together, as a team, over varied facets of client care and treatment. It is a highly self-conscious image in that it is the body of beliefs about themselves and troubles they deal with, commonly referenced by staffers when asked about their work, its routines, its ideals, and its shortcomings. It is the image they most explicitly reference in the service of improving the quality of their work. It is also the image they speak of in the service of containing the discretion permitted in carrying out their professional obligations.

Staffers also experience and organize their affairs together in relation to a constructive image. It is an altogether more tacit image of what they do than the professional one. It is tacit in the sense that it does not enter into their affairs as the usual object of their deliberations. Rather, the constructive image is what "everybody knows you do" when one is doing anything that is ostensibly meant to be one activity rather than another, in this case, a staffing as opposed to another matter.

What does the distinction between the professional and constructive image tell us about what the human service

professionals involved in the foregoing staffings are doing? First, it tells us that there is a limit to the degree that professional ideals of care planning and application may be realized. The limit is rather different than the one often referenced by professional spokesmen; namely, the belief that technical shortcomings (e.g., inaccurate data, incompetent service providers, recalcitrant clients) are what prevent the realization of ideals. Rather, the limit is that any model, idea, plan, or whatever, cannot completely specify the rules or guidelines necessary for substantive action in practical circumstances—circumstances whose very meanings emerge with shifts in the attentions, reflections, and dialog of those who participate in them. To a certain extent, what staffers are doing in the various examples is reading behavior and appreciating clients *in the service* of a professional image of their activity. The professional image, as such, does not inform them how to do this. What we have tried to emphasize in the foregoing descriptions is staffers' constructive contribution to the very objects of their professional considerations.

Second, the distinction tells us that it is staffers' capacities as everyday actors in the world that makes the work of staffings a reasonable thing for them to do. This suggests that to the extent anyone possesses a working, constructive image of everyday life, he too can do staffings, save for the knowledge of some professional language with its terminology, kinds of explanations, and body of acceptable caveats. In this sense, what it means to be doing professional work like staffing a patient is to be *using* the language, not just putting the language to use.

Third, the distinction tells us something about how staffers create unity out of diversity. We have seen how a variety of professional orientations and organizational interests enter the deliberations of staffings. According to the professional image, the variety serves to enrich the search for solutions to client troubles by allowing a wide range of expertise and experience to share in the task. In this view, the staffing organizes specialists in the service of common goals: assessment, care, and treatment. The constructive image casts a rather different light on the problem of creating unity out of diversity. The image suggests that staffers literally create unity out of diversity. What comes to be seen by them and presented in reports to others as "the final, concrete facts of a case" are not innocent of staffers' constructions. Indeed, troubles and treatment are as much an artifact of staffers' deliberations as they are its topics. It is staffers' basic competence in doing everyday affairs like staffings that makes available to them and others "what the real trouble or most effective treatment was, all along"—at least, for all practical purposes (Garfinkel 1967).

Fourth and finally, the distinction tells us that to understand what goes on in staffings and to insightfully appreciate the by-products of staffings (e.g., treatment reports and statistics) as an observer of such everyday scenes, one must be willing to see and, of course, look at staffers in both their claimed and assumed capacities. When staffings are seen in this fashion, the stuff of human service provision becomes, at once, as much the folly of remedies as of troubles.

REFERENCES CITED

Buckholdt, David R., and Jaber F. Gubrium
1979 Caretakers: Treating Emotionally Disturbed Children. Beverly Hills, Calif.: Sage Publications.
Cicourel, Aaron V.
1970 Basic and Normative Rules in the Negotiation of Status and Role. *In* Recent Sociology No. 2, Hans Peter Dreitzel, ed. Pp. 4–45. New York: Collier-Macmillan.
Douglas, Jack D., and John M. Johnson, eds.
1977 Existential Sociology. New York: Cambridge University Press.
Emerson, Robert M., and Sheldon L. Messinger
1977 The Micro-Politics of Trouble. Social Problems 25(2): 121–34.
Garfinkel, Harold
1967 Studies in Ethnomethodology. Englewood Cliffs, NJ: Prentice-Hall.
Gubrium, Jaber F.
1975 Living and Dying at Murray Manor. New York: St. Martin's.
1978 Notes on the Social Organization of Senility. Urban Life 7(1):23–44.

1980 and 1981 Annual Meetings
Society for Applied Anthropology

The 1980 Annual Meeting of the Society for Applied Anthropology will convene March 19–23, 1980 in the Denver Hilton Hotel, Denver, Colorado. Program chair is Dorothea Theodoratus, California State University, Sacramento, California 95819. Phone (916)961-7325. Deadline for program proposals is November 20, 1979.

The 1981 Annual Meeting of the Society for Applied Anthropology will be held April 14–17, 1981 in Edinburgh. Program chair is Dr. Joseph Kaufert, Faculty of Medicine, University of Manitoba, Winnipeg, Canada R3E OW3. Phone (204)786-3798. Deadlines for program proposals and other details will be forthcoming later.