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# How the Group Home Works:
# Everyday Knowledge and Authority in a Community-based Services Setting

by

Jack Levinson

A dissertation submitted to the Graduate Faculty in Sociology in partial fulfillment of the requirements for the degree of Doctor of Philosophy, The City University of New York.

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## Abstract

**How the Group Home Works:**
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Adviser: Professor David Goode

This dissertation is a study of the everyday practice of freedom and authority based on more than a year of participant-observation in a group home for adults with cognitive disability (mental retardation). Group homes emerged in the 1970s as the alternative to custodial institutions, ideally to provide services to individuals with disability not as inmates, but as citizens with rights. For this reason, the research site is not approached in the familiar way as a setting of social control, but as an emblematic, if unnoticed, example of the fundamental tension in liberal societies between authority and individual freedom. The dissertation draws on sociological traditions that treat organizational participation and commitment as a dilemma of liberal freedom rather than simply a problem of power and control. The focus of the study is how the inherent, ongoing tension between authority and freedom is managed in the group home through the government of residents. Government refers to the systematic attempt to shape the kinds of conduct that enable individuals to govern themselves, including individuals whose capacities for freedom are

always potentially in question.

Given the continuous and skillful activity this involves, the self-government of residents is treated as a kind of *work*, and the group home as a *workplace* in different ways. Michael Lipsky's concept of "street-level bureaucracy" is used to understand the organizational features that shape counselor work. The work residents do to "become more independent" is understood in terms of Nikolas Rose's analysis of the role psychological knowledge plays in contemporary practices of government. The competent participation of residents involves the endless clinical work they must do on themselves. Everyday life itself is approached as a third kind of work, an ethnomethodological notion with particular significance in this project for the study of cognitive disability. Authority and knowledge are observed in the everyday work that organizes the group home as a site of governmentality: staff meeting discussions, the role of records and written documents, individual clinical plans, and the know-how of residents and counselors. By showing how the group home works, the dissertation provides a new conception of the group home as it reflects broader ethical practices, and suggests, finally, that the work residents do to become more independent is not so very different from the way many individuals in contemporary society govern themselves.

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I am grateful to a number of other CUNY faculty: Phil Kasinitz and Julia Wrigley always helped me navigate CUNY's treacherous bureaucratic terrain with good humor and unwavering support along the way. Dean Savage has been a constant and comforting source of wisdom and advice. I owe many thanks to Charles Winick for introducing me to the social study of drug use and treatment. I pursued this interest with Harry Levine, John Morgan, and Lynn Zimmer, and though this dissertation has taken me elsewhere, it addresses many of the questions they helped me pose. To Lynn, especially, I owe a great personal as well as professional debt. Cynthia Fuchs Epstein taught me about the courage of conviction when we first worked together on department committees, and I am grateful to her for the many hours of vigorous conversation since. My thanks also to Patricia Clough for her continued interest and assistance.

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Finally, many thanks to my parents, Bob and Helene Levinson, for all their encouragement and support.

*This dissertation is dedicated to the memory of my uncle,*
*Martin J. Price.*

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# Chapter 1
## The group home as a site of governmentality

> . . . the citizen is construed and addressed as a subject actively engaged in thinking, wanting, feeling and doing, interacting with others in terms of . . . psychological forces. . . In the family, the factory, and the expanding systems of counseling and therapy, the vocabularies of mental hygiene, group relations, and psychodynamics are translated into techniques of self-inspection and self-rectification. These techniques are taught by teachers, managers, health visitors, social workers, and doctors. Through the pronouncement of experts in print, on television, in radio phone-ins, they are woven into the fabric of our everyday experience, our aspirations and dissatisfactions. Through our attachment to such technologies of the self, we are governed by our active engagement in the search for a form of existence that is at once personally fulfilling and beneficial to our families, our communities, and the collective well-being of the nation.[1]

## I. THE PROBLEM

This dissertation investigates the nature of liberal authority in a group home for adults with cognitive disability.[2] This is an ideal setting for such an inquiry because the

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1. Nikolas Rose, *Inventing Ourselves: Psychology Power and Personhood* (1996a:78)

2. Cognitive disability is in some ways an arbitrary choice of terms. Mental retardation remains the official term in much of the international English language research but is increasingly unacceptable in service, policy and political contexts in the United States. The United Kingdom, the Scandinavian countries, and others, have already abandoned the use of mental retardation in favor of more general categories like "learning difficulties" or "learning disabilities." I do not use mental retardation because I agree with the criticisms offered by critical professionals and self-advocates, themselves categorized in this way, that it represents disability as a clinical problem and more or less uniform "condition." The psychiatric association with the term "mental" also conjures an unfortunate institutional and cultural history. By choosing cognitive disability, I attempt to avoid a professional perspective. I have also chosen it over the term currently favored by self-advocates and critical researchers: intellectual disability. Cognitive disability does not reflect as sharply the current controversies about diagnostic classification and labeling. These are not unimportant concerns, but they are not central to this dissertation, at least not directly. Finally, it is important to note that, in this dissertation, cognitive disability functions only as a shorthand for a kind of person - historically, in an abstract sense, as well as sociologically, in the group home research site - and does not refer to any specifiable biological, cognitive, or developmental condition or state.

fundamental objective of the group home is to provide services to individuals as citizens in the community and not as inmates. Facilities of this kind emerged in the 1970s as the alternative to the egregious abuses and control in large, segregated institutions. The group home is thus an exemplary, if unnoticed, setting of liberal authority, and this dissertation shows how even the supervision of individuals deemed incapable of living on their own depends on their capacity for consent and participation.

The group home is organized by a tension fundamental in liberal society between authority and individual freedom that is managed by governing the residents. By government, I refer to the specific way the liberal practice of authority generally depends on the consent and participation of the governed. In the group home this involves the cultivation of specific capacities that enable individuals to govern themselves as residents. This occurs largely as a matter of clinical practice and reflects the central role of psychology in the community integration of cognitive disability. Since the 1970s, the dilemma of freedom posed by providing services in the community has been defined, and managed, as a specifically clinical problem of individuals. The group home can be seen thus as a setting organized to provide supervision and, at the same time, to promote the independence of its residents. Residents are governed through the ongoing clinical efforts they undertake themselves to promote and encourage their own independence.

To suggest that the group home is a site of governmentality, and thus representative of liberal authority, is not to deny the unique and brutal history of abuse suffered by individuals who have been considered cognitively disabled. Nor does this analysis deny the persistence of coercive control in community-based services.

Community-based residential services have in general not delivered on their promise of rights and integration. This has been a central theme in social research, which typically treats current services as a new form of domination, one that has only replaced the brutal coercion of institutional life with the normative control of expertise. I pose a different question about the nature of authority in the group home, one that does not focus on the distance between actual practice and the rhetoric of rights and choice. I do not approach the setting as an instance of the general failures of community-based services and do not evaluate services in the research site.

Cognitive disability provides an unlikely arena for the analysis of governmentality. Although the situated and social character of cognitive disability has long been demonstrated in social research and is reflected, more or less, in policy and services, prevailing cultural assumptions still imply that a diagnosis is equal to overall incompetence or inability. Effective government, however, depends on the capacities of individuals to govern themselves and this dissertation shows how this is no less true in the group home.

This dissertation is based on thirteen months of field research in which I approached the question of authority and professional knowledge as everyday practical matters. Clinical knowledge is not treated either as a tool or ideological mask for social control but as an available practical resource that is an organizing feature of the setting. The analysis shows how the inherent tension between authority and freedom is managed in the group home through the routine practice of government.

This dissertation brings together three different sociological approaches. Two will be discussed in this chapter: the analysis of governmentality, which emphasizes the

historically unique character of authority in liberal society, and ethnomethodology, which informs my study of everyday life in the group home. The third approach, sociology of work and organizations, will be introduced in Part I of the dissertation.

In contrast to other practices of ruling, liberal authority is indirect because it takes into account the liberty of individuals and the limits of state and professional authority. It therefore depends on the capacities of individual citizens to govern themselves in specific ways that are beneficial both to themselves and to the society at large. I draw on ethnomethodology to approach authority, knowledge and conduct in the group home as practical matters of everyday organization and not as theoretical problems to be corroborated by empirical observation. This dissertation is not an ethnomethodological study but uses some of its phenomenological and methodological insights to show in detail how residents actually govern themselves everyday. There is a challenging and fruitful fit between ethnomethodology and the analysis of government, which I describe later in this chapter.

Sociology of work and organizations will be introduced in the introduction to Part I. For the moment, what can be said is that treating the group home as a workplace uses a model of organizational participation and commitment which does not necessarily focus on the question of power. Given the level of activity it involves, I have chosen to treat the self-government of residents as a kind of work. The group home is therefore a workplace that depends on the work both residents and counselors do to govern themselves.

## II. COGNITIVE DISABILITY

It is only until recently that the consignment of individuals with cognitive disability to large, segregated, custodial institutions was the virtual consensus among professionals. In the early 1970s, several widely publicized scandals about brutal conditions, especially at the Willowbrook State School in New York City, galvanized the movement to close the institutions for good. Also during this period, a series of landmark judicial decisions held that individuals with cognitive disability had specific rights that were being denied by their institutional care.[3] Although these decisions established new standards for services, the process of deinstitutionalization grinds on still, with more than 50,000 individuals, in 47 states, living in institutional settings in 1998 (Braddock and Goode).

### Historical background

James Trent (1994) argues, in his history of mental retardation in America, that large, segregated, custodial institutions became the primary site of treatment and education after the Civil War for reasons that had as much to do with the professionalization of medicine and fiscal constraint as with conceptions of disability. The moral treatment and educational approaches that dominated the first half of the nineteenth century were abandoned largely because medicine's claim to authority over disability was

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3. Among the most significant: *Wyatt v. Stickney* (1972) found the right to treatment and habilitation in the least restrictive environment, and *Halderman v. Pennhurst State School* (1974) found that habilitation is the only justifiable basis of commitment. As a result of a court action begun in 1972, the Willowbrook Consent Decree was signed in 1975 by New York's Governor Carey. It established a timetable for closing institutions, the right to treatment, provision of normal living environments, and a number of safeguards against the further abuse of former inmates.

successful in the economic and political conditions of Reconstruction America. It was not long before medical "treatment" in institutions slipped into the practice of custodial "care" that now appears finally to be ending. Rapid expansion of the institutions in the 1860s and 1870s was justified by the rising influence of eugenics, which associated "feeble-mindedness" with moral depravity and criminality, and generated public fear of individuals with disability. By the 1920s, an emphasis on social adjustment and adaptation, drawn from the mental hygiene movement, was supplanting the moral concerns of eugenics. Eclipsed by the Depression, however, this was only a short-lived resurgence of interest in community integration. After the Second World War, institutional care again dominated the professional approach to disability until the mid-sixties. The successful expansion of institutions during this period, as in the 1860s and 1870s, reflected the "mutually profitable relationship between . . . the state" and those professional fields competing for authority over this domain of disability (Foster 1987:16).

Foster and Trent both emphasize the role of professional authority and professionalization in changing approaches to and conceptions of disability. Although after the War medicine once again consolidated its authority over what was then called "mental deficiency," now in the form of psychiatry, it was during this same period that psychology gradually began to establish control. Its success was marked in 1959, by the adoption of a new classification, "mental retardation," which added a behavioral component to the use of IQ scores, the sole basis of diagnosis for decades.[4] Medicine had

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4. Since 1970, the diagnostic classification of mental retardation has changed several times, each representing further elaboration of the behavioral and adaptive component. The American Association of Mental Retardation's 2002 definition is:

been at the helm since the 1860s, but by 1960, as Trent reports, 60 percent of the membership of the American Association of Mental Deficiency was comprised of psychologists and educators (Trent, 244). Trent points out the irony that institutions expanded rapidly after 1950 despite emerging calls for integration and criticism of their conditions. "By 1970, 75 percent of the public facilities housing mentally retarded people had been built after 1950" (Trent, 238).

More humane attitudes emerged from other quarters in the 1950s. The development of a parent movement, which would be a crucial force in deinstitutionalization, called for special education and employment training in the community, as well as family involvement in the institutions. The publicity of disability experiences in well-known families, books by Pearl Buck and Dale Evans among the first, began to change popular perceptions. In retrospect, this literature and the new parent associations ironically functioned to help educated middle-class families rationalize institutionalization as an option. The disclosures by famous parents meant "there could be

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Mental retardation is a disability characterized by significant limitations both in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. This disability originates before the age of 18. A complete and accurate understanding of mental retardation involves realizing that mental retardation refers to a particular state of functioning that begins in childhood, has many dimensions, and is affected positively by individualized supports. As a model of functioning, it includes the contexts and environment within which the person functions and interacts and requires a multidimensional and ecological approach that reflects the interaction of the individual with the environment, and the outcomes of that interaction with regards to independence, relationships, societal contributions, participation in school and community, and personal well being.

no shame in placing a retarded child in a public facility"(Trent, 238).[5] One reason the institutional population began to swell by the mid-fifties was the inclusion of well off children for the first time since the before the First World War (Trent, 238).

In the 1950s, the institution "survived by redefining itself," which served to increase the power of the state and professional authority over disability (Foster 1987:12). The institution extended itself into the community through special education in schools and a "network of social welfare and mental health systems . . . dominat[ing] the reform measures" in these areas, and establishing itself as their "locus of control" (Foster 1987:13). By the mid-1960s, as happened a century earlier, federal funds for constructing institutions were not followed by support for upkeep. Left to the states, the result was the deterioration of already terrible conditions, and by the end of the decade the drain on state budgets contributed to the mounting criticism of institutional care (Trent, 252). What had started earlier among parents and some professionals as a call for institutional reform, became a charge "that no innovation could alter the fundamentally custodial and abusive nature of these facilities" (Foster 1987:13). In the context of popular movements for civil rights and challenges to the authority of expertise in the 1960s, the deinstitutionalization movement gathered steam.

Community-based services have been consistently criticized for their overall failure to fulfill the promises of rights and integration that were first made some thirty years ago. The 1972 Willowbrook scandal and the courts set in motion a process that may not yet be

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5. The Kennedy family did not divulge the secret of Rosemary until 1962, although the Joseph P. Kennedy, Jr. Foundation was founded in 1946 to support research and treatment, if not advocacy, for mental retardation (Trent, 246).

complete, nor even especially successful, but which has nonetheless transformed utterly the concept and practice of cognitive disability. Part of this transformation has been the proliferation of forms of services in the community, such as the group home research site, that claim to promote and encourage independence.

**The principle of normalization and the sociological approach to competence**

In the early 1970s, "normalization" emerged as the dominant perspective in the effort to close institutions and integrate individuals with intellectual disability. Disability professionals drew upon interactionism, labeling theory and, in particular, on Goffman's *Asylums* (1961) and *Stigma* (1963) to argue that behavior often associated with disability is actually produced by the cruel distortions of institutional life. Normalization provided both a criticism of the institutions as well as the central paradigm for services in the community.

The idea was imported from Scandinavia by Wolf Wolfensberger, a psychologist and central figure in the movement for community integration. In his landmark 1972 book, *The Principle of Normalization in Human Services*, he describes normalization as the "utilization of means which are as culturally normative as possible, in order to establish and/or maintain personal behaviors and characteristics which are as culturally normative as possible" (1972:28). Through the 1970s, the service implementation of normalization generally involved a focus on the individual skills that would enable participation in community life. Although normalization provided a justification for smaller facilities, they often managed only to provide services that were limited or in outright contradiction to

integration. However uneven the implementation, Trent accounts for the widespread influence of normalization in terms of the way it provided both an "intellectual rationale [and] a moral grounding" for community integration (264). In fact, Wolfensberger intended the approach to extend "beyond mental retardation to deviancy and human management in general" (Wolfensberger 1972:27). Normalization not only provided a sociological vision of services, but of the very nature of community, defined by the capacity for inclusion and not by fear (Trent, 263).

It was not only that normalization provided disability professionals with an approach based on sociological perspectives like labeling and interactionism, social researchers also played a substantial role in the movement for community integration. Several studies demonstrated that competence is situated, laying the groundwork for a social rather than professional model of cognitive disability as individual pathology. Robert Edgerton's *The Cloak of Competence* (1967) was a study of people who had been tracked from special education classes into institutions and then released as adults during the 1950s. Outside the sphere of disability services, they were as capable of living independently as others with the same socio-economic indicators, even if they depended on certain kinds of assistance from spouses and friends. "Community adjustment" had been the chief concern of researchers and disability professionals since the 1920s. However, Edgerton's analysis of how the experience and management of stigma organized everyday life for his subjects, and his use of field observation and unstructured interviewing, established competence and, therefore, professional approaches to disability as areas of social inquiry.

In the early 1970s, other researchers also demonstrated the situated character of competence in order to question professional authority over disability and institutionalization. Henschel (1972) showed, in a qualitative study of individuals living in the community, that sociological variables such as ethnicity, marital status, and sex were greater predictors of life experience than the results of mental testing, especially IQ scores. Braginsky and Braginsky (1971) argued for abandoning the diagnostic category of mental retardation as a "crude metaphor" that only justifies incarceration (29). In their comparative study of children in institutions and in schools, they showed that mental retardation reflected few biological features, but was merely "a labeling process . . . a function of a social order" (29) that "structures deviance" (167). It was only through the "mythical power" of mental testing, which experts "refuse to reject," that mental retardation could become "objective" (14). The Braginskys used Goffman's notion of "impression management" to describe the children's different behavior in each setting in order to undermine the professional claim for institutionalization. Similarly, Mercer (1972) demonstrated the futility of mental testing and, in a limited way, of the category of mental retardation. In her study of children, both in an institution and the community, she contrasted these settings as clinical and social "systems" to show that mental retardation is an "achieved status." Mercer criticized the use of a statistical conception of normal to explain biological difference, describing behavioral differences as features of each system to demonstrate how the constitution of normal "depends on system specific role performance, conformity and expectations" (22).

In the late 1970s and 1980s, the focus of critical disability professionals and social

researchers shifted to community-based services. One area of criticism has been the persistence of a professional agenda and the institutional character of service settings despite the rhetoric of rights and normalization.[6] A related theme has been the experience and point of view of individuals with disability. This reflects the criticism of professional perspectives as well as recent concerns with the ethics and authority of social inquiry in general. Researchers have investigated how various methodological approaches enable them to capture the perspective of individuals with disability and to show what kind of knowledge and experience is lost in professional approaches: ethnomethodology (Goode 1994; Pollner and Goode 1990); ethnography (Angrosino 1997b); life-history (Bogdan and Taylor 1982; Langness and Levine 1986); action-research (Stalker 1998); and phenomenological sociology (Jacobs 1980).

Through the 1980s and 1990s, a broader intellectual context for this research has emerged in the interdisciplinary field of disability studies, which argues for the significance of disability as a fundamental category of social experience and analysis.[7] Ferguson, Ferguson and Taylor's (1992) edited collection emphasizes how qualitative and interpretive approaches are most suitable to the particular challenges and innovations posed by the study of disability. Linton (1998) argues that disability studies is distinguished by its guiding commitment to a social model, which does not emphasize

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6. Bercovici (1983); Copp (1988a); Davies and Jenkins (1997); Evans (1983); Foster (1987); Gleason (1989); Goode and Waksler (1990); Goodley (2001); Heshusius (1982); Johnson (1998); Kielhofner (1983); Kliewer and Drake (1998); Myers et al.(1998); Rose-Ackerman (1999); Stroman (1989); Taylor (2001); Taylor, Bogdan, and Lutfiyya (1995); Wing (1989); Young and Quibell (2000).

7. Some important examples include the interdisciplinary reader edited by Davis (1993); Davis (1995); Linton (1998); and Oliver (1996).

individual impairment but the cultural, economic and spatial determination or construction of experience. The individual model is presumed by the legal focus on accommodation to or discrimination against particular individuals; and clinical approaches often regard physical, mental and cognitive difference as individual pathology. Critical research on cognitive disability intersects with disability studies in the concerns about stigma, continued segregation, and the critique of individual and professional models of disability.[8]

**Beyond normalization**

Despite normalization's impact on community integration, not-for-profit agencies were at the helm of a massive expansion in the 1980s of community-based services "systems." These have been criticized as inattentive to individual needs, still more or less segregated, and characterized by complex and burdensome regulatory and professional requirements (McKnight 1980; Wolfensberger 1989). The meaning and implementation of normalization has also always been in contention (Brown and Smith 1992; Wolfensberger 1995). Many professionals have argued that it provides an ideological vision but no practical clinical or administrative plan for services. Many researchers, whose initial commitment to integration was shaped by normalization, have long criticized its emphasis on assimilation rather than broader cultural change. They argue that normalization, despite claims for integration, has amounted to the enforcement of normative values at the

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8. Angrosino (1997a, 1992); Baroff (1999); Bogdan and Taylor (1996, 1989, 1987); Danforth and Navarro (1998); Devlieger (1999); Dowse (2001); Dudley (1983); Ferguson, P. (1987); Gillman et al (2000).; Goode and Ellis (1991); Radford (1994); Rapley et al. (1998); Simpson (1995); Stockholder (1994); Taylor (2000); Woodill (1994).

expense of both broader political concerns as well as individual difference. Normalization has also been criticized for its specifically psychological focus on the individual. Simpson (1996) argues that psychologists endorsed normalization in the early 1970s because it provided a political discourse that could reconcile the individual orientation of behaviorism with the sociological critique of institutions.

Although a small debate continues about the suitability of institutional over community services, the closing of large-scale settings has continued unimpeded, if slowly and unevenly, since the 1970s (Taylor 2001). Individuals with disabilities, family and parent associations, and professionals all largely endorse living and receiving services in the community as a fundamental right and a humane approach. However, some researchers suggest that even supporters of integration do not adequately question the current state of affairs. Myers et al. (1998) conclude that research often unwittingly affirms a narrow service-oriented conception of integration, measured, for example, only by the frequency of activities. They argue this perpetuates segregation in the community and takes for granted the assumption of normalization that conformity is desirable in itself. For others, this criticism represents a "simplistic" understanding of Wolfensberger's arguments (Smith and Brown 1992).[9] However, such criticisms of normalization fit with the changing political context and direction of services. The interest in the category of

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9. Wolfensberger (1995) himself addressed the confusion about whether the point of normalization was to change individuals or to change the community. He abandoned the term normalization in 1983 for "social role valorization," commonly referred to as SRV, which emphasizes the diversity and mutual interdependence of roles that define community. SRV is a human service practice that aims to counter the effects of "devalued roles," and calls for a transformation of values to encourage mutual support as the organic basis of community.

identity that emerged fully in the 1980s and the persistent failure of systems-focused services raised questions about the importance of individual difference over normative standards of conduct, be they embodied in broader cultural values or in clinical practice.

The concept of the continuum of services, initially a central aspect of normalization, is another cornerstone of the deinstitutionalization and community-based services movements that some now criticize as a professional agenda. One of the first major court decisions, *Wyatt v. Stickney* (1972), found a constitutional right to treatment in the "least restrictive environment." The notion of a "least restrictive environment" presumes the organization of services along a continuum, from the most restrictive (characterized by more intensive services) to the least restrictive (characterized by greater individual autonomy). Previously, diagnosis simply meant institutionalization. Now, individuals are located along the continuum of services ideally on the basis of their specific needs. Taylor (2001) argues that although "least restrictive environment" has provided a standard for more individualized services, it has never been clearly defined. He points out that more restrictive environments have historically provided fewer services, as in the case of institutions. In practice, the standard is established on a professional basis that "confuses segregation, on the one hand, with intensity of services on the other" (19). Thus the continuum model sanctions the curtailment of basic rights in a way that makes the need for services analogous to the commitment of a crime: "The question implied by the least restrictive environment continuum is not *whether* the rights of people should be restricted, but *to what extent*" (20). As a "readiness" model, Taylor argues, individuals must "earn" the right to move to a less restrictive environment, which establishes

institutional "rhythms and routines" that are "fundamentally different than ordinary community life" (21).

Although normalization and the notion of the continuum together provided an approach to services that grappled with the problem of individual need, integration has taken shape in professionally oriented service practice, largely at the expense of the unique needs and participation of recipients. The criticism of professional authority in social research remains, but there is also now a concern with autonomy, self-determination, and "quality of life." Researchers are attempting to define and gauge the capacity for autonomy and self-determination of individuals whose services emphasize their participation and choice (Jahoda and Cattermole 1995; Barron, K. 2001; Treece et al.1999; Wehmeyer and Schwartz 1998). "Quality of life" has been suggested as a possible alternative conception of support (rather than services) in the community that balances the knowledge of professionals with the personal knowledge and desires of individuals with disability (Goode 1994).

The focus on the autonomy and self-determination of individuals with disability is accompanied by criticisms of some of the liberal assumptions about integration. Like normalization, rights-based approaches are criticized for not addressing the social and cultural contexts that narrowly define disability only as an individual matter. The notion of rights has been challenged as too "negative" and individualist for effective political organizing among people with intellectual disability (Young and Quibell 2000). Similarly, critics argue that contemporary conceptions of rights in Anglophone policy and legislation reflect an individual model of disability (Barnes and Oliver 1995; Chadwick 1996).

These arguments about the conception of rights in policy, legislation and political organizing are beyond the scope of this dissertation. It is worth noting, however, that as criticisms of liberalism they reflect the complex dilemma between authority and freedom that is at the heart of this project. This dilemma is reflected in another way in the social model of disability, which has long been the basis for challenges to the professional fields that rely on and preserve an individual model. At the same time, the social model has shown how these fields have also justified the subordination of individual differences and the curtailment of rights. These criticisms have actually had some influence and attempts to develop more individualized services are now a more or less mainstream concern.[10]

In sum, the very idea of community integration presumes the legal personhood of individuals with intellectual disability, and normalization and the continuum of services illustrate the convergence of new legal and clinical assumptions in the 1970s. Even though the concern with liberty has found its expression in professional models that emphasize the clinical value of choice and participation, researchers argue that the persistent, if changing, professional agenda has limited the autonomy and participation of individuals. Trent (1994), Foster (1987) and Taylor (2001) variously show how professionalization and the cultural, political and economic power of professional fields partly explain which paradigms of disability and service have prevailed at different times. Much analysis also involves demonstrating how the professional practice of autonomy functions as an ideological mask for practices of control and segregation in everyday

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10. For example, a state-federal funding mechanism that enables more "individualized" services in the group home is discussed in chapter 4.

service settings. Taylor (2001) criticism of the continuum provides one example of this central theme, showing how professional attention to the individual is at the expense of self-determination: the "readiness" model permits access to less restrictive settings according to clinical criteria and not on the self-evident basis of individual rights.

## III. THE GROUP HOME AS A SITE OF GOVERNMENTALITY

The role of professional knowledge in the group home research site is neither endorsed nor regarded as a problem to be explained. It is investigated as an aspect of the larger question posed about how the setting is organized in practical ways by its task of supervising citizens who are ostensibly unable to supervise themselves. The legitimate exercise of liberal authority is based not only on the fact that it is indirect and therefore requires consent. It also has an ethical basis in supposedly universal, disinterested expert knowledge rather than particular cultural traditions. More specifically, the task of providing services to individuals with cognitive disability as citizens has been defined, and therefore managed, as a psychological problem. Clinical knowledge in the group home is thus analyzed in the ways it governs the residents.

### The analysis of governmentality

In the analysis of governmentality, liberalism is not understood as a political program or theory of the state, but as a "rationality" that has been shaped by the ongoing practical problems posed by the "twin dilemmas" of liberal rule: the liberty of the individual citizen and the legitimate boundaries of state authority (Rose 1999). The role

of the state is not understood only as the locus of power, and government does not therefore refer only to the activities of the state. Foucault and others have argued that government is the historically specific problem of rule that, from the early nineteenth century, defined the state as it developed in relation to a range of specific areas of interest and intervention (Foucault 1991; Dean 2000; Rose 1999; Gordon 1991; Hindess 1996). For the modern state, the government of large scale matters is intimately tied to the ability of individual citizens to govern themselves. With recourse to measures of direct coercion only in specific situations, the state's authority over individuals must, in most cases, be exerted indirectly. Effective liberal government thus depends on the consent of the governed. The legitimate exercise of authority is measured by the resolution of the practical dilemmas of liberal rule and involves shaping the capacities of individuals to act freely on themselves for their own benefit and for the benefit of all.

Government occurs through technologies that mobilize individual conduct in relation to diverse problems. The term technology emphasizes the systematic and rational approach to conduct that seeks specific individual outcomes in accordance with collective goals. It is in technologies of government that the interests of the individual can be linked to the interest of the whole. Technologies of government attempt to shape individual conduct in relation to large-scale areas, such as national economies through tax and investment incentives (Miller and Rose 1990) and local ones, such as welfare programs through practices of self-esteem building (Cruikshank 1999). Governmentality does not thus refer to the production of uniform conduct but to an approach that attempts to shape conduct in relation to multiple, specific problems. The aim of research is to understand

particular problems of conduct, not as reflections of an overarching political program or theory, but as they are defined by particular practices of government. The empirical focus is on the technologies that shape the fields – poverty, child welfare, public health, disability – and local settings in which problems of conduct are identified, defined, and addressed: the charity associations, social service offices, clinics, group homes, and so forth, where individuals learn to conduct themselves.[11]

That government depends on the capacity for freedom does not mean that constraint or coercion cannot also be used. However, technologies of government are not simply mechanisms of control, direct or indirect. To govern effectively involves enabling new kinds of conduct. Every technology, Rose writes, "inculcates a form of life" (1999:52) and, in this way, individuals are "simultaneously capacitated and governed" (Rose 1996a:27). The analysis of how residents are governed does not therefore presume that social control is the primary function of the group home, although individual liberties are occasionally restricted there. It could be said that this analysis is concerned with the ongoing inculcation of a group home form of life through the government of both residents and counselors.

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11. Some examples of the analysis of governmentality in: accounting (Hopwood and Miller 1994); alcohol regulation and alcoholism (Valverde 1998); child abuse and prevention (Parton 1994); criminology (Smandych 1999); the emergence of economic science and the economy (Burchell 1998; Miller and Rose 1990); education (Barron, A. 1996); insurance and risk (Ewald 1991); poverty (Procacci 1978); the profession of medicine (Osborne 1993); community psychiatry (Castel 1991; Rose 1996b,1998); psychology (Rose 1990, 1996a); statistical sciences (Hacking 1986); unemployment (Dean 1995); welfare programs for women (Cruikshank 1999); transformations in the welfare state (Barry, et al. 1996; Rose 1999). For comprehensive arguments about governmentality see: Dean (1999) and Rose (1999).

**The government of residents**

Even in the group home, the routine exercise of authority depends on the freedom of individuals to govern themselves. Freedom is realized in practical ways, and, for the residents, it is the freedom to participate in their own supervision. It is through the residents' efforts to promote their own independence – the individual clinical plans and other activities that target specific aspects of conduct – that they govern themselves. The group home must shape particular capacities to act in order to fulfill its basic objectives without impinging unduly on the liberty of residents. As Rose explains the problem of liberal government: "individuals. . . must come to recognize and act upon themselves as both free and responsible, both beings of liberty and members of society, if liberal government is to be possible" (1999:68).

Providing services in the community has therefore meant more than just the extension of formal rights to individuals with cognitive disability. It has meant the extension of practices of "well-regulated liberty" (Rose 1999:72) that enable them to know and act on themselves in specific ways as group home residents. For example, Bannerman et al. (1990) argue that the very need to make choices can be a source of confusion for individuals with cognitive disability. This difficulty has often produced the contradictory result of compromising "personal liberties" because service providers, to be expedient, often make decisions for others (1990:79). However, integration and liberty are goals that need not be in conflict because, by their nature, "people strive for freedom in a broad sense, [and] they also enjoy making simple choices" (1990:79). The authors claim therefore that a fundamental task of services in the community must be to teach

individuals "how to choose" (Bannerman et al. 1990:85).

This dissertation investigates how residents are governed through this kind of systematic enhancement of their independence and the specific capacities such ongoing efforts presume and cultivate. As all citizens, the residents learn how to govern themselves in particular ways. As Bannerman et al. (1990:87) characterize the basic problem: "All people have the right to eat too many doughnuts and take a nap. But along with rights come responsibilities. Teaching clients how to exercise their freedoms responsibly should be an integral part of the . . . process." The insight of governmentality that freedom is not opposed to authority is true even in the group home. Freedom is produced *through* government, and the specific capacities of individuals to act on themselves as autonomous citizens defines what we take freedom to be. This raises a question that will be answered only by the detailed descriptions of the group home in the following chapters: what shape does freedom take for individuals who are defined – rightly or wrongly – as having a questionable capacity for freedom?

**The ethical authority of expertise**

To investigate the group home as a site of governmentality presumes a conception of expertise at odds with sociological arguments about professionalization and expertise as an ideology of social control. There is an ethical basis to authority in liberal societies in addition to the indirect character that defines its legitimate exercise. It is expert knowledge, and not the arbitrary particularism of tradition, that authorizes the government of conduct. To govern is not to seek "total regulation" but to "structure a field of

actions" (Dean 1996:61). Systematic attempts to "act on the actions of others" (Dean 1996:60) must take into account the nature and capacity of the governed to preserve the individual autonomy on which effective government depends. For this reason, government occurs through the biological, economic, and psychological processes fundamental to everyday life. It is only on the basis of ostensibly disinterested, universal expertise that individuals can be mobilized in systematic and rational ways to govern their own conduct in relation to specific problems of health, wealth and happiness.

Technologies of government established a new role for expertise in the nineteenth century that makes government ethical in another sense. Bringing expertise into the realm of everyday life made it a basis for normative ideals of conduct. Rose (1994; 1996) and de Swaan (1991) both argue that theories of professionalization and medicalization (Friedson 1970; Zola 1983) are unable to account for the ethical consequences of the dissemination of expert knowledge. These explanations reflect an anti-professional bias in their emphasis on power and imperial expansion. Rose and de Swaan argue that everyday experience cannot be understood separately from the diffusion of expertise. They do not take a normative position on either the substance or dissemination of knowledge but call for an analysis of how expert knowledge and techniques are available to and used by individuals to understand and act on themselves in particular ways. De Swaan shows that a focus on professional power cannot recognize that "in a society where so many and such serious troubles are entrusted to professionals" lay people themselves become experts on expertise (1991:106). He calls this "proto-professionalization," which is not simply the imposition of a "cognitive orientation, but also the acquisition of habits, of stances that correspond to

the basic attitude of [a] profession" (1991:105).

Explanations of the dissemination of psychology as a symptom of cultural degradation or the atomism of capitalist modernity (Lasch 1979; Jacoby 1975; Rieff 1966) also do not account for the ways it has shaped everyday life. Rose shows how psychology has been central to the government of different kinds of conduct in the twentieth century, and thus it is already as psychological selves that individuals govern their own conduct "therapeutically." They are constantly enjoined to do so, not simply by the imperial practices of a professional field, but in the many realms in which individuals are mobilized to govern themselves by their social workers, their teachers, their therapists, their parents, their own selves (Rose 1990, 1996a).

In the 1970s, providing services in the community – integration itself – was taken as a psychological problem of adaptation through the influence of disability professionals and the normalization. Psychological knowledge is the ethical basis of the group home, and the ongoing tension between supervisory authority and the freedom of residents takes form in everyday life as clinical problems of conduct. The group home's overall goal of services – "to promote and encourage independence, individuality, integration and productivity" in each resident[12] – actually indicates how all of life is a clinical matter.

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12. This phrase is from the Federal Development Disabilities Act (1975) and is used repeatedly by the NewYork Office of Mental Retardation and Developmental Disability (OMRDD) in its regulations and other written material (it is taken here from 14 N.Y.C.R.R. § 671.1). I often refer only to "independence" because counselors and residents frequently use it in everyday ways. In the routine course of group home work, individuality, integration, and productivity are realized in practical ways, largely through documentation. This is discussed in chapter 4.

**Psy knowledge and the enhancement of normality**[13]

In the nineteenth century, psychology developed in the study of pathology. Now it provides a vast knowledge of "normal" conduct. In his study of "feeble-mindedness," Rose (1985) argues that emerging technologies of mental testing also produced new knowledge about normalcy. This technical capacity has organized other fields – such as education and workplace management – not through the treatment of pathology, but through the enhancement of normal conduct. Since the mid-twentieth century, behaviorism has furnished many of the psy technologies central to this process. The techniques developed in operant conditioning, token systems, and milieu therapy established problems of conduct in the realm of overt behavior rather than in subjective meaning and experience. This enabled behavioral techniques to be used in many ordinary domains of life: in school, in the workplace, in the social worker's office (Rose 1999b). Like mental testing before it, behaviorism was adaptable to fields with no clinical or rehabilitative aims but in which conduct nonetheless needed to be governed. Behavioral psychology fit with the ethical practices of government because it furnished a new set of techniques able "to reconcile the requirement that human beings conduct themselves simultaneously as subjects of freedom and subjects of society" (Rose 1996a:98).

Behaviorism has also been central to the history of cognitive disability. Although it had been used since the 1930s, it was not until the 1950s that behaviorism posed a significant challenge to the psychometric model that, in the earlier part of the century, had

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13. Rose uses Donzelot's (1979) term "psy" to refer to the proliferation of psychological conceptions and practices too vast to attribute to a single professional field.

provided psychology a foothold in a field dominated by medicine. Behavioral techniques proved adaptable to a wider range of problems in clinical settings than the esoteric practices of psychiatry and psychoanalysis, and non-professional staff in schools and institutions could easily be trained in their use. Psychology thus established its clinical dominance by the 1950s (Rose 1999b), and this success helped revive the field's interest in cognitive disability (Simpson 1996:102). In 1959, the adoption of the diagnosis of mental retardation included for the first time an assessment of "adaptive behavior" alongside the IQ range and marked the victory in this field of psychology (and related areas in education) over medicine (Trent 1994:245).[14]

The transition of cognitive disability from the institution to the community, since the 1970s, provides a recent and accelerated example of how psychology has formed the ethical basis of normal living. Originally the diagnostic justification for institutionalization, psychological expertise now furnishes technologies of government in the community. The overall goal of the group home "to promote and encourage independence, individualization, integration and productivity" is realized through the concepts and techniques of behavior modification. Since normalization, the approach to integration has been defined as an individual problem of behavior and skill. Simpson argues that psychology thus claimed "the community" as its professional domain, something still seen, for example, in debates about "social competence" (Simpson 1995). Arguments for "social competence," as a category of assessment and an approach to service, describe it

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14. It is worth noting the irony that, as I mentioned, mental testing had itself been central to the role psychology played in disability and in psychology's formation as a discipline in the early part of the twentieth century (Rose 1985; Trent 1994).

as inclusive of social, psychological, cognitive and behavioral aspects of individual adaptation (Greenspan and Granfield 1992; Siperstein 1992). For Simpson, this category serves only to maintain psychology's hold over life the community, reducing it to the technical enhancement of individual competence (Simpson 1995:94). In the group home, techniques of psy knowledge organize the relationships that residents can and should have to their own conduct as potentially independent and always amenable to change. However, independence cannot be achieved in any conventional sense, which makes it an endless clinical pursuit for residents toward an ever-receding goal.

Although this dissertation investigates a setting that circumscribes the lives of its residents (and, in different ways, its staff), the motivating concern in the analysis of governmentality has been how social regulation in liberal society depends fundamentally on the practices of self-regulation which link the aspirations of free individuals with those of the whole. Through the latter half of the twentieth century, techniques of the self have become central to this process. Rose writes that the analysis of governmentality:

> . . . draws our attention to all those multitudinous programs, proposals, and policies that have attempted to shape the conduct of individuals – not just to control, subdue, discipline, normalize or reform them, but also to make them more intelligent, wise, happy, virtuous, healthy, productive, docile, enterprising, fulfilled, self-esteeming, empowered or whatever (Rose 1996:12).

From dietary regimes and exercise programs to advice-filled talk shows and psychotherapy, techniques for the ongoing enhancement of normality organize everyday life on the basis of what Rose calls the ethic of the autonomous self.

Everyday psy practices to enhance the normal self have equated freedom with autonomy as "the capacity to realize one's desires . . . [and] to fulfill one's potential

through one's own endeavors, to determine the course of one's own existence through acts of choice" (Rose 1999:84). This can be seen in various forms of "health promotion," which recruit individuals to take care of themselves in multiple, mundane ways (Kickbush 1989; McQueen 1989: Nettleton 1997). "Being healthy" has come to be defined and measured by the ongoing use of expert techniques to organize everyday life. Like independence in the group home, health is an ever-receding goal that individuals are able to achieve only in its pursuit by taking their own selves as projects of endless improvement and risk-reduction. There is a countless:

> diversity of procedures . . . by means of which individuals, with the aid of experts, can act upon their bodies, their emotions, their beliefs, and their forms of conduct in order to transform themselves, in order to achieve autonomous selfhood (Rose 1990).

This is the ironic history of behaviorism: the technical approach to being human that, in the 1950s and 60s, was vilified as the emblem of repressive, totalitarian, and anti-humanist control, has come to define freedom as a kind of personal liberation through the endless pursuit of autonomy that takes practical shape in our everyday technologies of the normal self (Rose 1990; Baistow 1995). This is no more the case for residents than for everyone else.

## IV. ETHNOMETHODOLOGY

The claim that the group home governs residents is plausible *prima facie* given its mission of integration and the indirect character of its clinical authority. However, only the observations of everyday life in the following chapters will show how the dilemmas posed by the residents' liberty are ongoing practical dilemmas that organize the setting.

More specifically, because of commonly held assumptions that equate intellectual disability with overall incapacity, only the description of how residents govern themselves will convince readers they actually do.

Ethnomethodology provides an orientation to everyday life that focuses on the situated and specific character of social competence as it is demonstrated in the capacity for practical reasoning. Ethnomethodology is a naturalistic inquiry that remains close to its phenomenological roots, defining its empirical phenomena as observable social action: ordinary verbal and gestural expression. Unlike phenomenology in sociology and philosophy, however, such expression is not treated as a problem of subjective meaning or as the indication or effect of social structure. The deductive logic of most social inquiry is not followed in ethnomethodology and observation does not proceed from general theoretical concerns. Nor is it an inductive approach that seeks to develop theories of social order and action from observation, a common confusion given the painstaking detail that comprises much ethnomethodological research and writing. Ethnomethodologists aim to describe everyday order in its own terms by using categories of analysis available in observable social action. Instead of seeking "real" but hidden causes, ordinary action is observable "in the ways an explanation or account or question is a feature of the organizational activity of which it is hopelessly a part" (Livingston 1987:58).

In ethnomethodology, social experience is understood as situated and indeterminate and, therefore, cannot be explained by reference to theories of a fixed social order. Although this dissertation is not an ethnomethodology in any strict sense, my concern is to provide descriptions of group home order that are intelligible in terms of the

practical conditions of action that organize it. My analysis does not proceed on the basis of any particular assumptions about the social construction of disability, the unequal distribution of power, or the general failure of community-based services. These claims form the basis for other kinds of analysis, and although I happen to agree with them more or less, they are relevant in this dissertation only as features of the action I observe. Readers will discover in the analysis below how such claims were used as practical resources by counselors and residents in what could be called their own ongoing analysis that is a fundamental and observable part of their participation in group home life.

In ethnomethodology, "the description and describability of the world" (Goode 1994:1) are treated as integral and organizing features of practical everyday activity. In parallel with the analysis of governmentality, ethnomethodologists do not seek to explain *why* action occurs, but *how*, as specific and accountable action. The focus is on the practical methods individuals use in the routine course of their action, the: " . . . commonsense knowledge and the range of procedures and considerations by means of which ordinary members of society make sense of, find their way about in, and act on the circumstances in which they find themselves" (Heritage 1984:4). "Ethno" methods refer to the innumerable "situated practices of looking-and-telling" (Garfinkel 1967:1), the "ordinary 'methods' through which persons conduct their practical affairs" (Lynch 1993:5).

These ordinary methods are methods of everyday reasoning, and observably organize action in ways that are accountable, to the actors, to researchers, to everyone. In the group home, these methods include the multiple ways of seeing, knowing and acting

furnished by psy expertise. They are available as features of the group home setting and, at the same time, their routine and often unwitting use by counselors and residents organizes the group home's specific and local order. As Lynch writes, "local" does not refer to:

> subjectivity, perspectival viewpoints, particular interests, or small acts in restricted places . . . [ethnomethodology does not] not deny the historical and social 'contexts' in which social action and interaction take place; rather, [it] insists that specifications of such contexts are invariably bound to a local contexture of relevance (Lynch 1993: 125).

In this way, the production of local social order is an ongoing, concerted accomplishment of individuals, whose everyday activities are organized in the course of their use of methods of everyday reasoning.

The local and accountable production of social order is reflexive: it is an *in situ* and self-organizing temporal order. The situated and indeterminate use of practical methods as observable accounting practices, and the action and events they describe, endlessly elaborate and modify each other. Ethnomethodologists are concerned with the ongoing, reflexive relationship between ordinary action and accounts of that action. Lynch writes: ". . . [T]he very terms we use to describe what is going on – that is, the way we characterize the events, participants, and actions – already imply the relevance of context" (1993:29). For ethnomethodology, "context" and "event" are not treated as distinct, because individuals "commonly have no trouble with seeing, and seeing at a glance, 'what's going on' in the situations in which they and others act" (1993:30). Ethnomethodological inquiries are able thus "to turn our attention to the reflexive way in which the identities of persons, actions, things, and 'contexts' become relevantly and

recognizably part of an unfolding 'text' (or, better, 'contexture') of practical details" (1993:30).

**Ethnomethodology and governmentality**

In ethnomethodology, the criticism of a certain kind of sociological analysis points to an inherent tension with governmentality. Garfinkel (1967) and Cicourel (1963) argue that the concern with "method and measurement" reflects an epistemological confusion about the relationship between social science practice and its topics of inquiry. *A priori* theoretical and methodological assumptions shape what can be known and understood in research and render invisible the already accountable organization of everyday action. From this perspective, governmentality commits the same errors of theoretical explanation it criticizes. The concept of governmentality itself is certainly meant to suggest topics of analysis, but does not organize observation in terms of an explanatory theoretical framework. The analysis of governmentality emphasizes the reflexive and practical relationship between its own theoretical concerns and empirical inquiry. In this way, governmentality functions as a "sensitizing concept" that does not indicate specific empirical features, only the general direction in which to look (Blumer 1969). This is not to suggest that the concerns of governmentality do not shape inquiry in ways that are untenable for ethnomethodology. However, both approaches share the assumption that theoretical categories cannot explain social life and, in different ways, that only in the empirical study of specific domains do adequate categories of analysis become available.

Ethnomethodology and governmentality are uneasy allies. Yet the connections

between them, however inexact, form an approach to the group home that offers an alternative to other research in similar settings. The claim that governmentality partly compensates for the errors of causal analysis is one that must be made about this dissertation. It is not an ethnomethodological study, but draws upon ethnomethodological criticisms of ethnography and the interactionist study of everyday life. The analysis of governmentality shares an understanding of the limitations of ethnographic and interactionist approaches that seek to identify the hidden causes of action in meaning, culture or social structure. Such approaches often understand the social world as equivalent to the interactional production of meaning. Although this is expressed as a methodological concern about the observable character of action, it is actually a commitment to a particular theoretical framework. Everyday interaction is also often understood as the observable "micro" level reproduction of a "macro" order, which similarly expresses a theoretical assumption about social order as a methodological claim about the utility of ethnography. Both ethnomethodology and governmentality undermine the distinction between "macro" and "micro" levels of social order and analysis. Ethnomethodologists claim that the absence of observable causes requires sociological analysis to posit an order of "macro" causes, which can only be represented by abstract methodological forms in opposition and external to the social experience that is ostensibly observed. In governmentality, the opposition between micro and macro orders of experience is collapsed in the analysis of the technical basis of conduct. That is, the difference between the government of large or small spaces and processes is understood only as a matter of scale, "not ontological but technological" (Rose 1999:5).

The use of the technological to specify an analyzable empirical domain is understood in this dissertation to overlap with the ethnomethodological focus on practical methods of everyday reasoning. Many techniques of psy conduct are the specification of already available practical methods of ordinary action, particular ways of seeing, knowing and acting. In this sense, I treat psy techniques as methods of everyday reasoning in the ethnomethodological sense, as practical resources available as organizing features of the group home. They furnish accountable ways of seeing, knowing and acting that counselors and residents use in the situated and reflexive course of group home life.

These approaches come together in the concern about how group home knowledge reflexively organizes the setting's local order. Both ethnomethodology and governmentality abstain from epistemological claims about their objects of analysis. Questions about the socially constructed character of professional knowledge (such as diagnostic classifications of disability or clinical interventions) are not pursued here. Social construction analysis often treats knowledge as external to achieved local orders, presuming causal relationships between structures and processes of power, such as labeling. Given that the approach outlined here emphasizes the reflexivity of social order, knowledge in the group home is investigated as it is observably available in the practical methods individuals use in the accomplishment of their everyday life. Knowledge is not understood as external to ordinary action and therefore no explicit claim of "skepticism" is necessary (Lynch 1993:17). This approach is simply "indifferent" (Garfinkel and Sacks 1971) to epistemological questions insofar as they presume causal social factors or any other external criteria of judgement. Knowledge, like " . . . culture, [is not] . . . a given

framework that lies behind and is expressed in action, [it] is, rather, a flexible repertoire of interpretive resources drawn upon by participants in accounting for action" (Watson 1992:xix).

**Agency and identity**

Finally, ethnomethodology and governmentality together provide an alternative to the conceptions of agency and identity that animate the analysis of intellectual disability (as well as a good deal of social research in general). I will demonstrate that residents are "active agents," but only indicate it here as such because of the common belief, no doubt held by some readers, that intellectual disability equals overall incapacity. I do not pose the question about whether residents are active agents. All socially competent people are, in the ethnomethodological sense, and people with intellectual disability are no exception.[15] Agency refers here, generally, to the relation between social order and individual capacities for action. For ethnomethodology, the question of such capacity is always a situated and practical one. The analysis of governmentality shares this conception, and the two approaches come together again in the understanding that empirical claims about agency (if it is useful to make them at all) should not be evaluative, as when, for example, they affirm personal expression or experience. In this way, agency is often equated with "resistance" to the professional agenda that dominates the experience and self-understanding of individuals with intellectual disability.[16]

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15. Goode (1994) observes capacities for agency in severely disabled, non-verbal people.

16. Angrosino (1998) provides a familiar example in the interactionist study of intellectual disability.

The study of identity poses a related problem. I aim to understand the nature of group home persons but this is not a study of identity in the sociological or subjective sense. Some field research emphasizes the perspectives of individuals with disability and aims to provide a venue for subjective expression. This is a worthwhile undertaking and has yielded some excellent research (Bogdan and Taylor 1987, 1989b; Langness and Levine 1986), but it often presumes the theoretical conceptions of agency and power I seek to avoid. In ethnomethodology and governmentality both, persons are not treated as passive social constructions or as determined by structures of power.

Following Hacking, Rose suggests that, despite the primacy of language, meaning and identity, the metaphor of social *construction* actually implies the practical and technical character of knowing and being (Rose 1996a:53). The analysis of governmentality is not oriented to the processes and structures by which identity or subjectivity is "asserted" or "determined," but to the technical ways in which certain kinds of person are "elicited, fostered, and promoted" (Dean 1999:32). Hacking characterizes this simply as a problem of "making up people" (Hacking 1986). He calls for an analysis of "kind-making" concerned with how kinds of persons are "made up" through the techniques of knowing and being that organize the practical conditions of conduct in local settings. Counselors and residents are analyzed as kinds of persons, made visible and knowable in the course of the very group home life they organize and that makes being a certain kind of person possible. To use Garfinkel's phrase (1967:1), residents and counselors are organizationally "incarnate." In this dissertation, conduct is therefore treated as a reflexive feature of the group home setting and not as an aspect of individual

character, skill or judgement. It is a study of group home kinds and how they are able to see, know and act on themselves and others as certain kinds of persons.

## V. METHODOLOGICAL ISSUES

This dissertation is a case study that treats the group home as a specific example of how government operates through and shapes the individual capacity for freedom. The group home is an especially compelling example, as it involves individuals who are widely, if incorrectly, understood to be incapable of the "well regulated liberty" that is the responsibility of all citizens. That the group home is a site of governmentality is not meant to imply that the current state of services are adequate, and I am aware of its uneven, often poor, quality. The group home is also not intended to be representative of similar community-based services settings, although many are likely reflected in these pages.[17] For this research, I sought a group home that would pursue its clinical mission in basic compliance with New York State regulations. I did so because a setting in which abusive treatment was the norm would pose a methodological problem for this research. Since I am obliged ethically to report any abuse I witness to the agency and to the New York State Office of Mental Retardation and Developmental Disability (OMRDD), a setting with poor services would have affected my role as a researcher and perhaps even the possibility of observation.

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17. This dissertation could be described as the form of case study called "situational analysis," following Max Gluckman (1961; 1967). Situational analysis does not focus on ethnographic events as evidence of social structures or culture, but on the observation of actors (rather than informants) and social processes. "Extrapolation is based on the validity of the analysis rather than the representativeness of events" (Mitchell 1983:190). See also Van Velsen (1967).

A voluntary agency in New York City agreed to permit access to a group home for the research. The administrators selected a facility based on the suitability of the residents, both in terms of their ability to consent informally and the likelihood that they would be receptive to having a researcher in their home. The agency required a copy of my university's approved IRB application. I had assumed it would be necessary to obtain a signed consent from each resident, but they were not regarded as competent and such decisions were made by the agency *in loco parentis*. Nonetheless, I made a point of discussing with each resident the nature of the research, confidentiality, and their voluntary participation.

The group home turned out just as I hoped, unremarkable in its day-to-day operations. It is worth noting again that this site is not intended to be representative of community-based residential services. To say this group home presented no troubles beyond routine ones, is not a claim that such settings are generally free of other, very serious troubles. The persistence of various forms of abuse and other professional excesses, as well as chronic fiscal constraint, is common in community-based services in the United States. In the group home research site, the rights of residents were observed in accordance with the regulatory requirements. It is not the aim of this study to evaluate the adequacy of the services described in the following chapters. While readers may make their own judgements, the critical evaluation of services is a complex issue I have chosen not to address (cf. Edgerton 1983).

**The collection and presentation of data**

Fieldwork was conducted as participant-observation. I never carried a pad openly because it would have been too cumbersome in the bustle of group home life, as well as a constant reminder of my role as a researcher. This would have made it difficult to develop a good rapport with residents and counselors. Such a rapport is often the basis of observational field work, but was especially important in the intimacy of the combined home and workplace of the group home.

I spent an average of thirty hours a week there for thirteen months, mostly on weekday afternoons and evenings, and on weekends. In addition to spending time with residents and staff in their everyday routines, there were numerous opportunities to observe weekly staff meetings, residents' meetings, case conferences, and support groups. I always sought residents' permission to attend closed case conferences, meetings and groups. I also had access to the treatment books and other clinical and administrative materials, which I read on weekdays in the early afternoons when there was little activity in the residence. Most of my notes were written after I left the group home. I always began writing by hand during the hour long subway ride home. When I arrived, I would continue on the computer, completing the notes for that day's visit.

The data is presented mostly as narrative description and occasionally in transcript form. They are not direct transcriptions, but are reconstructed from conversations recorded in my notes. Writing notes largely from memory, even of events earlier that day, means that the notes are already retrospective reconstructions of what I had observed. The data presented below represent an even further process of reconstruction, an

unavoidable aspect of my use of a narrative style. I followed this course out of concern to provide some context for the observation data. By context I do not mean that I made an effort to include every aspect of the circumstances or individuals being described. Aspects of the setting, the "tone" or "climate" of a situation, or the background assumptions of individuals, are described insofar as I have judged them to be relevant for a comprehensible reading. Following the insights of ethnomethodology, I have been careful to circumscribe my judgements about relevance by refraining from theoretical explanation of activities that would not also have been available to the participants. On the occasions that I directly impute an assumption to an individual, it is an assumption which would likely have been available to that person given my knowledge of them and the circumstance. This is certainly a methodological liberty, and is to some degree endemic to field observation, but is not unfaithful to my commitment to let the observable conduct of residents and counselors furnish its own categories of analysis. By the same token, I have also taken the occasional liberty of omitting or combining issues for the sake of clarity, but only where they were not relevant to the data being described. This is sometimes related to confidentiality.

There are two issues of confidentiality: the identity of the agency and the identities of residents and staff. In addition to changing the names and locations of the agency and the group home, maintaining confidentiality required me to change, alter or combine certain personal details. Also, voluntary agencies have latitude in the way they meet the standards of certification established by OMRDD, and therefore each agency has its own distinct jargon, job titles, and so on, that could easily reveal its identity. I therefore use the

regulatory language when it differs from the group home's own terms.

All the names of individuals are changed. However, preserving the confidentiality of residents required some additional adjustment for two reasons, which also relates to the identity of the agency. First, most of the residents are known within a set of overlapping networks through various sites that involve services, as well as work and recreational activities. As a result, individual residents are likely known to a large number of employees of different agencies. Second, discussions about residents with histories of institutionalization required particular care, because, in general, this cohort tends to be aging and are known to each other and to staff in yet more agencies. In some instances, as I describe above, preserving confidentiality on occasion by combining, altering or omitting personal features also happens to reduce confusion for the reader. When I have taken such liberties, I have done so only in ways that are inconsequential to the empirical analysis.

## VI. PLAN OF THE DISSERTATION

Chapter 2 provides an introduction to the group home and the people who live and work there. It also includes a methodological discussion about my role as a field researcher. Following chapter 2, the dissertation is divided into two parts. Part I includes chapters 3, 4 and 5, which focus on different aspects of group home work. A brief introduction to Part I describes the group home as a street-level bureaucracy, and work as a model of organizational commitment and participation that does not necessarily emphasize relations of power. It also discusses the different kinds of work used

throughout the dissertation. Chapter 3, "Endless, uncertain work," shows how some of the organizational features the group home shares with street-level bureaucracies make counselor work endless and uncertain in ways that must be managed as a matter of course. Some ways that counselors make sense of and manage their work are described, as is a kind of resident work, different from the work they do on themselves, but also related to everyday uncertainty. Chapter 4, "Paper technologies: The organization and documentation of group home work," argues that records and written documents are technologies in order to show how they are reflexively embedded aspects of the group home work they document. There is a discussion of conceptions of technology in sociology of work, science studies, and governmentality. Chapter 5, "Goal plans: Technologies of individual conduct," follows with an analysis of goal plans, the clinical technologies at the core of the group home's individual work with residents. The analysis shows how the specific techniques goal plans provide establish practical conditions of seeing, knowing and acting on conduct as a clinical problem, although this often occurs in unspecified and unintended ways.

Part II, which includes chapters 6 and 7, shifts to the analysis of what and how counselors and residents know as an organizing feature of everyday life and as an empirical focus for the study of group home work. The brief introduction to Part II discusses know-how and related concepts, such as commonsense and tacit knowledge, and how they have been used in sociology of work, governmentality, and ethnomethodology. Chapter 6, "Everyday know-how," considers all the time in the group home not taken up with the formal tasks that comprise counselors and residents' work. The group home has

no "back region" (Goffman 1961:106) where its workers can achieve sustained distance or relief. Since counselors and residents are always on view, they are always at work, which means there is no clear distinction between work and other aspects of everyday life. The analysis focuses on the way counselors and residents use their group home know-how and how it organizes everyday life as an open domain of clinical work. Chapter 7, "Clinical know-how," is concerned with the specifically clinical aspects of know-how that reflect the group home as a professional setting. The flexibility of psy knowledge is analyzed in the distinct kind of work counselors do in their weekly staff meetings: the clinical work of talk. The staff meeting is described as the group home's center of calculation and coordination that governs both counselors and residents at a distance.

# Chapter 2
## An introduction to the group home

### Introduction

This chapter provides an overview of the group home research setting and significant administrative procedures and staffing patterns. The people who live and work there are introduced, partly in descriptions of some routine activities from different times of day that illustrate the rhythms of group home life for counselors and residents. These everyday rhythms naturally shaped my own participation and this chapter also includes discussion of how I found my place as a researcher and managed the ongoing conflicts of that role. Although this chapter is partially descriptive, it is not a systematic ethnographic account. It provides a general context for the analysis in the main chapters of the dissertation.

The group home is in an apartment building, on a quiet side street off a busy commercial area in one of New York City's outer boroughs. With fifteen residents, it actually exceeds the current maximum number now permitted for new "community residences."[1] That space is tight in the group home is a common refrain of counselors, who often must negotiate where they carry out certain kinds of work. They sometimes explain the occasional conflicts between residents in terms of the close quarters, especially when they occur in common spaces or in the small shared bedrooms. The routine

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1. In New York State, 14 is now the maximum number of persons permitted in a community residence (14 N.Y.C.R.R. § 686.3).

negotiation and use of common areas is usually taken for granted and not perceived as a reflection of a shortage of space. There is no doubt, however, that the size and layout contributes to the evening bustle, when nearly everybody is home and the residence is going full steam.

In addition to the living room, dining room and kitchen, the common areas include the staff work areas: the medication, staff and supervisor's offices. The staff office, just across from the front door, is the administrative heart of the group home and serves as the base for counselors through the course of a shift. The staff office is also a prime social gathering place for residents. People are always coming and going. Residents and counselors sit at the long desk that lines the left wall, or on the low cabinet just opposite, chatting with each other, talking on the phone, looking at the paper. Depending on the time of day, one can easily find a mix of people and activities: staff doing paperwork or sending a fax; residents, alone or alongside a counselor, preparing a weekly budget; discussions of group home business; and simple hanging out.

Every room serves multiple purposes and, in the evening, there is constant movement as residents and counselors go about their routine business. There is no spot in the group home which does not sometimes function as a venue for work. The living room is the central social gathering place for everyone but also a place where matters of work are continuously and variously addressed: in the residents' discussion of group home operations; in the everyday interventions of counselors; in the ongoing negotiation of schedules. On Monday nights, the living room is fully transformed into a work setting for about an hour during the Residents' Meeting. The same is true of the small shared

bedrooms, which provide residents both a relative haven of privacy and, at other times, a setting to work on their "goals," alone or with a counselor.[2] The medication office is a small room next to the staff office and contains the regulation locked medicine cabinet, small desk, low file cabinet and mounted shelves. Its size makes it less amenable to the routine comings and goings that characterize the staff office as a social hub. When "meds" are not being dispensed, however, the "med office" offers a place with fewer interruptions: counselors catch up on paperwork there or hold meetings and counseling sessions that require privacy.

**Who are the residents and counselors?**

Of the residents, six are women and nine are men. They range in age from twenty-three year old Ruby to sixty-eight year old Theresa. Ruby is the only resident under thirty. Paul, 61, and Theresa are the only ones over sixty. The life experiences of the younger residents reflect changing attitudes and services for individuals with cognitive disability. James, 30, Johnny, 29, and Ruby grew up with their families and attended public schools.[3] Most of the other residents also moved into the residence from their families' homes, some well into adulthood when their parents died or were unable finally to keep them at home

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2. Goals, or goal plans, refer to the individual clinical plans that are written for each resident. They identify a specific aspect of conduct for modification or cultivation, and elaborate systematic techniques for both residents and counselors. Many residents have goals for becoming more independent with, for example, preparing a weekly budget, cooking, basic hygiene, or anger management. Goal plans are the subject of Chapter 5.

3. Congress passed the Education for All Handicapped Children Act (Public Law 94-142) in 1975, which mandated "mainstreamed" special education programs in public schools.

for reasons of age or illness. Diane, 39, Donna, 54, Evan, 43, Evelyn, 53, Jennifer, 46, Kenneth, 37, Marty, 36, and Paul, 61, were all raised with their families and placed in residential services because of changes in their households. With Ruby and Kenneth, despite the different generations they represent, their families believed they should not remain at home after a certain age. Residential community services like the group home shaped how the next step toward adulthood could be envisioned and acted on.

Theresa, 68, and David, 59, were both institutionalized at Willowbrook as adults, when their parents died. Irving, 53, and Chris, 48, were institutionalized as children, respectively, at Willowbrook and a comparable state institution elsewhere. As I mentioned in the previous chapter, until the late 1960s or so, institutional placement was the recommended course of action for a child with a disability. For children who also had physical disabilities, placement often occurred earlier because these decisions were based, to some extent, on the perception of care required. For this reason, it was not entirely unusual for some children to be raised at home as Theresa and David were. When their parents died, however, remaining family members (adult siblings in both cases), saw the institution as a viable option because there were no alternatives.

The residents are diverse not only by virtue of age, gender and history of services, although typical sociological categories of difference do not structure the group home's everyday order in any observable way. The residents and counselors together represent New York City's major racial and ethnic communities. Of the residents: five are Jewish, four are African-American, three are Protestant whites, one is Puerto Rican, and one is Italian-American. Of the staff: four are Protestant whites, four are West Indian, two are

African-American, two are Jewish, two are Puerto Rican, and there is one each Italian-American, Dominican and South Asian.

The residents come from a variety of class backgrounds but this makes little difference to their relative command of resources in the group home. It appeared to me, at first, that class background may be related to the amount of contact a resident has with his or her family. I presumed that more resources may make it easier to have sustained involvement with an adult child living in the group home. Chris and James' poor backgrounds, for example, seem a plausible explanation for why they have no family contact. Neither Chris nor the staff are aware of whether any members of his family are even alive. He experienced a long history of abuse as a child at the hands both of the institution where he was confined and his Protestant, white family in rural New York State. James, who is younger and African-American, hails from a New York City housing project and lived at home with his parents. At 23, he was living alone with his mother when she died suddenly. The exact story of his family, his mother's death, and his placement in residential services is unclear. He has no contact with his father and older brother, neither of whom apparently participated in finding him services, nor have they made any contact. For his part, James does not actually want contact and has refused offers from staff to try and locate them.

By contrast, Kenneth, who is from a middle-class family – his late father was a supervisor in a trucking company – regularly spends Jewish holidays with his mother, who still lives in the apartment where he grew up. The same is true for Diane, an African-American woman, who frequently visits her aging mother, a retired school teacher, and

regularly attends family gatherings. The association between class background and family contact is not consistent however. Jennifer moved into the group home when her father died (her mother had died years earlier). Johnny moved in when his parents became too ill to keep him at home and both subsequently died. Jennifer was raised in a well-to-do Jewish family in Manhattan and has little contact with her brother and an aging aunt. Johnny is from a working-class Puerto Rican family and spends many weekends at the home of his sister, brother-in-law, and young nephews.

All the counselors are from working or middle-class backgrounds. All but three have bachelor's degrees or are attending college part-time, some the first member of their families to do so. Of the ten core counselors: five are in their early twenties; three are in their late twenties and early thirties; and two are in their mid-forties. Eight of the ten express an interest in pursuing a career in social services. One is attending a master's program in social work and two are planning to pursue master's degree in social work or psychology. That half are in their early twenties and about a third in their early thirties reflects that the counselor position is considered an entry-level direct care job, and one with room for possible advancement.[4] Similarly, the class background of counselors reflects a basic demographic feature of this kind of employment.[5] As with the residents,

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4. This is certainly true in this and similar agencies in New York State, which emphasize the importance of training for their employees.

5. Many voluntary agencies encourage promotion from within to contend with the problem of retention and recruitment that are characteristic of the direct care workforce in the United States. Such problems are not likely as acute in clinically oriented settings like the group home research site as they are in "personal care" work (such as providing assistance with washing, going to the toilet, and dressing) or in bureaucratic public services. Recent initiatives to increase retention and recruit quality applicants emphasize job satisfaction through training, increased pay, and benefits.

however, neither class nor racial-ethnic background structures group home life in any obvious sociological sense. However, given my focus on the practical and ongoing basis of local order, I did not systematically investigate conventional categories of difference. The residents and staff of a single group home, in any case, do not provide an adequate sample for such an inquiry.

It is nonetheless true that racial-ethnic tradition shapes, more or less, many of the practices and personal styles of individuals. The cultural flavor of the residence is evident in Diane's attendance at a local Catholic Mass every Sunday afternoon; Evelyn's generous blessings and prayers for other residents and counselors in the Evangelical tradition of her late father's ministry; Jennifer's fascination with the Kennedy family and her acute memories of the President's assassination;[6] Paul's collection of movie serials from the 1930s and 1940s; and James' extensive knowledge of popular music, especially disco and funk. In an equally mundane, but literal way, the cultural flavor of the residence can often be tasted at dinner when Susan prepares her astonishing chicken curry, Angela makes manicotti as she was taught by her Neapolitan mother, and some of the other culinary

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In disability services, see: Jaskulski and Ebenstein (1996). See also Light (2002), a Brookings Institution study of low levels of job satisfaction and declining morale among federal workers. Two group home counselors – Lisa and Lydia – actually left after three and four months, respectively, and were replaced by people who had worked as substitutes and were already known to the counselors and residents. Despite the familiar feature of staff turnover in the group home, counselors expected residents to have difficulty with the counselors' departures. Apart from the brief sadness of a few, however, residents did not appear much affected.

6. In addition to childhood memories of the era, Jennifer is also aware of the Kennedy family connection to mental retardation. This appears to be one source of her interest in them. As an example: Jennifer and I were in the living room one evening and when President and Mrs. Clinton appeared on television, she said: "I hate them." I asked why and she replied: "They don't care about the retarded. They've never had any retarded people at the White House . . ."

delights that reflect the diversity of life in the group home and in New York.

Sociological categories are eclipsed in the group home by another kind of individual difference: the complex range of individual competencies. The diagnosis of cognitive disability residents share conceals the specific and practical capacities that individuals demonstrate in everyday life. As I mentioned in the previous chapter, one familiar theme of research is that professional models of disability preclude certain kinds of competence and emphasize deficits rather than capacities. My focus on the situated capacities of individual residents – which are not to be found in the pathology orientation of their treatment books – shows how they are reflexively organizing features of the setting. For this reason, the nature of each resident's disability is not presented in a comprehensive or general sense. Their individual capacities and competencies are described in the following chapters as specific and situated aspects of everyday life in the group home.

**Research work, group home work**

My own job as a counselor in a similar group home ten years earlier was not only the origin of this dissertation but contributed to the relative ease with which I found my place as a researcher. Apart from an initial concern about whether I would use a tape recorder, mentioned in the previous chapter, the counselors did not appear especially suspicious of me. I was careful to assure them I was not there to evaluate their work and that, apart from violations of the residents' rights, anything they talked about would be confidential and discussed neither with the agency nor Sonia, the supervisor. The

counselors saw from the outset that my own experience as a counselor meant I was in tune with the rhythms of group home life. This was especially clear when they realized my regular presence eased the demand residents make on their time.[7] Many routine activities did not require a counselor's assistance or explanation and permitted me to participate right away: preparing dinner; running errands with residents; helping with their laundry; helping to clean their rooms; packing for a weekend visit to their family; and many other things. Any overt concerns the counselors had about my regular presence were addressed by my willingness to "really get involved with the guys."[8] After a few weeks, counselors told me they had assumed I would simply "do nothing but hang around and get in the way," as visiting clinicians and interns are often perceived to do. It is also true, however, that even just "hanging out" with the residents slightly reduced the demand for staff attention.

My return to work in a group home as a researcher was regarded by counselors as a recognition of the importance of the work. When I started spending the research, they took time and effort to teach me about routines and procedures as they occurred. No doubt this can be explained partly by the fact that the supervisor told them to be of assistance. Counselors were always eager to talk about their work, however, especially

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7. Although the counselors were only convinced in a practical way, Sonia was frank from the outset that, quite apart from the research itself, my presence alone would be a benefit to residents and counselors alike.

8. Counselors frequently refer to the residents as "the guys" or, in the case of a counselor discussing his or her caseload (the three residents for whom they are specifically responsible), "my" guys. This is discussed in chapter 3.

their clinical work with residents, something that cannot be explained by supervisory pressure. At first, the counselors treated me as a kind of clinical expert. My status as former counselor *cum* researcher seemed to offer an opportunity to exercise their interest and skill with the clinical issues that are, for them, the most meaningful and professional aspect of their work. Once I got the hang of everyday routine, my presence no longer obliged spontaneous explanations of administrative issues, and counselors also stopped making a point of raising clinical concerns as matters of particular interest to me. Although I continued to ask for explanations of what they were doing through the thirteen months of research, counselors generally enjoyed these conversations. My presence, while certainly not unnoticed, was not particularly unusual either. The ongoing shop-talk of counselors is a central feature of their practice and my questions simply became a routine part of it.[9]

When the research began, I explained to the residents that I was not a counselor and did not work for the agency. I told them I was a researcher doing a project for school. I wanted to learn "what they do everyday." Most of them understood I was there "to learn about the group home" and for "the clients to teach me things."[10] There were a

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9. In chapter 3, I discuss counselor shop-talk as a kind of work itself.

10. The term "client" was introduced in the 1970s to emphasize the informed and consensual participation of social services recipients. Client has been replaced by the fully choice-making "consumer," which is now the term used by service providers and OMRDD, the Office of Mental Retardation and Development, the New York State agency that regulates and certifies services. Client is still used frequently by residents and staff. Consumer, however, is used only by staff, perhaps because it is more recent and introduced in their training. It is important to note that, in any case, the situated use of these terms in the group home does not invoke the ideologies of service intended by their "official" use in regulatory and provider agencies.

few – Donna, Evelyn and Diane – who appeared to know only that I was "not staff." In either case, it was in practical ways that my distinct "non-staff" participation came into focus. I did not have keys. I did not have access to residents' spending money, which for most was kept in a metal lockbox in the staff office. I did not "do meds."[11] The residents realized immediately that I was free from the demands of counselor work and had time to spend. Some were comfortable with me from the very beginning. Others were more reticent and I expressed interest in them cautiously. The intimacy of group home life meant that, within a short time, I was developing good relationships with even the shyest.

During my thirteen months of research, I was both a pal to the residents and a source of assistance and support. Often I just hung around the living room, chatting and watching television; went for walks; or spent time with residents' in their rooms talking, listening to music, or viewing their personal collections of memorabilia, photographs, magazines, books, puzzles, mugs, stuffed animals, and more. At the same time, I was also often asked to help with certain goals and innumerable mundane matters for which the residents usually turn to counselors.

Confusions about my role and responsibilities generally diminished after a short

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11. Only staff members trained and certified by the agency may dispense and administer medication. Counselors must be monitored and receive periodic training and evaluation by a nurse. Every aspect from storage to disposal is regulated and accountable through specific procedures. Medication includes not only over-the-counter treatments but vitamins and non-prescription products that have been ordered by a physician. There is a schedule for dispensing and only a medication prescribed "as needed" may be given at other times. Other off-schedule dispensing, such as a routine request for aspirin, requires approval by a medical professional, and a doctor or nurse must be accessible by telephone at all times (14 N.Y.C.R.R. § 633.17). At the group home, meds are given at seven am, and then at five and nine in the evening. Evening meds takes between an hour and an hour and a half.

time but ultimately defined the nature of my field research. Some counselors initially had far more difficulty recognizing that I was not there to "work" with the residents than the residents themselves. The counselors' expectations were difficult to dispel. This was so despite that initially my role and relationships were frequent topics of shop-talk because the residents' reactions to me furnished novel situations for clinical analysis. It seemed that some counselors saw the group home's clinical concerns as compatible with my research interests. My decision not to read the clinical records right away presented an opportunity to demonstrate, in a practical way, my intention to approach group home life from a "social" and not a "clinical" perspective. I wanted to avoid encumbering my developing relationships with residents by "official" diagnoses and other information. What I did not explain to counselors was that I also wanted to avoid having recourse to formal clinical accounts before observing how their own work organizes everyday life in the group home.[12]

When I did read these documents, it was only when residents were not around. Limited space, as well as the residents' eagerness to socialize, would have meant that I could read only in view in the staff office, or in an empty office, if one were available, where I would still be accessible. Attempting to limit interruption in this way would have required making the same kinds of claims about time and work that counselors do. Most of the residents understood I was a researcher and even that I had an interest in the treatment books and other records. However, I thought the claim that reading the records

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12. The group home's records and documents are the subject of chapter 4; the counselors' use of formal diagnoses of disability is addressed in chapter 6.

was "work" that warranted privacy might produce some confusion about my being "not a counselor." I also thought it would be simply insensitive to take advantage of my access to this information about residents at the expense of spending time with them. Although they have access to their own records, in a formal legal sense, the content is largely inaccessible even for those who are able to read.

I was also very conscious of how and when I would take field notes. After awhile, I realized that, in the staff office, I could jot things down quickly because "doing paperwork" there was not out of place. I would also often sit in the supervisor's office and write for the short time I could be alone, usually never more than ten or fifteen minutes. When Sonia was not at the residence, her office served as a refuge for counselors and residents. I used it when the normal buzz of activity had abated, on weekend afternoons and later in the evenings on weekdays, and residents frequently sought me out there for quiet conversation. They understood the purpose of the pad and, when they discovered me taking notes, often remarked on it in the unremarkable manner of Jennifer's question: "Are you writing about the clients?"

**Passing and the management of personal identity**

In order to preserve the trust of both counselors and residents, I had to demonstrate different kinds of competence in ongoing ways that can only be described as "passing"[13] (Edgerton 1967; Goffman 1963). My passing as a colleague was both risked

13. I am not aware of another example of the use of passing or research on stigma to describe the experience of field workers. Karp and Kendall (1982) discuss the analogies that have been used to describe the experience of anthropological field workers, such as

and reinforced by the questions I asked about counselors' clinical work with residents. I worked hard to avoid appearing to counselors as an "advocate," a role they variously claimed for themselves, and which would likely have been perceived as antagonistic. Counselors were sometimes quick to peg outsiders as naive about clinical issues and "the reality of the house." The organizational exigencies of their work and "what's really going on" with a resident, were what families, upper level supervisors, outside clinicians, and others, "just don't see."

At times it was a real effort to avoid appearing like a counselor. There is no clear distinction between "work" and other activities in the ongoing course of group home life. Passing in public required maintaining an appearance that the counselors could see as a kind of tacit agreement, and residents could at best see benignly as "different from staff." In the presence of both counselors and residents, I assumed an uneasy neutrality in relation to the ongoing, routine interventions in resident conduct. In situations, for example, where a counselor intervened in a resident's casual conversation because the topic was "inappropriate" or, for whatever reason, prohibited, I would not object to the counselor, even if I disagreed, and would permit the resident to determine whether or not to close the topic. Passing as a non-staff "normal," to use Goffman's (1963) ironic phrase, was much

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being a stranger, a second language learner, or the process of child socialization. They emphasize the paradoxes built into field work that I aim to capture with the idea of passing:

> Field workers are persons who both affirm and deny the validity of native conceptions . . . They know less than natives, but claim to know more. . . They must of necessity experience their mode of existence as profoundly alienated. To the degree that they deny the alienated nature of their existence, they will produce knowledge that is alienated in another sense. . ." (1982:269).

easier when residents and I were not in the presence of counselors. Alone, I did not pursue or enforce the clinical concerns of counselors and this is something the residents caught onto quickly. Passing with residents was easier because their expectations posed far less of a discrepancy with my "personal identity" in the group home.[14]

Counselors understood and agreed there were kinds of interventions I could not do without potentially causing confusion about my role.[15] Some presumed I should address the many everyday clinical concerns they regarded as necessary work with the residents. In the first month of my research, David came, in his bathrobe, to find me in the living room where I was watching TV with a bunch of residents. He asked if I would help him regulate the temperature of the water for his shower and I obliged him happily. Given that he seemed to have sought me out specifically made me suspect it was not an innocent or random request and that he must require such assistance every evening. I told Lisa about it later in the staff office and she frowned with displeasure: "Well, he's supposed to ask his peers for assistance and then, if they won't help him, he can come to staff." I acted contrite about having assisted him. Lisa emphasized the responsibility was David's - "he

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14. The concept of "personal identity . . has to do with the assumption that the individual can be differentiated from all others and that around this means of differentiation a single continuous record of social facts can be attached, entangled like candy floss, becoming then the sticky substance to which still other biographical facts can be attached. What is difficult to appreciate is that personal identity can and does play a structured, routine, standardized role in social organization just because of its one-of-a-kind quality" (Goffman 1963:57).

15. For example, there was a period when staff observed Marty in the shower to ensure proper washing, something that was discussed as too intrusive for my role. I also would not perform routine counselor functions like scheduled counseling or advocating for residents in medical situations. Medical and health matters involved a sphere of tasks that the agency would not permit me to perform because of liability or certification issues, such as administering medications.

knows what he's supposed to do" – but then chastised me for not having already known that he should be redirected to his peers. She suggested I read the goal plans right away so I will "know how to deal with the guys."[16]

This points to the kind of discretion I was able to exercise as a researcher. In many everyday ways, I often did not adhere to the group home's clinical procedures unless it would harm or confuse residents or pose work problems for counselors. Only the issue of Marty's psychogenic seizures, or falls, raised this question repeatedly. They had occasionally caused him injury and were an upsetting and frustrating issue for staff.[17] Given the possibility of physical harm, and to avoid confusion, Marty's "behavior plan" was one that I did follow.[18] His falls were understood as "inappropriate attention seeking" driven by anxiety. If he fell inside the group home and was not injured (most falls did not in fact result in injury), the plan required that counselors not participate in conversation with him until he could stand and walk on his own. Outside the residence, counselors would, if necessary, move Marty to safety (onto the sidewalk from the street, for example) and return him to the residence immediately. Marty and I took many neighborhood excursions on our own – for coffee and doughnuts, for errands, for walks – and this

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16. As an aside, Lisa, alone among her colleagues, did not appear at first to find it compelling that my research would include "the residents' perspectives" given their self-evident clinical needs. For the first month or so, she reminded me frequently that I was not an "insider." Especially when residents were upset or there was conflict in a staff meeting, she would remark: "Oh, that will be interesting for your research." After a month or so Lisa appeared to adjust to, and even enjoy, my presence.

17. Marty is discussed in other chapters, especially chapter 7.

18. Similar in form to goal plans, behavior plans target negative or disruptive aspects of conduct. Behavior plans are discussed in chapter 5. Marty's behavior plan is discussed in chapter 7.

enabled me to use greater discretion in the complex situation of his falls.[19] In thirteen months, there were only two episodes outside that, according to the plan, warranted returning Marty to the residence immediately. In both cases, I suggested instead that we sit and relax for awhile and he agreed — one time, on a conveniently located stoop; the other time, right down onto the sidewalk in front of our regular doughnut shop. These were situated judgements that departing from the plan would risk neither Marty's safety nor the staff's discovery of what I had or hadn't done.

**Quiet mornings**

On weekdays, I often arrived around noon in order to take advantage of the relatively quiet hours before the evening shift. Most of the residents are not at home during the day and it was during this time that I read the clinical and administrative records. Seven of the residents attend day treatment programs away from the residence.[20] The remaining eight have jobs in one or another capacity. Chris, David, Jennifer, and

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19. I do not mean to imply that counselors are not able to or do not exercise discretion, but only to describe the kind of discretion I was afforded by my role as a researcher. Lipsky (1979) and Perrow (1967) show that worker discretion is necessary to accomplish complex, non-routine tasks. Work with human conduct is inherently complex and, in chapter 3, I describe how discretion is a defining aspect of the counselor job.

20. Since the 1970s, day treatment programs and sheltered workshops (see note 21) have been a staple of non-residential community-based services for individuals with cognitive disability. Day treatment programs include "activities that provide a combination of diagnostic, active therapeutic treatment and habilitative services . . . [and] programs may vary widely" (14 N.Y.C.R.R. § 635.99-1). The programs attended by the residents resemble school: different levels of services are organized by classroom and staff are referred to as teachers.

Kenneth each attend sheltered workshops.[21] Ruby was a stock person, for a time, in a neighborhood shop that participated in a program which provided support in competitive jobs. Evan works in a similar arrangement bagging groceries at a large supermarket. James attends an employment training program that places him in temporary supervised jobs in not-for-profit settings, both public and private.

On weekday mornings, most of the residents are gone by eight o' clock. The morning counselors arrive between 6:30 and 7:30, in time to assist the residents with breakfast, give meds, and keep after the stragglers — especially Chris and David — always in danger of missing their program bus or being late for work. Sonia might arrive anytime after nine, although she sometimes spends days at the agency's administrative office for meetings and training. Angela, Maria and Monica's chief responsibility as morning counselors is to coordinate the residents' medical services. This involves a substantial amount of administrative work, as well as appointments, even for residents who have no health issues, because New York State mandates a variety of annual medical and psychological assessments for everyone. The large calendar, above the long desk on the left wall in the staff office, functions as a master schedule. The current month on display indicates in the counselors' varied hands the many appointments residents have with professional service providers of all sorts. The morning counselors not only ensure that

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21. OMRDD regulations describe a sheltered workshop as "a facility providing remunerative employment designed to provide a controlled and protective working environment and employment activities, with individualized goals to assist the individual to progress toward normal living and productive vocational status. The objective is competitive employment if the potential exists . . ." (14 N.Y.C.R.R. § 635.99-1). Sheltered workshops usually arrange to bring in piece work from private sector firms.

the group home is in compliance with the monitoring of residents' health and escort them to appointments, they function as advocates and health educators in doctors' offices and at home. On a day when a resident has an appointment, he or she stays home from work or program. That it is usually quiet during the morning shift means the counselors spend a great deal of time with residents, especially alone. Traveling to and from appointments also affords opportunities to spend time together out of the residence, often going shopping or out to lunch as well, breaks from routine that most residents relish.

Irving is the only resident always at home during the day because he also happens to be a group home employee, paid to do light cleaning in the kitchen three hours a day during the week. He is aloof, in certain ways, but for a willing listener always has a story from his long experience with social services which began in childhood at Willowbrook. Irving has occasionally been involved in self-advocacy, a movement that urges individuals with cognitive disability to represent themselves in professional and political contexts, and my familiarity with it turned out to be a ticket to friendship. I would often lean on the radiator below the kitchen window and we would talk while he cleaned. Irving is one of three residents who do not share a bedroom, and he spends most of his time there watching television, sometimes with Ruby, his one regular friend (and maybe even occasional lover, something they both implied but never told me outright, and was suspected by the counselors). I often stopped in to hang out in the evenings, too, and chat about current events with the TV turned to the news.

Theresa is home more often now that she attends day treatment only three days a week, sitting quietly in the living room or with the morning counselors in the staff office.

A five-day schedule had become too difficult with her arthritic knee but this semi-retirement at 68 has in no way diminished her active vigilance over domestic order in the group home. Theresa keeps an eye on things: stopping to return stray items to their proper place; attending to someone who seems upset; dispensing orders to residents and counselors about unfinished chores and other matters. Daniel once remarked to me with great affection: "C'mon, she's like my grandmother!" At night, after eleven, when the evening counselors leave and the house is still, Theresa does her rounds. In powder blue felt slippers, a housecoat over her nightgown, she replaces any pots, now dry from dinner, in the cupboards; wakes Paul or Donna if they have fallen asleep in the living room in front of the TV; and checks on the overnight counselor in the staff office, before heading to bed herself.[22]

Daniel did not mean to imply that Theresa is a sweet old lady however. Her infamous temper is occasionally provoked by Angela's persistence about doing her knee exercises. On many days, I arrived to find a grumbling Theresa, perched on the edge of a chair in the middle of the staff office, Angela cheerily instructing her movements and counting out loud. Theresa is given to running her fingers through her thick white-gray hair and the occasional curse (in English or Italian), which is usually met with a peal of laughter and a wink from Angela who, all the while, is usually doing other work as well: back and forth to the shelves and drawers for filing; an open treatment book on the desk;

22. Between the hours of 11 pm and six am only one counselor is required to be in the residence.

or the telephone in the crook of her neck as she waits on hold to speak to a doctor, day program teacher, or psychologist.

Paul also now attends program only three days a week. For him, semi-retirement means more free time "out in the community."[23] It wasn't long into the research period that he invited me to join him one afternoon to return a video to the library. His arthritic knees make his walking slow and give him something of a shuffle. His obvious pleasure being out and about on his own seems to compensate for his pace. That the five block walk to the library took a half hour however had nothing to do with his gait. As a 23 year denizen of the neighborhood, Paul has a good deal of local business to conduct. He is a sparkling character, with his captain's hat covered with pins and buttons, and on occasion other accouterments (a toy Western-style pistol or airplane). The shopkeepers, waitresses and newsstand clerks we visited along the way largely welcomed us. When we were shooed out of one shop as soon as we crossed the threshold, Paul explained it with only a dismissive wave of his hand. We had a different reception up the street, however, at a discount store that carries toys, videos, CDs, and assorted gift and novelty items. Speakers in the doorway were pumping *merengue* inside and out and Paul treated us to his version of the dance. The two clerks standing inside laughed with us and greeted us with shouts of "You go!" and "Huepa!" Noticing my delight at his Caribbean Spanish cheer of

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23. Counselors and residents use the phrases "out in the community" or "in the community" to refer to being away from the residence and not under the auspices of a services setting. An example would be Monica coming in at midday and asking after Paul's whereabouts. If he had left without indicating his purpose, the answer could be simply: "he's out in the community."

excitement and appreciation, one of the clerks said with affection: "Oh, we know him for years and years. Yeah, he's been coming here forever."

**After three o' clock**

After three o' clock, the calm of the weekday morning begins to give way to the buzzing activity of the evening. The office begins to brim with counselors changing shifts and residents coming home from program and work. Most residents are home by four o' clock. Around 3:30, Marty, Evelyn and Diane arrive together because they attend the same day program (although in different classrooms), and usually come piling directly into the office from the front door across the hall. They produce their own fanfare upon arrival, full of back slapping, hand shakes, and hugs. Pictures and other projects they have made are often passed around to accompany their enthusiastic stories about the day.

Diane is shy but can also be very expressive and friendly in these moments. After the excitement of arrival, she settles into her more solitary pleasures, listening to her walkman, often in the living room in front of the television. Diane moved from her mother's house only three years ago. Although her mother is 85 and has significant health problems, Diane often visits but can never be persuaded to sleep there, always returning to the residence for the night. Evelyn has been living in the group home for five years, when she moved from the home of her long widowed father. He became too frail to provide the regular support and attention she requires and died shortly after she moved. Evelyn is the opposite of shy. A garrulous character, with an easy and generous laugh, she is both comfortable and coy. Like Diane, however, she treasures her solitude and is also famously

attached to her walkman. Evelyn can often be found at the back of the laundry room, her tapes spread before her on top of the dryer, gazing out the window and listening to music.

Marty is also extremely sociable and always eager for conversation. Our relationship had an opportunity to develop right away because he was home for medical appointments during the first week of the research period. Marty was delighted to have a new companion for conversation, especially someone who responded to him with equal delight. Having just arrived as a researcher in a workplace of busy people, his enthusiasm was both exciting and a relief. We often sat together in the living room looking at magazines he had purchased. I was initially puzzled by his choices, which often included *Black Hair*, *Entertainment Weekly*, and *Soap Opera Digest*. Although it was not obvious in the way he looked at these diverse, and unlikely, publications, I soon figured out that his pleasure in them was the beautiful women variously featured. Those first days also established a practice we continued on and off throughout my thirteen months there: sitting together and going through the daily paper. Marty does not read well enough to make the paper an interesting activity on his own, but the collaborative reading and discussion made the tabloids interesting for us both.

**Into evening**

When residents return in the late afternoon having fulfilled their outside responsibilities, like all people home from work, they pursue routine personal pleasures and take care of household chores. Residents, however, have additional responsibilities that relate to becoming independent. Evening counselors' spend time with residents in the

bustle of their home life: giving meds, supervising dinner, chores, and most goals.[24] Five and nine o' clock meds are central organizing features of the evening schedule. The counselor giving meds often takes a walk through the residence to announce that he or she is starting. Given that it takes at least an hour, some residents hang out in the living room until the counselor comes through again or a resident returning from the med office tells them it is their turn. David, Diane, Donna, and Jennifer, paper cups of water in hand, often assemble in the staff office around nine. Although these four do not converse with each other much, it is a lively spot at that hour and just next door to the med office. Giving meds can also shape the course of an evening by occasionally disrupting previous plans. For example, Daniel became ill and went home on an evening he was going to do nine o' clock meds. Susan happened to be the only certified counselor who was available that shift and this took priority over the date she had to do Evelyn's hair. The changeable course of group home life is largely unremarkable, although this does not mean that residents do not find it frustrating on occasion.

On weekday afternoons, it isn't long after the residents get home that some gather in the living room to hang-out, chat, and watch TV while they wait for dinner. Individuals use the living room in their own ways. Although the television is on, it never prevents conversation, and often people just sit quietly or, as Diane does, in the middle of the

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24. It should be noted that the counselors have all worked both morning and evening shifts, sometimes swapping or covering for each other when there are schedule changes. In fact, counselors take for granted the difference in kind of work and tone between shifts that I am emphasizing in order to describe the overall rhythm of the group home's schedule. It is only the occasional practical conflict between staff about how to distribute responsibilities that any difference between shifts becomes relevant.

action with her own soundtrack. The living room is pleasantly furnished, with three couches and two large armchairs, all in burgundy or brown. Wallpaper, some framed still lifes in the same color scheme, and two end tables with lamps give the room a comfortable glow. Only the chairs, at the far end in front of the window, and one couch face the television, but this does not create a shortage of seats for viewers. (The World Series was the only broadcast that caused such a problem.) Dinner is usually served between 6 and 7 o' clock, depending on the skills and schedules of the counselor and residents at work in the kitchen. Counselors and residents are always passing through, with five o' clock meds and other activities, and the traffic between the living room and the rest of the house brings regular news about the projected time of dinner. That dinnertime varies from day to day is a frequent source of annoyance for Kenneth, and he watches impatiently for Ruby to set the table. This is not a new problem, so he himself told me, and on many occasions he stops himself in the middle of his own complaining to say: "Really, I shouldn't be so upset about dinner. It's not something to be upset about. I worry too much."

Aside from talk about what is being served up, and when, there is an ongoing conversation among certain residents about group home logistics.[25] Chris, Irving, Jennifer, Kenneth, Marty, Ruby and Theresa know everyone's schedules: medical and other appointments and who attends evening recreational programs on which nights and what time they come home. These residents are aware of the general medication procedures and which counselors are certified to give meds on a given shift. They follow

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25. This is described as resident shop-talk in chapter 3.

staffing issues with a keenness and accuracy one expects of an actual worker. The practical ramifications of a counselor out for illness or vacation are an endless source of discussion and analysis. There are animated debates about how doing meds can and should be allocated given the staffing patterns and schedules. When counselors wander through the living room, also waiting for dinner to be served, they are often consulted for missing pieces of information: "When is Cheryl getting back from her vacation?" They are also informed of the discussion's findings. Carlos came in one day at about five to announce he was giving meds and appeared surprised by the attentiveness Kenneth displayed when he inquired: "So what happens if Daniel's sick again tomorrow?" Carlos replied matter-of-factly: "He *is* gonna be sick again tomorrow. He has the flu." Kenneth was incredulous: "But that's not fair! That'll mean you have to do meds three days in a row!"

Which counselor cooks dinner is decided during "shift meeting," the brief, informal huddle that occurs around three o' clock when the evening counselors arrive. There are several routine responsibilities that must be assigned on each shift, including giving meds. Cooking is unpopular with some counselors because being tied to the kitchen can be contrary to work that is largely characterized by contingency and the juggling of multiple tasks. My willingness to cook pleased counselors and provided me an opportunity to spend time with residents who were not as outgoing as Marty, Jennifer, Kenneth, or Theresa. There is supposed to be a resident working on their cooking goal with the counselor preparing dinner, but most evenings residents do not want to participate. Counselors are also not concerned with cooking goals because they are too busy keeping their eye on activities occurring elsewhere. Cooking goals organize meal preparation in

terms of the specific techniques that teach residents how to do it. There is an analogy between recipes for cooking and goals as recipes for conduct. The systematic approach to cooking that recipes represent often exacerbates counselors' routine workload conflicts. Following a cooking goal did not pose this problem for me but residents themselves actually have little interest in doing them.[26] Since cooking provided an opportunity to have contact with residents, I tried to involve anyone who expressed even vague interest, if only by pitching in for a few minutes on their way to the living room.

When dinner is ready, it only takes a casual mention to a nearby resident to marshal everyone into the kitchen. From all over the house, residents and counselors respond to the familiar and welcome cry: "Wash your hands! Dinner's ready!" People take the plate from where they will sit at one of the four round tables, already set in the dining room, and file through the kitchen to be served. As each resident finishes eating, he or she gets up and deposits their dish, silverware and cup in the kitchen sink where they pile up for Diane to load them into the dishwasher. This is her chore, one of many that are done in a slow swell of activity that increases as people finish their meal and continues into the evening. In addition to cleaning up the kitchen and dining room, the chores include cleaning the bathrooms, emptying all the garbage cans in the residence, and vacuuming the offices and living room. Some people disappear into their rooms or hang out in the staff office when they finish their chore. Others settle in the living room and a typical scene

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26. The precision with which goals are written does not determine how they are actually followed or shape conduct. Cooking goals appear to be a low priority for residents and counselors do not generally pursue or encourage them, partly because of the practical matters mentioned. At one point, Sonia thought residents were not participating enough in cooking and told counselors that it was their responsibility to encourage residents to do their cooking goals. This had little effect.

might include: Diane and Marty watching TV; Kenneth, Ruby and Theresa talking about which counselors are working the weekend shifts; Johnny doing one of his word-finder puzzles; and Donna snoozing.

To say that people settle down after their chore is really to say that the evening settles into its regular rhythm. In the group home, there is always movement. Through the course of routine evening activities, residents and counselors are always passing between the staff office at one end of the house and the living room at the other. In addition to specific goals and other tasks that residents and counselors do and demand of each other, weekday evenings include various scheduled activities. The Residents' Meeting on Mondays at eight is the only event that includes everybody, and most attend. On other nights, there are activities involving only individuals or specific groups of residents and additional people are even added to the mix. On Tuesdays, the speech therapist comes for a few hours to work one-on-one with four residents, and uses the med office or supervisor's office for privacy. On Thursdays, Cynthia comes and, with Miles, runs a "peer support" group with four or five residents in the supervisors office at eight o' clock. For three months, a master's student in psychology came on Wednesdays as an intern.

**Some quiet**

The relatively predictable pace of weekdays – the quiet morning giving way to the bustle of evening – does not mean the group home is not characterized by almost daily contingencies of all kinds which must be managed as a matter of routine practice. I

learned quickly that there are fewer surprises on weekends. The house is typically tranquil all day. Residents come and go on their own or in small groups. Some prefer to hang around the house and relax. Others go to the movies or the park. On Saturday or Sunday, there is usually a recreational outing that has been organized by residents and staff. "Rec trips" might involve taking a large group in the van to the beach or Daniel's mother's house for a barbecue. It might also mean a few residents getting on the subway with Sally and going to a department store and out to lunch. The easy feel of weekends always kept me around the residence, hanging out and talking, listening to music and watching TV, going out with residents for haircuts, lunch, shopping, or a walk around the neighborhood.

The general rhythm of the house is set by the counselors' shifts. Although I often arrived before the evening counselors, I rarely stayed after eleven o'clock because the house was already quiet for the night, most residents are in their rooms with the exception of two or three in the living room or staff office. Theresa and David are often just returning before eleven from their nightly excursion to a neighborhood coffee shop. It is really Theresa who presides over "going down for coffee." She and David go every evening, but more often than not they are joined by James, Kenneth, Ruby, or me. Donna is always keen to join unless she has already gone down earlier with James. The staff do not consider her independent enough to go out on her own although she is permitted out with most of the residents.[27] The counter was never especially busy when we would arrive

27. Evelyn is the only other resident who is not considered independent enough to "travel" alone in the community but is permitted to go with other residents. Marty is not permitted out without the accompaniment of a counselor because of the issues introduced briefly above. I was permitted to take him out because the supervisor believed that I could handle what problems might arise.

around nine-thirty or ten o' clock at the 24 hour coffee shop. The night waitresses would have just come on duty and seemed to enjoy beginning their shift with our dependable visit. We were not the only regulars. There were the familiar faces of a few hospital workers, cabbies, and others having a meal or coffee at the beginning or end of their workdays. Some acknowledged us warmly. Others took no notice at all. The hour or so we spent at the counter each evening provided an alternative to the bustling group home, but the wide range of topics were the same: the logistics of scheduling and appointments; rec trip plans; disputes or trouble in the house; and so on. The waitresses knew us by name, and as they wiped down the stainless, filled creamers, and cut pies, they would inquire about the group home pleasures and problems they followed nightly. Often we would just sit and sip our coffee in comfortable silence.

## Part I
## Introduction: Different kinds of work

The idea of a workplace permits an approach to organizational participation and commitment as a dilemma of liberal freedom, and is an alternative to the familiar conception of group homes as settings of social control. The group home is not only a workplace because of the livelihood it provides counselors. The chapters in Part I investigate different ways the setting is organized by three kinds of work: the work of counselors, the work residents do on themselves, and the work of everyday life as an accomplished local order.

As a conventional workplace, the group home is described in terms of some of the organizational features it shares with "street-level bureaucracies." Lipsky (1979) regards such settings as fundamental to contemporary social order, and his analysis indicates that they are essentially sites of government. Across a vast range of services, they "delimit people's lives and opportunities . . . [and] provide the social (and political) contexts in which people act" (Lipsky 1979:4). Although Lipsky does not emphasize their "capacitating" (Rose 1996a:27) function, welfare offices, public medical clinics, group homes, and social services of all kinds, are "organizational embodiments of contradictory tendencies" in the welfare state (183) and, therefore, always both normative and coercive.

> Schools are coercive in that they require attendance by law, they have strong sanctions against deviant behavior, and they are the only institutions in the society where parents can send children to learn basic skills. They are also normative in that they attempt to motivate children by socializing them to want to participate in the system. A drug rehabilitation program is coercive when it stands as an alternative to jail, but it is also normative because it cannot succeed unless people are motivated to accept the orientation and discipline of the program (1979:43).

Lipsky also shares the concerns of governmentality analysis when he explains that street-level bureaucracies are partly constitutive of citizenship. Such settings "socialize citizens to expectations of government services and a place in the political community. . . [and] mediate aspects of the constitutional relationship of citizens to the state. In short, they hold the keys to a dimension of citizenship" (1979:4).

Counselor work reflects many of the "dilemmas of individuals in public service" that Lipsky describes. "People-processing" settings are characterized by an inherent conflict between a climate of regulation and accountability – which demands the bureaucratic rationalization of services – and an ideology of care – which emphasizes the autonomy and individuality of clients. Lipsky shows how routine work practices emerge to cope with these conflicts and get the job done in more or less satisfying ways. In street-level bureaucracies, as in the group home, the uncertainty and ambiguity of working with people is exacerbated by limited resources and creates an endless demand for service. Street-level bureaucrats develop patterns of practice, often informal and unwittingly opposed to official principles of service, to manage the ongoing clash between professional ideals and the organizational exigencies of work. It is in these routine practices, Lipsky argues, and not in policy meetings and legislative chambers, that service outcomes are actually determined.

The organizational and reflexive character of counselors' people-processing work is an inseparable aspect of the ongoing accountable production of everyday group home order that ethnomethodologists understand as a kind of work. This notion is drawn from Alfred Schutz' (1970) argument that "the world of working," the sphere of overt action

that organizes everyday life (212), is "paramount reality" (226). For ethnomethodological analysis, there is a more specific empirical focus which Garfinkel and Wieder characterize as: "the lived, concerted, unavoidably embodied, smoothly achieved work in content-specific detail that makes up the accomplishment of the most ordinary organizational things in the world" (1992:202). Ethnomethodologists have turned to the investigation of the work of everyday life in actual workplaces in order to show how even formally structured settings depend on distinct and local orders of mundane activity.[1] Even "the most ordinary organizational things" are the basis of a very esoteric kind of work, scientists' work. Scientific research can thus be approached in terms of the "work-specific competencies" that constitute the local order of biology laboratories and astronomy observatories (Lynch 1993:114).

The work-specific competencies that are an organizing feature of the group home are not only the province of counselors. Residents are also group home workers because their participation is organized by the endless everyday work they do to enhance their own "independence, individualization, integration and productivity." The residents' official group home work is not the kind of activity usually regarded as work in sociology. Nor can it be understood only in terms of the residents' competent and ongoing accomplishment of everyday group home life. The work residents do on themselves is the work of self-government, and their skillful, endless pursuit of independence is the very

1. Ethnomethodological Studies of Work (1986), edited by Garfinkel, includes studies of corporate offices, martial arts studios, courtrooms, and other workplaces.

work that defines residents as certain kinds of group home persons.[2]

Residents are not the only people in contemporary society who take their own selves as objects of endless clinical work. The group home only reflects a broader ethic of autonomy in contemporary society that:

> impels the subject to 'work' on itself, to take responsibility for its life. It seeks to equip the self with a set of tools for the management of its affairs such that it can take control of its undertakings, define its goals, and plan to achieve its needs through its own powers (Rose 1996a:159).

The equation of activity with health, self-knowledge and autonomy can also be seen in the government of welfare recipients through self-esteem building (Cruikshank 1999) and in the structured employment programs that now govern individuals, not as unemployed, but as active "job seekers" (Dean 1995). Client self-empowerment, only recently the buzzword of anti-professional movements, is now also a central objective for many kinds of social services (Baistow 1994-95). Even getting old is defined by an ethic of "activity." Katz (2000) shows how the ordinary, occasional difficulty experienced in later life has been taken up by gerontology as a universal problem of adjustment. Being well-adjusted in old age means being "active," and the ideal of activity organizes everyday life itself as the prevention against the potential consequences of poor adjustment: dependence, illness, and loneliness. A similar ethic of activity also defines the risks and demands posed by the other end of life. Cultivating children's autonomy had become a primary aim by the

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2. Of course, resident work is not paid work. However, social services increasingly reflect a "contractual ethos," in which the government of recipients involves activities that are seen to fulfill a social obligation, thereby "earning" services and even state entitlements. This issue is addressed in governmentality analysis of changes in the welfare state and public sector services see: Cruikshank (1994) and Dean (1995). For an analysis of "contractualism" see: Yeatman (1998).

1980s, and experts began urging that parenting be active because infants require a high level of intellectual stimulation and "observant" rather than passive care (Wrigley 1989).[3]

As Rose characterizes it: ". . . individuals are incited to live as if making a *project* of themselves: they are to *work* . . ." on their own selves (Rose 1996a:157, emphasis in original). In contemporary society, "the quotidian affairs of existence have become the occasion for introspection, confession and management by expertise" (Rose 1996a:159). The group home presents residents with the endless opportunity of their own ordinary experience. This dissertation suggests that, in one form or another, the never-ending pursuit of self-enhancement is the mundane work we all must do. What sets the residents apart is not their questionable capacities for freedom, but the organizational and documentary practices that make their own work group home work.

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3. The ideal of autonomy is also seen in developmental psychology. Cushman (1991) accounts for Daniel Stern's influence in this field partly in terms of the way his laboratory observations of infants reflect cultural aspirations and political ideals of autonomy and the individuated self.

# Chapter 3
## Endless, Uncertain Work

## I. INTRODUCTION

This chapter is concerned with the endless and uncertain character of group home work that must be managed in the routine course of the work itself, in order to get the job done, and to get it done in meaningful ways. I describe several everyday monitoring practices, both formal and informal, that group home workers use to manage both their problems and pleasures.

As a workplace, the group home shares certain organizational features with "street-level bureaucracies" (Lipsky 1979). Michael Lipsky shows that individual workers in public services must cope with the conflict, confusion, and pressure inherent in "people-processing" work by developing informal patterns of practice. Often counter to official policy, these practices become routine and functional aspects of the work for individuals as well as the organization. Work is uncertain n settings such as welfare offices, police stations, and public clinics, because human conduct is by nature unpredictable and outcomes are therefore difficult to define and measure. This complexity is exacerbated in street-level bureaucracies by the characteristic tension between an ideology of care and demands for the rationalization and accountability of services.

Although the group home resembles street-level bureaucracies in several fundamental respects, Lipsky's analysis, like most sociological studies of social services *as* workplaces, ultimately focuses on power and the conflicts between organizational demands and professional ideals. This is true not only for the sociology of work and

organizations. Much research in deviance and social control is also often concerned with the coerced nature of identity and experience, and group homes and similar settings are largely approached in Goffman's terms as "forcing houses for changing persons" (1961:12).

I approach the group home as a workplace because it enables an understanding of organizational participation and commitment as a dilemma of liberal freedom and not simply a problem of coercion. This is an especially suitable approach to the group home because the premise of community-based services is that individuals with intellectual disability are citizens. Many researchers have already shown that community integration has generally fallen short on the promise of rights first made more than thirty years ago. This paper does not address the question of whether services overall have adequately extended rights and choice. Like many community-based settings (though by no means all), the group home is organized by the practical problem of individual liberty. This is not to suggest that this research site has actually fulfilled the promises of community integration, only that the basic functioning of the group home depends on the residents' capacities for consensual participation.

My approach combines conventional ethnographic description with insights from ethnomethodology about the reflexive, situated, and temporal character of action. Approaching everyday life as a local, contingent accomplishment allows me to draw on insights from both deviance and work and organizations without focusing only on questions of conflict and power. It also enables me to understand work as more than the counselors' remunerated activities. Counselors are not the only group home workers.

The competent participation of residents is organized by the ongoing clinical work they do to "become more independent," and this makes the group home a workplace beyond the livelihood it provides counselors. I show how the group home's everyday work involves the continuous and skillful activity of both counselors and residents.

That the overall clinical goal of independence is out of reach for residents in any conventional sense is one way in which group home work is endless. There is also little distinction in the group home between work and other activity, which makes everyday life a potentially limitless clinical domain. The endlessness, uncertainty, and ambiguity of group home work must be managed in taken-for-granted ways just to get the job done, and, as often as possible, to get it done in meaningful ways.

The inherent difficulties of working with people are managed in routine practices that ultimately define what group home work actually is and how it gets done. There are several routine practices of monitoring that function for both counselors and residents to make sense of their everyday work. The next section begins with a discussion of how the group home resembles a street-level bureaucracy and how counselors' situated accounts of their own role, the residents, and the group home provide an ongoing basis for assessment in work that is inherently ambiguous and indeterminate. I then describe two monitoring practices: one, "doing the log," which requires the counselors to use documentary techniques that shape the endless character of work in the perpetual monitoring of everyday life; and two, "shop-talk," the informal and ongoing conversation among counselors, which reflexively organizes both failure and success in the continuous and close monitoring of work. In Section III, I describe how residents also manage

uncertainty as an aspect of their own group home work. This is the routine uncertainty of everyday life, however, and I show how it takes shape in the informal monitoring of mundane group home operation and in their own shop-talk. The paper concludes with a discussion of how the routine practices that counselors and residents use sometimes come into conflict, which reflects a paradox inherent in the group home.

## II. COUNSELOR WORK

In this section, I describe how the group home resembles a street-level bureaucracy, and some of the ways counselors' accounts of the clinical work in which outcomes are difficult to define and measure. As Lipsky argues, such work demands the constant exercise of individual judgement and cannot be accomplished with standardized procedures. Counselors regard their high level of discretion as an indication of the technical character and, therefore, the importance of their work. This discretion is related to their relative autonomy from supervisory authority, which stems from the fact that a good portion of counselor work is done individually with residents and out of view of supervisors and colleagues.

Counselors are committed to the clinical orientation of the group home, and have an "expectation" of the "human dimensions" of their work that make it a kind of legitimate professional work (Lipsky 1979:50). By contrast, the good deal of paperwork for which they are responsible is often regarded as a burden imposed by agency superiors and state regulators who appear to counselors as out of touch with everyday demands. Clinical work is the "real" work, both meaningful and interesting, and along with their low pay and

occupational status, indicates the job's moral value and personal sacrifices.

The therapeutic model that counselors value as complex and skilled also serves to define group home work in specifically manageable ways. Both Lipsky and Nikolas Rose (1996; 1999) challenge the typical argument that clinical approaches function to manage work by controlling behavior. The pervasive use of therapeutic and medical models in a range of services settings can be explained less by professional power than by the way these models function to clarify and simplify goals (Lipsky 1979:48). A clinical approach:

> provides a defense against personal responsibility . . . by resting responsibility for clients in their physical or psychological development. It [also] provides a theory of client behavior to help explain the complex world of the street-level bureaucrat (Lipsky 1979:15).

Rose (1996; 1999) argues more broadly that psychological knowledge has come to furnish a fundamental ethical basis in contemporary society. In this vein, I argue that psychological knowledge does more than provide "goal clarification" and "a theory of client behavior." Psychological knowledge in the group home shapes the nature of consensual participation, because clinical assumptions, jargon, and modes of intervention, function as practical techniques that enable ideal goals to be realized in the actual, everyday work of both counselors and residents. However, the complexity of human conduct, and therefore the conflict and ambiguity of work goals, can never be eliminated, and even "the accepted definitions of . . . tasks call for sensitive observation and judgement . . [and] are not reducible to programmed formats" (Lipsky 1979:15). The situated use of clinical techniques available shapes the contours of counselors' discretion, what counts as a clinical matter, and even the nature of clinical work itself, and are a practical resource for managing uncertain and complex situations.

The difficulty of measuring and controlling outcomes means that counselors account for their daily successes and failures with various clinical and moral beliefs about their role, the residents, and the group home's mission and indicate the complex and often contradictory ways counselors understand their work.[1] The following examples are not meant to illustrate the limitations of the training or individual capacity of counselors, but only how such accounts are necessary in work that is ambiguous and indeterminate. Lipsky emphasizes that street-level bureaucrats:

> believe themselves to be doing the best they can under adverse circumstances, and they . . .salvage service and decision-making values within the limits imposed on them by the structure of their work. They develop conceptions of their work and of their clients that narrow the gap between their personal and work limitations and the service ideal (xiii).

Counselors at times portray the group home as a buzzing and chaotic place that makes for demanding but exhilarating work; sometimes as thankless but satisfying; supervisors are, at times, regarded as insensitive to the actual demands of work and the counselors' needs; and when even this failure-prone work is understood as clinical work, it can be enjoyed for the discretion and knowledgeable judgement it demands.

When counselors indicate a taken-for-granted acceptance of the technical importance and moral value of clinical work, they appear to share the approach of the agency emphasized in training, in weekly staff meetings, and in ongoing individual meetings with Sonia, the group home supervisor. This is not always the case, however, because counselors often make their work accountable by in criticisms of the agency,

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1. I am using the more general term "accounts" to include what Lipsky refers to as "personal conceptions."

Sonia, and each other.

Staff often regard themselves, as Sonia once put it, as "translators for people with mental retardation. They have feelings but don't always know what to do with them or how to express them, and . . . [we] partly are there to assist with this." Daniel, who at age 42 was older than most of the counselors, made frequent analogies to parenting and attributed his understanding of, and even ease with, residents to his experience having teenage daughters. The general assumption that both teens and residents are characterized by their questionable autonomy means, as Daniel explained, they similarly require "guidance and leadership," but also need to be encouraged to be "as independent as they can" and to have "the confidence to take risks." He described the group home ideally ". . . as a cushion for them to fall back on," a notion he immediately qualified by acknowledging one aspect of work with residents that makes it endless: "of course there are guys here who can't go beyond where they are, which is fine."

Counselors must make sense of routine frustration and conflict in their work with residents. In a staff meeting, Sally described her recent frustration with Diane: "She's so hard to motivate– refusing rec trips, requiring lots of prompts for ADLs,[2] you know?" Sally paused before expressing her exasperation in a rhetorical question that presumed her sentiments were shared: "I mean, where do we draw the line? They're adults, I know, but we're providing a service." Like Daniel, in his analogy to teenagers, Sally articulated the ongoing dilemma counselors face exercising authority without unduly compromising the liberty of individuals who are considered incapable of living independently.

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2. ADLs are Activities of Daily Living and include basic hygiene and self care.

Counselors express ambivalence toward the clinical work that, at other times, is so meaningful. Sally told me that the training counselors receive when they start the job, and then occasionally, often "creates the idea that it's more clinical and not just a house where people live." In another conversation, Daniel similarly commented also that:

> the training is good but it contributes to the idea that it's sort of, you know, like a hospital. I mean I love staff meetings. We talk about everything from the most complex clinical stuff to tooth-brushing. It's fascinating. But some staff, young staff, come in and think it's like a hospital.

Miles was less ambivalent when he described how clinical work determines what it means to be a group home person:

> Really, you get to know people in terms of their goals and not fully at all. The other day I hung out with Chris for like an hour, which, you know, is very unusual, and I realize that I didn't know him at all.

Even Sonia, who must attempt to represent the agency's clinical approach and is herself often implicated in criticisms, complained to me privately that the counselors' clinical expectations make them unable to:

> see who Irving really is. They don't treat him like an adult, they get frustrated with him, and his complaining. But sometimes despair sets in. Can someone be in therapy for life? I'm not saying they shouldn't work with him, but accept him.

Counselors sometimes regard the group home's clinical orientation as an obstacle in their work when it poses a conflict with what they claim residents' "really" need. This kind of criticism is often used when clinical arguments do not include, or even contradict, a counselor's understanding of the problem at hand. Sometimes this is even expressed as a generalized hostility. For example, when Cynthia, whose job consists of supervising the development and implementation of the clinical plans, once arrived late to a weekly staff meeting, Carlos whispered sarcastically to Miles and me: "Cynthia's here. Oh, goody!

Now we can talk bullshit." But the reverse occurs sometimes, too, when counselors see a clinical course of action as self-evident but are hindered by larger principles of service, such as the problem of rights. Daniel made this point in one staff meeting by drawing the opposite implication of his analogy between residents and children. Rather than providing guidance and support, here the "parenting" function of the group home was "to teach them responsibilities. I mean, we can talk all about their rights but if they are going to learn to be more independent then they also have responsibilities."

Finally, counselors do not regard their clinical work as limited only to the residents, and often invoke the challenging nature of group home work in terms of the personal challenge to themselves. Being a good counselor involves knowing and understanding one's own feelings and how to "keep them in check." The feelings one has when residents express resentment or anger toward them, when clinical interventions fail, and when one is simply taken for granted, must be "separated from your own issues." Counselors' clinical work on themselves provides an account of their ability to tolerate disappointment and frustration – "that's what we're for" – and an inclination toward self-reflection is seen as an indication of "the kind of person who chooses this work."

In a staff meeting discussion about how Marty was not responding to intervention, counselors turned to the problem of their own frustration and encouraged each other not to "take him personally" because "he can't help himself." After Miles reassured Monica that it is virtually impossible to understand and predict certain Marty's conduct, Daniel addressed the group: "We have to remember how hard it is not to personalize it [Marty's episodes] and feel frustrated." Miles agreed: "Marty can't help how he behaves . . . we

shouldn't be expecting to cure him." Counselors account for the vexing emotional nature of their work by understanding Marty's conduct as his personal failure and by understanding their work as involving the additional personal work of managing their own feelings and expectations. Their mutual support was expressed in available clinical techniques that indicate what knowledge one must have and how to use it. Being an effective counselor not only requires knowing and understanding Marty, but also knowing and understanding how to maintain realistic expectations and not personalize the work.

**"Doing the log"**

This section describes how uncertainty and endlessness take specific shape in the group home's clinical work, and, in particular, how "doing the log" organizes the endlessness of work in its technique of monitoring everyday life. As in all street-level bureaucracies, group home work is endless because the demand for services always exceeds supply. In settings that typically have limited resources, some rationing of services must also occur informally in routine practice and, quite apart from official procedure, often determines how the work is actually accomplished. Demand must be understood as more than a transaction, but as shaped "transactionally," in relation to changes in both actual resources as well as clients' perception of the services available (Lipsky 34). Moreover, demand cannot be understood in quantitative terms alone. It always has specific qualitative dimensions, and in the group home, where all of everyday life is a potential domain of clinical work, even the most mundane interactions shape the perception and demand for services. Counselors ration demand in situated and practical

ways, making residents wait in order to finish paperwork, for example, or claiming to have a meeting in the staff office in order to shut the door for a few moments of quiet.

Group home work is endless because demand is endless, but also because "clients' problems are not subject to closure. Although street-level bureaucrats are regarded, and regard themselves, as able to solve problems, the problems do not end or are not resolvable" (Lipsky 78). Outcomes are difficult to control because "people do not stay 'fixed'" (Lipsky 78). For Lipsky, this is an aspect of his criticism of the "inadequate solutions" that make social services bureaucratic "revolving doors" (Lipsky 78).

That work is "not subject to closure" in the group home is additionally related to the nature of clinical goals. Although psychological knowledge provides a framework for clarifying counselors' goals and expectations, it also comes with particular kinds of ambiguity and indeterminacy. (40). The very formulation of the group home's overall goal, for example, indicates that it is a "process" goal and thus ambiguous by definition: "*to promote and encourage* the independence, integration, integration and productivity" of residents. The goal is not independence *per se*, but its pursuit; and for individuals unable to achieve independence in any conventional sense this is an endless pursuit. Defining and measuring outcomes, for residents and counselors both, is uncertain and endless because work on human conduct – others' conduct and one's own – is organized by a temporality of progress. A clinical process goal, like independence, is "ever-receding," which means that there can always be progress.

Although counselors, much like sociologists of work and organizations, often regard the documentary and other demands of paperwork as posing conflicts with ideal

clinical practice, "progress" actually gets defined and measured (and goal ambiguity is reduced) in the documentary technologies that realize abstract "needs" and "problems" in actual tasks of work. The multiple demands for documentation, which are a large part of the counselors' responsibilities, thus make the monitoring and assessment of group home work a central aspect of that work. The "daily log" is the most basic example of a monitoring technology partly because "doing the log" (which refers specifically to writing notes) is a responsibility of counselors at the end of each shift, and partly because it is not designed with any specific clinical outcomes in mind. The log thus appears as a simple instrument of communication that also generates a record of events. It is a technology of perpetual monitoring because it functions around the clock. A daily "face sheet" provides for the documentation of emergencies, changes in medical orders, unusual events, and any information that must be communicated across shifts (even, for example, when to expect the plumber). The face sheet serves as a cover page for the two pages of notes.[3]

Writing log notes twice daily reflects a concern with accountability that, although not unique in social services, is stringent with intellectual disability given the history of institutional abuse. The daily log certainly functions as it is intended, but it functions in another way too. In addition to the communication and documentation of information vital for regulatory compliance – from changes in medical orders to physical plant matters – the log also includes all of everyday life within its documentary purview.

The log is thus sometimes used to make troublesome aspects of resident conduct

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3. One page for morning and one for evening; they are photocopied forms with twelve spaces for writing, each containing a resident's name.

an observable problem. One example was a note for the morning staff about a dinnertime flare-up of the long-standing but occasional conflict between Evelyn and Johnny as a possible harbinger of problems. In another instance, David's day services program contacted the group home because they believed he was shaving too infrequently and not combing his hair. The counselors decided to press him each night to shower and shave. This meant that, for a time, evening log notes frequently indicated when this occurred and how much reminding he required.

That the daily log does not permanently include any specific clinical outcomes makes this technology of perpetual monitoring *endless,* in the sense that the innumerable mundane aspects of residents' lives must ostensibly be kept in view. In this way, the endlessness of work is organized for counselors by the simple documentary techniques involved in "doing the log." Only a very few aspects of everyday life, however, actually get documented as knowable and seeable matters of counselor work. The following are representative notes from relatively uneventful shifts:

From the morning log notes:

| | |
|---|---|
| David: | *A little agitated Very slow to motivate – went to work.* |
| Diane: | *Fine, no issues* |
| Evelyn: | *Please observe for having too many clothes on i.e. t-shirt and two sweaters and a jacket* |
| James: | *Great mood, went to work early.* |
| Kenneth: | *Upset re: funeral @ work. Counselled by staff. Perseverated all morning about the [party on the] 17th.* |
| Marty: | *A little agitated this am, went to program* |

From evening log notes:

| | |
|---|---|
| Chris: | *Great help. Out in the community for smokes.* |
| Donna: | *in the community with staff. Good evening, showed interest in cooking a lot.* |
| Evan: | *Got in late but okay mood.* |
| Irving: | *Isolated, except from Ruby.* |

| | |
|---|---|
| Jennifer: | *very friendly to staff, good evening* |
| Johnny: | *got upset when he thought Evelyn was mad at him. Redirected and was great.* |
| Paul: | *Was caught by counselor eating Ritz crackers in bed. Spoke to Nurse about his test next week.* |
| Ruby: | *stayed in room a lot. Came out to do chore. No issues.* |
| Theresa: | *Good mood, [out] for coffee* |

**Shop-talk**

In this section, I describe another monitoring practice of counselors, one that is also continuous but not based on a formal technology. It is the ceaseless informal conversation counselors hold among themselves throughout the course of their shift. I call this "shop-talk" to distinguish it from the chatter and small talk that occurs among colleagues in many workplaces. Shop-talk is the ongoing conversation about matters of work sustained throughout and across shifts as counselors come and go: called to the laundry room, to administer medications, to cook dinner. A topic may be interrupted in the dining room and picked up again later in the staff office. Or maybe not. There is no shortage of topics and, so it often seems, none is too small.

Shop-talk is both talk *about* the work and, as Michael Lynch (1985) describes it, talk *in* the work.[4] Shop-talk is thus a kind of work itself, a fundamental and reflexive aspect of the work that is continuously monitored. The ongoing and situated selection of topics shapes what is knowable and seeable in relation to the group home's formal technologies of documentation (of which the log is one example). These technologies, which are a large part of the counselors' responsibilities, clarify goals and organize the

4. I have taken this concept of shop-talk from Lynch's (1985) study of the work of laboratory biologists.

course of work in specific ways and over various durations (from the daily log all the way to annual reviews of each resident's progress). However, these technologies alone do not adequately manage the ambiguity, endlessness and uncertainty of the work. Counselors therefore also rely on the close and continuous monitoring of work with the situated selection of topics in shop-talk to keep a handle on complex situations, as well as to see and share their accountable successes. Shop-talk makes observable the counselors' moral and professional commitments, especially to that aspect of the job which is most satisfying – helping residents work on their independence – but also the most prone to failure.

What may appear to be casual conversations among colleagues, as shop-talk, are actually an aspect of the ongoing, situated process of defining and acting on resident conduct that constantly transforms the field of intervention. In the example of shop-talk below, knowledge of the substantive topics is not necessary for an understanding of how shop-talk functions as a practice of monitoring. I have provided details when necessary and certain issues are elaborated in the analysis that follows.

> "Don't you think Diane has been really quiet tonight?" Sally asked one evening in the staff office during a lull after nine o' clock meds. Miles hadn't noticed: "D'ya think so?" Sally was tentative: "I dunno. She went straight to her room when she came home from program. I think maybe something happened at program." Miles asked: "Oh, did you hear something?" When Sally nodded she hadn't, Miles was reassuring: "You know what she's like. Sometimes she just sort of retreats. I mean she's shy anyway." Sally agreed. As Miles was talking, Daniel came in and sat across from them on the file cabinet. He asked: "Who are you talking about?" Sally posed the question anew to him: "Diane. Do you think something's up with her? I think she's quieter than usual." Miles laughed, apparently at himself for failing to convince her, and Daniel answered in Miles' jocular spirit: "No! She's the same as always. Daniel indicated Miles and said to Sally: "He's right. You know she sort of has periods. Who knows? Remember she was really obnoxious for a while. Wouldn't brush her teeth or anything without hundreds of prompts? You had to remind her a hundred times?" Both Sally and Miles remembered and agreed. Daniel added: "Then at one point, she

just started being more independent with her hygiene again." This settled the issue for Sally: "No, you're right."

At this moment, Theresa came in and faced Daniel, who joked: "And what do *you* want, Miss?" "My dollar," she replied, "Gimme my dollar. We're going out for coffee," as she and David do every evening. She turned back to the door and called: "C'mon David. Let's go!" Miles asked her whether David had showered and shaved. He appeared in the doorway before she could answer yes. Daniel was standing in front of the cabinet where he had been sitting, retrieving money from the lockbox. Theresa looked at Sally and said in an offhand way: "Marty's on the floor." Sally reacted with good humored exasperation: "Oh, you're kidding?" She rose from her chair. "Where? In the living room." Theresa said: "Yes," and after a pause, to no one in particular, "he's a pain." Sally headed toward the living room and then Theresa and David crossed the hall and left the residence.

Daniel gestured out the door of the office and both Miles and I knew that, by indicating the direction Sally had gone, he meant Marty: "What's up with him? It's like he doesn't need anyone around anymore, you know, it just happens." Miles agreed: "It used to be only with the counselors that he'd fall. Well, I haven't gone in there since dinner. Who's around?" I said that I had earlier seen him talking to Christina.[5] Miles laughed: "Well, that should have *prevented* a fall. All that attention." Daniel joined in the joke: "Yeah, talking to her? You mean he wouldn't let *her* talk to anybody else?" Then he asked: "What the hell does she do here anyway? It's ridiculous." Miles returned to the topic of Marty: "I just don't understand what's up with him really. He had such a good week last week. He even went to ABC House on Saturday night." Daniel was shaking his head skeptically. Miles added: "I think Angie took him to the doctor on the subway. I mean— " Daniel became stern: "He's only getting worse. He fell last week, a few times, I think." Miles shrugged. Daniel appeared increasingly frustrated as he continued: "We have done everything for him, you know. I mean how much can he be restricted here. He really needs to be at Driggs House.[6] It's not fair to him." Perhaps to avoid upsetting Daniel further, Miles was non-committal and did not encourage the topic: "Oh, I don't know. I guess you're right ." Daniel responded: "They are just not listening to us. It's not fair to us either. I mean it's really stressful. You never know when you come in what's gonna happen with him." Sally returned and we all looked at her as she sat down, which she took as a

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5. Christina was a psychology master's student who was an intern at the residence for several months on Wednesday evenings.

6. Driggs House is an Intermediate Care Facility (ICF) and, for this reason, is more restrictive than the group home, which is a Community Residence (CR). These are regulatory categories and an ICF requires more structured programming and therefore a larger staff. How counselors' raise the issue of placement is discussed in chapter 7.

> request for a report. "He's fine." She waved her hand to indicate it was nothing out of the ordinary: "He was on the floor in the doorway of the living room and he just got up when I asked him to. Who knows?" I asked: "What was Christina doing? Is she in there?" Daniel's eyes widened and he seconded the question eagerly by saying: "Yeah?"

There is no way to present shop-talk without losing some sense of how it is embedded in the ongoing course of counselor work, and where this selection begins and ends is somewhat arbitrary, determined by what I have chosen to feature. The constant monitoring of residents' affect, mood and conduct is one frequent feature illustrated here in Sally's tentative queries about Diane, and in Daniel and Miles' joking about Marty's interaction with Christina. However different these discussions, both display the microscopic scale of attention to residents' conduct that commonly characterizes shop-talk. The most subtle changes are noted, discussed and theorized by counselors, and unexpected occurrences, large and small, are continuously puzzled over and analyzed.

Marty is one resident who embodies the unpredictable and failure-prone character of group home work. Counselors assign responsibility elsewhere by defining the problem in terms of the agency's failure to act on the counselors' knowledge and experience or in terms of Marty's personal failure to respond to the group home's interventions. It would be a mistake to understand these accounts as anything but a practical way of managing work that is "not subject to closure." When Daniel remarks: "They are just not listening to us," he is referring to the refusal of the supervisor to follow the counselors' persistent requests to move Marty into a more restrictive residential setting. They realize that decisions such as placement are made neither quickly nor on the sole basis of their recommendation, but counselors often manage unsolvable problems by hashing over them

in ways that are actually outside their sphere of authority and discretion. For this reason, Marty is a frequent topic of shop-talk – *we have done everything for him*; *they're not listening to us*; *he should be in a lower house*; *we don't have the staff here*; *it's not fair to us* – and repeated discussions enable counselors to keep hold of an upsetting problem that has no apparent solution. Daniel's frustration about the situation with Marty and Sally's hunch that "something's going on with Diane," both indicate how shop-talk itself often can function as an intervention, not an intervention in the conduct of residents, but in the counselors' own conception and experience of their work.

Given that "there are too many variables to take into account to make evaluation realistic" (Lipsky 1979:49), in shop-talk, uncertainty is often managed by acknowledging it in clinical analysis. The discussions about Diane and Marty, however abbreviated and general the terms, demonstrate the counselors' use of clinical reasoning to make sense of uncertainty. In shop-talk, the counselors' commitment to their clinical work is observable in the practice of analytic skill, the use of psychological concepts and practices, and the memory of previous problems and solutions (as when Daniel adduced an earlier experience with Diane). Counselors often demonstrate their clinical skill by analyzing the impossibility of knowledge in certain situations, sometimes using the issue of complexity just to express exasperation in the assertion that "nothing can be done."

The acknowledgment of uncertainty as a strategy to manage it not only demonstrates the general value placed on psychological knowledge and skill, but is a situated account of what counselors believe they know and do. Counselors often imply the esoteric nature of the knowledge they possess in an analogous way to the claims of

superior skill based on uncertainty and complexity in an occupation like medicine (Attewell 1992:438). Virtuosity can also be a feature of uncertain work as when new, risky, or especially technical medical interventions are associated with particular members of the profession (438). A parallel emphasis on the virtuosity of skill in the group home can be seen in the identification of certain counselors who are "good with" certain residents. Skill is seen here, however, in individual attributes and personalities as predictors or accounts of positive clinical outcomes: Kenneth is needy and responds to Drew, who is "consistent," "firm," and a "male role model;" Ruby is able to overcome her shyness especially well with Susan, who is also "firm" and "no nonsense;" Irving, who is "obsessed with his privacy," works well with Miles, who is "gentle" and "keeps a low profile."

It is in shop-talk that counselors engage those aspects of the work that generate personal satisfaction. Although they work individually with residents, unlike many street-level bureaucrats, counselors spend a lot of time together, and, when on duty, share responsibility for everyone's welfare and the smooth operation of the facility. Shop-talk makes observable the personal and organizational identification that brings counselors together in work perceived as generally stressful and demanding mutual support. For example, Daniel and Sally both indicated in different ways the personal toll counselors pay in their work. As in the staff meeting discussion above about managing their own feelings, counselors frequently share tips about how best to approach clinical as well as administrative situations. They often complain about residents and supervisory problems, but they also remind each other of the work's moral and professional importance, and the

challenges they face in a job that rarely yields clear, and only ever modest, results.

Even the vernacular term routinely used to refer collectively to the residents – *the guys* – reflects the personal dimension of counselor work that is at once so satisfying and so confusing. The term functions to manage the ambiguity inherent in work that is seen as professional but for which intimate personal relationships are necessary for success. In their shop-talk, as well as in meeting discussions, counselors frequently refer to the residents as *the guys* and, in the case of a counselor discussing his or her caseload (the three residents for whom each counselor is specifically responsible), *my* guys. *The guys* acknowledges the fact that the residents are objects of work, but informally without invoking clinical categories. There is an inherent confusion for counselors who work in a setting based ostensibly on the rights and choice of individuals who, for all practical purposes, are defined by an asymmetry of knowledge and authority. Although *the guys* functions essentially as jargon in the group home, it nonetheless always has the ring of familiarity and often even affection.

## III. RESIDENT WORK

Previous sections have described different aspects of how counselors manage the endlessness, ambiguity, and uncertainty in their work. However, the monitoring practices that organize everyday life are not done only by counselors. Residents do their own monitoring work in addition to the work they must do to become more independent. Routine group home operation provides a practical opportunity for participation that involves monitoring each other and staff, and is often observable in the residents' own

informal and ongoing shop-talk.

There is a group of residents who are regularly involved, and they serve as resources for others (including counselors), who bring questions about scheduling, recreation trips, appointments, and so on. Chris, Irving, Jennifer, Kenneth, Marty, Ruby, and Theresa actively work on routine group home operations, and though their shop-talk may range over a number of topics, it always returns to the ongoing concern with administrative issues. These residents pay continuous attention to the staff schedule and the coordination of residents' many medical and other appointments and activities. In their shop-talk, these residents demonstrate an adequate practical knowledge of staffing patterns; medication procedures and certification; which residents have appointments when, their mode of transport, whether they will be accompanied, and by which counselor; which residents attend evening leisure programs during the week, when they are expected home; and more.

Resident shop-talk occurs often in the living room, when people are gathered to relax or just to wait: for dinner, for meds, to work on goal plans with counselors, or for other residents to go out in the community. On a typical evening after dinner, Kenneth and I were sitting together on the couch facing the door to the dining room and he was telling me what he did at workshop that day. Theresa was on the cater-cornered couch, facing the back of the living room and, across from us, Ruby was watching TV. She turned toward Theresa and asked: "How are we getting to bowling on Sunday?" Theresa replied: "Cheryl's gonna drive us." Kenneth stopped talking to me: "She can't drive the van. No." That was apparently Ruby's concern and she agreed, still looking at Theresa:

"Yeah." Theresa speculated: "What about— Is Daniel working?" "No," Ruby chided, "he'll be on vacation. I don't think anybody can drive us. We have to take the subway. I'm not going." "Me neither," Kenneth agreed. Theresa shrugged, Ruby turned back to the television, and Kenneth resumed our discussion. When Jennifer came into the living room a few minutes later, Theresa greeted her with the question of which counselor would drive to bowling on Sunday. She answered tentatively: "Cheryl?" and Kenneth, Ruby and Theresa responded with a disappointed "no" or a dismissive wave. Jennifer sat next to Ruby. After a while, Daniel came in and Theresa greeted him as she had Jennifer. He answered: "I'm not gonna be here, remember?" "Oh, right," she said. Daniel added: "What's the difference who drives anyway? What do you care if you want to go bowling?" Ruby explained that without a counselor to drive it would mean the subway, and she would not bother to go.

Administering medications is a familiar topic of resident shop-talk. One evening at dinner, during a discussion about what activities people were planning for the approaching weekend, Jennifer mentioned in an offhand way that Angie would not be working on Sunday. From another table across the dining room, Ruby asked: "She's not? Who's going to do meds?" On another occasion, I was sitting with Ruby and Kenneth in the living room on a Sunday afternoon, even quieter than usual because a large group of residents had gone on a rec trip to a shopping mall some distance away. Kenneth noted that it was just after 4:30 and he was worried that the group would not return by five o' clock. Ruby asked: "Oh, because of meds?" Kenneth was bothered: "Miles shouldn't have gone with them. Now there's no one to do meds." Cheryl drove the van but, for

whatever reason, Miles went along too. Kenneth and Ruby reviewed the counselors on shift and determined that Miles was in fact the only one who was certified to dispense medication. This confirmation increased Kenneth's annoyance and agitation and he repeated his criticism of Miles' decision to join them. I said: "It's only twenty to five or so, they could still get home in time." Kenneth was not convinced: "That place is too far away and— Linda should have gone instead." Ruby rolled her eyes: "It doesn't concern you so why are you worried?" Kenneth retorted: "It's not right." Ruby ended the conversation by saying: "Gimme a break. You don't even get five o' clock meds." Kenneth stood abruptly and, as he left the living room, announced: "I'm gonna see where they are?" Ruby looked puzzled and laughed, calling after him: "How're you gonna do that?"

Although shop-talk is used by all group home workers as a continuous and informal practice of managing routine difficulty, uncertainty does not pose the same obstacle for residents as for counselors. Both engage in routine situated practices that are ostensibly unrelated to their official group home work. For residents, this work is unremarkable because interest and involvement in group home operations reflects the pleasures and frustrations most people experience and manage in the quotidian detail of domestic life. Counselors understand this as a clinical matter and constantly encourage the residents to be "invested" in the group home as a measure of their healthy participation – "it's your house, after all."

This does not prevent counselors from occasionally seeing this resident work as "inappropriate." This is a paradox of conduct in the group home that partly reflects the

need to ration services. One aspect of the residents' work involves gathering and analyzing information, and counselors are continually called upon with questions and advice. The frequent consultation of posted schedules and the appointment calendar in the staff office also puts residents in counselors' way. Attending to day-to-day operations happens to be one form participation can take living in a setting that aims both to create a personal, domestic environment and to work on becoming more independent. The very activities that often demonstrate investment may thus also be seen, for whatever situated reason, as outside the "appropriate" sphere of concern for residents. It is when counselors see and act on the inability to recognize the boundaries of legitimate involvement that routine resident work becomes a clinical problem of conduct.

Certain counselors were particularly annoyed, at one point, about residents' information gathering activities in the office. The problem was discussed at a weekly staff meeting after Chris openly started reading the log. Residents were constantly looking at the staff schedule, the large appointment calendar on the wall, and now even at the daily log, often left open on one of the desks. Residents also talked openly about other people's business, especially medical appointments. Angie suggested that the access of residents to the staff office be limited in some way. Daniel agreed: "There has to be a shared responsibility if they want access. Looking at the calendar is a violation of others' privacy." Susan was incredulous: "I can't believe the guys are reading the log notes! That is interoffice communication only." Cynthia reminded everyone: "They have a right to know whose working with them and that's why they can look at the schedule." As the counselor primarily responsible for coordinating outside medical services, Angie was

particularly concerned about the posted appointment calendar, which generates many of the residents' questions, many of which are put to her: "they go on about things that don't pertain to them. It's a source of anxiety." Daniel suggested posting the staff schedule outside the office because of the residents' right to have access to it and "maybe on the calendar, doctors' names instead of specialities as a way of concealing the nature of the appointment." After a pause, Daniel laughed and said: "But they don't know what the specialties mean anyway." The fact that access to the staff office was never addressed again – as a topic in staff meeting, by limiting the residents, or by changing how the calendar is displayed or the log left out – indicates that confidentiality and privacy were raised less as concerns about what, after all, was routine resident work, than as an attempt by frustrated counselors to ration their time and to exert more control over their work space.

## IV. CONCLUSION

The point of this chapter has been to show how the uncertain, endless, and indeterminate character of such work takes specific shape in the group home, and is managed in routine ways that are organizing aspects of the work itself. The investigation of work extends beyond the prescribed activities of counselors to include the routine participation of residents. This approach reflects the organizational and clinical nature of the setting, which not only treats the involvement of residents as a kind of work, but in which there is also little distinction between work and the rest of everyday life.

The idea that the pressures, conflicts, and confusions inherent in this work must be

managed in everyday ways just to get the job done, and to get it done in meaningful ways, is drawn from Lipsky's (1979) analysis of street-level bureaucracies. Work that takes human conduct as its object is not "subject to closure," as Lipsky describes it, because people do not "stay fixed." This is partly the ambiguous and indeterminate nature of social service goals and technologies; and partly the inherent conflict between organizational demands and professional ideals of service. This conflict is particularly acute, he argues, given chronic resource deprivation and the way social services conceptualize the problems they aim to solve. When essentially structural problems are approached piecemeal with personal solutions, social services become a "revolving door" for unfixable problems. This particular criticism applies less easily to the group home than to the public sector settings that provide many of Lipsky's examples. Nonetheless, I have described some ways group home work is shaped by the everyday management of the conflicts between organizational demands and ideal professional practice.

Unlike Lipsky, however, I do not presume that the group home is organized fundamentally by the conflicts between bureaucratic rationalization and service ideals and or between resident demands and counselor resources. I have described how certain routine monitoring practices organize and manage the endlessness, ambiguity and uncertainty of group home work in its course. These routine practices may be informal, like the ongoing and situated monitoring in shop-talk that is an organizing feature of work; or prescribed and systematic, like the daily log, which shapes the experience of endlessness in the particular technique of perpetual monitoring the counselors use everyday. Both kinds of routine practice ultimately define what group home work actually is and how it

gets done.

The ambiguous and indeterminate nature of working with people take particular shape in clinical work; and, in the group home, this is clinical work with individuals who, in any conventional sense, are unable to become "independent." This process goal, ambiguous by definition, organizes the practical work of counselors and residents as an endless pursuit, and, along the way, defining and measuring outcomes is never a simple matter. The informal practice of shop-talk affords a continuous and close scrutiny that enables counselors to emphasize and make sense of particular problems and pleasures in their endless and indeterminate work. Work is endless also because demand for group home services is endless, and counselors must ration services informally in order to accomplish their work. In a setting where there is little distinction between work and other activity, all of everyday life is a potentially clinical domain, something which is both reflected and organized by "doing the log."

Although the group home poses different kinds of problems for residents, they are still problems that must be managed as a taken-for-granted aspect of routine work. The uncertainty residents face, that I have described here, is the kind of uncertainty that characterizes everyday life, and, it would be fair to say, is managed in one way or another by everyone everywhere in the rhythm and detail of domestic routine. Of course, this universal experience only ever takes specific shape in the settings and mundane practices in which it is defined and managed.

Without fail, every time I arrived at the group home, the residents asked: "how long are you staying?" My hours were fairly predictable, but they were not posted and I

was not bound by the shift schedule. In order to carry on with their work, residents had no choice but to obtain this information from me directly. Counselors occasionally intervened with a question of their own, usually on the order of: "What does it matter? He's here *now*." As a practice of participation, monitoring group home operations is a kind of resident work. It is a kind of work that can generate conflict, however, because it places demands on counselors and sometimes puts residents just plain in the way. This is a paradox inherent in the group home, and when such conflict occurs, this routine resident work becomes yet another aspect of the work that counselors must endlessly manage.

# Chapter 4
## Paper technologies:
## The organization and documentation of group home work

> To focus on the technology of an organization is to view the organization as a place where some type of work is done, as a location where energy is applied to the transformation of materials, as a mechanism for transforming inputs into outputs.[1]

## I. INTRODUCTION

This chapter considers some of the records and written documents that are part of the ongoing collection, assessment and display of data about the group home's activities. The treatment books, plan of services, monthly progress notes, and so forth, that are integral to the operation of the group home, are more than instrumental means of administrative and clinical operation. In this chapter, they are understood as technologies to show how they reflexively organize group home work as an ongoing aspect of that work. More specifically, documentary practices furnish a range of specific techniques for monitoring, assessment and intervention that shape what can be seen, known, and acted on in the group home. This approach follows the social studies of science, which does not understand technology in opposition to cognition and perception, as distinctly human capacities, but as shaping them in specific and practical ways. Documentary practices cannot thus be understood as independent of the activities and services that are the "real" group home work. As paper technologies, they are embedded aspects of that work,

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1. W. Richard Scott, *Organizations: Rational Natural and Open Systems*, (1992:20).

organizing what counselors and residents know and do in reflexive and ongoing ways.

The next section discusses conceptions of technology in sociology of work and organizations, science studies, and the analysis of governmentality. The second section is an analysis of the reflexive relationship between the group home's paper technologies, the ideal of "individualized" service, and the New York State regulations for community residences.

## I. TECHNOLOGY

Parsons' distinction between authority based on "technical competence" and authority based on bureaucratic hierarchy has widely influenced the study of work and organizations (Perrow 1986:42). Perrow (1986) argues that this distinction, based on a misunderstanding of Weber, presumes a narrow conception of expertise that "fails to recognize the technical character of administration" (1986:46). Research on how technology determines organizational structure defines technology narrowly as the apparatuses and production processes in manufacture, and is thus limited to certain kinds of workplaces. Even when technology is defined more broadly to include, what Scott refers to as, "the technical knowledge and skills of participants" (1992:20), administrative competence is still presumed to be distinct. Perrow (1967) offers a conception of technology that encompasses a wide range of work activities. Technology is defined not by technical apparatuses, processes and skill, but by the distinct character of raw material. Different raw materials – for example, steel, paper, or human conduct – require specific kinds of processing that form the "core technology" of plants, mills, and group homes.

Organizations are thus conceptualized in terms of their technologies: how work is determined by the specific requirements of different raw materials. For Perrow (1967), the relationship between technology and organizational structure is defined and measured by the degree to which tasks are routine or non-routine, which require higher levels of discretion. Although this approach enables a greater range of tasks to be understood as aspects of "core technology," it does not include records and written documents. They remain what Scott characterizes as "basic coordination mechanisms" (231), ultimately distinct from the core technology. Documentary practices function to reduce the complexity and uncertainty of work required by a particular technology but are not technologies themselves.

The relationship between technology and the structure of work is also a concern in science studies. Criticisms of structural and cognitive approaches illustrate the reflexive relationship between the technologies so integral to scientific knowledge and everyday laboratory work. Electron microscopes, particle physics detectors, and observatory oscilloscopes make visible the activity of brain cells, atomic particles, and optical pulsars but they do not function only as neutral instruments. The particular ways in which the visual objects of scientists' work are made available shape the kinds of problems and processes that organize the practical course of research. (Lynch 1985; Traweek 1988; Garfinkel, Lynch and Livingston 1981). This is not an epistemological claim about distortion. In their study of a biology laboratory, Latour and Woolgar (1979) show that technologies of writing and graphing functioned as more than just tools for the efficient manipulation of vital information. The way that data could be used depended on how it

was visually available in standard and durable formats. Photographs, displays, scopes, diagrams, graphs, tables, charts, and graphs are thus reflexively embedded aspects of the practical everyday work of science.

Historical research has also demonstrated how technology enables new ways of seeing and knowing. Law (1986; 1987) shows that sixteenth century Portuguese navigational devices, shipbuilding techniques and written protocols made new modes of communication and, therefore, new political relationships possible. New kinds of persons were possible too: the emissaries who traveled back and forth, more confident that the crucial knowledge they carried, not to mention themselves, would arrive intact. "Action at a distance"[2] depends on forms of knowledge that are durable, mobile, standardized and reproducible. They enable "centers of calculation" (Latour 1986) where information from afar can be received and evaluated, problems and courses of action assessed, and orders dispensed to be carried out elsewhere.

Causal models of power are unable to attend to the new possibilities of knowing and acting that are harnessed through and enabled by specific technological innovation: "commercial interests, capitalist spirit, imperialism, thirst for knowledge, are empty terms as long as one does not take into account Mercator's projection, marine clocks and their markers, copper engravings of maps, rutters, the keeping of the 'log books'. . ." (Latour 1986:6). Law suggests that technologies be "seen as forming an integral part of such systems, interwoven with the social, the economic and the rest . . . their form is thus a

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2. Law calls it "long distance control" (Law 1986). "Action at a distance," Latour's (1986) more inclusive phrase, is used here because of its adaptation in the analysis of governmentality, which is discussed below. Giddens (1994) uses "action at a distance" to discuss globalization.

function of the way in which they absorb within themselves aspects [of] their seemingly non-technological environments" (1986:236). Callon (1986) suggests "translation" as a way of understanding the reflexive relationship between technology and social action. Translation refers to how available forms of technical knowledge reflexively define the problems (and fields) that enable institutions and individuals to act, and to mobilize the actions of others, in particular ways.

At first sight, the group home setting might not appear to reflect the kind of complex, historical practices that are the concern of the approaches sketched here. However, the group home functions by acting at a distance in several ways, all made possible by its paper technologies which translate clinical and administrative ideals into accountable everyday work. The group home is also not a scientific laboratory, but the production of knowledge about group home work forms a large part of that work. Like microscopes and particle detectors, treatment books, goal plans, and other paper technologies, most certainly function in instrumental ways to gather the information vital for day-to-day operations. What makes the group home like a laboratory is the way technologies reflexively shape what can be seen, known and acted on in these two settings' different but equally endless work of identification, monitoring, assessment and intervention.

**Technologies of government**

Technology is used in the analysis of governmentality to emphasize the systematic orientation toward individual conduct that is characteristic of liberal societies. Individual

liberty and the limits of state authority are practical dilemmas that must be resolved, in most cases, when the state intervenes in the lives of its citizens. For reasons of logistics as well as legitimacy, the state's interest and interventions in spheres of activity, such as the economy or public health, cannot occur through the direct control of citizens. Government occurs at a distance,[3] by cultivating the capacities of individuals to govern freely their own conduct in relation to specific outcomes according to the concerns of the state and the larger society.

Similar to Perrow's conception, the analysis of technologies in governmentality emphasizes the unique character of the material to be transformed. Technologies of government have emerged reflexively in relation to human conduct and its transformation. As Dean explains, it is the:

> . . . technological orientation to human being . . . as a resource, the capacities of which are to be unlocked, harnessed, etc. and combined with other types of resources in the constitution of centres of power. [More specifically] . . . a technology of government differs from a technology of production . . because government is about ways of conducting conduct, ways of acting upon the actions of others. A technology of government does not seek a total regulation or ordering of human beings as a technology of production might aim at producing a completely ordered and replicable material object. It seeks rather to structure the field of possible actions (Dean1996:60-61).

Conduct can only become a "resource," in this sense, when the systematic attempt to shape it is based on the ostensibly disinterested and universal claims of expertise. In contrast to the arbitrary particularism of tradition, it is the rational, calculative approach to conduct that forms the ethical basis of government.

Technology can be understood as the "linchpin" between expertise and the

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3. "Government at a distance" is Rose's adaptation of Latour's phrase.

government of conduct (Dean1996:47). As Rose (1985; 1996; 1999) shows, psy knowledge has become central to, and has shaped, previously unrelated areas of practice because it has been able to "cross a technological threshold" (Dean 1996:55). Community-based services provide an example. The government of individuals with cognitive disability, as citizens, involves the translation of ideals of rights and integration as the clinical problem of independence. The psy technologies of community-based services are thus more than just a mode of technocratic control, "softer" than institutions. Although the group home certainly does "manage" residents, governing them is also "capacitating," as Rose puts it, of new psychological kinds of personhood (Rose 1996:27). The effective operation of the group home depends on, and shapes, the capacities of residents to govern themselves freely as psychological selves of endless improvement and independence.

In the group home, this translation – of rights into the everyday technical work of independence – reflects the role of psy knowledge in contemporary society in general. The vast diffusion of psy is often explained as a cultural or social problem (Jacoby 1975; Lasch 1979; Rieff 1966). Rose, in contrast, approaches it empirically, investigating the use of psy technologies in a range of settings – from the workplace to the work of the therapist's office – and the everyday techniques of the self widely used by individuals to understand and act on themselves.[4] In this way, the assumption in contemporary society

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4. Rose's research on experimental and clinical psychology is akin to the science studies examples described above. For developmental psychology and the study of "feeblemindedness," in particular, he has argued that various technical representations (in photos, numerical translations, and spatial arrangement of experimental settings) transformed the mothers and babies, from subjects of research into technical objects. This process was central to disciplinary formation as

that the "self" is a psychological self is not understood simply as a matter of discourse or ideology. Rose explains:

> . . . [the] focus shifts from psychology itself to the modes in which psychological knowledges and techniques have grafted themselves onto other practices. Psychology here is seen [in terms of] . . . its capacity to enter into a number of diverse 'human technologies.' The notion of a human technology is not intended to imply an *inhuman* technology – one that crushes and dehumanizes the essential personhood of those caught up within it. Quite the reverse: it is most frequently the promise of personhood, of being adequate to the real nature of the person to be governed, that underlies the power that psychology seeks and finds within such technologies. I use the term 'technology' to direct our analyses to the characteristic ways in which practices are organized to produce certain outcomes in terms of human conduct: reform, efficiency, education, cure, or virtue. I seek to draw attention to the outcomes – ways of combining persons, truths, judgements, devices, and actions into a stable, reproducible, and durable form. And I suggest that psychological modes of thought and action have come to underpin – and then to transform – a range of diverse practices for dealing with persons and conduct that were previously cognized and legitimated in other ways, via the charisma of the persona of the authority, by the repetition of traditional procedures, by appeal to extrinsic standards of morality, by rule of thumb" (Rose 1996:87-88).

To Rose's list of "outcomes of human conduct" could be added independence. Psychology "grafted" itself thus onto the domain of practice that is the general concern of this dissertation: the government of cognitive disability in the community. The "promises

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well as the popular dissemination of knowledge about normal development, childhood, etc. (Rose 1989, 1985). There is similar work in psychology that does not happen to use the concept of technology. See: Hornstein (1988) on how the availability of statistical analysis shaped the conception of psychical phenomena through quantification and helped establish the naturalist methodology of experimental psychology; Morawski (1988) on how procedures of experimental method and the organization of research settings organized the identity and cognition of both subjects and observers in new ways; and Morawski (1985) on the way measurement procedures established the currency of gender and gender difference as objects of psychological knowledge. For analyses of the role of technology in the formation of "social problems" see Zimmer and Jacobs (1992) on the refinement of drug testing technologies in the 1980s that enabled the "casual user" to become visible and, thus, a new workplace concern. This resulted in the widespread use of employee testing and reinvigorated government prohibition efforts by shaping the very problem it promised to solve.

of personhood" translated in the group home's technologies, and the "outcomes of conduct" they seek, make certain persons and problems visible and knowable as the objects and agents of everyday clinical work.

**The group home as a technology**

When individuals with cognitive disability became free to live in the community and to choose for themselves, the familiar tension in liberal societies was raised specifically between supervisory authority and the individual freedom of residents. This is not simply a tension between the professional, moral and individual "values" that compete in this domain. It is a practical tension that must be managed in ongoing technical ways. The group home itself is a technology, a setting organized according to clinical and administrative expertise to govern the residents by shaping their conduct as the clinical problem of independence. As Dean points out, in liberal societies the question about "how to govern" is really a question about how we "should" govern most effectively (Dean 1999:34). Community-based services provided a technical solution to the appalling violations of institutional life. The promised task of group homes has been to translate the ideals of rights and integration into actual services while managing the everyday conflicts posed by the freedom of residents. The New York State regulations describe it this way:

> A community residence shall provide an environment that ensures client rights, promotes freedom of client movement, and increases opportunities for clients to make decisions and to participate in regular community activities consistent with their needs and capability. A community residence shall allow for the maximum level of independence consistent with a client's disability and functioning level (14

N.Y.C.R.R. § 686.3)[5]

The unspeakable treatment in institutions was the measure of an extraordinary abuse of professional authority that made accountability a central concern. As a result, community-based services operate in a complex regulatory climate that involves the authority of several state and federal agencies over a vast network of service providers and local settings. This "mistrust" is translated in the elaborate audit technologies that, Power (1997) shows, are now an aspect of almost all professional service. Audit technologies are the "control of control," governing professional activity ideally by making it transparent without undermining its autonomy (Power 1997; Rose, 1996). However, audit technologies do not only make the activities of professionals transparent but shape them in particular ways. In the group home, ideals of accountability and service converge in the paper technologies that organize the everyday work.

These paper technologies make it possible to govern at a distance. "For a domain to be governable," Rose writes, "one not only needs the language to render it into thought, one also needs the information to assess its condition. Information establishes a relay between authorities and events and persons at a distance from them" (Rose 1996:73). There is naturally a far greater distance between Brazil and Lisbon (especially in the sixteenth century example below) than between the group home and the New York

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5. Here is a more specific definition: "A facility providing housing, supplies and services for persons who are developmentally disabled and who, in addition to these basic requirements need supportive interpersonal relationships, supervision, and training assistance in the activities of daily living. Community residences are designed to accomplish two major goals: 1) provide a home environment; and 2) provide a setting where persons can acquire the skills necessary to live as independently as possible." (14 N.Y.C.R.R. § 686.99)

State Office of Mental Retardation, and especially between a resident and a counselor. Each case nonetheless reflects a relationship of government that requires the ability to mobilize organizational and individual others indirectly to act on themselves in certain ways.[6] The paper technologies that make it possible to govern at a distance, "capacitate" the group home, the counselor, and the resident each as particular kinds of self-governing entities.

## II. PAPER TECHNOLOGIES IN THE GROUP HOME

### Records and written documents as paper technologies

This approach to records and written documents as social phenomena in themselves is not common. The social significance of records and written documents is often understood in terms of the factors that inhibit their efficacy or proper professional use, and how they mediate lay experience or are used to exercise professional and organizational authority.[7] One exception is ethnomethodological analysis, which has

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6. The analogy extends further: counselors are also governed in indirect ways because most of their work takes place out of the supervisor's view. This is discussed in chapters 7.

7. This approach in a very general sense is equivalent to the epistemological claim that technology generates distorted representations of the natural world in scientific knowledge production. Select examples include records and written documents: as an instrument of client control or worker discretion in people-processing work, Goffman (1961); Lipsky (1979); Prottas (1979); McCleary (1977); Meehan (1993); as professional and organizational accounts in contrast to the perceptions and experience of victims, Fleury (1998), patients, Weiss (1997), and elderly nursing home patients and children, Gubrium (1979); in contrast to actual practice in social work, Floersch (2000) and Monnickendam, et al. (1994); as they reflect racial and ethnic bias, Mesch and Fishman (1999) and Weiss (1997); in the history of corporate control (Yates); and in a range of organizations, Wheeler (1969). Garfinkel, Lynch and Livingston (1981) use the term "compliance documents" to describe the organization of scientists' accountability as part of their specific criticism of the social study of science. This is akin to Callon's use of translation to characterize the relationship between technology and power in terms of defining and mobilizing the identity

demonstrated the practical, situated and constitutive character of records.[8] In Garfinkel's (1967) well known paper, he explained the "poor" and "incomplete" quality of psychiatric records encountered by coders in terms of the "organizationally relevant purposes and routines" of actual clinic work and not according to ideal administrative or clinical standards. Social science researchers cannot treat records as 'actuarial' because reading them 'correctly' relies on the practical know-how that is itself an organizing feature of the clinic's everyday practice. Hak (1992) shows how psychiatric reports reflexively transform the nature of a case in an ongoing process of "reformulation" that depends on practical methods of both psychiatric and everyday reason. Ethnomethodological analysis provides one way of characterizing how records and written documents function as technologies: as reflexive "sense making procedures" that depend on and shape what can be seen and known in the practical course of work.

**Paper technologies in the group home: overview**

The treatment book is the comprehensive record maintained for each resident and is at the heart of group home operations.[9] In it is gathered all the information deemed

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action of others (1986). In this sense, the "compliance" function of records has also been addressed by Lipsky (1979) in various people-processing settings.

8. See Parton (1994) and Zimmerman (1969a, 1969b). Smith (1978; 1990) uses ethnomethodology in her study of texts as embedded aspects of institutional relations. However, she departs from ethnomethodology in her concern about the ideological functions of the "textually mediated forms of social organization" which she argues is characteristic of institutional control in contemporary societies.

9. Although it is not directly relevant to this analysis, it is worth remarking on the anachronistic use of the term "treatment book" to refer to the row of plastic binders placed centrally on the shelves in the staff office. The group home ostensibly reflects the changes in social services over the past

relevant – for a variety of reasons – to the resident's "placement" in the group home. It functions as a technology, in the simplest sense, as a physical object for counselors to manage, transport, and store their ongoing work, much of which is defined in specific ways by the treatment book itself. As a "master" technology, it is comprised of and regulates all the technical practices of accounting, identifying, gathering and formulating the knowledge about group home work that are primary aspects of that work. It is in the treatment book that the group home is made material in a single technology. The organization of the book itself can be understood as a reflexive technical rendering of group home work. The sections into which it is divided and the standard placement of certain forms, evaluations and assessments reflect the group home's accountable domains. The first section establishes a resident's eligibility, both diagnostic and financial, containing the annual "documentation that services are necessary to meet the person's needs" (14 N.Y.C.R.R. § 671.6). The "psychological" section additionally contains the mandatory annual evaluations of a resident. In the same way, the "medical," "financial," and "employment" sections are also comprised of the various reports, assessments, and evaluations that document the "auditable" aspects of a resident's life and, at the same time, the "auditable" work required by the State of New York.

The paperwork system that is the subject of the following analysis is complex and

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three decades in response to challenges to professional authority, especially medical models of authority in non-medical settings. In many other respects the language of support and reciprocity has supplanted the hierarchical language of professional services. Staff are no longer taught to refer to the residents as "clients," the term which came into widespread use in the 1970s and 1980s, or its short lived successor, "participant." The current term is "consumer" (see note 11 in chapter 2.) In any case, the fact that it is called the treatment book does not indicate how it is used by counselors in their work.

warrants a brief overview by way of introduction. Not every paper technology in the group home is included here. This analysis focuses on the network of technologies related to the provision of habilitation services, the "activities, interventions and therapies" that promote each resident's "independence, individualization, integration and productivity" (14 N.Y.C.R.R. § 671.1).

The Individual Service Plan (ISP) is a comprehensive description of an individual and the services he or she receives. It is central to the provision of services and must be prepared annually. Although the ISP is not the responsibility of counselors, it requires and depends on the counselors' network of six paper technologies related to habilitation services:

*Residential Plan of Services*: lists a resident's specific "activities, interventions and therapies;"[10]

*Annual Summary of Services*: is part of the annual review of a resident's plan of services;

*Monthly Progress Notes*: monitor a resident's progress with each service outcome;

*Goal Plans*: the individual clinical plans written in the group home, and each goal is considered a habilitation service;

*Data Collection Devices*: the variety of technologies used to monitor the progress of each goal;

*Habilitation Services Billing Form*: indicates on a monthly basis the services for which provider agencies will claim government reimbursement.

The section of the treatment book that concerns this analysis is called "progress"

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10. A clarification: there is potential for confusion between the *plan of services* and the *individual service plan* (the ISP). The ISP is the responsibility of a resident's service coordinator and is comprehensive, including more than the specific habilitation services indicated on the plan of services, which is the responsibility of counselors.

and contains a copy of a resident's ISP (Individual Service Plan) and these six paper technologies. These paper technologies translate the ideal of individualized service into the everyday work they document. This network forms the technical basis of governing group home work at a distance by organizing several relationships of accountability at once: between the group home and OMRDD;[11] between counselors and their supervisors; between residents and their counselors; and between group home persons and their own selves.

**Translating the ideal of individualized service**

Current ideals of service, as well as of cognitive disability, are reflected in the way OMRDD regulations formulate the "overall goal [of residential habilitation services] to promote and encourage independence, integration, individualization and productivity" (14 N.Y.C.R.R. § 671.1). The 3IP, as they are called, are defined by the opportunities that a service, and its delivery, must provide: independence is defined by "opportunities to develop capacities that lessen his/her dependence . . . integration, by "opportunities to engage in experiences and activities with those who are not disabled . . . individualization, ensures that, in their services, "the person is given meaningful choices, respected, addressed and provided services in terms of his/her unique and valued individuality . . . and productivity is defined by the "opportunities to make an increasingly meaningful contribution to his/her living and community environment" (14 N.Y.C.R.R. § 671.6).

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11. The Office of Mental Retardation and Developmental Disabilities (OMRDD) is the New York State agency that, among other things, regulates and certifies community-based services.

Formulated thus, the 3IP furnishes general instructions about the overall goal of habilitation services and the significance of how they are delivered.

The translation of independence, integration, individualization and productivity into actual everyday work occurs through the group home's specific paper technologies. Habilitation services are funded through a state-federal Medicaid Home and Community Based Services Waiver Program (HCBS).[12] What gets waived is the right to "medical" services – like a nursing facility – so that Medicaid funds may be used instead for services that enable individuals to live in a community setting. The HCBS waiver was developed as an alternative to earlier kinds of funding, which provided a set amount and standard package of services for each resident.[13] It enables an "individualized services environment" (ISE) in which an individual's "activities, interventions, and therapies" are funded separately from their room and board.[14]

> . . . a service delivery system in which the person's living arrangement and service delivery reflect the person's personal goals, preferences and needs are not linked, with services considered discretely rather than in a package. That is, housing and services are mutually exclusive considerations, as is the selection of specific services from the list of available approved services. The individualized services environment is in distinct contrast to an overall or comprehensive residential services model, in which housing and some services are intrinsically linked (i.e., where a person lives determines the services received). In the individualized services environment, where a person lives has no necessary connection to the services received, even those which may be received at the housing site. The administrative separation of housing from service, and the separation of services

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12. This description of the waiver services and regulations is only the most general overview and addresses basic requirements and definitions as they relate to the group home work of counselors and residents. It is intended only as background and omits many details.

13. Social Security Act Section 1915(c); HCFA 42 CFR 430.25

14. There are complex formulae for calculating room and board fees paid by a combination of an individual's federal benefits (SSI) and the OMRDD.

> from categorical groups, is the keystone of the individualized service environment structure. It is this feature which makes it possible to achieve the goal of designing completely individualized service plans. (14 N.Y.C.R.R. § 635-99.1)

The funding mechanisms of the waiver program shape the translation of the ideals of individualized service in specific technical ways by requiring that each habilitation service be billed separately. An individualized service *environment* (an ISE) can thus be assembled for each resident service by service.

In the OMRDD regulations, current ideas about the importance of participation and rights for individuals with cognitive disability are expressed as general standards and compliance procedures. The regulatory ideals embodied in the concept of the ISE, for example, must be translated into everyday group home work, something that occurs through the waiver program's central technology, the Individual Service Plan (ISP).[15] The ISP is meant to reflect every aspect of a resident's life and is meant "to help the consumer achieve his or her Individualized Services Environment" (Core 1-21). Sometimes ISP refers to the single documentary technology and sometimes to the system of technologies that it coordinates and on which it depends:

> A written person-oriented record system . . . which documents the process of developing, implementing, coordinating, reviewing and modifying . . . [the system itself]. It is maintained as the functional record indicating current assessments, all planning activities as well as services (i.e., activities, therapies and interventions), and interventions provided to the person . . . it constitutes the main portion of the clinical record . . . (14 N.Y.C.R.R. § 671.99)

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15. OMRDD is apparently concerned about the potential effects of its own bureaucratic and regulatory climate. One employee training manual instructs: "Avoid Acronyms. The use of unexplained or confusing acronyms puts people off, and makes them feel uninformed. It's okay to use acronyms – after you have explained what they mean" (MSC Core Training, May 2000:3).

> [The ISP is] . . . the written document that is developed . . . [that] describes the services, activities and supports, regardless of the funding source which constitutes the person's individualized service environment. The goal of the individualized service plan is to ensure the provision of those things necessary to sustain person in his/her chosen environment and preclude movement to [a more restrictive setting]. These services, activities and supports, identified in the individualized service plan, are to reflect the preferences, capabilities and capacities of the person and emphasize the development of self-determination (i.e., making personal choices), independence, productivity, and integration into the community. (14 N.Y.C.R.R. § 686.99)

The waiver program requires that each recipient have a "service coordinator" who provides comprehensive coordination of their services (14 N.Y.C.R.R. § 671.1).[16] This involves monitoring the ISP to ensure that it is being implemented and reviewed properly, efficiently, and to the resident's satisfaction. There is a potential conflict of interest between counselors who provide services daily and the service coordinator, who is not actually a group home employee. However, they spend time, in effect as colleagues, working together with the resident and to ensure the smooth implementation of services. Service coordinators maintain their own "master" technology in the staff office for each resident – referred to as the service coordinator's book – that contains the ISP, case notes on their meetings with residents and the special services they arrange, usually with outside

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16. A resident has the right to select their own qualified service coordinator. Many agencies now have service coordination departments and someone is assigned unless a resident specifically requests a service coordinator from elsewhere. There are obvious advantages for the efficiency of administration and communication in this arrangement. However, the New York State Commission of Quality of Care criticizes the HCBS waiver program as merely a financial advantage to states that, in New York anyway, does not adequately "individualize" services or create the full separation between services and living arrangements that the service coordinator position represents. See the Commission report Shifting Costs to Medicaid: The Case of Financing the OMRDD Comprehensive Case Management (CMCM) Program, December 1995.

providers.[17] The service coordinator's book can be understood as the equivalent documentary technology to the group home's treatment book in a parallel system of accountability.

Service coordinators are "responsible for assisting the person . . . as needed, in creating and sustaining an individualized service environment by developing, implementing, reviewing and revising the [ISP]" (14 N.Y.C.R.R. § 671.1). The ISP can be more than ten pages. It contains an abundance of factual information about financial entitlements, names and addresses of service providers, day treatment programs, a resident's capacity to evacuate in emergencies, and more. It also contains narrative descriptions meant to capture the individuality of a resident. This documentary emphasis does not encompass the function of the ISP, and service coordinators are urged to understand an individual's preferences and personal goals in terms of the 3IP.

In summary, the ISP translates the ideal of individualized services into everyday work for counselors and residents as both documentary tasks by specific psy techniques of conduct. The waiver's funding mechanism fundamentally enables the ISE to be more than just a concept because of the ability to bill for each particular service. Professional expertise, the state-federal waiver funding mechanism, and provider accountability all come together in the categories of "allowable" services specified in the state regulations. These categories are formulated as "skills training," as the "activities, interventions and

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17. For example, service coordinators are responsible to arrange any special or unusual activities, such as a resident's vacations with one of the agencies that runs tours for adults with cognitive disability. As the "direct service providers," however, counselors are responsible for the everyday work of preparation, scheduling, and so forth.

therapies" selected to "promote" or "maximize" a resident's 3IP. These categories do not invent new kinds of clinical problems.[18] By specifying them in the regulations, however, the everyday clinical work of service selection automatically produces accountability in other systems. The "individualizing" of services makes aspects of providers' clinical work specifically auditable.

**Paper technologies: the organization and documentation of accountable work**

The counselors are responsible for the network of technologies that are required by and also organize the provision of habilitation services to each resident: the [plan of services], the annual summary of services, monthly progress notes, individual goal plans, the data collection related to goals, and the monthly services billing form. These six basic technologies are linked in a network by the knowledge they are used to produce, organize, and transfer between them. They reflect the standardization characteristic of technical forms of knowledge, which involve procedures of simplification that permit ease of circulation and administration in ways that preserve a recognizable object (Latour 1986; Knorr 1981; Star 1983). Each technology depends on and furnishes specific documentary procedures of defining, collecting, formulating, analyzing and displaying knowledge about the residents' services. The knowledge produced by each is usable for its own specific purposes, one always being the ongoing transfer of knowledge to or from other

18. The allowable categories of service are: training in health skills; self-administration of medication; socialization skills; communication skills; assertiveness/self-advocacy skills; behavior skills; community integration and resources utilization skills; motor skills; and employment skills. (14 N.Y.C.R.R. § 671.5; 14 N.Y.C.R.R. § 635.10-4).

technologies in the documentary network. As work tasks that are durable forms of knowledge, these technologies can be physically gathered and brought to meetings, and are available to staff not co-present, across shifts and up and down the chain of command.[19]

The plan of services is at the heart of the counselors' network. It specifies a resident's chosen habilitation service outcomes, which are agreed upon at the annual comprehensive case conference and described in the ISP. At the case conference, the annual summary of services is used to review a resident's progress in the past year, furnishing, at a glance, eleven months of counselors' documentary work. The summary presents the durable and mobile data that have been collected, organized and displayed by the monthly progress notes and the often daily documentation of progress with specific goals. Finally, counselors submit monthly the billing form to the supervisor, the information from which is used by the agency to claim reimbursement under the waiver program.

James' simple "personal appearance goal" can be used to illustrate the network of documentary technologies and some of its functions. James occasionally neglects his personal appearance, which staff regard as a sign of depression. It was agreed the use of a daily checklist (Figure 1) would "help James monitor his own appearance and provide assistance in times when he is having a depressive episode." Goal plans are the most specific individual technology, translating an individual's specific "needs" into systematic

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19. The weekly staff meeting is discussed as a group home technology in chapter 7.

and accountable practical work.[20] The basic formula of a goal plan includes: a concise statement of the outcome(s) of conduct that the plan seeks; the plan's rationale; the specific techniques for the resident and staff to follow; procedures for documenting the resident's progress; and specific counselor responses to the resident's conduct in relation to the outcome(s). The outcome for James is stated thus: "James will monitor his personal appearance daily."

**Figure 1.**

James Franklin's Appearance Checklist

* Are my clothes clean?
* Do I need to shave?
* Have I brushed my teeth?

The goal plan specifies the following procedure: "James will be presented with his personal appearance checklist and will be required to work through it independently daily." A technique of reinforcement is specified for counselors when James achieves the outcome by using the list successfully: "James will be verbally praised for looking well groomed."

The goal plan establishes an association between James' depression and managing his appearance in the conduct that is required of him and of the counselors. Such an

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20. Chapter 5 is an analysis of goal plans.

association – between a resident's inner state and conduct that is regarded as its visible manifestation – is not simply a theoretical matter, but must be translated in techniques of assessment, intervention and documentation as practical and accountable work. The goal plan itself – the durable, written technology – establishes practical conditions for certain kinds of persons in the possible ways of knowing and acting it specifies about contact between James and the counselors and in the relationship it organizes between James and aspects of his own conduct.

Counselors are required to "document daily whether James was able to monitor his personal appearance on the data sheet + (yes) or - (no)" (see Figure 2). The daily work of collecting data on the goal furnishes the basis for the monthly progress notes (see Figure 3) counselors must complete and file in James' treatment book. The regulations require that "progress notes shall be recorded, at least monthly, by the staff member(s) having a substantive responsibility for delivering or monitoring delivery of the plan of services" (14 N.Y.C.R.R. § 671.6).

**Figure 2.**

DATA SHEET

Name: James Franklin
Month: *April 2000*

Outcome: James will use his appearance checklist to monitor his appearance with his personal appearance checklist.

Documentation: Staff will document James' success using the following codes:
+ = James successfully monitored his appearance independently using his checklist.
- = James required prompts to follow his hygiene.

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| James followed his checklist | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Initials | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

**Figure 3.**

Monthly Progress Notes

Name: *James Franklin* Month: *April 2000*

Goal Plans

| Res Hab Service | Outcome | Is it Effective? | | Summary | Recommendation (Continue, revise, discontinue, or completed) |
|---|---|---|---|---|---|
| *RSFS* | *James will monitor his personal appearance daily* | *Y* | | *James has been very independent with his checklist this month but needed some prompting.* | *continue* |
| | | | | | |
| | | | | | |

These paper technologies not only organize the services they document but also certain conditions of accountability. The precise format of the monthly progress notes, and almost all the group home's paper technologies, are at the discretion of the agency providing services but must contain certain information indicated in the regulations. These documentary technologies function as the specifically "auditable" practices of group home compliance. Agencies must therefore develop paperwork systems that meet the state standards, but which can also be designed to function as internal technologies of monitoring and accountability.[21]

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21. The regulations are presented in two forms: principles of compliance and standards of certification. They are "written to stand independently of one another; however, standards may reflect and/or explicate concepts or requirements set forth in principles" (14 N.Y.C.R.R. § 633.1).

> Principles of compliance set forth the basic and necessary conditions with which a facility must be in compliance . . . [and] focus on particular service or administrative components . . . The intent of such principles is to clearly indicate the scope and extent of the State's interest . . . Unless otherwise indicated, an agency/facility will have the authority to demonstrate through policies, procedures, and other documents, or any means, the methods and practices it will it will utilize to establish and ensure continued compliance . . . (14 N.Y.C.R.R. § 633.2)

> Standards of certification are those criteria which OMRDD specifies as necessary to be met in order for a facility to demonstrate that it can and does provide the appropriate environment in which to adequately address the matters of quality of care and welfare, rights, safety and/or fiscal accountability . . . Surveys [audits] are conducted for the purpose of documenting conformity with standards of certification. Such conformance . . . is the basis for issuing an operating certificate and/or renewing [one] . . and constitutes one of the underlying premises justifying OMRDD's continued presumption of a facility's compliance . . . (14 N.Y.C.R.R. § 633.2)

In a sense, the translation of principles into standards is a device for explicating minimal required tasks for services sites. It is worth remarking that this regulatory strategy - "to set forth the specific minimum requirements and standards" (14 N.Y.C.R.R. § 633.1) - reflects how New York State's authority operates over these services. OMRDD regulations are not unusual in the latitude they create for voluntary service providers in this domain. One explanation of this latitude is that it reflects trends in neo-liberalism, privatization, and so on. However, it can also be understood in terms of how services are governed at a distance, something which no doubt both reflects and shapes the changing role of the state. Such regulatory latitude permits, even

For example, as monthly progress notes are used to monitor residents' goals they can be used to monitor counselors because they make visible to the supervisor certain aspects of their work, much of which takes place out of view in individual contact with residents. In this way, the schedule of review and revision of habilitation services required by the state provides technologies for supervision within the group home. The ability to follow instructions and simple deadlines, in addition to assessment and writing skills, are available indicators of the counselors' organizational capacities, knowledge and commitment to their work. The network of documentary technologies organizes a chain of accountability that stretches from the daily details of a resident's goal work; to the performance of individual counselors; to the performance of the supervisor reflected in the data she submits to the agency (and thus the overall performance of the group home); and so on.[22]

The monthly notes show how techniques of collecting data on goals make it durable and transferrable as it "moves" continuously across the network of documentary technologies. The monthly progress notes must identify a resident's specific services, indicate when and how they are delivered, significant events that have occurred in relation to their delivery, and any recommendations for change. The daily monitoring of each goal, the monthly notes that monitor each resident's progress, and the semi-annual case-

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encourages, agencies to translate general principles of compliance in their own, technical systems, so they can be designed to reflect a variety of circumstances and philosophies of service practice.

22. These relationships of accountability extend indirectly all the way up to the state: the technologies submitted by the supervisor enable the agency to govern her and the group home site, at a distance; in turn, the agency must continuously demonstrate to OMRDD that is meeting its standards of certification in each of its facilities in order to operate and therefore to receive reimbursement (14 N.Y.C.R.R. § 635-4.2).

conference are aspects of an ongoing, ever adjustable review process.

It is in the plan of services (Figure 4) – the technology that reflexively organizes, modifies, and documents this ongoing process – that each chosen category of service, the "need" it addresses, and the specific nature of its delivery, are formally elaborated. At the annual conference, the annual summary of services (Figure 5) is used to make an overall assessment of the past year's plan of services. It organizes twelve months of data about services, transferred in various ways from the monthlies and goal data where it has been collected, into a form that is easily readable and usable at a glance.

As the primary deliverers of service, counselors are responsible for maintaining this network of technologies. They are also responsible for coordinating and documenting services provided by others (outside psychotherapists, speech therapists, physicians, and so on). The "description" required of specific services is a distillation of a year's daily and monthly work that is organized by the other technologies.[23] At the end of each month, counselors complete the billing form (Figure 6), the data from which is transferred again, presumably in a new form, by the supervisor to the agency.

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23. The specific requirements of billing are not explained to counselors as they are unrelated to their work and, for this reason, are not elaborated here. In brief, there is a "minimum duration of service . . . to sustain a claim for reimbursement" from Medicaid, "at least four occasions of service delivery per month" (14 N.Y.C.R.R. § 671.99, 671.6). The group home exceeds this minimum.

**Figure 4.**

ANNUAL SUMMARY

Name: *James Franklin* Date: *August 2000*
Facility: *The Group Home*

Describe the individual's progress over the previous 12 month period in meeting the habilitation service goals defined in the plan of services.

Goal Plans

| Res Habilitation Service | Outcome | Progress Summary |
|---|---|---|
| *functional skills training* | *James will independently monitor his appearance.* | *Every night James gets his checklist from staff. He still needs prompts a few times a month but he's learned to be more independent using the checklist.* |
| | | |
| | | |

**Figure 5.**

Residential Plan of Services

Name: *James Franklin* Annual Case Conference date: *August 2000*

Semi-annual: *February 2000*

| Habilitation Service | Identified Need | Intervention | Staff Responsible | IP | Semi-annual Review |
|---|---|---|---|---|---|
| Socialization Skills<br><br>- diminishing tendencies toward isolation and withdrawal.<br><br>- interpersonal skills | *James does not always maintain his personal appearance when he is depressed. A checklist helps James maintain his appearance and provide assistance during depressive episodes.* | __ Couns.<br>__ Group<br>X Goal<br>__ Outside Service<br><br>Goal:<br><br>*James will monitor his appearance independently.* | *All Staff* | X Independence (opportunities to develop capacities)<br><br>Integration (participating in activities with people who are not disabled)<br><br>X Individualization (giving meaningful choices and providing individualistic services)<br><br>Productivity (make meaningful contribution group home and other environment) | Progress:<br>X Yes __ No<br><br>Recommend:<br>X Continue<br>__ Modify<br>__ Terminate<br><br>__ Achieved<br><br>Rationale:<br><br>*The checklist helps James maintain his appearance independently.* |

**Figure 6.**

Habilitation Services Billing Form

Service Delivery: Indicate information as it relates to the goal.

| Date of Service | Service Provided | Code | Duration* Yes | No | Description | Outside site** | Initial |
|---|---|---|---|---|---|---|---|
| April 2000 | RSFS | 1111 | X | | James uses a daily checklist to monitor his appearance. | | JL |
| | | | | | | | |
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Signature: _____

* Indicate yes if service is 15 minutes or longer in duration.
** Indicate only if service is delivered outside the residence.

## CONCLUSION

It is apt to conclude this chapter with an example of how the group home's temporality of progress is expressed in an administrative emphasis on "continuity." As many voluntary agencies, this one has its own compliance department to ensure that its various sites are prepared to pass an OMRDD audit. In one staff meeting, a compliance staff member came to conduct a training about the documentation for the annual case conference. She summarized her own presentation as follows:

> All plans and goals are written with a one year target dated from the Annual Case Conference. At the semi-annual, progress is noted in specified sections [on the plan of services] (see above). Addenda can be added if there are significant changes. The ISP must contain every plan, activity, or goal that is indicated on the Rehab Plan of Service or it cannot be billed. This continuity is one of the things that DQA looks for. A new ISP must be written every year and there has to be some progress, some growth.

That there can *always* be progress – there *must* be – is one indication of how fundamental the group home's paper technologies are to its ongoing clinical and administrative work.

Although the group home is not a scientific laboratory, this chapter describes how much of its work involves the endless technical production of knowledge about that work. The network of technologies translate the services they document into everyday activity. At the same time, this network organizes a chain of accountable relationships that enables the government of the group home at a distance: in the work that is auditable from Albany; in the counselors' administrative and clinical capacities their documentary work makes visibly available to the supervisor; in the resident's work that is endlessly monitored; and in the resident's monitoring and documentation of their own selves.

# Chapter 5
## Goal plans: Technologies of individual conduct

## INTRODUCTION

The previous chapter described paper technologies as embedded and reflexive aspects of the ongoing work they document. This chapter shows how they establish practical conditions of knowing and acting in the group home, with a focus on goal plans, the clinical technologies at the core of the group home's individual work with residents. In work with people, Lipsky writes, goals (in the generic sense) have "an idealized dimension that make them difficult to achieve and confusing and complicated to approach" (1979). In the group home, goals (as in goal plans) specify techniques for identifying and acting on conduct in particular ways. The "needs" of individual residents are translated by goal plans into practical matters of clinical work. "Preferences, capabilities and capacities" are translated in specific techniques of assessment and intervention into "what residents are working on," and shapes the relationships individuals are able to have to their own selves and to others, if often in unintended and unspecified ways.

Goals provide a way of observing how residents and counselors are "made up" (Hacking 1986) in and through their ongoing and practical work on goals. This is an analysis of "kinds" because it seeks the "ways to be persons . . . [the] conditions of personhood" (1986: 225) in the everyday techniques that reflexively organize group home life. "Working on goals" provides a way to observe how residents govern themselves through routine practices of self-knowledge and accountability. More than other paper

technologies, goal plans furnish – in myriad clinical vocabulary and techniques – ways of seeing, knowing acting on oneself and others as kinds of group home persons. The conduct of both counselors and residents is organized by these practical conditions of conduct although more attention is paid here to the residents.

The next section briefly describes goal plans as documentary technologies and also as clinical technologies that furnish the specific psy knowledge that forms the basis of group home work. The remainder of the chapter focuses in detail on select goals of three residents, Ruby, Jennifer, and Kenneth.

**Goals as documentary and clinical technologies**

A resident's goal plans are filed in the "progress" section of his or her treatment book. Copies are also filed in the service coordinator's book as documentary support for the individual service plan (ISP). What indicates the significance of goals to everyday work is the "goal book" for each resident kept in the staff office, which contain the plans a resident is working on and any documentary technologies they may involve (such as James' appearance checklist described in the previous chapter). In addition to each goal book, the "data book" is kept in the office and contains the documentary technologies used to monitor progress on goals for all the residents. These data collection technologies are assembled in a single book for a practical reason: "doing the data," the daily task of documenting the residents' progress at the end of each evening, is easier for the counselor assigned this task in the shift meeting,.

As clinical technologies, goal plans translate a resident's "needs" into actual work

on specific features of conduct. As all technologies of government, goal plans are based on ostensibly expert knowledge about the nature and needs of the residents. Behavioral psychology furnishes both the objectives and outcomes of goal plans, defining problems in the sphere of overt conduct, even when overt conduct is seen as a sign of something "deeper." The ideals of 3IP are realized in the techniques specified by goal plans, and most establish specific outcomes for self-improvement, maximization, and growth, but some seek to "lessen dependence or minimize loss of functioning or adaptive capacity" (14 N.Y.C.R.R. § 633.2). There are also "behavior plans" designed to act on negative, disruptive, and even dangerous conduct, which have the identical format as goal plans. The distinction between goal plans – which attempt to enhance or cultivate skills – and behavior plans – which attempt to reduce or extinguish negative conduct – is not always clear in practice. All plans are ultimately based on the attempt to cultivate the capacities of individuals to conduct themselves more independently. Even behavior plans intended to eliminate "target behaviors" such as verbal and physical aggression are focused on enhancing a resident's capacity for self-management. Behavior plans specify techniques of conduct that are meant to shape the resident's relationship to his or her own conduct in new ways, as something that can and, sometimes, must be managed.

**Ruby's problem with self-assertion**

When a particular feature of a resident's conduct is identified, defined, and acted on as a warrantable clinical problem, it is available to shape how other matters of conduct are understood and addressed. In this example with Ruby, difficulty asserting and

advocating for herself had already been identified as something she needed to work on and was the target of a goal plan. Self-advocacy thus provided a rationale for continuing her room cleaning and tooth brushing plans.

I attended Ruby's annual conference where this decision was formally decided. Danielle, the service coordinator, who leads case conferences, began this one as all the others I attended, by posing this question to Ruby: "So, why are we all here?" All the residents know the answer: "to see how I'm doing." This opening strategy, and the conference itself, reflect how participation and consent is ensured in the development of individualized services.[1] During the discussion about goals, Ruby said she wanted to continue her goals from the past year: budgeting (which raised no questions), self-advocacy, room cleaning, and tooth brushing. She agreed quietly that, because she is actually independent with tooth brushing and room cleaning – that she can do these things without any assistance – these goals would be written again to incorporate self-advocacy. I later learned this was essentially a deal struck between Ruby, Cynthia and Danielle ahead of time in conversations about preparing for the case conference. As the clinical specialist, Cynthia does not routinely attend case conferences, but was present because she believed that Ruby "doesn't want to be independent" and "needs encouragement." Cynthia told me

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1. The regulations specify who will participate in the planning and review process: the resident, service coordinator, relevant group home staff, and advocate or family member; the planning process must include "consideration of the person's input relative to choices about how his/her needs and interests are to be met;" the review process must include "an evaluation of the person's satisfaction with the activities, interventions, and/or therapies being provided;" however these requirements are met, the standards of certification require that a resident's participation is auditable: "OMRDD shall verify that the person directly participated in the program planning process . . ." (14 N.Y.C.R.R. § 671.6).

privately, after the conference, that Ruby had been slightly annoyed in earlier discussions, asking why staff were "pushing her to be independent." The notion that Ruby's "difficulty . . . asserting her needs" hinders her capacity to pursue independence, for Cynthia, was itself a warrantable clinical problem.

Apart from a series of medical issues that have required Ruby to learn technical aspects of self-care (dealing with a urinary catheter, for example), she is independent with all personal matters, raises no behavioral problems, and "accesses" the community on her own, which means she is able to come and go from the group home independently and requires no additional supervision. Nonetheless, the minimum reimbursement requirements for habilitation services mean that everyone must have goals (see note 24, chapter 4). However, even for a resident without any apparent needs, like Ruby, there are always aspects of her own conduct that potentially compromise her further progress in some way. Once identified, these aspects of conduct will no doubt be amenable to new kinds of self-management and can thus become the focus of a resident's work, as self-advocacy has for Ruby.[2]

In the self-advocacy plan, the outcome is expressed generally: "Ruby will develop her self-advocacy skills." As is the plan's rationale:

> Ruby is very interested in both the concept and practice of self-advocacy. . . She continues to have difficulty in asserting her needs and desires and has therefore requested that she work on self-advocacy formally. This goal is therefore being implemented to allow her a more structured plan to address self-advocacy.

The specific methods of working toward this goal involve a weekly meeting to discuss

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2. This could be understood as a specific, everyday example of McKnight's (1980) criticism that "need" is defined in social services systems only in ways that can be met by professional services.

self-advocacy. The counselors are required to document Ruby's work on this goal by keeping weekly progress notes of each meeting. The plan specifies the topics that counselors should cover in the meetings:

> the concept of self-advocacy (what it means and why it is important), a review of rights and responsibilities, the practice of self-advocacy (via Ruby's goals as well as incidentally), assertion, areas wherein Ruby tends to have difficulty (medical issues, peer relations, job issues).

Ruby's room cleaning goal was seen as an opportunity to "practice" self-advocacy:[3]

> Ruby recently requested assistance in maintaining her room. As she has also requested encouragement in regards to self-assertion and advocacy, she will be responsible for alerting staff that it is her day to do room cleaning.

The goal requires that Ruby conduct herself assertively: "Ruby will independently initiate and complete her room cleaning twice a week." The first step thus requires that Ruby herself "alert staff" on her room cleaning days (Tuesdays and Fridays). "With supervision and prompts when necessary, she will complete her room cleaning." A list of specific cleaning chores is included, and counselors are required to document whether she has completed each chore independently or with "prompts."[4]

Although Cynthia develops and supervises most goal plans, this is ideally a collaborative process involving the counselors because of their direct work with residents and knowledge of their needs and capacities. The agreement of counselors is especially necessary for the practical implementation of a goal plan. In Ruby's case, the counselors

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3. So is her tooth brushing goal, which I do not describe here, because it is virtually identical to the room cleaning goal.

4. A prompt is a verbal or physical attempt to indicate to an individual him or herself to engage in a particular kind of conduct. In general, prompts at the group home are verbal. An example in this case would be: "Are you going to hang up your clothes?"

agreed with Cynthia that Ruby was "resistant" to becoming independent and should be permitted to continue her tooth brushing and room cleaning goals only if they now incorporated a way of also working on the problem of self-assertion. Ruby is certainly shy in a general sense, but some of her qualities of shyness in the group home are visible in the specific ways that counselors act on them as warrantable clinical conduct, variously encouraging, coaxing, and cajoling her. Apart from her goal work, Ruby is routinely required to practice asserting herself: being joked with, asked to speak up, and reassured when she is reticent or appears intimidated. In the course of everyday life, the counselors urge Ruby to act on her self as an assertive self.

The problem of self-assertion seems to have emerged reflexively from Ruby's shyness because the treatment book provides little basis for it. Counselors do on occasion claim that Ruby has "a bad attitude" or is "depressed." A recent annual psychological update, written by Cynthia's predecessor, also indicated that Ruby is "occasionally non-compliant," something that is "being addressed in counseling" (counseling refers to the weekly meeting between residents and their primary counselors). In the same document, it is also remarks that she "isolates but is friendly with one other resident." However, every other description of Ruby in the treatment book's various documentary technologies indicate a model resident: "engaged," "cooperative," "good frustration tolerance," "good impulse control," "a support to peers."

Ruby may be shy but she is certainly not afraid to use sarcasm to make a joke. In an informal conversation with Kenneth about what kinds of things would help me learn about the residence, they were equivocal about goals. I pressed earnestly: "But I mean

aren't the goals important?" Ruby answered flippantly: "Well, yeah, they run your life." I attempted without success to sustain this topic. Given the available ways of knowing and acting on Ruby, her occasional expression of this sort is plausibly heard by staff as evidence of "non-compliance" or a "bad attitude." By plausible I mean "normal and natural," Garfinkel's description of simply being "in accord with prevailing rules of practice" (1967:191).

However, I did not tell Cynthia that when I asked Ruby's permission to attend the case conference, she replied: "Sure . . . if it accomplishes anything. I hope it's short." There was no way for me to know whether these remarks expressed "genuine" disgust or annoyance. Ruby's remarks could just as easily have been heard as intimidation or nervousness about the demands of the annual review process. Or, for that matter, as a way of coping with or concealing her difficulty with self-assertion.

**Jennifer's doing it for herself**

Jennifer, on the other hand, is quite frank about her lack of interest in and concern for the group home's clinical and administrative requirements, and the various niceties they justify.[5] Jennifer has a daily hygiene checklist that requires she monitor her self. It furnishes specific techniques that force her not only to acknowledge her hygiene problems, but to acknowledge them in regular contact with staff. The rationale for Jennifer's goal is:

Jennifer has a long history of having difficulty maintaining her hygiene. She has

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[5]. There is a discussion of polite conduct in chapter 6.

> worked on numerous hygiene plans over the years with differing reinforcers but with little success. Jennifer is aware of her personal responsibilities but experiences little motivation in participating. Although she claims to dislike staff intervention, she appears to respond to it, particularly if the intervention is direct, allows for choice of time, is done by one staff member.

The plan lists specific hygiene "responsibilities" – showering, tooth brushing, hair combing and clean clothes – some during the evening only, and some during the morning.

> Although one staff per shift will be responsible for asking Jennifer if she has completed her hygiene tasks, all staff will directly and honestly comment on her appearance and the consequences. The consequences should be explained honestly and directly but privately and should include issues of health and safety as well as social consequences.[6]

All goal plans formulate the mundane work they require of residents in a quasi-contractual form, as voluntary participation. Jennifer's plan, however, reflects special attention to the contractual elements and technical specifications of participation. She is especially immune to the endless group home talk about the importance of "working on yourself," and this poses a particular kind of challenge in counselor work. The plan specifies in more detail than usual the kind of counselor conduct, based on what is seeable and knowable about Jennifer in the group home, that will contribute to the conditions of her successful participation. Their interventions should be "honest" and "direct," come from only one counselor (to minimize her feeling hounded), and permit her to "choose" the timing of her own hygiene work.

Jennifer's participation in a more general sense, as a group home citizen with responsibilities as well as rights, is also reflected in this plan. The notion that she

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6. Only a regular staff member would know that Jennifer's diabetes and her history of related dermatological problems are referred to here.

"responds" to intervention despite her claims to dislike it, presumes that she is concerned about being integrated into group home life. Counselors are instructed to address not only the potential health problems related to poor hygiene but also its "social consequences." The presumption that, despite her curmudgeonly attitude, Jennifer wants to be included, is indicated in the prescribed reinforcement: "Staff will praise Jennifer every time she appears and smells clean and invite her to join the conversation." As a technique of inclusion – "the conversation" presumably refers to everyday activities and "hanging out" – this reinforcement establishes the practical conditions for the reverse, but unspecified, intervention: "exclusion." Counselors expressed this practical possibility in the staff meeting in which the nurse suggested that another hygiene plan be developed for Jennifer (the suggestion that produced this checklist). The counselors agreed. Angela, who staff understand as the only one among them who has any affect on Jennifer, and who is the only counselor she actively claims to like, said: "Yeah, she's impossible! Just don't engage with her when she stinks. She really does get the message." This was considered a plausible intervention only for Angela.

The checklist alone could not ensure the accomplishment of Jennifer's hygiene responsibilities. As a documentary technology, it translates Jennifer's participation – in the plan and in the group home generally – into precise techniques of conduct: deciding whether to do each task of self-care, or even whether to use the checklist and initiate contact with staff. Jennifer usually bristles at the degree of attention and monitoring to which she is subjected in the group home (which is why the plan specifies that she be approached by only one counselor). The specific documentary work of the checklist thus

functions daily as the material expression of her contractual arrangement with staff. The voluntary nature of participation is emphasized by providing lines that require Jennifer to mark – a literal checklist – and the formulation of each task as her responsibility alone, in declarative sentences.[7] At the bottom of the checklist, as with all proper contracts, there is line for her signature – the most elemental of contractual technologies – so that Jennifer can daily acknowledge (or certify or endorse) the sentence that captures what counselors hope she herself will come to regard, by working on this plan, as a regular goal of conduct: "I am clean today." (See Figure 1).

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7. Contrast this to James' appearance checklist in chapter 4, which consists of questions that function essentially as mnemonic prompts. The voluntary nature of James' participation is not emphasized by invoking the techniques of a contract, but by organizing his relationship to his own conduct in a series of questions he must pose to himself.

**Figure 1.**

Jennifer's Daily Hygiene Checklist

Date: _____

1. I showered today. ____
2. I washed my hair today. ____
3. I brushed my hair today. ____
4. I brushed my teeth today. ____
5. I wore clean clothes today. ____

I am clean today. _____

Signature

Jennifer's hygiene goal, as all goal plans, theoretically cultivates new capacities to act on her own conduct, freely and for her own best interest. She uses the checklist but nonetheless requires additional incentives to complete her hygiene tasks. Angela's unique personal relationship with Jennifer, allowed an informal deal to be struck, at one point, that they would go out to lunch if she showered daily for a week. This was one contractual obligation Jennifer was keen to fulfill. One day during that week, Jennifer decided to join me on some errands because she needed to purchase shampoo. On the way out, we stopped by Sonia's office for some money. The very purpose of Jennifer's

errand warranted, for Sonia, a query about how her hygiene goal. As Sonia was unlocking the metal petty cash box she asked: "So how is your showering going?" Jennifer replied: "Angela said that if I showered for a week she'd go to lunch with me." Sonia asked: "Well, who are you doing it for?" Jennifer replied matter-of-factly: "Angela." Sonia stood with the bills in her hand and smiled knowingly. She asked, with exaggerated emphasis: "*Only* for Angela?" Jennifer was slightly impatient: "Yes." Sonia's tone shifted to one of sincere concern, asking and then answering her leading question with more leading questions: "What about for yourself? To feel better? To feel clean?" Jennifer said simply: "Yes." Sonia agreed, smiling: "Yes. Always say that. That's who you're doing it for. You!"

**Kenneth's behavior plan: the problem of problem solving**

This analysis is not meant to suggest that goal plans determine the conduct of counselors and residents in any simple sense. Goal plans shape the conditions of knowing and acting by making techniques available that are used in situated and practical ways. Adding a new plan to a resident's goals book does not necessarily change conduct. Sometimes, plans are actually ignored, or modified and even discontinued. Some active plans have little practical relevance and residents participate in them without enthusiasm, as a chore. Counselors occasionally discover that a plan is unhelpful or inconvenient, after it is implemented. In designing a goal plan, they may misjudge its feasibility, the demands it places on their time, and the how a resident will actually use it. However, the development and implementation of a goal plan functions in a reflexive relation to the

counselors' ongoing, everyday work of defining, assessing and intervening in a resident's conduct.

Kenneth's behavior plan was carefully wrought, yet it was rarely used according to its specifications. The plan furnishes various techniques of assessment, monitoring and intervention that, in their situated and practical use, reflexively shape the conditions of possible conduct in indeterminate ways, despite their systematic procedural explication. It defines "neediness" as an identifying, and specifically identifiable feature, of Kenneth's conduct. This is not a claim that the plan "constructed" a problem that had not existed before. The "need" for a behavior plan emerged reflexively from the practical ways in which the counselors had long defined and acted on Kenneth's conduct as needy. However, the very purpose of such plans, to translate conduct into actual, accountable work, involves the technical organization of "neediness" as a problem that counselors and Kenneth can see, know and act on in specific ways. The plan makes neediness available as an accountable domain of conduct that enables different kinds of work relationships – between the counselors and Kenneth, and between Kenneth and his own conduct.

The desired outcome in Kenneth's behavior plan is formulated as a problem with "problem solving" and restricts certain topics only to discussions with his primary counselor: "Kenneth will independently use his problem solving worksheet when faced with daily challenges and discuss private concerns only with his counselor during scheduled sessions 25/30 days for 3 consecutive months." In the rationale, there is an acknowledgment of improvement in Kenneth's management of his own conduct but that the increase in other, apparently unrelated, "concurrent" behaviors warrant the plan:

> Kenneth is a man with mild mental retardation who often presents as emotionally needy and preoccupied with securing attention from direct care staff. He is described as being anxious, having poor impulse control, and poor problem solving skills. In the past, he has displayed a wide range of problem behaviors in his attempts to secure staff attention (ex: physical outbursts, verbal outbursts, property destruction). He is now described as being less aggressive, however, there is concurrent increase [in] other problem behavior. Kenneth will often provoke his peers in an attempt to be made into a "victim", and thus receive supportive attention from staff. In addition, he perseverates on death, dying, and his relationship with various family members. There is some basis in history for these concerns, and Kenneth is currently in psychotherapy to resolve issues related to his family, disability, and previous losses. On rare occasions, Kenneth will mimic the problem behavior of peers in the residence in an attempt to secure attention. The purpose of this plan is to teach Kenneth how to solve his own problems, decrease his dependancy on direct care staff, encourage using appropriate forums for getting his emotional needs met, and reinforce progress toward these goals.

Two target behaviors are specified:

> 1. Perseverating on Negative Topics: Bringing up either directly or indirectly a depressive/negative topic in an attempt to engage staff in a counseling session.
> 2. Provoking Peers: Making statements towards peers or engaging in provocative behaviors that are known to upset or provoke select peers.

The plan provides two sets of techniques in relation to the target behaviors. What are called the proactive or teaching procedures are meant to cultivate new capacities in Kenneth to manage his own conduct. These includes specific techniques for Kenneth and the counselors. The reactive interventions specify the conduct of counselors that is designed to act on Kenneth's conduct when target behaviors occur. The reactive interventions are discussed below. Here are the proactive procedures:

> Proactive Procedures and Teaching Component:
> 1. Structured Counseling: Kenneth will have preplanned counseling sessions in order to encourage him to limit his discussions of negative topics to appropriate time and place (in private, with his counselor). Counseling sessions will occur once a day in the evening. These sessions will be scheduled as at a time that is mutually agreeable to both Kenneth and his counselor. During counseling sessions, Kenneth will receive emotional support and assistance with problem

solving in accordance with problem solving methodology (see next section). Staff should also review with Kenneth that he does not need to create negative situations if he would like to talk to staff. Explain to him that staff are always happy to hang out with him and discuss positive events.
2. Problem Solving Worksheet and Binder: Kenneth will be provided with a problem solving worksheet and a binder in which to keep old completed worksheets. When the problem solving worksheet is initially introduced to Kenneth, staff should spend sufficient time teaching him how to use it. Once Kenneth understands how to use his worksheet, staff will explain to him the importance of learning to solve his own problems and that before staff will assist him, he must first complete his problem solving worksheet. Kenneth must make an attempt to answer all questions on his worksheet before staff will help him with a problem. When Kenneth presents staff with a completed worksheet, staff will review it with him and assist him with implementing a solution to his problem. Once the problem solving worksheet has been completed, Kenneth will place it in his binder for future reference. He should be encouraged to consult his problem solving binder when confronting future problems.
3. Reinforcement Procedure: Verbal praise is highly reinforcing to Kenneth. As such, he will be praised when he engages in positive interactions and uses his problem solving worksheets.

From a clinical perspective, these are instrumental procedures by which the plan's specific outcomes should be pursued. Even when they are followed to the letter, their function cannot be understood adequately as mere "procedures" or "rules." The procedures that are reflexively available in goals function for counselors and residents as "sensitizing devices," which provide "a general sense of reference and guidance in approaching empirical instances" (Blumer 1969:148). They organize the technical conditions of possibility for certain kinds of time, space, and conduct in the situated and practical course of everyday work. These techniques are also available to Kenneth, not only in the interactions with counselors, but in the new relations to his own self they make possible as he manages his own conduct in particular ways.

The problem solving worksheet (Figure 2) is properly a data collection technology, but appears in the plan as an intervention, as an aspect of Kenneth's work, and not as a

documentation procedure. The description of the worksheet in the plan indicates that its specific technical requirements were understood to be self-evident. Apart from the copy attached to the plan, the worksheet itself furnishes its own instructions, the only other specification is that "Kenneth must attempt to answer all the questions before staff will help him with a problem." The worksheet is transparent to counselors because, even though it is a clinical intervention, it operates like one of their own documentary technologies. The very fact of the worksheet and its general purpose – to teach the importance of solving problems independently – shapes the nature of Kenneth's contact and expression. Before seeking support from counselors, he must "use" the worksheet to attempt to solve his "daily challenges" independently. The knowledge about himself that he gathers and evaluates does not alone constitute the work of Kenneth's self-intervention. The worksheet also furnishes, in a series of questions, the techniques of assessment, reflection, comparison, and decision making, that constitute "independent problem solving." The order of the questions can itself be understood as a technique, formulating for Kenneth the logical order of this process.

**Figure 2.**

Problem Solving Worksheet

What is my problem: _____

Have I had this problem before? Yes or No

How did I solve this problem before? _____

_____

Did my solution work? Yes or No

One way I can solve this problem: _____

_____

Another way I can solve this problem is: _____

_____

Which solution I think will work better: _____

_____

My plan for solving this problem:

What I will do: _____

With who: _____

When I will do it: _____

I need help with: _____

How did my plan work: _____

The proactive procedures above specify the techniques of conduct for Kenneth and the counselors meant to teach him – through counseling and the worksheet – new ways to manage himself. The reactive interventions instruct counselors in the way they should attempt to manage the target behaviors, and Kenneth's relationship to such conduct, when it occurs.

> Reactive Interventions
> 1. Perseverating on Negative Topics: When Kenneth is perseverating on negative topics or displaying mild behaviors (hand against face, pouting) attention should be minimal. Remind Kenneth that he does not need to engage in those behaviors and that when he is ready you will give him any assistance he needs. Continue responding in this neutral fashion until Kenneth approaches staff and expresses his concerns appropriately.
> 2. Provoking Peers: When these behaviors occur, Kenneth should not be allowed to assume "victim status" and receive excessive emotional support. He should be encouraged to use his next scheduled counseling session to discuss the incident. During counseling, Kenneth should be assisted in seeing the relationship between his behavior and those of his peers and encouraged to take responsibility for the situation. If indicated, he should make amends to the peer he provoked.

The reactive interventions are explained in scenarios of instruction that describe the target behaviors again. These descriptions presume the reader's specific knowledge. Goal plans often seem as though they are meant for any professional reader. Apart from their format, which reflects a basic type of behavioral intervention, the plans sometime include information that is taken-for-granted in the group home ("Kenneth is a man with mental retardation . . .") or that substitutes formal methods for practical ones (as in the documentation requirement for James' goal, described in chapter 4, which requires the use of + and – instead of "yes" and "no"). Despite the formal appearance and expression of many plans, it is the "occasional and elliptical character" (Garfinkel 1967:201) of description that make them relevant and usable in group home work.

The contractual function of goal plans can be observed in the range of accountable ways of knowing and acting they make possible.[8] The meaning, for example, of "minimal attention," "being ready," even "assistance" and "emotional support," is not contained within the plan itself and cannot be. The reactive interventions must be general enough to permit counselors' situated judgements about when and how they can be relevant and usable. The plan enables, in technical ways that cannot be specified without making the work practically impossible, the situated but accountable use of certain kinds of knowledge and conduct. At the same time, the only additional details in the reactive interventions, provided parenthetically to distinguish, and define, "mild behaviors," function in the reverse, defining certain kinds of conduct as having a fixed meaning. "Pouting" and "leaning into hands" are thus attention-seeking strategies made seeable as problem clinical conduct.

The worksheet, the most systematic aspect of Kenneth's plan, turns out not to be a routine aspect of counselor work. Actually, there are no precise instructions on how counselors' are supposed to "use" it. I observed staff use it as a direct intervention all of three times. Two occasions involved Cynthia, who used it to "redirect" Kenneth when he attempted to initiate conversation about a negative topic. Perhaps this reflects Cynthia's position as the clinical "expert" and the plan's primary author. In any case, the plan as written is simply not practical for the counselors in their routine work. Counselors do however identify and act on Kenneth's conduct in ways that are shaped by and accountable to the plan. Both Susan and Carlos have complained, on many occasions,

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8. Garfinkel discusses the contractual function of psychiatric records (1967:197).

that Kenneth actually makes up problems in order to seek counseling. Once, in the staff office, Susan shooed Kenneth away by saying: "I'm busy and don't have time to talk to you right now." Carlos laughed and said to me: "he makes up issues because he likes to get counseling. You know, he comes and tells things he's done wrong and stuff so that he'll get counseling." Susan affirmed this by saying defiantly: "When he's like that I just won't talk to him." Their complaints reflect the plan's formulation of Kenneth's conduct and the general logic of intervention. Although counselors are supposed to remain neutral and pay minimal attention to Kenneth when he pursues negative topics, their dismissals of him, and their regular informal assessments of his conduct – as needy and attention-seeking – are accountable to the plan without actually using its specified clinical techniques.

That it is a practical strategy of rationing services provides a plausible explanation for the Susan and Carlos' informal but accountable management of Kenneth's conduct. Redirecting Kenneth by asking that he complete a worksheet is actually an implied contract, stipulating the conditions that will permit him to make a claim on a counselor's time later that day. This is a commitment they may not be willing to make because, as a practical matter of work, Kenneth's conduct may be much easier to manage spontaneously with the available techniques at hand than the systematic and calculative conduct the worksheet requires. As with all goal plans, the counselors must document Kenneth's target behaviors – perseveration on negative topics and provoking peers – if they occur. The data collection technology also requires counselors to indicate whether Kenneth has "used" the worksheet. Although the plan itself implies that the worksheet should be used

as needed, the counselors data collection imply that the worksheet should be a routine aspect of Kenneth's conduct. However, the worksheet was not one of the features of their own conduct that counselors' were required to document.[9]

The behavior plan also does not capture how the worksheet actually shapes Kenneth's own practical everyday work. According to the counselors, Kenneth never mentions the worksheet and is even "secretive" about it, keeping the binder hidden in his room. Carlos told me that Kenneth "acts surprised" when the worksheet is mentioned and "seems to think that staff do not know about it." In the course of my own many casual conversations with Kenneth, he mentions the worksheet in various ways. These mentions sometimes function to indicate his capacity for solving problems without staff in a way that can be understood as "using" the worksheet without actually completing one. Kenneth also sometimes uses in conversation some of the techniques of evaluation and assessment that the worksheet makes available:

> . . . you know, I have this problem a lot . . . I've had this problem before . . . I worry too much . . . I don't want to bother staff . . . once I talked to Sonia and she told me . . . I told Daniel about it and he helped me . . . I'll tell you what I'm gonna do to stop worrying . . .

On a few occasions early in the research, I asked whether he would show me his worksheets and explain how he uses them. Normally quite forthcoming and eager to show me things, he always deferred these requests, saying "another time" or "maybe later."

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9. In addition to the daily data collection technology there is a "behavior log" for particularly disruptive occurrences of the target behaviors. Although these rarely occur, the behavior log is intended to monitor Kenneth in detail because of his potential for negative conduct. The log requires narrative descriptions of the occurrence of the target behavior, its antecedents, and, here, "how counselors responded."

About three months into the research period, Kenneth was upset for nearly a week about the planned change in his primary counselor from Lisa, who was leaving the job, to Daniel, who had been his counselor once before. Kenneth felt Daniel was "too strict" and also said that his mother did not like him. All this worry was compounded by the fact that Kenneth had been informed of the change while Daniel and his mother both happened to be away (Daniel, on vacation for a week; his mother, visiting relatives out of town). One of the times I observed Cynthia using the worksheet as an intervention was during this period. We were in the staff office and when he initiated a conversation about Daniel, she said: "I'll talk to you about what's bothering you but you have to fill out a problem worksheet first." Kenneth agreed and headed toward his room.

Several hours later, after the evening chores were finished, I was in the living room with Kenneth and some other residents, and he asked to talk with me privately in his room because he was upset. We sat on the bed and started talking about his concerns about Daniel and his mother's reaction ("She's gonna be upset when she gets back."). After a few minutes, I interrupted, telling him I had heard Cynthia mention filling out a worksheet and wondered if it helped? He said yes, but continued the conversation without elaborating or extending to me any kind of permission to pursue it. When, at one point, he asked rhetorically, "what do you think I should do?," I took it as another opportunity. "Well, I really don't know. But I mean you have these worksheets that are supposed to help. Do they? I don't even know what they look like? Aren't you supposed to fill one out when you're upset?" Kenneth replied: "They help a little." Then I asked if he would show me one and he replied: "Okay, I'll show you one as an example." He went into his

closet and removed a binder, and from it a single sheet. It was the sheet he had used earlier that day and he read it aloud to me as I was looking at it. Just as the proactive procedures in the goal plan presumes the worksheet's instructable character, Kenneth simply read it, letting the questions themselves serve as techniques of explication.

> What is my problem? *Getting a new counselor and he won't let me talk to other staff except the boss* [the supervisor, Sonia]. Have I had this problem before? *Yes.* How did I solve the problem before? *Talking to the boss.* Did my solution work? *No.* One way I can solve this problem. *Moving out.* My plan for solving this problem. [pause] What will I do? *Talk to the boss.*

Kenneth replaced the sheet in the binder. I said: "Okay, I see how it works now. Does it help to fill one out when you have a problem?" He replied simply: "yes." I persisted: "Why does it help?" He hesitated and then said ". . . umm, when I write out the issues . . ." before trailing off. He rose to return the binder to the closet and resumed our conversation by asking if I was going down for coffee with Theresa tonight. Perhaps Kenneth simply could not produce an explanation because my question did not make sense. To pose it as I did assumes that, as an intervention, using a worksheet should have a measurable outcome. Kenneth apparently does not share this assumption. The technique of ordering the questions, mentioned above, provides but does not require a particular temporal logic. To the question "How did I solve the problem before?" Kenneth answers "Talking to the boss," then indicates that this solution did not work. Yet when he arrives at the final question, "What will I do?" the answer is the same. For him, the problem solving worksheets are a kind of work that makes sense only in terms of the specific things that he can use them to accomplish. The logical relation between his prior, unsuccessful solution and solving the problem at hand was not reflected in the ordering

technique the worksheet provides. The situated and practical character of such decision-making means that it often cannot be, for Kenneth or anyone else. Kenneth did not indicate whether he noticed his "contradiction." Even if he did, it would not likely trouble him. At least one of the specific accomplishments that completing the worksheet affords is the fulfillment of the contractual arrangements that entitle, and organize, certain kinds of contact with counselors.

Kenneth is aware that talking about, what he calls, "my problems," is always potentially annoying to counselors. This awareness is observable in how he manages his conduct, not to "become more independent" but to avoid "getting [counselors] mad." However, the counselors' interventions – whether the plan is used or not – translate Kenneth's "talking too much" into warrantable clinical conduct, technically, as the problem of problem solving, inappropriate attention-seeking, neediness, and so on. Similarly, Kenneth manages himself, one might say preemptively, to "miss" the target behaviors, or at least to conceal his aim. For example, he and I were standing in the doorway to the kitchen one afternoon as I was cooking dinner. I had my back to the hall and he was talking about something at workshop that had upset him earlier that day. Kenneth suddenly stopped talking, turned on his heel and headed through the kitchen toward the dining room. Then I heard Daniel's voice call from behind me: "What's the matter?" Kenneth paused. Daniel continued: "If you have a problem, write about it." Kenneth said, "right," and proceeded into the dining room out of sight.[10] On another

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10. This was the only time I ever observed a counselor using the worksheet as an intervention as the plan implies. As with Carlos and Susan above, however, Daniel's intervention departed from the plan in an accountable way. The plan implies that individual counselors should intervene when

occasion, Kenneth had been annoyed at Evelyn about something she said to Evan during dinner. He discussed it with me briefly during dinner and again, afterward, as he was sweeping the dining room. About an hour later, I was sitting in the staff office reading. Carlos was helping Donna on the computer. Kenneth came in, slid into the chair next to me, and said *sotto voce*: "I'm still upset . . . you know . . . about what we talked about."

Kenneth also discussed his conduct openly. One afternoon not long after I started spending time at the group home, I was sitting in the dining room with Chris, listening to the radio. Kenneth had come home from workshop and joined me at the table. He was discussing one of his regular problems, the health of an aging aunt. After a few minutes, we talked about Cheryl, who had just started as an evening counselor, and Kenneth raised his problem of talking about problems.

> *Kenneth*: I'm not allowed to talk about my problems with the new staff.
> *JL*: Why not?
> *Kenneth*: Only with Sonia and Daniel [the supervisor and his primary counselor].
> *JL*: Who says? Is that a rule?
> *Kenneth*: It's inappropriate to talk about personal problems with people you don't know.
> *JL*: Oh.
> *Kenneth*: But soon I'll know them [new staff].
> *JL*: Who said so?
> *Kenneth*: My counselor. He said I can't talk to anybody but him. And Sonia too.
> *JL*: You're talking to me?
> *Kenneth*: That's because you learn things. You learn things from what clients talk about.

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Kenneth is inappropriately seeking attention from them. Although Kenneth was not actually talking to Daniel, who likely did not hear what was said or whether he was even complaining, for Daniel, Kenneth was "doing what he always does."

## CONCLUSION

In order to answer my question about whether there is an actual rule that restricts his conversation to certain kinds of persons, Kenneth did not refer to the goal plan but to the practical knowledge it provides about inappropriate conduct. A resident's ability to know and act on their own need is shaped reflexively by the kinds of conduct that goal plans enable. Counselors and residents do not question that everyday life in the group home is organized by their own ongoing clinical work. Taken for granted clinical ideals must take shape as actual work and goal plans provide many of the practical techniques that enable both counselors and residents to act on conduct – their own and each other's – in relation to becoming more independent. Each plan translates the overall goal of independence into particular problems of individual conduct. Difficulty with self-assertion, poor hygiene, neediness and attention-seeking are a few examples of how everyday conduct takes shape as matters of work. The purpose of this chapter has been to show how conduct takes shape in technical ways in the practices of identification, assessment, intervention goal plans provide. This is not to suggest that plans function simply as a set of instructions. On the contrary, how, when, and why plans are used in everyday life does not necessarily follow from the plans themselves, and if goal plans restrict the conduct of counselors and residents too much, they are not be available as practical and usable resources for their ongoing work.

All residents have goals because there is always work to be done on one's own conduct. This certainly reflects an organizational pressure to generate services in order to fulfill minimum billing requirements. However, this is something only Cynthia and Sonia

are likely to keep in mind. For the rest of the counselors, it is a fundamental clinical assumption that there is always work to be done. The fact that counselors and residents both take for granted the clinical organization of everyday life is not to say they do not criticize and complain about it: residents express frustration with the burden of the endless work they must do on their own selves; and counselors balk at the clinical judgement of their peers and supervisor.[11]

Whether a plan seeks to enhance skills or extinguish negative behavior, the object of the group home's clinical work is normal life. Although the kinds of problems that organize this endless work may appear self-evident to readers, it is only in the group home's specific practical conditions that they are seeable and knowable as clinical problems. The goal plans provide one way of observing the detailed work of governing because the psy techniques they furnish, are the situated and practical resources residents and counselors use to govern themselves in the particular ways that make them group home persons.

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11. Counselor disputes are described in chapter 7.

## Part II
## Introduction: Know-how

Different kinds of group home work were described in the introduction to Part I. Residents are governed according to an ethic of autonomy that requires them to take their own selves as objects of work. For staff members, the group home is an actual workplace. Chapter 3 described how counselors and residents manage different kinds of uncertainty in practical and situated ways. The analysis in chapters 4 and 5 showed how paper technologies are embedded aspects of the work they organize and establish practical conditions of seeing and knowing in the group home. The emphasis shifts in Part II to the third meaning of work, the ordinary accomplishment of everyday life, a kind the work from which there is no relief.

The focus of Part II is the know-how of residents and counselors, the local knowledge they use to organize the course of their group home work. This is based on the ethnomethodological insight that even the most esoteric knowledge and skill has an embedded and practical character. Previous chapters have made clear that my analysis of group home work does not begin with ideal representations of service available in individual service plans (ISP), treatment books, staff development manuals and elsewhere. For counselors and residents, know-how is the clinical and administrative knowledge that is usable and, therefore, relevant to the situated and specific accomplishment of everyday work. Know-how reflects the work-specific competencies that are an organizing feature of the group home.

Workplace know-how has been the subject of research on technological changes and its consequences. In challenges to arguments about deskilling, research has shown how automation actually demands new kinds of skill, and even "unskilled" work depends on a wealth of tacit knowledge (Attewell 1990; 1992). Zuboff (1988) describes how paper mill workers are not simply deskilled when computer systems replace the manual management of equipment, but develop a new and fundamental kind of "craft know-how." In an automated textile factory, Juravich (1985) shows how "craft knowledge" is integral to production because workers rely on it to solve frequent equipment crises. For Juravich, craft knowledge is not meant to conjure a notion of artisanal production, but to recognize the role of "knowledge that cannot be rigidly systematized to procedural rules but is developed through years of experience" (305). This type of knowledge not only develops in unskilled work but is fundamental to it. Deskilling arguments also hold that automation erodes the historic basis for collective organizing. However, Kusterer's (1978) research in different low and unskilled occupations demonstrates that workers are not as alienated as deskilling predicts. Know-how, a fundamental component of what Kusterer calls "working knowledge," is actually a source of pride, meaning, personal investment, and worker control of the larger process. Given that know-how is integral to production, yet largely hidden from management, Kusterer suggests that it actually provides a new basis for organizing which is compatible with technological change.

In their challenges to deskilling arguments, Juravich (1985), Kusterer (1978) and Zuboff each seek to reveal the unrecognized but essential role of know-how that makes even low and unskilled workers integral and active participants in the work process.

Although my analysis of tacit knowledge is not meant to address how workers adapt to technological changes (a question that does not actually apply to the group home workplace), I share the basic assumptions of this research about the relationship between the process of work and the practical, unspecified knowledge of workers. In Part II, a question implied in previous chapters is posed explicitly: what do counselors and residents know and how does it relate to the accomplishment and organization of their group home work? The answer is in the analysis of know-how not simply as an integral but hidden component of work, but as the work itself. My intention is not to demonstrate that group home work involves more than can be recognized by the institutional and ideological focus of Marxist or neo-Weberian perspectives (Attewell 1990). The aim in chapters 6 and 7 is to show what group home work actually consists of by making the everyday use of know-how the focus of empirical inquiry.

Know-how provides a particularly suitable conception of work in this setting. All people-processing is characterized by complexity and uncertainty. In the group home, however, these aspects of work take specific shape in relation to clinical knowledge. As chapter 6 describes, counselors and residents are *always* at work because there is no distinction between "work" and other group home activity. This is an organizational feature that fits with fundamental assumptions about the clinical significance of everyday life. Chapter 7 is concerned with the specifically clinical aspects of know-how. Unlike textile plant and mill workers, whose craft knowledge can be assessed easily by production output, the outcomes of counselor work are difficult to define and measure, something that Lipsky observes generally about service provision not organized on a market basis.

Counselors must always be able to account for their actions in the group home's clinical and administrative terms. This is also true for residents, if in different ways, and, as chapter 6 shows, residents use their group home know-how to manage their own conduct and conditions of work.

Finally, a focus on know-how as work provides an analysis of disability and professional authority that brackets questions about social control and social construction. This is not to suggest that the social control of residents is not an aspect of the group home, only that everyday life in this setting cannot be reduced to matters of power and domination without precluding other analyses or engaging in normative assessment. Similarly, the concern with social construction in general too often substitutes for argument and analysis a practice of debunking which leaves its own epistemological assumptions unexamined (Hacking 1999). The epistemological status of professional authority and knowledge (including knowledge about disability) is not a concern here. I approach the operation of authority and knowledge as everyday practical matters in order to understand what kinds of conduct and persons group home work makes possible. This neither permits nor requires any prior epistemological, normative, or explanatory theoretical commitments about the setting's function or the people who live and work there. In the next two chapters, work is analyzed in group home know-how: the methods of practical and clinical reasoning that residents and counselors use in the ongoing and situated accomplishment of everyday life.

# Chapter 6
## Everyday know-how

## I. INTRODUCTION

The paper technologies that make the group home a workplace do not comprise all of its workers' everyday activities. Group home workers can often be found watching TV and hanging out in the living room and staff office, looking at the paper or a magazine, down for coffee, and so on. This chapter considers all the time not taken up by the documentary technologies described in the previous chapter that are in an obvious sense "the work." In fact, residents and counselors are always at work because the group home provides no "back region" that can guarantee relief or distance.[1] Like flight attendants, dining room staff on the floor, and certain other service workers, the constant visibility of counselors and residents means that what counts as work extends far beyond their specified tasks. Counselors' presence alone is understood to have an impact on residents. As role models, counselors are always at work managing their own conduct as they maintain a vigilance over everyday life and the ceaseless opportunities it presents for clinical work, forever intervening in the problem conduct of residents. Thus residents are kept always at work in the mundane course of life, oriented again and again to their own conduct, to the project of becoming more independent – the endless work that defines them as residents.

Any aspect of a resident's conduct can at any time be defined and acted on by

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1. Goffman uses the phrase "back region" in *Asylums* (1961:106).

counselors as a clinical problem. This takes shape in the spontaneous exchanges between counselors and residents that are an ongoing, routine aspect of group home life. I was sitting in the living room one Sunday afternoon, for example, talking with Cheryl about her college and career issues. The usual level of house activity was at an ebb because most of the residents were on a rec trip. We were at the window and Paul was adjacent to us on the couch watching TV. He turned to Cheryl and asked: "When will dinner be ready tonight?" Cheryl said: "You know, Paul, we're having a conversation and you didn't even say excuse me." Paul responded with rote frankness: "Excuse me." Then after only a second or two, he asked again: "When will dinner be ready?" Cheryl answered simply: "Six-thirty" and resumed our conversation without further comment.

This is an example of the kind of work that is the focus of this chapter: the ongoing work observable in the situated use of know-how that reflects and organizes everyday life as a clinical domain. It is exemplified by the spontaneous interventions of counselors that define and act on resident conduct as a warrantable problem. In this chapter, these interventions are discussed as practical methods in relation to several kinds of conduct, to show that the clinical significance of everyday life is not merely an abstract professional commitment nor a mode of control. The counselors' spontaneous and practical use of everyday know-how requires residents to work in the moment on their own problem conduct. This illustrates the specific, situated clinical contours of everyday life. Resident know-how is also analyzed in the practical methods of talk they use to demonstrate their competent participation in group home life, sometimes in their skilled use of talk in conventionally incompetent ways. Routine work matters are also available

to residents to make claims on counselors and to "help" each other. Helping each other, however, can be spontaneously defined by counselors as "acting like staff," which indicates a resident's failure to be independent. As a warrantable clinical problem, acting like staff reflects a paradox of conduct that derives from a practical confusion inherent in counselor work.

**The clinical significance of everyday life: two staff meeting discussions**

That there is much clinical work to be done in the routine course of group home life may appear as a familiar aspect of "total institutions," where all spheres of activity are also conducted in a single setting. Goffman's ideal-type, however, defines work largely in terms of organizational control. By contrast, the approach here to counselor work emphasizes its reflexive and situated character in the use of know-how, which furnishes for counselors the specific techniques of conduct that, in the course of their own work, actually define what it is to be a counselor. For example, the counselors' commitment to the clinical significance of everyday life can be observed in their know-how about when and how to intervene in resident conduct. Everyday life takes its clinical shape in ongoing ways through the counselors' interventions, which constitute mundane conduct as specific clinical problems. The following descriptions of two weekly staff meetings show how situated expressions of this commitment emerged in and organized these occasions of counselor talk.

Mike, the regional supervisor, was present at this particular meeting and, at one point, took the floor to say that he heard the weekly residents' meetings were not being

held regularly. He asked the counselors why and to describe their understanding of the meetings' purpose. Daniel described them as the venue for assigning house chores, deciding on weekend recreation trips, and general house business if there is any. He continued without pause: "But there's a problem with the meetings now," as though answering the question Mike was "really" asking: why have counselors shirked their responsibility to call these meetings weekly? Daniel explained that some months earlier, the chore system had been changed from the weekly swapping of chores each Monday night to more or less indefinite assignments. As a result, the meetings now lack a "sense of urgency."

Daniel's response to Mike's request that swapping chores was a main purpose of the meetings was actually no longer true, but it established the counselors' account for their failure to call the meetings. Daniel and several other counselors then successfully organized the conversation by making their account its central topic: the new chore system as "the problem all along." Residents were now less interested in attending on Monday nights. "The meetings need a sense of urgency to get everyone there." Miles said that the new system was a "catch-22" because "everything works" – the kitchen and dining room are cleaned after dinner, the bathrooms and hallways are cleaned, and the garbage is collected from all the rooms and offices. It had become "routine" however and the residents "take it for granted."[2] Mike was apparently satisfied by the account offered by the counselors because he made no attempt to return to his initial question: why they

2. As far as I knew, there had been no complaints from the residents. They seemed satisfied with the arrangement, and even an individual's occasional desire to swap chores was easy to address by negotiating here and there without reorganizing the whole system.

had not been calling meetings regularly.

The way the counselors' organized this conversation is a simple example of how everyday life becomes a domain of clinical work in situated accounts of specific problems and solutions. In this conversation, the chore system provided both a questionable aspect of everyday life and a solution. Miles identified "complacency" as the problem. Susan agreed: "residents just do their chores without thinking about them." Complacency was also implied as a problem of counselors. Permitting the residents to take their chores for granted had encouraged "dependency," defined tacitly as "getting too comfortable with things." Counselors had failed to take advantage of the opportunity inherent in daily chores to work on "independence" or, more precisely, to require residents to work on their own independence. Housecleaning and kitchen chores were defined here as opportunities to "stimulate" the residents' capacity to be "proactive."[3] Daniel claimed it would be good "to shake things up for the sake of it" and "to stoke a fire" because residents should be "less dependent and more proactive." These claims were formulated as clinical imperatives that reflected the counselors' sense of entitlement – even obligation – to disrupt a perfectly functional chore system that garners no complaints.[4]

A second example of how counselors define everyday life as a domain of clinical of

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3. The meaning of proactive here was assumed by the counselors. It seemed to mean "extra initiative" in some general sense. See the analysis of counselors' use of indexical expressions in chapter 7.

4. This conversation occurred during my second month in the residence and, in the eleven months that followed, the chore system was not changed, nor was the issue again raised in this way during a staff meeting.

work is from a staff meeting discussion about hiring a new housekeeper.[5] The housekeeper position was vacant when I arrived and the supervisor was asking for "feedback" from the counselors about a candidate who had been recommended by the personnel office of the agency. Although he was apparently suitable for the position, his rudimentary English concerned Sonia, who wanted to know if the counselors agreed. Since there were positions available in other agency facilities where language was less relevant, this decision would not affect his gaining employment. Maria, who spoke Spanish, had already met with the candidate to assess his language skills at the supervisor's request. She reported that he could certainly manage the job but she was also concerned about how he would "deal with the guys." The staff agreed overwhelmingly that a housekeeper must be able to "communicate with the guys." It was not simply that some of the residents enjoy being involved in aspects of house management routinely handled by the housekeeper – especially ordering and stocking supplies – but also that the housekeeper "must be able to do counseling" when residents need it. Chris was mentioned as evidence for the counselors' account of the clinical demands of the housekeeper position. His eager participation in household affairs, especially organizing and stocking the pantry, was typically encouraged as positive involvement. However, it was precisely Chris' eagerness that counselors believed disposed him to problem conduct like being "bossy" or "too involved." What "counseling" meant was not explicated, but reference to it as a distinctly professional kind of conversation defined this mundane activity as a potential clinical problem. The unremarked transition from "communicate

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5. The housekeeper is responsible for regular heavy cleaning and managing the household supplies.

with the guys" to "counseling" indicated the counselors' concern that even something understood as positive, Chris's ordinary pleasure in helping with everyday tasks, could at any time become a matter of clinical work.

## II. SPONTANEOUS INTERVENTIONS

There is no aspect of everyday life that does not have potential clinical significance. Goffman notes a similar "license" in *Asylums*.. Given the "legitimate claim to deal with the 'whole' person, [staff] need officially recognize no limits to what they consider relevant" (1961:156). However, the spatial aspects of work are different in the two settings. In Goffman's total institution, spatial arrangements enable the control of "collective blocks of people" and help preserve the integrity of professional service by separating it in certain ways from the imperatives of administration. In the group home, the clinical significance of everyday life takes its practical shape in the constant, close proximity of counselors and residents.[6] The spatial arrangement of the asylum also enables the "underlife" that Goffman describes, which provides certain kinds of relief from the institution's demands. Although the organizational demands of the group home are of a very different sort, there is little relief from the work.

The description of Linda chiding Paul at the beginning of this chapter is a simple example of how everyday life is constituted as a domain of clinical work in ongoing, practical ways through counselors' situated and spontaneous intervention. This is a kind

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6. See Prior's (1988) analysis of the relationship between hospital architecture and medical discourse, which is partly a criticism of over general theoretical claims about the "social construction of space."

of work that is embedded in and organizes the routine and orderly course of group home life. At the same time, the idea that this type of intervention is *spontaneous* is intended to emphasize how it can be used to manage the contingent and indeterminate group home work of which it is a part. Spontaneous intervention refers to a general mode of counselor conduct that encompasses the range of ways in which the clinical significance of everyday life is routinely organized through the specific resident conduct that, on the spur of the moment, counselors define and act on as warrantable problems.

Spontaneous interventions are the situated and practical use of know-how by counselors. Know-how should be understood not only in terms of ideas or values, but as technical, in the sense described in chapters 4 and 5, because it is always "bound into ways of seeing and acting" (Rose 1996:83). As an empirical focus for the observation of work, the situated use of know-how shifts the focus from meaning, discourse, identity and so forth, categories which can explain work only retrospectively and theoretically. Widely available methods of practical reason are used with, and often indistinguishable from, the clinical methods that define the group home as a specific professional setting. Clinical assumptions, cliches, vocabulary, modes of monitoring, assessment, and intervention are available – and can only be available – as specific methods that translate professional knowledge as relevant and usable at the level of everyday life.[7] These methods of know-how are the techniques available to counselors and residents that enable them to know and act on the persons and problems of group home work in its course.

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7. Lave (1986) makes a parallel argument about the situationally specific character of cognitive activity in her research on the everyday use of arithmetic.

Spontaneous interventions mobilize the capacities of residents to apply the available techniques of conduct to themselves. This routine work furnishes for residents the know-how that makes the problem aspects of their own conduct visible and knowable in specific and manageable ways. For example, Carlos and Kenneth were in the kitchen preparing dinner. This was the evening of Kenneth's cooking goal, and Kenneth was not paying much attention because he was preoccupied with problems he was having at his workshop with his girlfriend. Carlos said: "C'mon! Stop talking about Janet already. You are supposed to be working on your cooking goal." Kenneth was contrite, but after only a few minutes of chopping carrots said he was too tired tonight to cook. Carlos responded perfunctorily: "Well, fine, but finish the carrots before you leave." Kenneth finished chopping and went into the living room, but returned after a few minutes and leaned in the kitchen doorway. "I am too worried about Janet to do my cooking goal tonight." Carlos' immediate reply was reassuring: "No problem." Kenneth started to talk about Janet and the workshop again and Carlos listened passively as he prepared dinner. After a few minutes, Kenneth returned to the living room. Carlos was still preparing dinner when he returned and resumed talking: "I don't think it's right that Barbara doesn't let me sit next to Janet." Carlos stopped his work and gave Kenneth an incredulous look, but said with affection: "You have told me about this ten times since you got home today!" Then Carlos sympathetically offered an alternative to Kenneth's preoccupation: "Why don't you help me more with dinner?" Kenneth said: "Sorry, sorry, I worry too much" and stepped toward Carlos indicating that he was willing to help.

Carlos acted on Kenneth's action in observable ways that depended on his situated

use of practical and clinical know-how. As an "intervention," this is more than a mere exercise of counselor authority. Kenneth has a behavior plan that already makes available certain ways of knowing and acting on his conduct as needy and attention-seeking. Although Carlos does not, in this instance, follow either the spirit or letter of the plan, he draws on some of the ways it makes knowing Kenneth's conduct possible. Kenneth's own formulation of his conduct as "worrying too much" shows how clinical work – his and the counselor's – can make sense only in its situated use, tied to specific conduct. Moreover, the available clinical know-how that shaped the reflexive course of this exchange cannot be separated from other practical techniques of conduct: patience, impatience, sympathy, self-awareness, and so forth. Carlos' attempts to mobilize Kenneth indirectly to act on his own conduct, just then, in this specific exchange, illustrate the temporal and situated character of group home work in the use of know-how.

**Conducting oneself politely**

The exchange between Linda and Paul again provides an example of one regular way counselors use know-how spontaneously in the situated course of everyday action. Counselors frequently demand that residents fulfill their conversational obligations by uttering social formalities such as thank you, please, or excuse me. Residents often dispense with the routine 'hello' and 'how are you' and launch immediately into their own concerns: appointments, special events, their goals, or what's being served for dinner and when. These are routine requests and questions when they are so answered, but they can also be met with joking, sarcastic and annoyed responses from counselors. A response

such as 'Can't you even say hello?' or a friendly, if exaggerated, 'Hello, Donna, how are you?' demonstrate to residents that a slew of questions is not an acceptable form of greeting. For residents, it appears that the proximity of counselors and the comfortable intimacy that generally characterizes group home relations do not always require formal greetings. Although this situated judgement is often affirmed, counselors can also spontaneously transform this mundane aspect of everyday life into clinical opportunities that urge residents to manage their conduct in "socially appropriate" ways.

Counselors sometimes define conduct as impolite by trying to correct an "absence," attempting to extract a specific utterance from residents that they overlooked or ignored. For example, one evening, Susan was fixing Diane's hair in the staff office. Diane was seated in a chair and Susan was perched over her, sitting on the desk. There were several counselors and residents hanging around and the mood was jovial. When she finished she said, "Okay, I'm done," and Diane simply stood up and left the office. Susan called after her jokingly: "Don't you say thank you?" She received no answer and, again with a laugh, called out: "Excuse me, Miss A, don't you say thank you?" Sally, who was sitting next to them at the computer, smiled. There was no reply from the hallway. Susan suddenly got down from the desk and exclaimed with exasperation, "I can't believe her! I do her hair all the time!" and raced out of the office after her. Sally looked over at me with an incredulous and disapproving roll of her eyes.

Sally's expression indicated that counselors might understand Susan and Diane's conduct in different ways. It was also Sally's situated use of know-how that assumed I shared, or could share, her understanding. I was not able to ask Sally what she meant

because there were residents with us in the office. I understood it as a criticism of Susan's conduct: she was too serious about such a minor issue and, thus, was taking herself too seriously. Susan's conduct could have been understood plausibly as excessive. On the other hand, Diane's conduct could have been understood plausibly as rude. What *was* observable was Susan's commitment to intervene in rude conduct, which is a practically available way of knowing and acting on residents. Regardless of how Susan's conduct might be evaluated, it reflected her specific capacity as a counselor to act in a spontaneous and accountable way. Her situated and reflexive use of know-how made observable to me one way of being a counselor.

In an ongoing practical sense, politeness is within the clinical purview of counselors, although, as Sally's expression indicates, they do not act on it uniformly. Some counselors regard it as central to their clinical work, as Susan does; others regard it generally as a matter of "personal style" and therefore, not clinically warrantable conduct. The identification of conduct as impolite, when it occurs, is always situated and practical, but always available to counselors as a method of clinical intervention. There is an instructive analogy to group home work on politeness in the responsibility adults often assume to teach manners to children. Goffman uses the analogy to explain the treatment of inmates. Inmate status is by definition the reversal of an individual's achievement of personhood and adulthood – that is, autonomy. Children and inmates *de facto* share the same limited status: "only children can be openly sanctioned . . . for showing improper deference; this is one sign that we hold children to be not-yet-persons." Therefore, "to the degree that the inmates are defined as not-fully-adults, staff need not feel a loss of self-

respect by coercing deference from their charges" (1961:115). Goffman notes that within total institutions the display of deference is more formal than elsewhere, something that is not the case in the group home. Impolite conduct is not a self-evident violation, partly because group home authority is less rigid, and partly because manners in general are far less formal than they were in the middle 1950s.

Goffman's analogy in the total institution does not obtain in the group home for a more fundamental reason however. In *Asylums*, he actually does identify the tension between free individuals and the demands of organizational life in liberal societies, and even anticipates some of the ways this tension later emerges in various theoretical and political movements. However, he assumes a binary conception of personhood as autonomy that *ipso facto* defines children, inmates, group home residents, and others, as "not yet" or "non" persons. This binary conception was necessarily abandoned in the rights-based movement that started to bring inmates into the community in the 1960s and 1970s. Tensions posed by liberty, which had been insignificant (especially in the institutional treatment of individuals with mental retardation and mental illness), have transformed the professional practices of managing certain kinds of persons. Although deemed incapable of fully managing themselves, individuals in community-based services, as citizens, are managed in terms of their rights. For this reason, the analogy between the treatment of children and group home residents now also reflects more complex conceptions of status and the conferral of rights that have been extended to both, as new

kinds of persons.[8] The professional consensus regarding adults with cognitive disability is that they should – as a legal and clinical matter – be treated in "age appropriate" ways. Thus, in the community, residents must be governed, which presumes their capacity for freedom and, by extension, their adulthood. In the group home, however, impolite conduct is a clinical concern that makes it possible to cast residents as "child-like" in specific and situated ways, but not completely as in Goffman's analogy. The analogy is instructive therefore in a more precise formulation: what children and residents share is that they can both be acted on in ways that presume their capacity to act on themselves. Both are expected to demonstrate their responsibility to general notions of propriety by at least attempting to govern themselves.

Although it is not a matter of professional practice, adults often feel entitled, even obliged, to teach children manners by insisting on 'thank you' or 'please.' In a similar way, counselors' occasional use of a patronizing tone, however offensive, presumes a capacity in residents to learn how to conduct themselves in specifically polite ways. In the field of cognitive disability, the emphasis on the "self-determination" of individuals as "consumers" of services no longer sanctions staff attitudes that reflect older, but resilient, cultural assumptions about disability. In the group home, although it is clear in staff training that condescension is unacceptable, it remains available as a practical method of counselor know-how. For example, one Thursday afternoon as the weekly staff meeting broke up, a few residents came crowding into the office with most of the staff. It was the

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8. For an account of the children's rights movement see Hawes (1991). In a different vein, see Postman's (1982) argument about the "disappearance" of childhood in the blurring of legal and cultural distinctions between children and adults.

usual bustle with people carrying extra chairs back to the living room, gathering up their material, chatting, and greeting each other. Some residents are keen to be around when the meeting breaks up as it is convention that they may eat the leftover snacks. Donna strategically squeezed her way through the crowd to a bowl on the desk that contained a modest amount of popcorn. As she was eating, Damian noticed her over the hubbub and asked in a patronizing tone: "Donna, have you had enough popcorn?" Damian was patronizing because his question indicated the "preferred" answer (Sacks 1987), which Donna provided. "Yes." She paused briefly before taking another handful. Damian: "Donna, I thought you had enough?" Donna said nothing and Damian attempted to elicit a response. "You're going to have dinner soon." Donna remained silent, arms at her side. Damian persisted, because questions, as a practical method of talk, usually oblige an answer: "What about leaving some for other people?" Donna mumbled "yes" and finally resigned to forego the little remaining popcorn. Damian asked again: "Don't you think you should leave some for other people?" Donna nodded in agreement as she left the office. Damian's condescension was a method of intervention that was not a direct disciplinary prohibition but oriented Donna to her own conduct – eating too much popcorn before dinner and not leaving any for others. Counselors disagree about the clinical warrant of precisely this kind of conduct. The fact that Damian treated Donna "like a child" does not reflect a standard of group home practice. Nor do counselors' necessarily regard such an exchange as contradictory to their own ongoing work to enhance the independence of residents *qua* adults. As a technical matter, counselor work is always work on and with adults, but adulthood is itself a situated and practical matter in

the group home.[9]

**Known Problems of Conduct: Marty's Perseveration**

Counselors intervene spontaneously in conduct that is an already known problem with regular identifiable features and signs of occurrence. Such conduct may have been specified by counselors in their informal talk, during the course of a shift, in which they may also agree to act in the same or coordinated ways. Problems of conduct are also known because goal plans furnish counselors with techniques for seeing, knowing and acting on them. In general, spontaneous intervention is accountable as an attempt to shape conduct in the moment and, at the same time, to provide residents with techniques, either implicit or explicit, that they can use to manage themselves in some imagined future. Susan insisted that Diane say thank you, for example, so that "next time" she might say it "independently." An intervention in a known problem is somewhat different, and can be understood as the use of a "documentary method of interpretation" (Garfinkel 1967). Conduct is identified and acted on as it reflects an underlying pattern, and makes accountable and confirms what counselors know about the resident's "deeper" problem. In Garfinkel's words:

> The method consists of treating an actual appearance as 'the document of,' as 'pointing to,' as 'standing on behalf of' a presupposed underlying pattern. Not only is the underlying pattern derived from its individual documentary evidences, but the individual documentary evidences, in their turn, are interpreted on the basis of 'what is known' about the underlying pattern. Each is used to elaborate the

9. And elsewhere. See: Copp (1998) on the social construction of adolescence and adulthood in a workshop for individuals with cognitive disability; and Baker (1984) on the use of membership categorization devices in adolescents' "search for adultness."

other (1967:78).

Known problems of conduct are used as evidence and, reflexively, as confirmation of ongoing clinical issues. Counselor interventions manage known conduct in the moment and provide methods to the residents for future self-management. They are additionally accountable as part of the group home's ongoing efforts to work on the underlying issues. Counselors often intervene in known conduct before it actually occurs, since the mere sign that it *may* occur can also be taken as warrantable conduct. Thus the use of the documentary method to intervene spontaneously in known problems narrows the latitude of resident conduct in their own ongoing and visible everyday work.[10]

"Perseveration" is a known problem of Marty's conduct. Perseveration is a clinical term that refers to the verbal repetition of one or a few ideas or words. It is a regular source of frustration for counselors because, in practical terms, it is knowable partly by Marty's relentless attention-seeking. He occasionally annoys other residents as well, sometimes to the point where they yell at him to "shut up." Counselors regularly intervene in Marty's conduct in very public ways. Marty's responsibility to the residence, to manage his own conduct less disruptively, is an available method of counselor know-how. One Sunday afternoon, for example, Marty had a hamburger and fries delivered from a neighborhood coffee shop and ate it just before dinner was served. It was a quiet Sunday because most of the residents were at another house for a party. Marty had a "bad

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10. A parallel has been observed in education research when teachers use "typologies"of conduct as a method of identifying students, which determines how they are actually treated and how they are able to respond (Waksler 1991).

day" and was not permitted to join them.[11] As often happens when he remains at home for this reason, he was very upset about his "nervous moments" and their consequences. The more upset, the greater his demands on the counselors. When I arrived hours earlier, the counselors told me they were already frustrated with him. When the few of us there assembled for dinner, Marty stood around the dining room making conversation. He asked no one in particular about that night's snack. Irving said they had fruit the night before so it would be "junk" tonight. Cheryl was in the kitchen getting her dinner. She passed by the door in sight of the dining room and Marty included her in the conversation, asking whether we would in fact be having junk food for snack. Cheryl reappeared in the doorway ready to come in and sit down but stopped. Plate in hand, she stared at Marty and said, without affect: "Marty, snack is at what time?" Without waiting for his answer, she resumed more sternly: "You don't need to talk about it now." Marty said with some surprise: "I was just asking." Cheryl persisted in a frustrated tone: "You don't need to be worrying about snack now. The rest of us are just eating our dinner." Cheryl then sat next to me and whispered in an exasperated but concerned tone: "he's so anxious, I don't know what to do for him." Marty's question about snack was produced reflexively as a sign of his known problem by Cheryl's intervention. His claim that he was "just asking" denied his conduct was a problem and thus warranted further intervention. Her remark to

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11. "Bad day" is Marty's own phrase to refer to days when he has fallen or, in general, his conduct has drawn the attention of staff. An informal agreement within the group home maintains that on a day when Marty "has a fall," he not be permitted to leave the residence at all, even with a counselor. This is informal because it is not specified in the behavior plan which, because of its restrictions – not permitting him to go out in the community on his own and requiring that he wear a protective helmet at home – required approval from the agency's human rights committee.

me – carried by her whisper into a professional "staff only" realm – made her intervention accountable in terms of her own helplessness and further defined the troublesome nature of Marty's conduct, as persistent known conduct.

Another evening at dinner just after I had begun my research, I was sitting with Marty, James, and Lisa. In the course of chatting, Marty told me he was going to Boston on a group trip with an outside holiday agency and asked whether I had ever been there. Lisa interrupted him sternly: "Marty, you really shouldn't be talking about your vacation." Marty said nothing and proceeded with his dinner. Her intervention and his silent assent indicated that talking about his trip had already been defined as a warrantable problem. I did not ask about it then because I thought it might embarrass Marty and, in his presence, would anyhow have been regarded by Lisa as a criticism.[12] Later that evening, I learned from Lisa and Daniel that he was "not allowed" to talk about the trip, just under three weeks away, until two days before, because "he's so anxious" and "he is perseverating all the time." There was a consensus among counselors that Marty's perseveration was more of a problem than usual. They had agreed informally the day before to intervene when he talked about the trip. Prohibiting the topic was a technique to manage his actual perseveration and, by repeatedly shaping his conduct in this way, urge him to recognize it as a problem, and as a problem related to his anxiety. When I spoke privately with Marty

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12. The assumption that staff should never contradict or challenge each other in the presence of residents is clinically accountable in terms of "continuity" and "not sending mixed messages." This does not however reflect the stark polarization between resident and staff "worlds" that Goffman portrays in *Asylums*, but certainly reflects a practical understanding of the staff's responsibility in the presence of residents to manage their own conduct as an aspect of their work. This is one of the reasons that weekly staff meetings produce a distinct kind of clinical work in counselor talk, which is the subject of chapter 7.

that evening he criticized the counselors. He asked incredulously: "Why won't they let me talk about my vacation? They say I talk too much. So what?" Clinical know-how can account for his pointed criticism. For counselors, perseveration is the outward sign of underlying anxiety, and his inability to manage himself indicates that Marty does not "know" the nature of his own problem. This is not only a problem in itself, it is *the* problem, the accountable basis of counselors' clinical interventions in general.

To conclude this section, here is a brief example of a known problem of Kenneth's, which is the target of his behavior plan.[13] The plan provides technical descriptions of Kenneth's conduct and some of the signs that make it visible and knowable as a warrantable problem. Conversely, it also furnishes clinical terms and phrases (neediness, worrying, anxiety, and so forth) that, as with Marty, function as a kind of shorthand. As counselor know-how, they are used to refer to what "everybody knows" to be the resident's fundamental problem. Everybody, that is, except the resident. Here is an example of how Kenneth's neediness was acted on and thus produced in a spontaneous intervention of Lisa's. He was sweeping the dining room after dinner. I was in the kitchen with Diane, who was loading the dishwasher while I was wrapping up leftovers at the counter next to the door into the dining room. Lisa entered the dining room from the hall on her way to the living room and looked straight ahead without acknowledging Kenneth across the room. He stopped sweeping and asked: "Is there a rec trip this weekend? Paul said we're going to the beach." She turned fully and faced him as he was asking his question. Without a pause, she responded earnestly: "We can talk about that

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13. Kenneth's behavior plan is discussed in chapter 5.

later. It seems to me that you've got a job to do right now. You don't need to be worrying about Saturday right now." As he nodded in agreement she asked in a friendlier tone: "Okay?" He replied: "Okay." She turned and proceeded into the living room and Kenneth resumed sweeping. Lisa's answer was an attempt to foreclose the possibility of a conversation. She closed it finally by making the exchange accountable: eliciting his agreement – "Okay?" – with both her refusal to talk and that his worry was unnecessary.

**Spontaneous reinforcement**

Everyday life can also be organized as clinically significant by intervention in "appropriate" as well as problem conduct. Counselors intervene spontaneously to "reinforce" what they regard as a resident's acceptable self-management. This usually occurs in situations where it is assumed that a resident would have conducted him or herself otherwise, especially as angry or upset. When Evelyn is upset she often cries and complains in ways that counselors regard as "dramatic," referring to her among themselves as a "diva," a characterization also often used positively. There is a behavior plan that targets Evelyn's "outbursting," which instructs staff to "redirect" her until she is "calm" and able to seek their assistance "appropriately." The specified technique of Evelyn's self-management is to find a "private space" and to "relax" before she approaches a counselor for "support." At dinner one evening, Evelyn was sitting at the back of the dining room with Theresa, Chris, and Johnny, and an argument sparked

between her and Johnny.[14] Her loud and tearful remark: "I hate you!" drew the room's attention. All at once, we turned our heads toward the back to see Evelyn rise from her chair, yell at Johnny, and make for the opposite end of the dining room with the apparent intention of leaving. Linda happened to be sitting at a table near the door and stood up to block Evelyn's passage. Linda took her arm and asked earnestly: "Are you going to your room?" Evelyn, who had been barrelling through with her head down, looked up and sobbed "yes." Linda smiled and said: "That's good!" She released her arm and Evelyn disappeared from the dining room.

Linda's question – "Are you going to your room?" – did not indicate whether it was intended as an intervention to reinforce Evelyn's conduct (managing herself in accordance with the plan) or as a spontaneous intervention in target behaviors (yelling and crying). In the end, her intervention reflexively constituted Evelyn's conduct as "appropriate." Some goal and behavior plans specify techniques for counselors to reinforce successful conduct. These may involve material reinforcers (such as money or special privileges) or a kind of conduct, like "verbal praise." Evelyn's plan does not actually specify any reinforcement. However, practical methods of reinforcement are available to counselors to organize their work in terms of its moral and professional satisfaction. By using a smile and encouraging tone, Linda's intervention constituted, before the fact, Evelyn's specific capacity for self-management as a personal triumph. This was not only Evelyn's triumph, however, because it was also a situated opportunity

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14. Conflict with Johnny happens to be a known source of upset for Evelyn because they occasionally describe themselves as boyfriend and girlfriend and this particular evening, I later learned, she became upset when he said: "You're not my girlfriend anymore."

for Linda to act on her work as a practical reflection of that work's success.

Reinforcement work is a practical method of satisfaction on occasions when problems of conduct are constituted by acting on their absence. For example, counselors will praise residents for their cooperative negotiation over TV channels or for their arrangements to cover the chores of residents who are not at home. When a resident's conduct does not accord with their expectations, counselors also act on their own work satisfaction in their shop-talk. Johnny had planned a week's vacation long in advance that was cancelled about a month beforehand because too few people signed up. The holiday agency phoned one afternoon to inform the group home, and the counselors' concern about how Johnny would "take it" became a primary topic of shop-talk that day. When Johnny arrived from his program, Carlos earnestly broke the news to him in the staff office. He responded with a shrug, saying "Oh, okay, that's too bad" and then proceeded routinely by asking for his afternoon dollar for coffee. There was no indication through the afternoon and evening that Johnny was upset about the cancelled trip. The counselors treated his unremarkable conduct as a reflection of "how well he is handling it." They were astonished that Johnny was in a "good" mood (a situated distinction for counselors that usually means he's not in a "bad" mood). In their talk, the counselors equated, without any demonstrable basis, his good mood and his handling of the disappointment he *must* be feeling.

Counselors were explicit with each other about their pleasure in Johnny's conduct. In the living room at one point, I observed Daniel reinforcing Johnny with the offhand remark: "it's great you're not upset about the trip." Johnny's quiet, gracious acceptance

of this praise was enough to confirm Daniel's assumptions about Johnny's successful management of his feelings. It was only at the very end of the evening that an alternative account of Johnny's conduct was suggested, when the counselors were in the staff office completing their documentary work for the shift. Even then, it was a joke. Sally laughingly mused over the possibility that he may actually be pleased the trip was cancelled. Whatever the counselors assessment, their pleasure in Johnny's conduct that evening was enshrined in the daily log.

## III. MANAGING WORK

Counselors' spontaneous intervention is available to organize their work in another way, as a situated technique to ration their attention and manage the conditions of their work. Clinical know-how is always ready-at-hand for counselors to intervene in resident conduct, something they regard as a responsibility, in ways that also manage the residents' demands, sometimes a matter of necessity. Interventions can function as situated techniques to ration and manage counselor work at the same time they act on resident conduct as a warrantable clinical problem. One evening Johnny was upset because he wanted a dollar from the lockbox where residents' spending money was kept and Carlos explained that he did not have another dollar budgeted that night. Johnny was extremely persistent and Carlos was growing annoyed. When Johnny came in and asked, yet again, Carlos said: "Why are you doing this? You know, we did your budget and you don't have a dollar today." Johnny just stood there glowering. After a minute Carlos continued impatiently: "Don't you have anything else to do? Well, *I* have to do paperwork." He

turned back to the desk. Johnny looked deflated and left the office. It would not be adequate to explain Carlos' response as simply dismissive, finally frustrated by Johnny's persistence. Carlos' question "why are you doing this?" and the answer he himself provided – "You know, we did your budget and you don't have a dollar today" – oriented Johnny to his own conduct and functioned therefore as an intervention. More specifically, Carlos presumed a mutual understanding of what a budget is, having done one together, and how it functions, assumptions Johnny may not have shared. It is not possible to know whether Johnny appeared finally to give up because of the intervention, although Carlos later indicated to me he thought this was so.

Another time, Kenneth was upset about his brother's employment difficulty, talking about it at great length with any counselor in his vicinity. I was in the office talking to another resident and Kenneth was sitting alone. Sally came in and took the data book down from the shelf. As she was sitting down, across the room from him at the desk by the window, he said: "I'm upset about my brother." Sally was the only person in the office who was ostensibly free to talk, and she heard Kenneth's remark as directed to her. She replied with unusually flat affect: "I know you are, Kenneth, you already told me . . . several times." Sally turned to the open binder with her back to the room. Kenneth registered her tone and made an apologetic defense: "But I can't help it. I worry about my family, my mom, all the time." Sally turned half-way as he spoke but said nothing before turning back to the data book. After about a minute, Kenneth pleaded to the room: "I am just worried about my brother." That a line of communication had already been established, Sally was obliged to respond and took the opportunity to address his inability

to manage his own conduct: "Will you please stop telling me about it. I know that you're upset but you can't talk about it over and over. You get more upset. And you're bothering everybody else. I have to finish this before I leave." Kenneth interrupted her last sentence with an embarrassed apology: "I know I worry too much." Sally turned back to her work.

The use of spontaneous intervention as a situated technique to manage resident demands can be observed in the now familiar question about the propriety of greetings. One day, it was already busy in the staff office shortly after three: Angela and Irving were sitting together, she on the telephone making medical appointments; Daniel was retrieving money for Johnny and was standing before the open lockbox on the file cabinet; I was sitting with Paul and we were looking through the Daily News for the coupons he likes. Diane, Evelyn, and Marty burst in the front door and Diane and Evelyn came directly across the hall into the office full of happy hellos. I put my finger to my lips and pointed to Angela on the telephone, Daniel said "Ssshhh!" They quieted immediately and disappeared from the office, presumably heading to their rooms to dispose of their coats and bags. Marty came into the office as they were leaving, said hello to the room, and then stood facing Daniel, who said nothing, but quickly glanced up and down again to the little manila money envelopes in his hands. Marty spoke: "We went out in the community today. I had Chinese lunch." Daniel remained silent, looking down at the envelopes he was shuffling. After about ten seconds, Marty asked: "Can I go to the party at ABC House on Saturday?" Daniel's immediate response was incredulous but friendly. Looking at Marty, the envelopes now still, he said: "Don't you know how to say hello?" "Oh,

hello, Daniel," Marty said with a laugh, "I'm sorry. So can I go?" Daniel resumed his work and, without smiling, answered: "I'm serious. It's totally rude of you to barge in like that with questions – and you don't even say hello. Anyway can't you see that I'm busy?" Marty looked sheepish, uttering a quiet, contrite "sorry," which Daniel acknowledged immediately by smiling and adopting a sympathetic, even forgiving tone: "Why don't you go relax, you just got home. Then we can talk about ABC House later when I'm not in the middle of doing things." Daniel's advice and promise furnished an account of Marty's impolite conduct as an honest and understandable result of the excitement of having just arrived. Whatever Marty specifically understood, he heard Daniel's remarks as a sympathetic acknowledgment of his request for attention, deferred only until "later," thanking him happily as he left the office.

**Scheduling**

Counselors and residents both manage group home work spontaneously. Whether or not an activity is regularly scheduled (Daniel and Marty always do his budgeting goal on Fridays, for example) or occasional (like Sally taking Evelyn to the store for batteries for her walkman), when it actually occurs is often the result of ongoing, multiple negotiations that are themselves a reflexive part of the day's work.

> Daniel found Theresa watching TV in the living room: "I can't help you with your trip plans at eight, wanna do it now?" Theresa suggested: "What about before I go down for coffee?" Daniel hesitated: "Well, okay, we'll see if that works."
>
> James came into the office with Donna and said to Sally: "We're going down for coffee. Donna needs her dollar. Wanna come?" Then, to the rest of us (Paul, Miles and me): "You guys wanna come?" As she was getting Donna's money, Sally asked James: "What about working on your clothes?" James thought and

said: "Oh, yeah. Let's do it tomorrow," and she agreed.

Carlos said to Johnny one afternoon: "I can't go with you to Barnes and Noble because Damian called in sick and I have to do meds." Johnny asked: "Tomorrow?"

It is usually taken for granted that group home life is full of contingencies but, on occasion, scheduling can cause tension. Both residents and counselors initiate negotiations to schedule and reschedule activities but, ultimately, counselors are able to use their authority to determine when things actually get done. In some circumstances, they intervene spontaneously in order to set a specific time by acting on residents' demands as a warrantable problem of conduct. A resident who is "too demanding" may be required to "wait their turn." This deters them from pursuing attention and directs them to demonstrate in their conduct a "reasonable" understanding of the constraints of group home work, what counselors call "the reality of the house."[15]

One evening, for example, I was sitting in the living room with Marty who was extremely eager to meet with Sally to arrange his payment for a weekend trip. He explained there was nearly a week before the deadline but he was keen to do it that night, and was upset that Sally had not been available. He said she promised to do it with him after dinner and now, nearing nine o' clock, she had to do meds and did not know whether she would have time at all. At one point, Sally came into the living room to fetch Evelyn for something and Marty asked: "Can we do my budgeting now?" Sally was clearly frustrated with him but in an even tone said: "I already told you five times already. We'll

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15. Lipsky writes: "When clients are forced to wait they are implicitly asked to accept the assumptions of rationing: that the costs they are bearing are because the resources of the agency are fixed" (1979:95).

try to do it if we have time. You know, I have other things to do and you're not the only person here. It doesn't matter if we get it done tonight anyway." Marty said: "I'm sorry, Sally." When she left the room, he said: "She's very busy. I won't bother her."

## IV. RESIDENTS' METHODS

Residents' know-how is available in their own methods of practical reasoning and local knowledge of group home life, and provide an alternative approach to the social analysis of cognitive disability. As discussed in Chapter 1, this study is indifferent to the professional diagnosis of "mental retardation" and whether it is adequate to the residents' capacities or experience. This concern is not relevant to the analysis of how residents are governed through their participation in the group home's everyday work. However, routine conversation distinguishes them socially in some specific and observable ways. It provides another method of investigating – through their own methods of talk – some of the ways in which residents are observably different in the group home, and are known and acted on as a certain kind of person, as residents. This is not to suggest a new diagnostic classification based on observable methods of talk. However, they yield an alternative to cultural or institutional perspectives because the focus on competence in ordinary talk enables an empirical analysis of disability that remains outside the controversies about social construction and social control.[16]

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16. There are already some examples but few. Cicourel (1974) analyzes deaf communication practices; Goode (1994) uses ethnomethodology to investigate situated systems of communication with people who are non-verbal; and Robillard (1999) uses his own paralysis to demonstrate the embodied nature of talk.

Sacks showed how the principles of everyday social order are observable in the temporal, situated accomplishment of everyday talk. Insofar as the residents competently use talk, like most people, to negotiate their everyday lives – and, to a greater or lesser degree, all of them do – their observable methods of talk demonstrate aspects of their relationship to the local social order of the group home. The efficacy of a person's talk in the situated occasions of its use is a measure of social competence. In general, those situated occasions span a vast range of settings and competencies. For the residents, the competent use of talk is often limited to a narrow range of topics. This reflects that their lives are largely circumscribed by "the complex institutional topography" of day programs, workshops, recreation programs, the group home, and so on, that is "the community" (Rose 1998:179). Most resident talk is about their participation in these various settings as well as their recreational activities. Individual pleasures in music, movies, TV programs, major political and sporting events, and myriad other routine pastimes are also certainly topics of conversation.

Although all the residents display a situated methodological competence in group home talk, they often have a limited comprehension of that talk's topics. Despite the wide range of individual capacity among residents, the inability to sustain a particular topic, or an extended conversation generally, is typical and does indicate that, however defined and measured, their cognitive abilities are in part independent of social factors. This broad assertion does not provide an explanation of who the residents are or what has made them residents. It should be said that, as individuals, their characteristics and capacities make them far more different than alike. What the residents do share, more or less, are some

observable methods of talk by which they are able to accomplish social competence in the everyday life of this group home.

One way residents do this can be observed in their competent understanding of the moral order of talk. The widely available practical methods that individuals use unwittingly to construct everyday talk makes morality observable as a local order (Sacks 1975; Sacks, et al. 1974; Schegloff and Sacks 1974). Sacks' research provides another instructive parallel with children. Children's rights in conversation are limited and they know, at a young age, how to use questions as a practical method to gain adult attention (Sacks 1992a:256). In a similar way, residents know how to make claims on counselor time and attention: to generate conversation as an activity in itself, to show off new purchases, to seek comfort, to share news, and so on. They are aware that direct questions usually oblige a response and that refusal is an accountable failure. Silverman describes this as a "trading off" of conversational rights that are not equitably distributed (1998:20). Residents oblige counselors with questions to assume the role of hearers. They know that even a first name can function this way. In the staff office, even when hunched over her paperwork, Kenneth's question obliges her to respond: "Sally?" She may fulfill her obligation by saying: "Not now, Kenneth, can't you see I'm busy." Her more likely response – "What?" – permits him to discuss anything he chooses: the weather, personal niceties and compliments, his problems, the day's business, and so on.

That residents competently use questions to oblige counselors to become hearers shows how the distribution of authority in the group home is not a zero sum game. Authority can be exercised "at all points," to borrow Sacks' phrase about where social

order can be observed in talk. As a method, questions come in handy when residents want attention but they also know that counselors can exercise their authority to refuse the obligation to respond. They may also intervene at any moment and define resident conduct as impolite. Once residents have secured their right to speak, they continually make their talk "tellable," as all competent speakers, through methods that preempt or resist counselors' attempts to close the conversation. By asking questions of the hearer and pointing out details in the telling of them, residents continually indicate their talk in the course of it. Like all participants in talk, when counselors are in the role of hearers they use what Sacks calls "response tokens" as methods of permission to the speaker to continue and to indicate that they are not poised to claim a turn to speak, punctuating the resident's talk with questions, "mm-hmm," "uh-huh," nods and other gestures (Sacks 1992b:410-412).

The residents' competent participation in the group home is sometimes accomplished through conventionally incompetent talk; specifically, their routine failure to attend to their hearers in the usually expected ways. For example, residents continue speaking even when counselors refuse their methods to retain the right to speak. Residents persist despite the absence of regular response tokens, often ignoring counselors' demonstrated impatience or boredom. How individuals initiate and close conversations often reflects the differential rights of individuals in a particular setting. Counselors, for example, move conversations to an end, they "open up closings" (Sacks and Schegloff 1974), in ways that determine whether a resident has ultimately demonstrated competent participation. There are situations of talk in which a resident's

competence as a speaker breaks down, becoming repetitive or confused. Counselors may act on these situations as mere incompetence, claiming the role of speaker in order to close the conversation. They may also withdraw abruptly, claiming an exemption from the general obligation of hearers to secure from a speaker the practical permission to close a situation of talk. On the other hand, counselors often participate in ways that make the competence of a resident possible, when they hear and act on incompetent talk as evidence of cognitive disability. They often thus defer to the residents' persistence and permit them to retain the role of speaker far longer than conventionally competent talk requires.

Paul, for example, often sits in the office looking through the newspaper and chatting with the counselors. His extensive knowledge of the neighborhood and the city, a function both of his age and his twenty odd years in the group home, is always a useful method to initiate conversation. One afternoon, he secured the attention of Angela and then switched the topic after only one turn. We were in the office and he said: "I'm going to visit Moses Pool on Friday. Have you ever been there?" Angela said: "Oh, yeah. That's been there forever. When I was a kid we used to go there." Paul then said: "I am going to buy another airplane." Angela accepted this switch in topics by asking: "What kind?" Despite what, in other circumstances, would have been a strangely abrupt switch in topic by the person who initiated it, Angela acted on and, thus, permitted his talk to be competent simply by asking a question.[17]

An example of a counselor's refusal to maintain a resident's competence in the

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17. I took there to be a topical relevance in this switch for Paul – being out in the community where there are places to visit and things to buy – and maybe Angela did too.

face of their conventional incompetence occurred with Kenneth. He was discussing one of his regular problems, his mother's age and health, with Lydia in the office. When he returned to an earlier point in the conversation, she ended it abruptly.

> *Kenneth*: She's getting old and my brother doesn't live here anymore. Maybe I should move home and take care of her?
> *Lydia*: Do you think she would want you to do that?
> *Kenneth*: Yes, I can live in my old room.
> *Lydia*: But, Kenneth, do you really think that you would be able to take care of her?
> *Kenneth*: Yes.
> *Lydia*: Like how?
> *Kenneth*: Well, I could cook and um, you know, go to the store and –
> *Lydia (laughing)*: But you don't even like to do your cooking goal here. Or help with the shopping or anything.
> *Kenneth*: But she's old.
> *Lydia*: Well, I know. But she is happy that you're here.
> *Kenneth*: But my brother is not here and—
> *Lydia*: Okay, I've got some things to do. We can talk about this later. *(As she spoke, she rose and left the office.)*

Residents also demonstrate competence as hearers in their use of response tokens. The inexhaustible variety of available response tokens are available not only to provide ongoing and practical permission to a speaker to continue. They are also used to display attention to and understanding of a speaker's talk. Schegloff (1982) shows that in their competent placement, response tokens are markers of attention, comprehension and sometimes agreement. They are ambiguous, however, because the demonstration of attention or agreement does not necessarily require comprehension. As with the familiar method of non-fluent, second language speakers, response tokens enable the ongoing display of competent attention without having to demonstrate comprehension.

## Confusing Identifications

*Resident "shop-talk" as a practical method*

Residents' methods can be observed in claims they make on counselors by using what is essentially a kind of shop-talk, initiating discussion about staff schedules, chores, goal and behavior plans, and any of the activities that organize their everyday lives as residents. This shop-talk is often able to oblige counselors because it is the situated and specific demonstration of the very initiative and self-knowledge that is constantly urged of residents in their work. When Kenneth is helping with dinner or assisting other residents with their chores or laundry, he frequently attempts to corral passing counselors: "Look what I'm doing. I'm helping with dinner." Or: "I'm helping Donna with her laundry." Kenneth's "announcements" attempt to engage counselors by indicating what he's doing and, in effect, his own reflexive awareness that doing it is a good thing. In a similar way, Marty repeatedly poses questions for which answers are already known: "Do you know Sally is my new counselor?" or "Didn't I have a good night?" He also routinely announces to counselors, entering the office in his bathrobe, his hair wet, that he has showered and shaved.

This kind of shop-talk can result, however, in a counselor's spontaneous intervention in their conduct paradoxically, not as the situated expression of a resident's commitment to work on their independence but as a failure of self-management. Counselors are often impatient, even sarcastic with Kenneth, acting on his announcements of routine work as attention-seeking and needy. Similarly, Marty is merely "asking for praise" for having accomplished mundane personal tasks, seeking an "acknowledgment for

things that he should already be independent with."[18] As everyday know-how, resident shop-talk reflects and organizes the reflexive relationship of individuals to their work, furnishing the practical methods of knowing and acting on themselves and others as certain kinds of group home persons. Marty and Kenneth's use of shop-talk above reflects a practical commitment to their own work, as residents, and what they take it to be. It also reflects a practical knowledge of counselors and counselor work. They are making themselves available as residents, as objects of the group home work they also appear to understand as the perpetual monitoring, assessment and intervention in their lives.

*Acting like staff*

There is another kind of attempt to shape residents' conduct that produces paradoxical results. The distinction between mere assistance and "acting like staff" is a situated one that counselors draw in spontaneous intervention. Counselors' assumptions about how residents should conduct themselves with each other are not necessarily available to residents in practical and relevant ways. Counselors often intervene spontaneously in conduct by defining it as "acting like" or "identifying with" staff: as "bossy," "not minding your own business," "controlling," "acting superior," "undermining" others' independence, and so on. I was out on the terrace one autumn day

18. Counselors "know" that Marty is capable of these tasks, and describe him as having "confused" the ability to accomplish them with "being independent." In such situations, counselors often claim that, for Marty, being independent requires doing these tasks without counselor involvement and attention.

in the sun when Sally was helping Evelyn transfer a plant from a little plastic pot into a larger ceramic one. Chris was also there, just watching them work. At one point, they were awkwardly handling a large bag of soil and Chris stepped up to assist. The three of them worked together without any demonstrable concern from Evelyn but Sally said: "Chris, this is *Evelyn's* plant" to imply that he was dominating the activity. Evelyn jokingly said "Yeah, Chris" indicating her appreciation of his assistance or, at least, that she did not mind it. The three resumed their work and Sally did not mention it again. Her intervention in this instance of routine cooperation was presumably warranted by something in Chris' conduct. There was no such indication from where I was sitting, and perhaps she intervened on the basis of a gestural or bodily action (such as tugging on the pot). In any case, Sally appeared to use a documentary method to identify Chris' conduct either to "protect" Evelyn or to urge him to conduct himself as cooperative and supportive, as a resident. He is known to identify with staff, and counselors often assume that he is bossy with other residents.

Theresa is also known to act like staff. When chores are being done during the evening, she assumes a supervisory role, actively monitoring the other residents' performance of their duties, and offering criticism and encouragement as she coordinates the work. After dinner, she circulates from the living room through the dining room and kitchen and back, dispensing compliments, orders, and criticism as she goes. Theresa frequently returns from her rounds to alert residents watching TV that "it's time for your chore" and usually they respond by getting up and going to do it. Kenneth was particularly upset one evening, sitting in the living room with his head in his hands.

Theresa thought it was time for him to sweep and, tapping his shoulder, said: "Diane is finished. You can sweep now." He looked up at her with an expression that indicated he did not appreciate her interruption and looked down again. She said: "C'mon it's time for your chore." He remained still, without looking up. After a minute or two, she said emphatically: "C'mon, Kenneth, it's time for your chore now." He responded angrily: "Shut up, Theresa! You're not my counselor. You're always telling me what to do." Miles asked from the other side of the room: "What's the matter?" Kenneth replied in an upset tone: "Theresa's telling me what to do. I'll do my chore! Tell her to mind her own business." Miles looked at her blandly and said: "Theresa, leave him alone" and then, to Kenneth: "But you don't have to get so upset about it. She's only trying to help."

In other situations, counselors were not as accepting of Theresa's informal role. Once I remained sitting with Marty at dinner because he arrived late. Theresa was sweeping the dining room and supervising the chores as she worked. Daniel was walking through to the living room just as she was saying to Ruby: "C'mon, clear the tables so I can sweep. Hurry up!" Ruby replied, half in amusement, half in anger: "Shut up! I'm working as fast as I can." Daniel stopped and stared at Theresa. She asked with mock indignation: "What?!" He replied: "Why are you bossing everybody around? It's not your job, you're not staff." Theresa dismissed him by jokingly waving him on and saying: "G'wan get outta here." He went on his way into the living room and Theresa continued sweeping.

When residents appear, in my own estimation, to act like staff, but in ways that are useful to a counselor's immediate work, there is no problem of conduct. One evening

people were assembled in the office getting their money to go down for coffee and Miles told Paul he had already spent his dollar for that day. Paul protested, demanding the next day's dollar. The other residents vigorously discouraged him. Theresa said, "You don't have the money and that's that. Okay?" She paused. "You can come down tomorrow night." James seconded: "You don't want to spend tomorrow's money. You have a budget." Miles gently agreed and Paul relented. Counselors do not intervene in "minding other people's business" if it serves their work. When residents' use their know-how to shape others' conduct and it turns out to be assistance, rather than acting like staff, counselor work is observable by its absence. Not intervening thus, can make residents' know-how with their peers available as a practical method in the situated accomplishment of counselor work.[19]

**The paradox of peer support**

Whether the situated distinction between support and control is defined and managed by counselors in spontaneous intervention or by residents with each other, it often reflects a practical confusion inherent in the work. Counselors' concern to encourage "peer support" is in tension with the way their ongoing spontaneous intervention organizes everyday life as a clinical domain. This tension produces the possibility for certain kinds of paradoxical conduct, the management of which is a routine

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19. Miles' refusal to give Paul another dollar is not an instance of rationing services, but the story shows how residents' methods function in a way Lipsky describes: "[Clients] are also controlled by the social pressures exerted by others who wait . . . [who] share the burden of waiting for services" (Lipsky 1979:95).

aspect of work.

Counselors believe that resident relationships of mutual support promote independence by tempering the hierarchy of group home authority. In the counselors' formulation, decreased reliance on staff is *ipso facto* increased independence. This is an ongoing practical effort and counselors are always attempting to shape residents' conduct toward each other as "peers" by encouraging mutual assistance in various ways both out in the community and at home. The importance of peer support for counselors is reflected in the way it extends even into intimate areas of the residents' lives. For example, David has difficulty regulating the water temperature of the shower and nightly requests assistance from staff, who regard it as a sign of dependence. This problem is addressed with a goal plan that requires David, first, to ask a peer to assist with the shower and, only if no one is available or willing, may he then ask a counselor.

As the practical and situated expression of authority, spontaneous interventions furnish residents with a know-how about advice-giving that can yield precisely the conduct that counselors often define as acting like staff. Counselor authority itself is a routine practical method that residents use to undermine the right of their peers to offer assistance and support: "Hey, you're not my counselor, you know?!" Irving is frequently confused by the way counselors respond paradoxically to his attempts at peer support. Acting like staff was a known problem of Irving's conduct that had become more visible because of his paid job in the house, cleaning the kitchen and dining room for three hours a day

during the week.[20] The counselors were adamantly opposed to Irving's employment because it would only increase his own already inflated sense of his authority. It "puts him above his peers" and "reinforces" his tendency to identify with staff. Counselors account for Irving's sense of "superiority" to the other residents as "denial." That he expresses resentment about having to live in the group home enables them to account for his tendency to identify with staff not as occasional bossiness but in "deeper" psychological terms. They regard his refusal to attend a sheltered workshop, for example, as denial of "the way things are," even though the counselors largely agree that such work programs contribute very little, either to the residents' wallets or to their independence.

Some of the specific ways that Irving acts like staff only confirm the counselors' concerns. He frequently monitors the health of other residents by telling them what and how much they should eat. One explosive evening, Evelyn ran crying into the staff office because Irving told her she was too fat to eat the cookies laid out for snack. Daniel and Sally went immediately into the kitchen and told him angrily: ". . . this job doesn't mean that you are allowed to mind other people's business, ya know?" and "you don't like it when counselors tell you to shower, right? Or to do what you need to do? Why should you do it to other people? You're not staff." This public intervention was unusually harsh in tone. Irving simply stared at them as they spoke. When they left the kitchen, he

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20. There are two rationales for this arrangement: his physical disability makes commuting to outside jobs difficult and he refuses to participate in a sheltered workshop with its nominal wages. When the housekeeper position became vacant, Sonia and Mike decided to offer him a small portion of the tasks. They argued this would benefit the house until the position was filled, at which time the new housekeeper would serve as his supervisor. They also regarded it as an opportunity to reinforce his willingness to work.

resumed his work sponging down the counter. In the office just afterward, Sally and Daniel accounted for its intensity as necessary to counter the negative, reinforcing effects of his job. Irving and I talked privately the next day and he was perplexed by what the counselors had said and how angry they were, given that "people here have medical problems, diabetes, blood pressure . . . then they just eat too much." I asked: "But why do the staff not like you to tell other residents about that stuff?" He shrugged: "They think I'm too bossy." His inability to understand why the counselors think he is bossy reflects the paradoxical character of his own conduct. Irving's conduct with other residents is "methodologically" correct but can unpredictably come into conflict with the concerns of counselors. Constantly enjoined to "help" his peers, he feels entitled to use the practical methods available to him in the counselors' routine spontaneous intervention in the same conduct. This confusion between helping and acting like staff is not a psychological one, as counselors have it, but a practical one produced in their own work.

Another example of this confusion can be seen in the way residents continued to respond to Marty even after the counselors' changed their own technique of intervention. Just before I arrived at the group home, the staff wrote a new behavior plan that aimed to avoid reinforcing Marty when he fell. It requires counselors to remain "neutral" until he is able to "regain control," to get up and walk on his own. Residents deal frankly with Marty's nervousness and falling. They sometimes comfort him when he is agitated, and sometimes chide him when he is annoying or disruptive. On occasions when Marty was "shaking" or "jumpy," jerking shoulder movements that sometimes preceded a fall, I often observed residents admonish him to "stop it," or express sympathy by saying: "Why are

you so nervous? Relax." Marty sometimes said simply, "Okay," and often said nothing at all. Marty said about other residents' comments that "it doesn't bother me because they care when they tell me to stop shaking." These spontaneous resident interventions distressed counselors, however, because they "undermine" their own techniques of intervention. Counselors always addressed this conduct as acting like staff: "it's none of your business," "we all have our problems," and "Marty isn't bothering you." I was sitting in the dining room during lunchmaking once with Marty, Ruby, and Theresa. When Ruby told Marty: "stop jumping around, you're making me nervous." Angela, who was leaning in the kitchen door, said: "Ruby, Marty has nothing to do with you right now." A few minutes later, alone in the kitchen, I asked Angela whether she thinks Marty is bothered by other residents' remarks and she answered by accounting for her own intervention. She shrugged, saying: "Well, I always say something because they just reinforce him and it undermines staff."

However, counselors are also keenly aware that the work residents do with each other is often functional. This is especially true with Theresa, who not only keeps in view all the evening chores, she often coordinates tasks if people are out and prevents them from being done twice. One weekday, when Johnny was in the house and did the vacuuming, it was Theresa, later that evening, who made sure that Evan knew his chore had already been done. Irving assists Ruby by accompanying her to the bank; Evan frequently makes lunch for himself and Kenneth on weekend afternoons; Chris takes Evelyn for batteries and other items in the neighborhood. Sometimes the assistance residents' provide each other is at the counselors' request. Theresa is frequently asked to

wake David, something she is able to do without incurring the wrath he apparently reserves for counselors, and to help him on Saturdays with laundering, folding and putting away his clothes. In the evenings, she knows without being asked to prod him to shower and shave so he can go down for coffee with her. Chris and Mark are frequently asked to take other residents on errands, especially Diane, Donna, and Evelyn, who cannot go out in the community by themselves.

Counselors understand the potentially paradoxical character of this kind of resident work. In a friendly and informal conversation between counselors in the staff office, Maria joked about David: "Well, you know that Theresa is his *real* counselor, at least he listens to her." When the others (and I) chuckled, it reflected a shared know-how about the potential confusion inherent Theresa's conduct with David. Counselors recognize that some personal relationships between residents do not necessarily conform to ideal notions of peer support but often relieve them of certain tasks. On Tuesdays, if Theresa she spots Evelyn lugging her full hamper she usually helps carry it into the laundry room and remains there to assist the always appreciative Evelyn. Laundry is actually a goal that specifies how Evelyn should complete the task. Theresa did not do it the prescribed way and I do not know whether she was even aware it was a goal. Evelyn, for her part, seemed to care only about getting her laundry done and not about working toward doing it independently. On many occasions when counselors saw Theresa and Evelyn huddled together over the machine, they left them alone at their work and returned to the staff office or the living room. They often even encouraged them by making remarks like: "Oh, great! Theresa's helping you." Permitting them to do the laundry on their own is always

a situated decision to refrain from intervening in Theresa's conduct (as acting like staff) or joining them to ensure the goal plan is followed. In the bustling course of group home work, counselors welcome the occasional surprise of being relieved of one of their tasks. Theresa's assistance certainly freed up a little extra time, but one task from which they could never escape was recording in the data book, before they left at the end of Tuesday evening, that Evelyn had successfully completed her laundry goal.

The impulse to assist one's peers is taken as a sign of self-knowledge and independence unless counselors determine that a resident has crossed the line into acting like staff. The location of this line is always a situated and practical matter, but crossing it means that a resident's conduct becomes a clinical problem. The confusion this produces for residents derives from the ongoing practical encouragement of peer support at the same time that counselors continually do their spontaneous work of intervention in everyday life. Counselors do not – and cannot – recognize this as a paradox because, in their view, acting like staff is a warrantable clinical problem of conduct like any other. Yet its conditions are unwittingly created by counselors' own conduct. So time and again, Irving discovers that in his everyday work helping his peers, the practical methods available to him can at any moment be claimed by counselors as theirs alone.[21]

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21. This analysis begs a comparison with Goffman's "lines of adaptation," which "represent a way of managing the tension between the home world and the institutional world" (1961:65). The group home does not function in such stark opposition to "the outside," which is what is historically distinct about community-based services. "Situational withdrawal," "flagrant refusal," "colonization," and "conversion" (61-63) might very well serve as useful descriptions of certain instances of resident conduct. However, there is no empirical basis for the assumption that "adaptation" is at the root of all resident conduct. That the group home's "walls" may not be as transparent as they are claimed does not mean that it is a total institution.

Walled-in organizations have a characteristic they share with few other social entities: part

## CONCLUSION

Even in mundane, passing exchanges, the group home affords little escape from work. Counselors and residents use their know-how just to make small talk, that unremarkable brand of offhand, friendly conversation that occurs when individuals appear to talk simply to be polite. Lydia and I were chatting on the terrace one Sunday afternoon in the spring sunshine when Johnny came out. He didn't join us for any particular reason apart from the weather and that we were already outside enjoying it. A plan had just been implemented to address the problem of his frequent preference to stay home from work.[22] The plan required Johnny to commit, on Sunday evenings, to which days that week he would attend work. The three of us exchanged friendly greetings. His presence required us to cease our conversation about other residents, and a long pause followed our greetings. Lydia filled the silence by asking whether he had plans to visit his sister. He

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> of the individual's obligation is to be *visibly* engaged at appropriate times in the activity of the organization, which entails a mobilization of attention and muscular effort, a bending of oneself to the activity at hand. This obligatory engrossment in the activity of the organization tends to be taken as a symbol both of one's commitment and attachment, and, behind this, of one's acceptance of the implications of participation for a definition of one's nature (Goffman 1961:176-177).

The group home's confusing identifications are meant to refer to several processes at once. Counselors' situated and specific identification of problem conduct is accountable in terms of a generic psychological understanding of identification, the residents confused identification with the counselor role. What the analysis above aims to show is that residents most certainly do identify with counselors in a number of ways, but their doing so cannot be explained simply as personal adaptation, in Goffman's sense. If so, unremarkable conduct by implication would have to be explained as strategic "keeping cool." Identification with counselors, as an observable form of conduct, is the everyday use of know-how that is the opposite of the strenuous conflict implied by "muscular effort" and "a bending of oneself."

22. Johnny referred to his day program as "work."

said he had been there last weekend and she asked whether he had a good time. After his affirmative answer there was another pause. She asked with good humored exaggeration that indicated she knew it was a leading question: ". . . and where are you going tomorrow?" Johnny answered: "Work." This topic established, Lydia resumed her usual tone: "What other days this week are you going?" Johnny replied: "Wednesday and Thursday but I have Friday off." Without a pause to permit another question, he changed the topic by remarking on the weather. Lydia allowed the conversation about work to be closed in this way by agreeing that the day was very nice.

This chapter began with the notion that the work of counselors and residents is not limited to their documentary tasks but includes the ongoing and visible use of know-how in everyday life. In a practical sense, there is no clear distinction between work and the rest of life in the group home since there is no back region where its workers can achieve distance or relief undisturbed. Counselors and residents are *always* at work. Counselors maintain a vigilance over everyday life, forever intervening in problem conduct as it arises, and this requires residents to assume their own endless clinical work on becoming more independent. Counselors variously express their commitment to the potential clinical significance of even the most mundane aspects of everyday life. It is in the actual course of work that this clinical domain takes shape, in the spontaneous intervention that reflexively constitutes the practical and situated conduct by acting on it. Conventions of politeness, such as greetings and expressions of gratitude, are taken as specifically clinical problems that residents must manage. Counselors also intervene spontaneously in problems of conduct that are already known, defined collectively in informal talk and in

behavior plans. In these interventions, counselors use a documentary method to define and act on conduct as a visible feature of a resident's deeper and ongoing "issues," which already are an object of ongoing clinical work.

Spontaneous interventions can function, at the same time, to shape conduct and to manage the conditions of counselor work. The clinical accountability for the organizational constraints of counselor work establishes in practical ways the residents' expectations and understanding of group home operations as a clinical matter. Interventions can also be used to organize counselor work in another way, as situated reflections of counselors' professional and personal satisfaction. Their interventions to reinforce the residents' appropriately managed conduct defines such conduct as a reflection of their work's success. Counselors use their know-how in this way to organize, as part of the work, its caring aspects, which are the most satisfying and meaningful, and also the most prone to failure.[23]

That residents use the everyday methods available in the group home to understand and act on their own conduct shows how they are able to govern themselves, even in unintended or unrecognized ways. To claim that residents govern themselves is not to deny the asymmetry of power between residents and counselors; or to deny that counselors have a great deal of authority over residents in a variety of ways. The purpose of this analysis has been to show how residents are able to conduct themselves competently as residents in the group home everyday. They demonstrate competence,

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23. From another angle, see Copp's (1998) discussion of the "emotion work [that] is doomed to fail" in a sheltered workshop for individuals with cognitive disability.

sometimes with the effective use of otherwise incompetent talk to keep the attention of counselors. Residents also make claims on counselors' in ways that demonstrate both their self-knowledge and commitment to their own work and their understanding of who counselors are and the work they do. Residents are nonetheless aware that counselors may intervene in their conduct and close the conversation, requiring that they manage their conduct in different and unexpected ways. A paradox of resident conduct inherent in counselor work is a result of the practical tension between the ongoing clinical emphasis on peer support, on the one hand, and the continuous spontaneous intervention in everyday life, on the other. Residents' work with each other draws partly on practical methods that are made available by the counselors' own observable work of "helping."

# Chapter 7
# Clinical know-how

## I. INTRODUCTION

This chapter focuses on the clinical aspects of counselor know-how that define the group home as a kind of professional setting. What counselors learn in their training and written material consists of clinical concepts and principles of practice that must be distinguished from the know-how they use in their everyday work. This distinction between clinical knowledge and know-how is not Schutz' (1970) distinction between the "scientific" and "natural" attitudes that Garfinkel (1967) used in his early work. The ethnomethodological study of natural science that began in the 1970s demonstrated that even the most refined, technical work, can be accomplished only as an everyday practical matter. The approach here does not therefore treat clinical knowledge as discourse, ideology, or as the "official" group home view in contrast to a "resident perspective."[1] This chapter is an analysis of how clinical work is actually accomplished *in* and *as* the situated use of know-how. Counselor know-how is clinical knowledge that is relevant and usable, and thus available, at the level of everyday life.

The data in this chapter is drawn largely from weekly Thursday staff meetings, the

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1. The distinction in this chapter between knowledge and know-how has a parallel in early research on formal and informal organization and the unintended consequences of bureaucracy (Blau 1963; Merton 1957; Gouldner 1954; Selznick 1948). In cognitive disability, Wolfensberger (1989) adopts this to analyze the implications for employees and clients of human service organizations.

primary formal venue for clinical discussion in the group home. These meetings are significant because, among other reasons, they establish the practical course of work from week-to-week and therefore exhibit a distinct kind of clinical work in talk. The next section of the chapter describes the staff meeting as a technology and as the group home's center of calculation and coordination. Clinical know-how exhibits a fundamental flexibility that both reflects and organizes the contingent and indeterminate character of group home work. In the third section, the flexibility of psy knowledge that enables counselors to define and manage indeterminacy will be shown in two general ways. First, the meaning of disability is analyzed in the practical conceptions counselors use in situated accounts of conduct as a reflection of a resident's general (as opposed to specific) limitations. Practical conceptions of disability are understood in terms of two contradictory ideal-types: disability as conduct beyond the capacity of a resident to control and manage on their own or, in contrast, disability as conduct that residents are able to manage themselves but, for whatever reason, do not. Second, the analysis of the indexical character of both vernacular and clinical expressions in several contexts will demonstrate how counselors make authoritative clinical and moral claims without evidence or explication.

## II. THE WEEKLY STAFF MEETING

The weekly staff meeting is crucial to the ongoing organization of group home work. It is held on Thursdays from two until five and all the staff attend except the weekend and overnight counselors. The supervisor, Sonia, and the morning and evening

counselors form its core membership. The attendance of the regional supervisor, clinical specialist and nurse is not expected, but they are often present, especially for the discussion of specific issues. The tone of the meeting is characterized by the general informal camaraderie of the staff. One of the morning counselors always manages a trip to the store with some petty cash to provide an array of soda, chips and dip for refreshment. On special occasions, such as a staff member's farewell, the morning counselors often provide a proper lunch, bringing homemade dishes or preparing them in the kitchen between tasks during their shift before the meeting. The staff office is barely adequate to contain the 11 or 12 people who assemble regularly. Extra chairs are brought in from the dining room and form a tight circle, backed up against the desks, cabinets and shelves lined with the treatment and goal books and other binders of vital group home information. Sonia usually sits at the front of the room with her back to the closed door because she runs the meetings, which means she must maneuver her chair or stand up to answer a knock or let staff members leave. The meetings begin in an informal and friendly way, with chit-chat about movies, politics, sports, and other matters of general interest. Sonia often participates in this chat, bringing it to a close when she decides to begin. She usually passes out an agenda, which includes the six or seven items that she plans to cover. During the meetings, she occasionally uses the agenda to close one topic and move on in an accountable way.

There are three general areas of staff meeting discussion: employment issues (benefits, payroll and other agency business); administrative issues (staff shift schedules, various documentary technologies, and other group home procedures); resident issues

(work on conduct and interventions, medical issues, and some non-clinical concerns). Resident issues are the primary concern of this chapter. They are given the most attention in meetings, usually at least two and a half of the three hours, which is an indication that the group home is understood and organized primarily as a clinical enterprise. As has been shown in previous chapters in different ways, there is often no distinction between resident and administrative issues. Although unusual, one example of the inextricable relationship between administrative and resident issues in the meeting is the six-week period during which Jennifer's diabetes was monitored intensively. Some of the technologies that document the health of residents were featured far more than usual. Each week during this period, a portion of the meeting was devoted to the presentation and discussion of data that had been collected, organized and analyzed over the course of the past seven days about blood sugar levels, medication effects, vital signs and more. It was not only medical data that furnished the material for these discussions. Jennifer's conduct in the relevant aspects of her life was also monitored and assessed in equally systematic ways: her nutritional choices, the degree of her cooperation with the doctor on office visits and with counselors, and in the house, when counselors pressed her to adopt a new medication and other regimens.

In all workplaces, the regular, formal assembly of employees serves multiple purposes, and the nature of a workplace determines the character and function of its staff and supervisory meetings. The Thursday staff meeting is a technology that is at the heart of the group home's work: it brings together the main counselor staff with the supervisor and shapes what they must know and do, establishing the practical course of group home

work from week-to-week. The range of durable and mobile documentary technologies that are available to be distributed and displayed, thus, often organize the actual course of discussion. These technologies of monitoring, assessment and intervention, as with all aspects group home work, establish the conditions of seeing and knowing that make possible the very topics of staff talk.

The staff meeting really involves a variety of technologies that enable it to function as the center of calculation and coordination of group home work at a distance – both counselor work to act on the conduct of residents, and the work of residents to act on themselves. The autonomous character of counselor work, discussed in chapter 3, requires that it also be supervised at a distance. The supervision of counselors, whose work is conducted out of the view of supervisors and often colleagues, requires the ongoing cultivation and mobilization of the capacities to manage themselves as a certain kind of group home worker. The staff meeting furnishes the specific techniques of accountability that organize the supervision of both counselors and residents. As I discussed in chapter 4, some of the ways in which residents are monitored and managed, at the same time, function to monitor at a distance the counselor work that occurs largely out of view. The organization and presentation of data in staff meetings that makes resident conduct visible as warrantable clinical problems in certain ways also makes specific aspects of counselor work visibly available and accountable to the supervisor.

A participatory style of supervision, which draws on the group home's clinical know-how, shapes ways of being a counselor in the meeting itself, by urging certain kinds of participation. The informality described above reflects not only the good relations of

staff, but the organization of the meeting to emphasize the significance of each individual and the conduct of commitment. Sonia runs meetings by encouraging and, often, requiring counselors to contribute. Their "input" is important because they are the ones "who *really* work with guys." For the supervisor, the collective work of discussion functions to make visible the character and commitment of each counselor in their participation in and commitment, at least to the decisions that organize their work, if not to their work itself.

It is not actually difficult to mobilize counselors as participants in the work of staff meeting discussions. Counselors recognize that the meeting serves crucial organizational functions, especially that the practical course of their everyday work is established in these discussions week-to-week. Counselors are largely keen to participate in the process of defining the problems of conduct that organize their work. Resident issues are both the most engaging and the most frustrating for counselors because they represent the professional and moral importance of group home work. In our private conversations, counselors often described the clinical discussions as "challenging" and "intellectually stimulating" in contrast to their more administrative work.

The meetings' friendly, informal and participatory sensibility in no way precludes the possibility of tension and even outright conflict.[2] The counselors's stake in clinical discussions is especially observable in disputes: how counselors raise and resolve questions about whether and how resident conduct can be understood as a warrantable clinical problem. Sonia always attempts to achieve a consensus. Although on occasions

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2. It should also be said, although it will not be addressed again, that the meetings are also sometimes boring, for the counselors and for me. This no doubt characterizes the occasional experiences of such regular assemblies in all workplaces.

when this is too difficult or time consuming, she imposes a solution. There are times – in the case of extremely contentious or, conversely, minor issues – when she simply announces, without discussion, the nature of a problem of resident conduct and provides instructions about intervention.

Disputes reveal the counselors' assumptions about the professional and moral nature of their work. The weekly staff meeting functions to determine the work and is a kind of work itself. It is the one regular occasion in which counselors are required to discuss clinical issues in a formal and collaborative way. That residents are absent means counselors are able to speak openly about their work as meaningful professional work. This talk is thus a distinct kind of counselor work, which makes staff meetings a suitable source of data for the analysis of counselors' clinical know-how. The meeting discussions are organized by the situated use of know-how, the accountable ways of knowing and acting – available in the clinical assumptions, cliches, vocabularies, and modes of assessment, monitoring, and intervention – that are the practical methods counselors use to accomplish their work.

## III. THE FLEXIBILITY OF CLINICAL KNOW-HOW

The flexibility of clinical know-how enables counselors to make intelligible the contingent and indeterminate course of the work they organize in their everyday practice. The group home's overall goal to enhance the independence of individuals shapes the work in terms of endless, overlapping processes that are subject to and defined by continual reassessment and modification. Flexibility can be observed in the way that

counselors act on their individual, clinical objects of work not as fixed but as open and adaptable.

The flexibility of clinical knowledge derives from its regulatory and relative function, which does not depend on the arbitrary standards of tradition, as in theology, or on the ostensibly unambiguous standards of professional authority, as in medicine. Donzelot (1979) argues that the regulatory function of psy permitted it to cross the technical thresholds of several fields without undermining them as legitimate and autonomous professional domains. In the nineteenth and early twentieth centuries, psy knowledge fundamentally shaped the problems and practices that define juvenile justice, child protection, and public hygiene. Psy knowledge enabled the normalization of any and all conduct by treating individual conduct and norms in an indeterminate, "floating" relationship and providing techniques of "automatic readjustment" when necessary (1979:217). In the example of juvenile justice, Donzelot describes how psy made it possible to assess the criminal conduct of adolescents not in terms of rigid moral standards, but in relation to a child's unique psychology and family experience. In this way, social workers' expert assessments about the causes of criminality and the prospect of rehabilitation became central to the management of adolescent offenders, as well as to the legal process it thus reshaped. Counselors keep a hold on the frequent contingencies in their work not by defining and acting on them in terms of rigid principles, but in terms of the infinitely adjustable and relative meaning that their clinical know-how makes available. It is in relation to the specific concerns about individual conduct – both the residents and the counselors' own – that the flexibility of psy knowledge becomes

necessary to the group home work it organizes. For Rose, this is the link between psy and the practice of governmentality.

> . . . a psychological ethics is intimately tied to the liberal aspirations of freedom, choice, and identity. . . [it] promises a system of values freed from the moral judgement of social authorities. Its norms answer not to an arbitrary moral or political code but only to the demands of our nature and our truth as human beings (Rose 1996:97).

**Practical conceptions of disability**

Professional definitions of cognitive disability are not relevant to counselor work. They are available in formal training and in various diagnostic scores and assessments collected in the treatment books, the mental tests and scales of functioning that define disability.[3] Early in my research several counselors were giving me an informal tour of the treatment books, and described the required psychological evaluations as interesting, but "obvious" in the context of their "relationships with the guys." Miles said that the residents' IQ[4] scores are "irrelevant to what people are really like and really capable of . . ." On occasion, however, IQ scores are meaningful when one first begins working at the group home, as: "with David it was helpful because it indicates how smart he really is. You know. He could easily have been placed in a lower house without it."[5] Daniel agreed: "I mean, he has a higher IQ than Irving but you'd never think that." The scores are used to confirm or challenge the counselors' own practical sense of a resident's

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3. Counselors actually complete some of the qualitative scales of adaptive functioning, usually as the "informant" for the evaluating psychologist.

4. On the rare occasions when counselors discuss IQ scores, they are standard Stanford-Binet scores, although scores from other kinds of assessment are also available in the treatment books.

5. "Lower house" refers to a more restrictive residential setting.

general capacity. They are rarely discussed, however, and this was one of only two conversations that referred to these measures in my thirteen months at the group home. The other occurred when an evaluation of Evelyn by an outside psychologist showed scores that were lower than they had ever been. The staff were "concerned" that "these can't be right." Evelyn's "doing fine." It was unusual for group home staff to challenge this kind of evaluation and, for this reason, it was Cynthia, as the clinical specialist, who contacted the psychologist to request that Evelyn be tested again. The scores were relevant only as they appeared to be at odds with counselors' practical knowledge of Evelyn. Such formal measures were "irrelevant," to borrow Miles' term, to the ongoing work because they do not reflect the varied and situated meanings of disability that are a routine feature of group home work.[6]

This section describes the counselors' practical conceptions of disability to illustrate the flexibility of clinical know-how. Practical conceptions of disability do not necessarily depend on the use of the term itself. They refer to a method of accounting for conduct in relation to a resident's general limitations of self-management rather than specific capacities or problems. For example, instead of using "anxiety" to account for a specific aspect of Marty's conduct, counselors use specific conduct as a reflection of his overall capacity: who and what he is and why he lives in the group home. These kinds of accounts function as practical conceptions of disability because, in the situated course of

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6. The counselors' description of the practical relevance of these diagnostics echoes the critical research on the use of mental tests in cognitive disability. See: Mercer (1972) for an important early analysis. Note that the practical irrelevance of mental test scores does not preclude the counselors' belief that they do actually measure *something*, as the concern about Evelyn's evaluation attests.

counselor talk, they constitute a category of persons.[7] Practical conceptions of disability are similar to Goffman's descriptions in *Asylums* (1961) of the way mundane conduct is treated pathologically, standing for or concealing an inmate's overall sickness, such as schizophrenia. They could not be easily explained or defended when they were used to refer to an inmate's "essential character," "but in practice these categories become magical ways of making a single entity out of the nature of the patient – an entity that is subject to psychiatric servicing" (Goffman 1961:375). In the group home, various, sometimes contradictory practical conceptions of disability function thus, to capture a resident's "essential character" in ways that organize counselors' accountable work.

Despite their situated meaning, it is nonetheless useful to define the range of practical conceptions of disability in terms of two contradictory ideal-types used regularly in counselor talk. One conception uses disability to refer to a resident's capacities as immutable, which thus makes the self-management of conduct impossible. Specific features of conduct are thus accounted for as the self-evident manifestation of general and natural limitations that a resident "can't help." This conception of disability is commonly used in discussions about problem conduct as criticism, consolation, admonishment, and so forth: "this is who Johnny is" or "Paul can't help himself." Counselors use it as a method to challenge the professional judgement of their colleagues, suggesting they overestimate a resident's capacities: if an intervention is being discussed that counselors think does not accurately reflect a resident's disability, then a claim can be made that it

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7. This is an example of what Sacks (1972) calls a "membership categorization device," which establishes an individual as a member of a specific population.

risks failure, frustration (for both counselors and the resident), and even defiance, and thus precludes its own aim, the independent self-management of conduct.

The second conception, on the contrary, uses disability to refer to the failure or refusal to self-manage conduct rather than to an essential, overall lack of ability. In this case, a resident's capacity for specific conduct is often affirmed to emphasize a failure or absence. This is often used to account for difficult or annoying conduct as intentional, as calculated to frustrate and upset counselors or other residents, and attributes to residents a knowing agency: Marty knows how to "push staff's buttons" or Kenneth "makes up issues because he likes counseling." In staff meetings, counselors use disability in this way to challenge each others' professional judgements and to criticize accounts of conduct perceived as too clinical or which, otherwise, do not admit a resident's culpability. Disability as the willful failure of self-management is used usually to justify more rather than less intervention and to express frustration with the persistent failure that is inherent in group home work: "We've done everything with him!"

Throughout my thirteen months at the group home, the counselors' work with Johnny was shaped by a few persistent problems of conduct that were the targets of behavior and goal plans. Most urgently, Johnny is occasionally physically and verbally aggressive when angry, shoving, hitting and screaming at counselors. Such "violent outbursts," as the counselors call them, are often provoked by the counselors' refusal to give him additional spending money. Mornings are a particularly volatile time of day for Johnny. In addition to his requests for spending money, which is typically provided by the evening staff, his frequent decision not to go to work (which is how Johnny refers to his

day treatment program) is a source of frustration. Counselors always attempt to persuade Johnny to go, which occasionally angers him, because they regard his staying home as both reflecting and exacerbating his "self-esteem problem." There is a protocol for calling 911 if counselors cannot subdue Johnny or believe they are at risk. On these occasions, the police come to the residence. A few times, Johnny was taken, accompanied by a counselor, to the emergency room of the local hospital and admitted to the psychiatric unit. More often, he became sufficiently calm to remain at home. Some counselors complain that Johnny actually enjoys the hubbub and is always fine by the time the police arrive, a common account that reflects the view that he prefers, and even enjoys, hospitalization (an issue that will be discussed below).

In one staff meeting, counselors complained with some urgency that the 911 protocol is ineffective. They were especially upset because he had "outbursted" twice in the last few days. This was more frequent than usual and one of the incidents uncharacteristically involved another resident. Johnny and Theresa were having a loud argument in the living room. When a counselor intervened, she abruptly turned and left but he followed her, screaming and cursing, into her room. He was not physically aggressive but counselors believed that he would have been if they had not been there to intervene. Counselors regarded this as an extraordinary violation of privacy and, in combination with the other incident (involving Maria), indicated the worsening of his conduct. The morning counselors were especially upset that "nothing was being done"[8]

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8. This expression of frustration is familiar in the way it poses an indirect challenge to the supervisor. Counselors sometimes refer to "the agency" or "the group home" as responsible for the problem they are addressing without naming specific individuals.

and that the evening counselors "didn't understand what he was like in the mornings."[9] A heated dispute ensued about Johnny's disability and who he "really" is.

> *Maria*: He needs to know the consequences–
> *Monica*: Pressing charges is the only way. Johnny is a threat to others. Just threatening 911 is not enough, it's not fair to everyone else. Theresa's family should have pressed charges.
> *Daniel*: You can't [press charges], because living in a group home already involves accepting some curtailment of rights.
> *Maria*: He should be taken down to the precinct, just to see the reality of it.
> *Miles*: That's unfair!
> *Daniel*: Yes, unfair.
> *Miles*: He's mentally incompetent. That's why he's here!
> *Daniel*: He can't control himself, it's not personal. These are not new behaviors. *Maria and Monica both nod in vigorous disagreement.* The issue is whether he belongs here. Johnny needs to be in an ICF.[10]
> *Miles*: . . . He's not able to verbalize, that means he feels bad and acts out.
> *Maria nods her head to indicate agreement with Miles but that his point is not relevant to her complaint. Several other staff members make sympathetic remarks about how difficult the situation is for Maria, always faced with Johnny's temper on the morning shift, which she did not acknowledge.*
> *Maria*: That's not the point. Calling 911 is not enough–
> *Daniel*: –this is what he's like!–
> *Maria*: You don't need to tell me what he's like, I work with him everyday.
> *At this point Sonia closes this topic, even though there is still tension, by assuring the staff that she will think about the problems they raised. She reiterates that the 911 protocol is "still an important resource" if counselors are concerned for their own safety.*

Which is it? Is Johnny unable to "help himself" because of "who" and "what" he

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9. This is an example of the occasional organizational tension between the evening and morning counselors. Although their jobs are different in fundamental ways, tension emerges only in situations like this, where work requires coordination between shifts or entitles the morning or evening staff to make specific claims on the other. The difference between morning and evening shifts is described in chapter 2.

10. ICF stands for "intermediate care facility" and is a step below a community residence (CR) on the continuum of care, which was discussed in chapter 1. ICFs vary but are characterized generally by more intensive programming and these facilities are sometimes geared to specific medical and behavioral needs. The staffing requirements of an ICF enable this kind of service but the group home "community residence" does not.

is? Or, on the contrary, is he capable of learning how to conduct himself differently by "seeing the reality," and facing the consequences from which he is now protected? These are situated questions and, for this reason, neither the counselors' clinical training about cognitive disability nor their everyday know-how about Johnny can necessarily produce consensus on the answers. Counselors' practical conceptions of disability organize situated accounts not only of resident conduct but of their own work. For Daniel and Miles, Johnny's disability was their method of criticizing Maria and Monica's suggestion, which presumed its own conception of Johnny as capable of understanding and learning from the consequences of his action. Maria and Monica did not respond to the criticism in the terms posed, perhaps the course of the conversation prevented them from doing so. However, Maria refused Daniel's attempt to shift the topic from the one she raised, the inadequacy of the emergency protocol given the pattern of Johnny's conduct, and illustrates how a practical conception of disability does not require justification. When some explication is provided, as it was by Daniel and Miles, it is often the assertion of positions that follow reflexively from the initial claim. For example, "mentally incompetent," an unusually harsh phrase that Miles used to express the intensity of his opposition, is defined by the very conduct that it is meant to explain. He and Daniel may have used Johnny's disability to challenge the morning counselors' professional judgement – "this is what he's like!" – but it also called into question their moral commitment to fairness and rights.

Marty occasioned similarly fiery staff meeting discussions in which counselors used practical conceptions of his disability. Counselors are very frustrated by Marty because

behavior plans have failed to eliminate or even reduce his falls. Early one Thursday afternoon, only a week after I started my fieldwork, Sonia described to me the new behavior plan that had been implemented just two weeks earlier. Various medical evaluations had finally determined that Marty's falling is not neurological and is likely a symptom of anxiety.[11] Group home staff understood the psychological basis of Marty's conduct to mean that it is amenable to change, and that he could learn how to manage or even stop falling through the systematic technical approach of a plan. The plan defines falling as inappropriate attention-seeking behavior that should not be reinforced. For counselors, the plan provides techniques that will not reinforce Marty: to "interact in a neutral manner" until he "regains control." As Sonia explained, Marty will learn that his falling is related to the way he manages (or doesn't manage) his own feelings.[12] When he falls, staff members are therefore not supposed to talk with him about "his issues" until he "calms down and is able to get up on his own." This has apparently frustrated him and, "for the moment," even increased his agitation. The fact that it is having some effect, however, indicates to Sonia and the staff that the plan is actually "working." In the staff meeting, counselors reviewed Marty's falls of the past week and discussed the plan. His falling was defined in the course of discussion as both calculated "attention seeking" and something that he "can't help." On one hand, that "he can't help what he does" justifies

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11. He was diagnosed with Factitious Disorder and Conversion Disorder and the falls, therefore, as "pseudoseizures." Staff described the falls as: "at times seem beyond his control," "resembl[ing] panic attacks," and at other times they seem to "function as attempts to seek attention" and for "escape."

12. Marty did not himself require neurological evidence to regard his falls as a troublesome problem or as involuntary. He himself describes them as "nervous moments." I do not know whether it was Marty or the staff who first suggested the connection between his falls and anxiety.

the behavior modification approach that upsets him. On the other hand, counselors accounted for the intervention's lack of success in terms of his willful recalcitrance, he "doesn't want to change." Such accountable contradictions show how the flexibility of counselor know-how enables them to make intelligible their unpredictable and failure-prone work.

Problems with Marty's conduct became increasingly disturbing over the next few weeks. He started to have "episodes" in the mornings, crying and screaming while still in bed and banging his head on the headboard. He would repeatedly call out the names of counselors, whether or not they were in the house, and occasionally called out to residents but they never responded. They were discouraged by counselors, told that it wasn't their "responsibility" and that it would only "reinforce" his inappropriate behavior. The residents, in any case, were too annoyed or frightened to enter his room when he was so upset. Counselors were unable to console Marty and, at times, their presence actually made him angrier. His "self-injurious behavior" (SIB) sometimes left him with bruises and cuts on of his head. This change in Marty's conduct was very serious. He was posing a threat to himself and the group home was not able to manage it.[13] One of the more severe episodes occurred on a Thursday morning and it was the opening topic of the staff meeting later that day. The counselors were very upset. The escalating severity of his conduct was explained as a manipulative expression of his unhappiness with the new plan but as an even further indication that it was "working." His conduct was a calculated

13. In fact, shortly after this he spent several weeks in the psychiatric unit of the local hospital. Staff meeting discussions related to this hospitalization are analyzed later in the chapter.

response: "he knows what he's doing." Angela said that Marty was "very smart" and knew that these episodes are "upsetting to staff." Daniel said that "with Marty it's a limitless extreme" and that, "with the SIBs, he's upped the ante." Susan characterized it as having "discovered self-abuse" because he "hates" the new behavior plan. Marty had "outsmarted" them.

Later in the meeting counselors, discussed their own frustration and encouraged each other not to "take him personally" because "he can't help himself." A few weeks earlier, a similar discussion about the counselors' management of their own feelings was provoked by their efforts to account for Marty's changing behavior. The morning counselors were upset because of his SIBs in the morning. Monica was bewildered: "Maybe I need info from the evening about incidents the night before so that I can understand when he's bad in the morning. I mean, Marty's really capable but doesn't want help." Miles' responded sympathetically: "It's never clear what precipitates his falls and stuff." Daniel addressed the group: "We have to remember how hard it is not to personalize it [Marty's unyielding conduct] and feel frustrated." Miles agreed: "Marty can't help how he behaves . . . we shouldn't be expecting to cure him." Counselors' practical conception of Marty's disability here accounts for and organizes his conduct as failure. Both ideal-types of disability were used and this ostensible contradiction is reconciled in the account they provide, not of Marty's persistent problems, but of the vexing emotional nature of counselor work. Their mutual comfort was provided in the psy techniques of self available as their own clinical know-how, which indicated, in what knowledge one must have and how to use it, a way of being a counselor, which itself

involves a demanding kind of counselor work. One must know Marty and his disability. One must also know one's own feelings and how to manage them, to remember not to be unrealistic or personalize relationships with the residents.

**The indexicality of clinical know-how**

Another way to observe the flexibility of know-how is in its indexical character (Garfinkel 1967; Garfinkel and Sacks 1971). In ordinary talk, what a word is taken to mean is not fixed lexically but is determined by the context of its use. To put it another way, the ambiguity of meaning is a functional feature of communication. The fact that specific meanings are heard and acted on cannot be explained by the notion that meaning is shared since it depends on the taken-for-granted assumptions that are an aspect of the context of talk. As situated indexes of meaning, expressions have "rational properties" that are observable in talk. It is only in use that expressions are heard to have particular meaning and, at the same time, organize the situated contexts that determine their meaning. The indexical character of clinical know-how makes clinical ideas, assumptions, cliches, and so forth, hearable and usable to counselors in ways that are situated and relevant in the course of their work. Insofar as clinical know-how is used to account for the ongoing, indeterminate work it organizes, and on which it depends, work provides its own meaningful context in the very course of its accomplishment.

That counselors' practical conceptions of disability enable contradictory accounts illustrates the flexibility know-how must have in the complex, unpredictable and often upsetting course of group home work. This analysis is not meant to criticize counselors'

understanding of disability, or their clinical practice in general, but to show that what counselors *can* know is shaped largely by the practical conditions of their work. Their know-how displays a breadth of accountability that can make intelligible all sorts of contingencies by defining and acting on them as clinical matters. The indexicality of counselors' common expressions also enables their clinical talk. In this section, some examples of expressions are analyzed to show how their indexical character functions in counselors' situated accounts in staff meeting discussions.

*That's not okay*

"That's not okay" is an expression of disapproval that counselors use frequently in a range of situations. Its meaning depends on the specific situation of its use and the taken-for-granted assumptions of listeners. It can express the mildest disapproval, even in humorous situations. It can also have the force of a clinical assessment but requires no explication, and thus permits the expression of implicit moral judgement, something that would otherwise be unacceptable to counselors. As a non-professional, vernacular phrase, "that's not okay" does not commit counselors to any specific clinical (or moral) position. It is a method of disapproval that can be heard in a variety of clinical or moral ways or both.

In one staff meeting, everyone agreed without question that Paul's can collecting is "not okay." This familiar issue was raised because, the day before, a counselor had seen him plundering the group home's store of recyclables. Sonia began the meeting by announcing this event and asking for general suggestions. The counselors reacted with a

combination of amusement and disgust: laughter, rolling eyes, and good humored disbelief at Paul's persistence. Sonia asked for ideas about "how we should handle this." Susan, still laughing, said: "that's not okay, that's really *not* okay!" This remark reflected (or, in retrospect, may even have shaped) the tone of the discussion: a mix of moral disgust, personal affection, and clinical commitment. The specific assumptions that organized the course of their talk required no explication. That Paul should not be permitted to collect cans in the building (his collecting in the community had already been prohibited) was simply presumed in various ways: it was morally objectionable conduct; can collecting in the building was actually a circumvention of the prior sanction and would lead to a resumption of the activity outside; and it indicated Paul's unwillingness to manage his own conduct, already a general problem in itself (although counselors expressed amused appreciation for his pluck and persistence). The moral and clinical accountability of "that's not okay" enabled counselors' to accomplish their work, deciding on a course of intervention with little disagreement.

In another example, Angela used the phrase in an informal conversation to convey the seriousness of a claim without explaining it. In the staff office as we waited for a staff meeting to begin, she told a story about Jennifer with some concern to two counselors and me. A few days earlier, Jennifer had encountered other tenants in front of the building, a woman and her eight-year old son. Jennifer screamed at the boy because he had been staring at her and then his mother "gave her a hard time." Angela heard this story, quite by accident, a half hour before this telling, because she and Jennifer were returning from a medical appointment and ran into the woman and her son coming into the building. The

woman volunteered the story, and Angela described her as "sort of annoyed" but "very understanding." Jennifer became angry and yelled at the woman to "leave me alone" and "mind your own business." Angela said: "I think she's really rude all the time and that someone's gonna let her have it." The three of us acknowledged by nodding. No one claimed a turn to speak so she continued, saying that the boy actually has autism, which is why his mother was "very understanding." Angela was perplexed about Jennifer's lack of identification with him: "You'd think that she'd be more sympathetic." I responded: "Oh, could she tell?" The counselors, who appeared distracted by the increasing bustle of preparation for the meeting, again nodded but said nothing and appeared content to let the conversation end. They had little reaction and, although I was somewhat more attentive, did not match the concerned tone that animated Angela's telling of the story. She shrugged in answer to my question and it appeared to me that the conversation was closed. There was little interest and no encouragement to continue. Angela suddenly spoke again, louder and emphatically: "That's not okay! I mean, she can't be trusted in the community!" She appeared intent on obliging the attention of the other counselors, and of convincing all three of us of the gravity of the story's message about Jennifer's conduct. She attempted to convince us by asserting her concern specifically, and as self-evident, offering no explanation of what her telling took for granted: that the mother was credible and that Jennifer's anger, in the original incident and earlier that day, was representative of her conduct in the community.

The ambiguity of "that's not okay" functioned for Angela to express her concern with increasing urgency and establish the tone for the specification she offered: "I mean,

she can't be trusted in the community!" Vernacular phrases like "that's not okay"enable the implication of moral judgements that are not accountable as such. The story could have been heard in this way. What I heard as concern about potential danger could have been heard as Angela's disapproval of Jennifer's rudeness and lack of empathy. "That's not okay" functioned as a method of emphasis and insistence and, as such, enabled Angela to reassert the self-evident basis of her concern without explaining it. However, whether or not the story was heard as moral judgement (as opposed to clinical concern) is not actually relevant since there was no observable indication that it was either heard or intended in that way. Although the indexicality of counselor know-how enables listeners to hear differently, it is nonetheless accountable only in clinical terms. The distinction between clinical accounts, which are usually taken-for-granted, and implicit moral judgements is a practical and situated one.

*Acting out*

Clinical expressions with established meanings also function indexically. "Acting out" refers to negatively defined conduct motivated by feelings of which the person is not aware. It is one formulation of a now pervasive, cultural assumption about the nature and function of feelings.[14] As a general description of a psychological process, "acting out" enables counselors to account for resident conduct as caused unwittingly by the residents'

14. Counselors draw on this assumption in one routine account of their own work: that being a counselor involves making the residents aware of their own feelings. In Susan's phrase: "They have a lot of feelings they don't understand. It's our job to help them express them." This is a specifically psychological formulation of counselors' general conception of themselves as "advocates."

own feelings. It is a frequently used method of know-how about what feelings are and how they operate that enables counselors to accountably act on a wide range of conduct in the group home as clinical conduct.

At one point, Sonia and Mike decided to have a meeting with the residents' family members to urge them to become more involved in the life of the group home. The "family meeting" was held one evening for an hour and a half in the staff office and neither the residents nor counselors were invited. The counselors were opposed to holding it privately because the exclusion of residents "defeated the whole purpose," as Miles said, of getting their families more involved. However, even the counselors did not predict the residents' dramatic conduct that evening. Many were demonstrably upset and even "outbursted," yelling, crying, and arguing with counselors and each other.[15] The counselors regarded this conduct as an extraordinary response to the meeting and as evidence of the foolishness of Sonia and Mike's decision to exclude the residents.

The next day, Miles and Sally were telling me about what had occurred, describing the residents' response as "acting out." When I asked what they meant by the phrase, Sally replied that the residents had "a lot of unresolved feelings about family issues." Miles added that: "some got upset because their family came . . . and some because their family didn't come." Although their answer reflected a correct understanding of the term, it functioned as an account of the residents' unusual conduct precisely because it did not require any specific evidence or explanation. Their use of "acting out" drew on the

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15. Apparently, eight out of 15 "outbursted" but the exact criteria for assessing this kind of conduct was taken-for-granted in the meeting where these figures were mentioned. I was not at the group home the evening of the meeting.

clinical know-how available in the group home by treating the residents' conduct and psychological processes as open domains of interpretation. The effectiveness of their account depended on specific taken-for-granted assumptions about "family issues,"[16] the nature of feelings and psychological processes, and the relationship of residents to their own feelings as something that can and should be managed. "Acting out" has a general, open-ended character because it does not indicate any particular intervention. Neediness, for example, is more specific in the sense that it contains within it possible modes of intervention.[17] The general character of *acting out* is available to produce accounts of more specific conduct, such as neediness or, in this case, outbursting. In the following week's staff meeting there was a discussion about the residents' conduct the evening of the family meeting. "Acting out" served counselors in their criticism of Sonia and Mike's decision to exclude residents over their objections. Their initial opposition to the closed family meeting was based on the claim that it was "unfair" because "it's their [the residents'] house," and not on predictions about their emotional reactions. In the staff meeting, counselors claimed with unusual vigor that their position had been correct. Their confident and direct criticisms can perhaps be attributed partly to Sonia and Mike's shared responsibility for the decision and even to Mike's presence. Counselors' criticisms of Sonia, their immediate supervisor, are usually less forceful when she is the sole

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16. "Family issues" is another good example of a useful category in the group home, and in general. Not only does "family issues" refer to something that everybody already knows but, after all, everybody also has them.

17. For example, counselors may redirect a resident, refuse to engage in conversation, directly identify a resident as needy, comfort, counsel, and so forth.

administrator in staff meetings. The counselors confidence also reflects their compelling account of the evening, even though it was unrelated to their initial concerns about the family meeting: the residents' were "acting out" the feelings (the family issues) raised by their exclusion. Sonia and Mike accepted this account, conceding that they would "do it differently in the future." The counselors used their clinical know-how to establish without explanation the relationships between the meeting, the residents' feelings, and their conduct. "Acting out" functioned not only as an index of taken-for-granted assumptions but also of the counselors' clinical skill. The account served effectively as a method of criticism in its situated organization of counselor work as legitimately professional work.

*The reflexive organization of a staff meeting dispute*

Know-how's clinical flexibility has thus far been analyzed in the indexical function of specific expressions. In this section, the focus broadens to include several expressions and how they reflexively organize a staff meeting dispute about whether and how a kind of conduct can be defined and acted on as a clinical problem. In the meeting, a specific concern about Marty's room led to a disagreement about the clinical significance of messy rooms in general.

> *Sally*: The disorderly room reflects his, you know, disorderly mind.
> *Miles*: Yeah, the room is who Marty is . . . chaos.
> *Sonia*: I don't agree! No one deserves to live that way.
> *Daniel*: Yeah, but if you clean his room for him, it will be right back that way.
> *Sonia*: But how can someone function that way!?
> *Miles*: People have different standards . . . and they function.
> *Susan*: <u>You</u> function, but Marty doesn't!
> *Sonia*: Staff's role is to pick up where clients leave off. We teach what they need

for normal living. We're not here just for supervision, their environment is for teaching. It's been proven that things function better when they're organized. Disorganized thinking leads to messy rooms is an excuse. We have to teach them, to afford them the opportunity to sleep in a clean bed! We can't deny that. Where do we pick up with their shortcomings?
*Daniel*: But they're adults and they have rights.
*Mike*: Well, I am concerned about health and safety. Look at Paul's room. I mean it's unhealthy but where do you draw the line?
*Susan*: A lot of the guys' rooms are health and safety violations. They wouldn't even pass an audit.
*Miles*: This is the tension of our job! The impossibility of making these decisions.
*Susan*: I'm sorry! This is a health and safety issue.
*Miles*: So health and safety is an excuse to do anything with the guys we want? We should make the room cleaning a group or a collective thing that creates some kind of investment, like a special Saturday where everybody does it.
*Susan*: Fine, but nothing happens.
*Sonia*: Well, when I started at Island House Program [her previous supervisory position] one of the clients peed all over himself, at home, at program, and he smelled. Everyone hated him. We developed a behavior plan and the staff was totally consistent with him. He then realized that he could do it himself. *She paused and closed the topic by introducing the next topic on the agenda.*

Sally's initial assertion that Marty's messy room reflected his disability in general was affirmed immediately by Miles and, after a turn, by Daniel. Sonia's first disagreement affirmed the counselors' assessment of the condition of his room but challenged their explanation. Her second, as did Susan's, shifted the topic and the dispute to another level. Sonia then claimed that Marty's disability actually warranted intervention and, moreover, intervention was their obligation as staff. Sonia's introduction of the staff role did not treat Marty's messiness as a failure of conduct but that counselors' refusal to intervene would be a failure of professional obligation. The dispute had taken shape between different practical conceptions of disability: one, in which Marty's capacities determined the natural limits of counselor work; the other, in which the obligation of counselor work rendered irrelevant the natural limitations of residents. Sonia's comments about the staff

role were formulated as a general problem that went beyond the specific issue about Marty's room. Daniel's immediate response accepted this level of generality by implying that protecting the rights of residents is taken-for-granted in the work. This was a challenge to her assumptions about the residents and counselor work implied that she and Susan were in danger of overreaching their authority.

At this point, the course of the dispute can be understood in terms of two shifts – in topic and level of generality – that were organized reflexively by the counselors' indexical claims. Challenges to taken-for-granted know-how can be defended with the use of specific evidence of conduct or general explication. This process itself can organize conversation as an ongoing exchange of professional judgements that, as such, are factually indisputable. The following expressions were used in situated ways as taken-for-granted professional know-how and thus required neither specific evidence nor explication of the broader positions that they were taken to represent: *disorderly mind*, *function*, *standards*, and *rights*.

As practical conceptions of Marty's disability, *disorderly mind* and *chaos* had never been used before nor did I ever hear them used again. Despite this unfamiliarity, and the ambiguity of their referents, these expressions effectively conveyed a shared recognition of Marty. Sonia and Susan's interspersed turns accepted an understanding of his limitations but challenged, instead, what they heard as the refusal to fulfill the obligations of counselor work. Both parties to this dispute imply the others' limited or incorrect clinical judgement. *Function* and *standards* were used to explicate each position and their situated meanings organized the opportunity for Sonia to shift the topic. Her

incredulous exclamation "But how can someone function that way?!" implied that the condition of Marty's room was a self-evident warrant for intervention. Miles challenged this, pointing out the ambiguous or relative character of the term "function." He heard Sonia as claiming that there is a clear (or single or simple) definition and assessment of functioning and raised its ambiguity as the problem by qualifying it with "standards" to imply different. Susan then accepted that the relative meaning of function is obvious, but in a different way. She drew a contrast by addressing Miles directly with her impatiently exaggerated "you," implying that he did not recognize that residents are different, despite the relative meaning of function. Sonia did not hear a specific contrast of Marty and Miles but of counselors and residents generally as certain kinds of persons with certain obligations.

Sonia's claims about the staff role also demonstrate the indexicality of know-how. They functioned to shift the topic (away from the specificity of Marty's room) and raise the level of generality, using platitudes about the obligations of counselors. Daniel's use of rights challenged her but affirmed this shift in topic that organized the dispute, in its course, as a problem of counselor authority and work. Neither the staff role nor rights are contentious topics in themselves, but were available as situated methods, as professional and moral accusations, challenges, and criticisms.

Mike's remark attempted to return the conversation to the initial, specific concern and used "health and safety" to establish a threshold of assessment. This phrase is a generic regulatory category that refers to basic standards of physical plant maintenance and practices of disease prevention for which service providers must establish policies and

procedures.[18] Health and safety is used in everyday group home work to refer to specific routine practices, such as basic infection control and disposing leftover food in a timely way. It also provides a method to define conduct not only as a warrantable problem, but to imply that it poses enough of a risk to violate the regulations. Mike used "health and safety" to establish a threshold of intervention in messy rooms to indicate that it is a potentially serious issue, because the procedural phrase would avoid appearing arbitrary and judgmental. He used the example of Paul to show that even this personal sphere may warrant intervention because his intensive room maintenance program has broad support from the counselors. Such a determination is not a simple one however – "it's unhealthy but where do you draw the line?" – which acknowledged Daniel's consideration of rights but attempted to return the conversation to the specific everyday problem at hand, Marty's room.

Susan maintained the broader topic, using "health and safety" to characterize many of the residents' rooms as already in violation, and that intervention was actually long overdue. The specificity of her use provoked an incredulous and accusatory challenge from Miles that "health and safety" is simply a license to do as they wish. Susan and the staff know that Miles' question has only one answer: no. The egregious use of professional authority is a violation of a resident's rights and, therefore, the law. She refused to answer and asserted again her claim about residents' rooms, relying on the indexical character of "health and safety" to do so without having to justify what, taken literally, is a rather serious charge. Susan was impatient. Miles shook his head in

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18. See: OMRDD regulations 14 N.Y.C.R.R. § 686.6:12 and 14 N.Y.C.R.R. § 635-8.

disbelief. The pause that followed their exchange was an opportunity Sonia took to return to the topic of the staff role and close the conversation with a moral tale that implied how even the most hopeless and objectionable problems of conduct can be solved by counselors' professional commitment and determination.[19]

*Group home know-how and clinical expertise*

Staff meeting disputes are not always among group home staff but can occur as disagreements with the work of outside professionals who provide services to the residents in other settings. These are the doctors, psychiatrists, day program teachers, and workshop supervisors scattered across the community. The group home functions – much like the weekly staff meeting in the house itself – as the center of calculation and coordination of a resident's dispersed services. The outside professional services residents receive elsewhere must be accommodated by counselors as routine aspects of their own work.[20]

When outside professionals are at odds with the way a resident's conduct is known and acted on in the group home, counselors often perceive assessments from outsiders as a criticism of their own work. This section describes staff challenges to psychiatric assessments of Marty and Johnny. Psychiatric expertise poses the emblematic challenge to counselor know-how because it concerns the aspect of group home work they regard as

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19. Not only objectionable perhaps. Urinary incontinence could be heard as humiliating, alienating, etc. However it was heard by counselors, Sonia appeared to use it as an exemplar of the kind of issue that defines the difficulty and importance of counselor work.

20. Dispensing medications and implementing the orders of health professionals is an example.

the most important, both the most interesting and personally meaningful. Counselors use clinical know-how to make situated claims for their own expertise, as specialized knowledge that, although "applied" in the group home, transcends it. At the same time, the assessments of off-site professionals are challenged with claims for the superiority of counselors' judgement on the basis that it is uniquely local. The flexibility of know-how makes local knowledge available in situated ways that do not undermine counselors' own clinical expertise. The technical vocabulary and grammar of psychiatry, already available as know-how, enables counselors to challenge assessments in the same professional terms, and also furnishes the professional basis for their ostensibly opposite claim: that their uniquely local expertise allows them to know the "real" Marty and Johnny, and not just by "looking in the DSM. We can do *that*!"[21]

Counselors frequently disagreed with outside psychiatric assessments of Marty and Johnny. Both attended weekly therapeutic counseling outside of the group home and, during my field research, they each had several voluntary stays in the psychiatric unit of the local hospital. Reports, both formal and informal, of hospital clinicians and floor staff were routinely brought back by counselors from visits, who then shared them in staff meetings. Although psychiatric hospitalizations were unusual, the presentation of outside clinical reports is utterly routine. In staff meeting discussions, counselors heard reports about Johnny and Marty from their psychiatrists as unexpected aspects of larger problems that had already been defined, if not solved. Contrasting psychiatric assessments were

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21. The DSM is the Diagnostic and Statistical Manual published by the American Psychiatric Association and used as for all psychiatric diagnosis in the United States.

seen and acted on by counselors as a wrench thrown into their already impossible work with these two clients. It was not only that group home workers claimed only they "really" know what's going on, but psychiatric challenges were also met with situated accounts of larger complaints – all involving the suitability of group home placement – that extend beyond the clinical treatment of Johnny and Marty *per se*. Counselors claimed in meetings that such complaints were already ignored by the agency and now they would be further obscured by the authority of outside physicians.

Marty was "fine" in the hospital. That is, he never displayed the self-injurious and other extreme conduct that warranted the admission and was "compliant" with hospital staff and routine. Counselors were often incredulous and angry that hospital staff "don't see the real Marty." In one meeting, Susan and the nurse, Beth, had met with the attending psychiatrist when they visited earlier that day. Beth reported that the psychiatrist "diagnosed anxiety disorder and panic attacks." The counselors nodded in agreement. Anxiety was one of the central ways that Marty's conduct was defined and acted on in the group home. However, the counselors were filled with a quiet expectation because they had already heard that the psychiatrist's comments were "a surprise." Beth continued in a measured tone that indicated her anticipation of the their upset and, it turned out, her own disagreement with the report. "He thinks that Marty's smart and should have more independence – " Some counselors sighed, rolled their eyes, looked around or quietly shook their heads in disbelief. Daniel and Sally both remarked sarcastically, "Oh, right!" Beth continued without acknowledging the counselors' skepticism: " – that the group home doesn't believe he can do more. I mean, he doesn't

think Marty should have to wear a helmet." Angela interrupted to ask whether he had talked to Marty's regular psychologist, Dr. Nunzio. Beth frowned in agreement with the question and replied: "No, he hasn't . . . he also wants to give him an IQ test. Basically, he said we're underestimating Marty, that we don't think he can do more." Susan chimed in incredulously that "the unit has been giving him passes to go out on his own." Several counselors laughed and said, "Oh, God" and "I can't believe that!" Miles alone had a positive response: "I think that's good." Nobody acknowledged his comment. Daniel said with astonishment and disgust: "When he's hospitalized he goes *out* because when he's hospitalized he's *fine*!" Susan adopted this tone, exclaiming: "They can't see beyond their noses, they don't listen to us. The person they see is *not* Marty!" Miles persisted, asking quietly: "Maybe it's the group home?" The collective exasperation of the staff enabled them to ignore him again.

Marty's self-injurious conduct was not a new problem in the group home even though there had recently been a change in its nature and frequency (which is discussed above). Daniel's account of this change and the events that led to his hospitalization challenged the psychiatrist's assessment. Marty's father had died a few months before and, although they had been estranged since childhood, Marty had been upset. "We know it's his father's death," Daniel asserted confidently. "I mean, for the developmentally disabled or delayed, mourning will be slower and longer. This is the displacement of his father's hatred of him." He concluded smugly: "Anyway, revolving door hospitalizations will get him quicker into an ICF." Whether or not Daniel's understanding of how people with cognitive disability deal with bereavement was correct, it was crucial local knowledge that

"we know" and the psychiatrist "doesn't see." Daniel's cynical comments about "revolving door hospitalizations" expressed frustration at the counselors limited authority over their own practice in the group home, to provide more structure for Marty. The comments were heard by other counselors as raising one of their fundamental accounts of the "real" problem with Marty, something they may influence but have no authority to decide: that the group home is actually not a suitable placement for him because it cannot provide the structured programming and individual attention he requires. The psychiatrist misunderstood this and refused "to listen." If his recommendations were followed it would only exacerbate Marty's problem conduct and thereby confirm the counselors' account. Given their limited authority to change the overall approach to Marty, the counselors' challenges to the psychiatrist's report appear as a kind of work itself: the work of defending their own practice as legitimate, if not actual, clinical expertise.

The claim that this is an unsuitable placement for Marty exonerates counselors from the failure of group home work. Counselors used a method of comparison between the hospital's structured setting and the group home, which requires residents to exercise their freedom and be independent. In a subsequent meeting, counselors again emphasized Marty's need for "more structure," that he would benefit from a residential environment with "more programming." This account also served to affirm that their own persistent failure with Marty was the result of his overall limitations and not counselors' skills or commitment. Cynthia was ironic about the psychiatrist's assessment because he did not recognize the significance of structure for Marty. "When he's in there" his behavior is not a problem, "but in the hospital, they shave him, it's like ICF structures." Miles heard this

as a claim that Marty's "calmness" while hospitalized is evidence of the general consensus that what he needs is more not less structure. He tentatively disagreed: "You know, there is a different significance to those things [activities of daily living] outside a CR or ICF. Okay, self-esteem in an ICF is automatically increased, we tried that here [imposing more structure on Marty's participation] but it alienated the other residents." Angela then asked: "Maybe a one-on-one?" This did not pose a direct challenge to Miles. She affirmed that previous attempts in the group home had failed but underscored the general view that Marty required more structure. At this point, Sonia, who had not yet spoken, moved to close the conversation: "I know that this is a frustrating issue and we'll talk more about how to deal with it when he comes home, but we have other things to talk about– anyway getting a one-on-one and the placement issue is really a higher up thing that we can't deal with now."

The next week, Miles and I went to visit Marty in the hospital and he was happy to see us, even cheery. He said that being in the hospital was "helping" him "get better." Our brief, informal report to the staff meeting was met with cynicism and frustration. The counselors extended their resentment of the psychiatrist in contradictory accounts of Marty's conduct. On one hand, that Marty is "good" in the hospital affirmed their belief in his need for structure. On the other hand, they characterized him as "manipulative" and effectively denied his claim to the patient role (Parsons 1951) that supports their account of his conduct. This is not meant to criticize counselors' clinical reasoning but to illustrate how they use their clinical know-how to manage the persistent failure of their work in a setting where their authority is very limited. They must manage the conflict between the

practical limits of their authority and their own clinical knowledge: "our hands are tied." Faced with the seemingly intractable problem of Marty's conduct, a disturbing sign of their own ongoing failure, counselors do the only work they are able to do: use clinical know-how to limit or deny their own discretion in order to manage group home work.[22]

This results in accounts that are organized in a similar way to what Goffman (1961) calls a looping effect – the way a resident's "reaction to his own situation is collapsed back into this situation itself." (Goffman 1961:35). For example, when the angry response of an inmate to forceful treatment is understood by guards as a symptom of illness that justifies even more force. Goffman describes looping as a feature of the tension between organizational and professional imperatives in total institutions. In the group home, it can be observed in the counselors' claim that Marty needs more structure – a goal of "treatment" which they have neither the resources nor the authority to pursue. In this case, counselors themselves account for his conduct as an organizational feature, but then define and act on the way he seeks their assistance and attention as a psychological problem. The practical conditions of counselor work make it difficult to consider that the psychiatrist may be right: that Marty's self-injurious conduct is a feature of the group home approach, which is already too structured approach and in this way "underestimates" him. Cynthia said indignantly that, for Marty: "Seeking help is just reinforcing. I mean the hospital is like a resort. It's a place with no responsibility. Everything is done for him there." The indexicality of "structure" is central to the

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22. Lipsky refers to the way street-level bureaucrats use "defenses against discretion" to modify their scope of responsibility (1979:149)

counselors' varying accounts of Marty. Earlier, his hospital conduct was seen as a feature of that setting's rigid structure, which made Marty work more on himself. Now his "good behavior" is attributed to hospital routines that permit him to work less by providing him "relief" from personal care and other responsibilities. Structure was still the basis of the claim, pressed again, that Marty really "needs" to be in a more restrictive residence, but in this case it would have the opposite effect: increased programming would rigorously organize him in relation to his own responsibilities and thus reduce his anxiety and his self-injurious conduct.

Counselors also use structure to challenge the professional perspective of another community setting, Marty's day treatment program, where he also does not exhibit the same problems of conduct. The teachers report many fewer falls and no SIBs and they observed no change during the time that this conduct was escalating at the group home. Susan said that "at program there are no expectations of him and this is the difference between home and school [in general], he's not in an appropriate [residential] setting." Other counselors affirmed the comparison and how it indicated that Marty's placement in the group home was unsuitable. In a way similar to their characterization of the hospital, the day program "demands no responsibility" in contrast to the group home, which is about "becoming independent." The reason there were fewer incidents of Marty's problem conduct at program was the "lack of expectations." The record of comparatively few incidents at program was adduced by counselors as evidence that Marty would benefit from the increased structure of an ICF. What was a simple, positive report from Marty's teacher was heard by counselors as a challenge to their practice that required an account

of Marty's conduct at home. They emphasized Marty's ongoing failure as a reflection of the lack of "fit" between his particular needs and the nature of support the group home can offer. It was not only that the group home placed more "expectations" on residents but also that "Marty can't handle the freedom" that group home participation requires. The need to wear his helmet at home (he did not wear it at program) and to restrict him from going out in the community unsupervised were accountable in terms of the frequency of his falls and SIBs. What indicated that the group home was unable to "help" him was his own conduct. For counselors, Marty's own capacities – he was smart, articulate, and vastly capable of many everyday life skills – were actually undermined by the group home's individualized and unstructured approach. His inability to "handle the freedom" was detrimental. Daniel exclaimed: "[Marty's] living here is like an alcoholic living in a liquor store! It's bad for him." Sonia responded impatiently: "Look, moving him is not an option at this time. We need to be creative." Some of the counselors heard this as a challenge to their know-how and not an administrative issue. Sally responded with exasperation: "We've tried everything with him."

Counselors defined and managed their work as failure. The discussions were often organized by issues that exceed counselor authority. Even the recommendations of "inside" experts provided counselors situated opportunities in meeting discussions to make the claims that larger problems are being ignored. Know-how is available to challenge and evade, in the guise of professional judgement, the recommendations of group home experts, like the nurse. In one meeting, a discussion about Marty's weight loss and lack of appetite provided a situated opportunity to complain that their frustration with Marty is

"not taken seriously by the agency."[23] Marty's placement organized the challenge yet again. Angela made the medical report in Beth's absence, who suggested (actually for the second time in a month) that because of Marty's weight loss he keep chocolates in his room because he is not eating adequately and needs the extra calories. Daniel and Susan interrupted Angela, defining Marty's calorie intake as a symptom. They abruptly shifted the topic to the larger issue of responsibility for the ongoing failure of work with Marty and its impact on counselors. Almost in unison they exclaimed: "That's ridiculous! Caffeine and sugar only contribute to his anxiety!" Daniel continued: "I mean he shouldn't even be permitted his coffee at night. Chocolate adds to the larger problem." Susan produced a clinical account of his conduct: "There are reasons underneath why he's not eating . . . he's always talking about things at inappropriate times– we need to give him an agenda." The topic had been shifted successfully to the larger problem of Marty's conduct. Sally then suggested developing a daily or weekly schedule or agenda that he could maintain and follow that would "structure his time." Susan affirmed this: "He wants the agenda." Daniel opposed this as a piecemeal attempt at increasing the structure because: "it will just be another thing for him to get anxious about." He used it to press the issue of placement again. His tone was suddenly earnest: "Marty doesn't belong here. It's a disservice to have him here, he needs more structure. . . The anxiety of working with him– I mean he's not a person anymore, it's just getting worse." Sonia responded sympathetically: "That's why it's so important for staff to document the experiences with

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23. This is another example of how counselors criticize without personal attribution. See note 8 above.

Marty as helping to make this case to the agency." Daniel returned to his tone of indignation: "Documenting more to build a case is ridiculous, we already have documentation!" Susan and Angela vigorously agreed.[24] Damian attempted to return the conversation to the specific concern about Marty's weight and lack of appetite and suggested that: "Maybe we can prompt him at dinner [to eat more]?" Susan said: "That upsets all the other residents, especially Johnny." Angela returned to the topic of his conduct by using an encompassing conception of his disability, indicating how thoroughgoing and fundamental is his incapacity to manage himself by invoking the most basic skills. She said impatiently: "he must do his hygiene everyday, that's the first step!" Miles agreed: "He waits for Daniel [for the evenings when Daniel works] to shower . . . four days a week. He needs to shave for himself." Daniel sighed: "the severity of the problem is not being recognized."

Placement and the structure of the group home, in relation to the hospital, are also used frequently in accounts of Johnny's conduct, which also make the contrast to the hospital setting. On page 10 above, the staff meeting discussion about the 911 protocol above illustrates the use of practical conceptions of disability. It is used again here, now in full, with a focus on counselors' use of the placement issue. Sonia opened this meeting by announcing, for those staff members who did not already know, that Johnny had been hospitalized again the day before. Carlos had to physically restrain him when he became too aggressive with Maria and she called 911. Carlos immediately said that calling the

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24. This is a reversal of Sonia's earlier strategy, expressing impatience with the counselors' insistence on discussing issues that were out of their, and likely her, realm of authority. Her attempt to "include them in the process" did not seem to succeed either.

police "doesn't really work." That Johnny "calms down as soon as you do" indicates that "he knows what he's doing." Maria affirmed this by accounting for Johnny's conduct specifically as a calculated attempt to be hospitalized. Johnny was "comforted when they [the police] arrived because they would take him to the hospital." He "wants to be in the hospital" and "prefers" it to being at home because "it's a relief from life." His comfort with the police was used as evidence that "he knows what he's doing" and, at the same time, is incapable of managing his feelings. It was thus the calculated management of his own conduct that paradoxically reflected Johnny's inability to "manage the freedom of the group home." Implementing the emergency protocol is a signal of Johnny's "success" at achieving hospitalization. The 911 protocol actually "feeds into" his conduct and does not require him to manage his anger and aggressive impulses in specifically appropriate ways. "Just threatening" is therefore not adequate and Johnny "needs to know the consequences" of his conduct. When they indicated disagreement, Daniel, used Johnny's placement to account for, and to repair, his initial to challenge to Maria and Monica – a professional challenge with moral implications. He acknowledged that the conduct they raised was a problem but reflected something more fundamental one that the 911 protocol issue avoids addressing. Maria responded angrily to Daniel that the issue of placement was irrelevant to her complaint.

The structure of the group home and the suitability of placement are substantive clinical topics that are also practical methods of know-how for counselors. In their situated work of talk, these methods reflexively organize counselors' disputes, with each other and with outside experts. Structure and placement themselves depend on a practical

conception of a resident's disability as more than simply immutable but as beyond the scope even of the group home's clinical capacities. These are methods of managing the conflicts in counselor work. In particular, the clinical argument for more structure as a method of exoneration that locates responsibility in the administrative and clinical decisions of superiors. It functions also as a defense of counselor work and as a challenge, in the same professional terms, to the assessments and recommendations of outside experts. Counselor know-how furnishes practical methods to demonstrate their capacities for professional judgement in situations that are beyond their authority to control. It is on a clinical basis that counselors attempt to persuade the supervisor of the impossibility of certain work. As Lipsky writes, street-level bureaucrats "assert discretionary dimensions of their job to a greater degree than called for in theory in order to salvage a semblance of proper client treatment as they define it" (1979:150).

As a kind of intervention, psychiatric hospitalization has special significance in staff meeting disputes and in group home work generally. When Cynthia described the psychiatric unit as a resort she did not have in mind the book by Braginsky, Braginsky and Ring.[25] In fact, hospitalization is accountable to staff only as an intervention of last resort. It is ultimately necessary only as it reflects Marty and Johnny's need for some "relief from life," from the burden of freedom that group home residents must bear. The intervention of hospitalization is a decision made on a professional, clinical basis but it is also a kind of failure – of the resident, of the group home, and of counselor work. Even

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25. Methods of Madness: The Mental Hospital as Last Resort by B. Braginsky, D. Braginsky, and K. Ring New York: Holt, Rinehart and Winston, 1969.

this clinical last resort is only a reminder to counselors of the failure they face daily and must manage as an aspect of their work. In the cases of Johnny and Marty, hospitalization is discussed after the fact not primarily as a reasoned clinical choice but as an indication of a bad situation getting worse. Know-how's flexibility was observable in Sonia's sympathetic reminder that counselors do not bear responsibility for Johnny's failure. She indicated that the 911 protocol is limited but " . . . this is what we have to work with. Anyway, hospitalizing him in this way isn't very therapeutic."

## IV. CONCLUSION

In this chapter, the technology of the weekly staff meeting furnishes a regular venue for the analysis of a distinct kind of counselor work: the work of talk about work. Clinical know-how is always at hand to make intelligible the very expertise that enables the counselors' everyday accomplishment of work by organizing it as an ever open and adjustable domain. The people-processing work of the group home is shaped by the pursuit of its unattainable goal: the independence of individuals who are ultimately unable to achieve independence in any conventional sense. That human conduct is its complex and recalcitrant object makes this endless work unpredictable. It is know-how's clinical flexibility that enables counselors to keep a tenuous but nevertheless competent hold on their contingent and often upsetting work. The breadth of their accountability can be seen in the way counselors can define and act on any conduct or conflict that arises as a practical clinical problem. In this chapter, clinical flexibility has been analyzed in several ways in the everyday use of know-how. The detailed, ongoing, processes of refinement

and readjustment that define the discussion work in staff meetings is shown in the indexical character of clinical know-how. Meaning in the work depends on the context that know-how's ongoing use organizes as practical and relevant.

The accountable contradiction flexibility enables is not considered here as a measure of the quality of counselor work and training. The adequacy of counselors' everyday conduct is described not by reference to external and abstract clinical standards, but to the situated and practical demands of their difficult and failure-prone work. This ever-receding character of clinical meaning is precisely the method available that counselors use to establish the apparently delimited sphere of their own conduct in situated ways. This is the "magical quality" of clinical accountability, to which Goffman refers, that endows counselors with a kind of "authority that cannot be discredited," either by residents or each other in their disputes (1961:370). Clinical know-how is thus available always to account for indeterminacy and, in it's ongoing, situated use, organizes reflexively the problems of conduct that it is endlessly solving.

# Chapter 8
## Conclusion

My aim in this dissertation has been to offer an understanding of the group home broader than the social control function it certainly also serves. It is a site of governmentality because the task of providing services to residents must be accomplished without unduly impinging on their liberty. The group home can be seen thus as an example of, rather than an exception to, the indirect practice of liberal authority. The integration of individuals with cognitive disability poses a fundamental and ongoing tension between authority and individual freedom, which must be managed in the group home by governing the residents through the capacities for freedom that enable them to govern themselves.

Given the level of activity this involves, I have chosen to understand the self-government of residents as a kind of work. The group home is already an actual workplace because it provides a livelihood for the counselors. Three different kinds of work have been addressed throughout this dissertation: the work counselors do in the conventional sense; the work residents do on themselves to become more independent; and the kind of work that has provided a way of analyzing counselors and residents both, what ethnomethodologists treat as "the unavoidable work of coming to terms with practical circumstances" (Garfinkel 1967:185). I have drawn upon a tradition in sociology of work that understands the organizational character of contemporary life as a dilemma of liberal freedom and does not explain individual participation and commitment solely in terms of power and domination. This tradition shares much with the concern in

governmentality to understand how authority operates indirectly through the specific capacities for conduct it shapes, not only in organizations but also for individuals in everyday life.

The various approaches I have brought together, in one way or another, point to the practical character of social action. Knowledge and authority have therefore been observed as routine matters of group home work. The people who live and work there are also described in the ongoing ways they participate in everyday life, and I have tried to capture in these descriptions how the group home makes possible certain ways of seeing, knowing and acting. This portrayal of the group home has been offered as an alternative to the familiar concerns of social control and social construction that focus on power and the domination of professional knowledge. I also approached this setting in a new way to suggest that group home work actually makes residents not so very different from the many individuals in contemporary society who make their own everyday lives work.

In chapter 1, I argued that deinstitutionalization and the move to provide services to individuals in the community not as inmates, but as citizens, posed new and ongoing problems that are not addressed by conventional models of power and professional control. Professional authority there, as elsewhere, can operate only with the consent and participation of residents. Without doubt, this is a "managed" consent, and I argued further that the dilemma of freedom in the group home is specifically defined and managed as a psychological problem. As it has been fundamental to the practice of government through the twentieth century, psy knowledge has shaped the integration of individuals with cognitive disability, and cannot be understood simply as a form of "soft" social

control. The participation of residents is organized by the commitment they must make to work on their own selves as endless clinical projects. Psy knowledge furnishes the practical techniques of seeing, knowing, and acting that enable residents and counselors to conduct themselves as certain kinds of group home persons.

Wider perceptions of cognitive disability as overall incompetence make the group home an unlikely, if exemplary, setting for the study of governmentality. Although community-based services are ideally technologies of government, this *prima facie* assertion does not alone provide an understanding of how the group home works. Even the residents, who have generally been regarded incorrectly in terms of their questionable capacity for freedom, are governed through the specific capacities for freedom their own group home work makes possible. In order to show how residents govern themselves, I have drawn upon ethnomethodology and its conception of everyday life as a situated accomplishment. It has provided an empirical approach to both counselors and residents' practical and reflexive group home work. Ethnomethodology has also provided, in ways compatible with governmentality, a critical alternative to certain epistemological assumptions and modes of causal explanation.

In Chapter 3, I showed how several situated practices of monitoring are used by counselors and residents to manage uncertainty. For residents, this is the uncertainty of everyday domestic life that is managed by involvement in the details of routine group home operation. Residents are constantly encouraged to be invested in the group home as a measure of their healthy participation. Although this kind of resident work is one practical form participation can take, counselors nonetheless sometimes make situated

interventions in types of involvement and specific issues as "inappropriate." When this happens, routine resident work becomes a clinical problem of conduct. For counselors, work is endless and uncertain because of the organizational features the group home shares with street-level bureaucracies. I described several practical ways that counselors manage their rather difficult work. First, counselors' personal conceptions of the group home, their role, and the residents, provide accounts of work for which outcomes are nearly impossible to measure and control. Second, I showed how a paper technology of monitoring, the daily log, organizes the uncertainty of counselor work through a perpetual monitoring of the potentially endless detail of everyday life. Finally, counselor shop-talk provides continuous, close monitoring of group home work through ongoing and informal conversation. The situated selection of topics enables counselors to make sense of and manage uncertain, ambiguous, unresolvable, and often upsetting situations of work. Counselors also use shop-talk to emphasize what is most satisfying about the job – the clinical work of helping – but also the most prone to failure.

In chapter 4, I analyzed monitoring practices of a different kind: the group home's records and written documents. I argued they must be understood as technologies, as embedded aspects of the work they organize that shape what can be seen and known in group home work. Science studies research offers a conception of technology as an integral and reflexive feature of particular social settings. This conception of technology provides an apt way of understanding how government involves the systematic shaping of individual conduct toward specific outcomes. The analysis of the group home's paper technologies showed how the collection and analysis of data about group home work is a

central aspect of that work. These paper technologies do not merely gather data, but also translate the clinical and administrative ideals of individualized services into actual everyday work for residents and counselors. Chapter 5 focused further on one paper technology, goal plans, and how they establish practical conditions of knowing and acting on conduct as a clinical problem. Goal plans form the core of individual work with residents and, more than other paper technologies, furnish the clinical techniques that counselors and residents use in the ongoing course of their work, though often in unspecified and unintended ways.

Chapters 6 and 7 turned to the analysis of work as know-how, the practical and often tacit knowledge relevant to residents and counselors in everyday life. This focus on know-how has not been to demonstrate that group home work involves more than is recognized by official procedure or other sociological perspectives. Know-how provides a suitable conception of work in the group home, as a professional setting that depends on certain kinds of knowledge. Both chapters emphasized, in different ways, that what and how counselors and residents know is a main organizing feature of local order. Chapter 6 focused on the time not taken up by the formally prescribed activities that are in an obvious sense "the work." There is only a situated distinction between work and other group home activity, and the analysis showed how the counselors and residents' reflexive use of everyday know-how makes all of life potential work. Counselors' use their know-how to intervene spontaneously in problem conduct, which organizes everyday life as an ongoing and situated domain of clinical work. Residents' know-how is observable in their skilled use of methods of ordinary talk, sometimes even in conventionally incompetent

ways, and in the use of practical matters that oblige the attention of counselors. Chapter 7 is devoted to the specifically clinical aspects of know-how. I argued that the particular flexibility of psy knowledge is both an organizing feature of group home work and a situated resource for the counselors' routine management of their complex and indeterminate environment. This argument is based largely on staff meeting discussions, which exhibit a distinct kind of counselor work: clinical work in talk. The weekly staff meeting is described as the group home's center of calculation and coordination, something the counselors recognize practically in their understanding of the crucial role meetings play in establishing the course of their work from week-to-week. I have argued in this dissertation that the government of residents occurs through the specific capacities for freedom endlessly cultivated in group home work. I do not claim that the group home does not also involve social control, and I have even described the restriction of certain rights, which is an available if infrequent intervention. It must be said there are good reasons why most social research on cognitive disability is concerned with the question of professional power and domination in community-based services. The unfortunate truth is that many settings still rely on routine coercion, in violation of both the law and the norm of autonomy now central to social service practice in liberal societies. Lipsky shows that most workers are committed to professional ideals of service and to their clients, and such violations do not usually reflect bias and lack of compassion but routine practice that develops to manage the relentless conflict between client-centered and organizational goals (1979:44). However true, this explanation is not adequate to the extreme nature of this conflict in many community-based services settings for cognitive disability in the

United States. Nor does it account for the particular vulnerability and the legacy of abuse many of these individuals bear. Much of the research on cognitive disability described in chapter 1 aims to expose the persistent, and sometimes brutal, denial of rights, even in settings that variously claim to promote and encourage independence. The vigilant contributions of this research are as crucial to the ongoing efforts toward adequate community integration as research in the 1960s and 70s was to deinstitutionalization. However, the conceptions of power and domination that are the concerns of this research do not preclude other kinds of social inquiry in the area of cognitive disability. This dissertation has posed different questions about the nature of authority and knowledge in one group home, questions that, I am aware, would not obtain in all services settings.

Although I have attempted to remain neutral in my analysis, I would like to make one critical observation: psy knowledge organizes everyday life in the group home far more extensively than seems necessary to create a supportive residential environment. One objection may involve the quality of training or supervision in this setting, a charge I cannot address properly on the basis of this single case study. My own judgement is that staff members discharged their duties adequately, certainly in the group home's own terms. It is my hunch that comparable residential settings are also characterized by an extensive use of psy knowledge. One partial explanation may be the claim I have supported throughout the dissertation that the dilemmas of freedom posed by integration are defined and managed as individual clinical problems. Perhaps the flexibility I analyzed in chapter 7 makes psy knowledge difficult to contain, especially in so intimate a setting where the beginning and end of work is always a situated matter? However, the problem

in the group home seems to be a feature of something much broader than the nature of social service practice.

That residents must take their own selves as ongoing projects of independence reflects a therapeutic ethic in contemporary life that urges us all to be endlessly working on our selves. This is not simply a question about values in the sociological sense. This concern with ethics refers to the way everyday life is pervasively organized by innumerable physical, psychological, and spiritual techniques of the self and the goals of conduct they both translate and pursue: self-improvement, self-knowledge, growth, health, and so on. These omnipresent techniques furnish thus a fundamental know-how in contemporary society, and not only in the group home.

It could be argued, of course, that however much resident work may reflect broader ethical practices of the self, it still does not overcome the ways in which the group home ultimately makes residents' lives completely different from everyone else's. It is true that the residents do not have certain capacities for freedom, especially independence from others authorized to monitor the details of one's normal life. As for the residents whose work has been the subject of this dissertation, with two or three exceptions, living in the group home does not appear to be experienced as a limitation and the work they must do on themselves is, therefore, not experienced only as a cost. Group home life also includes many pleasures and comforts.[1] The endless work residents do on their own

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1. I do not mean to suggest the group home, or any group home, is a desirable place to live or would be the choice of these residents if there were one. The fact that most of the residents are not miserable and sad is not in itself an unreasonable point, however, and seems especially worth making before concluding this dissertation given the common response to my research: "how depressing."

selves may appear vastly different from being properly free to choose how to know and act on oneself. The particular conception of freedom this presumes, however, derives from the taken-for-granted everyday practices which equate freedom and choice with autonomy. Freedom from the endless monitoring and assessment of normal life is one that certainly should be extended to the residents. Yet it is difficult to imagine an alternative to psy knowledge as the ethical basis for government in contemporary American society. Were it only true, in any case, that most individuals are actually independent of one or another kind of endless monitoring. Our own ethical practices always occur "under the actual or imagined authority of some system of truth" (Rose 1996:29) and are largely organized already as activities of endless *self*-monitoring.

I certainly do not mean to overlook the no doubt wide variation of individual participation in such pursuits, nor to resort to caricature to make the comparison between residents and everyone else. I cannot deny that the residents are in fact quite a different kind of person by virtue of their group home life. Perhaps the dissertation yields little insight on these ethical matters, just a gentle reminder that, in contemporary society, it is not only residents who govern themselves. Or who do so through the endless enhancement of the normal self. Put this way, it seems reasonable to suggest that whatever the technologies of conduct available to know and work on one self as a certain kind of person, what residents *must* do is what we all unwittingly do more or less. Self-government in the group home is only easier to see because of the organizational and documentary character of the practices that make residents' lives work.

# Appendix

## List of residents and counselors

This is a reference for basic personal information about individuals. Age, gender, and race-ethnicity are indicated for staff and residents. For the residents, I have indicated prior living and services arrangements very generally and the year they moved into the group home. A job title is indicated for staff and I have included a general sense of their career status and aspiration.

### Residents

*Chris*, 48, is a white Protestant man who is from rural New York State. He was placed in an institution at the age of ten and since the mid-1970s has been living in community-based care settings. He moved into the group home in 1986.

*David*, 59, is a Jewish man who was placed at Willowbrook in the early 1960s when his parents died. He moved into the group home in 1987.

*Diane*, 39, is an African-American Catholic woman who moved into the group home in 1996 because her ailing, elderly mother found was finding it difficult to keep her at home.

*Donna*, 54, is a white Protestant woman who lived with her family in another part of New York State. In 1997, her remaining parent died and she moved into the group home to be near to her brother and his family.

*Evan*, 43, is a Jewish man who lived with his parents until the early 1990s. He moved into the group home in 1997.

*Evelyn*, 53, is an African-American woman who was raised at home. She moved into the group home in 1995 when her long-widowed, elderly father became ill. He died shortly after.

*Irving*, 53, is a Jewish man who was placed at Willowbrook as a child and since the mid-1970s has lived in several community-based settings. He moved into the group home in 1986.

*James*, 30, is an African-American man who was raised at home and moved into the group home in 1995 when his mother died.

*Jennifer*, 46, is a Jewish woman who was raised at home and moved into the group home in 1983 when her father died.

*Johnny*, 29, is a Puerto Rican man from New York City who moved in 1995 from his parents' home when they became ill. They both died within a few years.

*Kenneth*, 37, is a Jewish man who moved into the group home in 1986 because his parents thought he should live more independently.

*Marty*, 36, is a Jewish man who was raised at home his mother until he was a teenager, when he moved into residential community services. He moved into the group home in 1995.

*Paul*, 61, is a Jewish man who was raised at home. He moved into the group home when his widowed mother was killed in a car accident in 1978.

*Ruby*, 23, is an African American woman who was raised at home with her mother. She moved into the group home in 1995 because her mother thought she should be more independent.

*Theresa*, 68, is an Italian American woman who was placed in Willowbrook in her late twenties when her parents died. She moved into the group home in 1989.

**Staff**

*Angela*, morning counselor, is an Italian American woman in her early forties and has a bachelor's degree. Older than most of her counselor colleagues, the job suits her personal schedule and she has declined offers of promotion from the agency. She does not want increased responsibilities to interfere with her family life and additionally prefers direct care to administrative work.

*Beth*, nurse, is a Jewish woman in her late fifties who has worked at the agency for about ten years. She monitors the residents' health issues and works with counselors to coordinate and implement services; she supervises medication administration. Beth works in four agency facilities and spends one day a week at the group home.

*Carlos*, evening counselor, is a 24 year old Puerto Rican man from New York City. He was originally hired in the group home as the housekeeper and eventually promoted to counselor because he communicated so well with the residents. He is a high school graduate and has no plans to pursue a college degree.

*Cheryl*, evening counselor, is about 30 and recently emigrated from Guyana. She is a part-time college student and is considering a career in social services.

*Cynthia*, clinical specialist, is a white Protestant woman in her late twenties and has a master's degree in psychology. She works with counselors to develop the residents'

outcome plans. Cynthia works in two agency facilities and spends two or three days a week at the group home.

*Damian*, evening counselor, is a Greek American in his early thirties who has a bachelor's degree. He is committed to a career in social services and has a variety of relevant work experience but no present plans to return to school for an advanced degree.

*Daniel*, evening counselor, is a Jewish man. He has prior work experience in a variety of business and retail settings and is slowly pursuing an associate's degree in social services. He enjoys direct service work and does not aspire to move into an administrative position.

*Danielle*, service coordinator, is in her mid-twenties and spent a two years as a counselor in the agency before taking her current position. She works in two facilities and is in the group home two or three days a week.

*Linda*, substitute counselor,[1] is a 27 year old Puerto Rican woman from New York City who has a master's degree in social work and works full-time as a day treatment program teacher in another agency. She substitutes regularly on the evening and weekend shifts for additional income.

*Lisa*, evening counselor, is a 23 year old Jewish woman who left the position three months into the research period to pursue a master's program in psychology.

*Lydia*, evening counselor, is a 24 year old white Protestant woman who left position five months into the research period to enter a master's program in social work.

*Maria*, morning counselor, is a 24 year old Dominican woman from New York City and a recent college graduate. She previously had a supervisory position in a large, well-known clothing retail chain with opportunities for advancement that she decided to forego to pursue a career in social services. She intends to pursue a master's degree in social services or psychology.

*Mike*, regional supervisor, has responsibility for several residences and is Sonia's immediate supervisor. He is a 46 year old Irish American with a bachelor's degree and has worked in social services since his late twenties.

*Miles*, evening counselor, is a 22 year old white Protestant college graduate. He is

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1. There is a pool of substitute counselors used to meet staffing requirements. Linda worked frequently at the group home throughout the research period and had a developed relationship with the residents, who understood she is a substitute but treated her as a member of the group home. She was very familiar with general procedure but did not have ongoing the clinical and administrative responsibilities of regular counselors.

undecided about whether to pursue a career in social services.

*Monica*, morning counselor, is a 22 year old African American college graduate who is applying to master's programs in social services.

*Sally*, evening counselor, is in her early twenties and South Asian and has a bachelor's degree. her interest in psychiatric and mental health issues led her to the counselor job, but she is undecided about her career plans.

*Susan*, evening counselor, is about 30 and recently emigrated from Guyana. She is enrolled in a master's program in social work.

*Sonia*, supervisor, is a 42 year old Puerto Rican woman from New York City who has a bachelor's degree and has worked in social services for cognitive disability for about ten years.

## References

Angrosino, M. (1998) "Mental Disability in the Unites States: An Interactionist View" in R. Jenkins, ed., Questions of Competence: Culture, Classification and Intellectual Disability. Cambridge: Cambridge University Press.

Angrosino, M. (1997a) Opportunity House: Ethnographic Stories of Mental Retardation. Sage Publications.

Angrosino, M. (1997b) "The Ethnography of Mental Retardation: An Applied Perspective." *Journal of Contemporary Ethnography.* 26:1, 98-109.

Angrosino, M. (1992) "Metaphors of Stigma: How Deinstitutionalized Mentally Retarded Adults See Themselves." *Journal of Contemporary Ethnography.* 21:2, 171-199.

Attewell, P. (1992) "Skill and Occupational Changes in U.S. Manufacturing" in P. Adler, ed., Technology and the Future of Work. New York: Oxford University Press.

Attewell, P. (1990) "What Is Skill?" *Work and Occupations.* 17:4, 422-448.

Attewell, P. (1986) "Imperialism Within Complex Organizations." *Sociological Theory.* 4:2, 115-125.

Attewell, P. and Gerstein, D. (1979) "Government Policy and Local Practice." 44:2, 311-327.

Baistow, K. (1994-1995) "Liberation and regulation? Some paradoxes of empowerment." *Critical Social Policy.* Issue 42.

Baker, B. Seltzer, G. B., and Seltzer M. (1977) As Close as Possible: Community Residences for Retarded Adults. Boston: Little Brown and Company.

Baker, C. (1984) "The 'search for adultness': Membership work in Adolescent Talk." *Human Studies.* 7:301-323.

Bannerman, D., Sheldon, J., Sherman, J. and Harchik, A. (1990) "Balancing the Right to Habilitation with the Right to Personal Liberties: The Rights of People With Developmental Disabilities To Eat Too Many Donuts and Take a Nap." *Journal of Applied Behavior Analysis.* 23:1, 79-89.

Barnes, C. and Oliver, M. (1995) "Disability Rights: rhetoric and reality in the UK." *Disability & Society.* 10:1, 111-116.

Baroff, G. (1999) "General Learning Disorder: A New Designation for Mental Retardation." *Mental Retardation.* February, 68-70.

Barron, A. (1996) "The Governance of Schooling: Genealogies of Control and Empowerment in the Reform of Public Education." *Studies in Law, Politics, and Society.* 15:167-204.

Barron, K. (2001) "Autonomy in Everyday Life, for Whom?" *Disability & Society.* 16:3, 31–447

Barry, A., Osborne, T. and Rose, N. (1996) "Introduction" in A. Barry, T. Osborne, and N. Rose, eds., Foucault and Political Reason: Liberalism, neo-liberalism, and rationalities of government. Chicago: University of Chicago Press.

Bell, V. (1993) "Governing childhood: neo-liberalism and the law." *Economy and Society.* 22:3, 390-405.

Bercovici, S.M. (1983) Barriers to Normalization: The Restrictive Management of Retarded Persons. Baltimore: University Park Press.

Blau, P. (1963) The Dynamics of Bureaucracy. Chicago: University of Chicago Press.

Blumer, H. (1969) Symbolic Interaction. Englewood Cliffs: Prentice-Hall.

Bogdan, R. and Taylor, S. (1989a) "Relationships with Severely Disabled People: The Social Construction of Humanness." *Social Problems.* 36, 135-48.

Bogdan, R. and Taylor, S. (1989b) "What's in a name?" in A. Brechnin and J. Walmsley, eds., Making Connections: Reflecting on the Lives and Experiences of People with Learning Difficulties. London: Hodder and Stoughton.

Bogdan, R. and Taylor, S. (1987) "Toward a Sociology of Acceptance: The Other Side of the Study of Deviance." *Social Policy.* Fall:34-39.

Bogdan, R. and Taylor, S. (1982) Inside Out: The Social Meaning of Mental Retardation. Toronto: University of Toronto Press.

Bowler, I. (1995) "Further notes on record taking and making in maternity care: the case of South Asian descent women." *The Sociological Review.* 43:36-51.

Braginsky, B. and Braginsky, D. (1971) Hansels and Gretels: Studies of Children in Institutions for the Mentally Retarded. New York: Holt, Rinehart and Winston.

Brown, H. and Smith, H. (1992) "Introduction" in H. Brown and H. Smith, eds.,

Normalisation: A Reader for the Nineties. London: Routledge.

Burchell, D. (1998) "'The mutable minds of particular men": the emergence of 'economic science' and contemporary economic policy" in M. Dean and B. Hindess, eds., Governing Australia. Cambridge: Cambridge University Press.

Burchell, G. (1996) "Liberal government and techniques of the self" in A. Barry, T. Osborne, and N. Rose, eds., Foucault and Political Reason: Liberalism, neo-liberalism, and rationalities of government. Chicago: University of Chicago Press.

Callon, M. (1986) "Some elements of a sociology of translation: domestication of the scallops and the fisherman of St Brieuc Bay" in J. Law, ed., Power, Action and Belief: A New Sociology of Knowledge? London: Routledge and Kegan Paul.

Callon, M. (1987) "Society in the Making: The Study of Technology as a Tool for Sociological Analysis" in W. Bijker, T. Hughes, and T. Pinch, eds., The Social Construction of Technological Systems: New Directions in the Sociology and History of Technology. Cambridge: The MIT Press.

Castel, R. (1991) "From Dangerousness to risk" in G. Burchell, C. Gordon and P. Miller, eds., The Foucault Effect: Studies in Governmentality. Chicago: University of Chicago Press.

Carrithers, M. (1985) "An Alternative Social History of the Self" in M. Carrithers, S. Collins and S. Lukes, eds., The Category of the Person. Cambridge: Cambridge University Press.

Chadwick, A. (1996) "Knowledge, Power and the Disability Discrimination Bill." *Disability & Society*. 11:1, 25-40.

Cicourel, A. (1974) Cognitive Sociology: Language and Meaning in Social Interaction. Hammondsworth: Penguin Education.

Cicourel, A. (1964) Method and Measurement in Sociology. Glencoe, IL: The Free Press.

Commission on Quality of Care, New York State (1995) Shifting Costs to Medicaid: The Case of Financing the OMRDD Comprehensive Case Management (CMCM) Program. December.

Copp, M. (1998a) "Adult 'Adolescents:' Social Control of Sexuality and Adulthood in People with Developmental Disabilities." *Sociological Analysis* 1:3,

Copp, M. (1998b) "When Emotion Work is Doomed to Fail: Ideological and Structural Constraints on Emotion Management." *Symbolic Interaction.* 21:3, 299-328.

Corbett, J. (1996) Bad-mouthing: The Language of Special Needs London: The Falmer Press.

Cruikshank, B. (1999) The Will to Empower: Democratic Citizens and Other Subjects Ithaca: Cornell University Press.

Cushman, P. (1995) Constructing the Self, Constructing America: A Cultural History of Psychotherapy. Menlo Park, CA: Addison-Wesley.

Cushman, P. (1991) "Ideology Obscured: Political Uses of the Self in Daniel Stern's Infant." *American Psychologist.* 46:3, 206-219.

Danforth, S. and V. Navarro (1998) "Speech Acts: Sampling the Social Construction of Mental Retardation in Everyday Life." *Mental Retardation.* 36:1, 31-43.

Davies, C. (1998) in R. Jenkins, ed., Questions of Competence: Culture, Classification and Intellectual Disability. Cambridge: Cambridge University Press.

Davies, C. and Jenkins, R. (1997) "'She Has Different Fits to Me': how people with learning difficulties see themselves." *Disability and Society.* 12:1, 95-109.

Davis, L., ed., (1997) The Disability Studies Reader. New York: Routledge.

Davis, L. (1995) Enforcing Normalcy: Disability, Deafness, and the Body. New York: Verso Press.

Dean, M. (1999) Governmentality: Power and Rule in Modern Society. London: Sage Publications.

Dean, M. (1996) "Putting the technological into government" in *History of the Human Sciences.* 9:3, 47-68.

Dean, M. (1995) "Governing the unemployed self in an active society." *Economy and Society.* 24:4, 559-583.

Dean, M. and Hindess, B. (1998) "Introduction: Government, Liberalism, Society"in M. Dean and B. Hindess, eds., Governing Australia: Studies in Contemporary Rationalities of Government. Cambridge: Cambridge University Press.

De Swaan, A. (1990) The Management of Normality: Critical Essays in Health and Welfare. London: Routledge.

Devlieger, P. (1999) "From handicap to disability: language use and cultural meaning in the United States." *Disability and Rehabilitation.* 21:7, 346-354.

Devlieger, P. (1998) "(In)competence in America in Comparative Perspective" in R. Jenkins, ed., Questions of Competence: Culture, Classification and Intellectual Disability. Cambridge: Cambridge University Press.

Devlieger, P. (1995) "Why Disabled? The Cultural Understanding of Physical Disability in an African Society" in B. Ingstad and S. Whyte, eds., Disability and Culture. Berkeley: University of California Press.

Dexter, L. (1964) The Tyranny of Schooling: An Inquiry into the Problem of "Stupidity." New York: Basic Books.

Donzelot, J. (1979) The Policing of Families. New York: Pantheon.

Dowse, L. (2001) "Contesting Practices, Challenging Codes: self advocacy, disability politics and the social model."
*Disability & Society*. 16:1, 123–141.

Dudley, J. R. (1983) Living With Stigma: The Plight of the People who we Label Mentally Retarded. Springfield, IL: Charles C. Thomas.

Edgerton, R. B. (1993) [1967] The Cloak of Competence: Stigma in the Lives of the Mentally Retarded. Berkeley: University of California Press.

Edgerton, R. B. (1983) "Failure in Community Adaptation: The Relativity of Assessment" in K. Kernan, M. Begab, R. B. Edgerton, eds., Environments and Behaviors: The Adaptation of Mentally Retarded Persons. Baltimore: University Park Press.

Emerson, E. (1992) "What is normalization?" in H. Brown and H. Smith, eds., Normalization: A reader for the nineties. London: Routledge.

Epstein, C. (1991) "All About Work: On the Non-Work Aspects of Work." *The Antioch Review*. 49:46-57.

Evans, D. P. (1983) The Lives of Mentally Retarded People. Boulder, CO: Westview Press.

Ewald, F. (1991) "Insurance and Risk" in The Foucault Effect: Studies in Governmentality. Chicago: University of Chicago Press.

Ewick, P. and S. Silbey (1998) The Common Place of Law. Chicago: University of Chicago Press.

Ferguson, P. (1987) "The Social Construction of Mental Retardation." *Social Policy*. Summer.

Ferguson, P., Ferguson, D. and Taylor S. (1992) Eds., Interpreting Disability: A Qualitative Reader. New York: Teachers College Press.

Fidler, D. and Hodapp, R. (1988) "Importance of Typologies for Science and Service in Mental Retardation." *Mental Retardation.* 36:6, 489-495.

Floersch, J. (2000) "Reading the case record: the oral and written narratives of social workers." *Social Service Review.* 74:2, 169-92.

Fleury, R., Sullivan, C., and Bybee, D.(1998) "What happened depends on whom you ask: a comparison of police records and victim reports regarding arrests for woman battering." *Journal of Criminal Justice.* 26:1, 53-9.

Foster, S. B. (1987) The Politics of Caring. London: The Falmer Press.

Foucault, M. (1991) [1978] "Governmentality" in G. Burchell and P. Miller, eds., The Foucault Effect: Studies in Governmentality. Chicago: University of Chicago Press.

Foucault, M. (1988a) "The Political Technology of Individuals" in L. Martin, H. Gutman, and P. Hutton, eds., Technologies of the Self: A Seminar with Michel Foucault. Amherst: The University of Massachusetts Press.

Foucault, M. (1988b) "Technologies of the Self" in L. Martin, H. Gutman, and P. Hutton, eds., Technologies of the Self: A Seminar with Michel Foucault. Amherst: The University of Massachusetts Press.

Foucault, M. (1988c) "Truth, Power, Self: An Interview with Michel Foucault" in L. Martin, H. Gutman, and P. Hutton, eds., Technologies of the Self: A Seminar with Michel Foucault. Amherst: The University of Massachusetts Press.

Foucault, M. (1987) "The ethic of care of the self as a practice of freedom: an interview" in J. Bernauer and D. Rasmussen, eds., The Final Foucault. Cambridge: The MIT Press

Foucault, M. (1986) "Of Other Spaces." *Diacritics.* 16:1, 22-27.

Foucault, M. (1980) The History of Sexuality, Vol. 1: An Introduction. New York: Vintage.

Foucault, M. (1979) Discipline and Punish: The Birth of the Prison. New York: Vintage.

Fox, R. (1957) "Training for Uncertainty" in R. Merton, G. Reader and P. Kendall, eds., The Student-Physician. Cambridge: Harvard University Press.

Garfinkel, H. (1996) "Ethnomethodology's Program." *Social Psychology Quarterly.*

59:1, 5-21.

Garfinkel, H. (1986) Ethnomethodological Studies of Work. London" Routledge and Kegan Paul.

Garfinkel, H. (1967) Studies in Ethnomethodology. New York: Polity Press.

Garfinkel, H and Sacks, H. (1970) "On Formal Structures of Practical Action" in J.C. KcKinney and E. Tiryakian, eds., Theoretical Sociology East Norwalk, CT: Appleton-Century-Crofts.

Garfinkel, H., Lynch, M. and Livingston, E. (1981) "The Work of a Discovering Science Constructed with Materials from the Optically Discovered Pulsar." *Philosophy of Social Science.* 11:131-158.

Garfinkel, H. and D.L. Wieder (1992) "Two Incommensurable, Asymmetrical Alternate Technologies of Social Analysis" in G. Watson and R. Seiler, eds., Text in Context: Contributions to Ethnomethodology. London: Sage Publications.

Giddens, A. (1994) Beyond Left and Right. Stanford: Stanford University Press.

Gillman, M., Heyman, B. and Swain, J. (2000) "What's in a Name? The Implications of Diagnosis for People with Learning Difficulties." *Disability and Society.* 15:3, 389-409.

Gleason, J. (1989) Special Education in Context: An Ethnographic Study of Persons with Developmental Disabilities. Cambridge: Cambridge University Press.

Gluckman, M. (1956) "Foreward" in V. Turner Schism and Continuity in an African Society. Manchester University Press.

Gluckman, M. (1967) "Introduction" to A.L. Epstein, The Craft of Social Anthropology. London: Tavistock.

Goffman, E. (1961) Asylums: Essays on the Social Situation of Mental Patients and Other Inmates. New York: Anchor Books.

Goffman, E. (1963a) Stigma: Notes on the Management of Spoiled Identities. Englewood Cliffs, NJ: Prentice-Hall.

Goffman, E. (1963b) Behavior in Public Places. New York: The Free Press.

Goode, D. (1994) A World Without Words: The Social Construction of Children Born Deaf and Blind. Philadelphia: Temple University Press.

Goode, D., ed. (1996) Quality of Life. Cambridge: Brookline Books.

Goode, D. and Ellis, E. (1991) "Some Current Issues in Labeling People with the term 'Mental Retardation' ?

Goode, D. (1983) "Who is Bobby?" in G. Kielhofner, ed., Health Through Occupation. Philadelphia: F.A. Davis.

Goode, D. (1980) "Behavioral Sculpting: Parent-Child Interactions in Families with Retarded Children" in J. Jacobs, ed., Mental Retardation: A Phenomenological Approach. Springfield, IL: Charles C. Thomas.

Goode, D. and F. Waksler (1990) "The Missing 'Who": Situational Identity and Fault-finding with an Alingual Blind-Deaf Child." *Sociological Studies of Child Development.* 3:203-223.

Goodley, D. (2001) "'Learning Difficulties', the Social Model of Disability and Impairment: challenging epistemologies." 16:2, 207-231.

Gordon, C. (1991) "Governmental Rationality: An Introduction." in G. Burchell and P. Miller, eds., The Foucault Effect: Studies in Governmentality. Chicago: University of Chicago Press.

Gordon, C. (1987) "The Soul of the Citizen: Max Weber and Michel Foucault on Rationality and Government" in S. Lash and S. Whimster, eds., Max Weber, Rationality and Modernity. London: Allen and Unwin.

Gouldner, A. (1954) Patterns of Industrial Bureaucracy. New York: The Free Press.

Greenspan, S. and J. Granfield (1992) "Reconsidering the Construct of Mental Retardation: Implications of a Model of Social Competence." *American Journal on Mental Retardation.* 96:4, 442-453.

Hak, Tony (1992) "Psychiatric Records as Transformations of Other Texts" in G. Watson and R. Seiler, eds., Text in Context: Contributions to Ethnomethodology. London: Sage Publications.

Hacking, I. (1986) "Making Up People" in T. Heller, M. Sosna, and D. Wellberry, eds., Reconstructing Individualism Stanford: Stanford University Press.

Hacking, I. (1995) Rewriting the Soul: Multiple Personality and the Sciences of Memory. Princeton: Princeton University Press.

Hacking, I. (1999) The Social Construction of What? Cambridge, MA: Harvard

University Press.

Hak, T. (1992) "Psychiatric Records as Transformations of Other Texts" in G. Watson and R. Seiler, eds., Text in Context: Contributions to Ethnomethodology. London: Sage Publications.

Halpern, A., Close, D., and Nelson, D., eds. (1986) On My Own: The Impact of Semi-Independent Living Programs for Adults with Mental Retardation. Baltimore: Brookes Publishers.

Hawes, Joseph (1991) The Children's Rights Movement: A History of Advocacy and Protection. Boston: Twayne Publishers.

Heritage, J. (1984) Garfinkel and Ethnomethodology. Cambridge: Polity Press.

Heshusius, L. (1982) "Sexuality, Intimacy, and Persons We Label Mentally Retarded: What They Think–What We Think." *Mental Retardation.* 20:4, 164-168.

Hindess, B. (1986) "'Interests' in political analysis" in J. Law, ed., Power, Action and Belief: A New Sociology of Knowledge? London: Routledge & Kegan Paul.

Hindess, B. (1996) Discourses of Power: From Hobbes to Foucault. Oxford: Blackwell Publishers.

Hopwood, A. and Miller, P., eds. (1994) Accounting as Social and Institutional Practice. Cambridge: Cambridge University Press.

Hornstein, G. (1988) "Quantifying Psychological Phenomena: Debates Dilemmas, and Implications" in J.G. Morawski, ed., The Rise of Experimentation in American Psychology. New Haven: Yale University Press.

Hughes, E. (1958) Men and Their Work. Glencoe, IL: The Free Press.

Hutton, P. (1988) "Foucault, Freud, and the Technologies of the Self"in L. Martin, H. Gutman, and P. Hutton, eds., Technologies of the Self: A Seminar with Michel Foucault. Amherst: The University of Massachusetts Press.

Ingleby, D. (1985) "Professionals as Socializers: The "Psy Complex." *Research in Law, Deviance and Social Control.* 7:79-109.

Jacobs, J., ed., (1980) Mental Retardation: A Phenomenological Approach. Springfield, IL: Charles C. Thomas.

Jacoby, R. (1975) Social Amnesia: A Critique of Conformist Psychology from Adler to

Freud. Boston: Beacon Press.

Jahoda, A. and Cattermole, M. (1995) "Activities of People with Moderate to Severe Learning Difficulties: living with purpose or just killing time." *Disability & Society.* 10:2, 203-219.

Jaskulski, T. and Ebenstein, W., Eds., (1996) *Opportunities for Excellence: Supporting the Frontline Workforce*. President's Committee on Mental Retardation.

Johnson, K. (1998) Deinstitutionalizing Women: An Ethnographic Study of Institutional Closure. Cambridge: Cambridge University Press.

Juravich, T. (2002) [1985] "Women on the Line" in A. Wharton, ed., Working in America. Boston: McGraw Hill.

Karp, I. and Kendall, M. (1982) "Reflexivity in Field Work" in P. Secord, ed., Explaining Human Behavior: Consciousness, Human Action and Social Structure. London: Sage.

Katz, S. (2000) "Busy Bodies: Activity, Aging, and the Management of Everyday Life." *Journal of Aging Studies.* 14:2.

Kickbush, I. (1989) "Self-Care in Health Promotion." *Social Science and Medicine.* 29:2, 125-130.

Kielhofner, G. (1983) "'Teaching' Retarded Adults: Paradoxical Effects of a Pedagogical Enterprise. *Urban Life.* 12:3, 307-326.

Kliewer, C. and Drake, S. (1998) "Disability, Eugenics and the Current Ideology of Segregation: a modern tale." *Disability and Society.* 13:1, 95-111.

Kusterer, K. (1978) Workplace Knowhow: The important working knowledge of unskilled workers. Boulder: Westview Press.

Langness, L.L. and Levine, H.S., eds. (1986) Culture and Retardation: Life Histories of Mildly Mentally Retarded Persons in American Society. Dordrecht: D. Reidel.

Lasch, C. (1979) The Culture of Narcissism: American Life in an Age of Diminishing Expectations. New York: Warner Books.

Latour, B. (1983) "Give me a Laboratory and I will Raise the World" in K. Knorr-Cetina and M.
Mulkay, eds., Science Observed: Perspectives on the Social Study of Science. London: Sage Publications.

Latour, B. (1986a) "The powers of association" in J. Law, ed., Power, Action and Belief: A New Sociology of Knowledge? London: Routledge & Kegan Paul.

Latour, Bruno (1986b) "Visualization and Cognition: Thinking with Eyes and Hands." *Knowledge and Society: Studies in the Sociology of Culture Past and Present.* 6, 1-40.

Lave, J. (1986) "The values of quantification" in J. Law, ed., Power, Action and Belief: A New Sociology of Knowledge? London: Routledge & Kegan Paul.

Law, J. (1986a) "Power/Knowledge and the dissolution of the sociology of knowledge" in J. Law, ed., Power, Action and Belief: A New Sociology of Knowledge? London: Routledge & Kegan Paul.

Law, J. (1986b) "On the Methods of long-distance control: vessels, navigation and the Portuguese route to India" in J. Law, ed., Power, Action and Belief: A New Sociology of Knowledge? London: Routledge & Kegan Paul.

Law, J. (1987) "Technology and Heterogeneous Engineering: The Case of Portuguese Expansion"in W. Bijker, T. Hughes, and T. Pinch, eds., The Social Construction of Technological Systems: New Directions in the Sociology and History of Technology. Cambridge: The MIT Press.

Light, P. (2002) *The Troubled State of the Federal Public Service.* Washington, DC: The Brookings Institution.

Linton, Simi (1998) Claiming Disability, Knowledge and Identity. New York: New York University Press.

Lipsky, M. (1979) Street-Level Bureaucracy: Dilemmas of the Individual in Public Services. New York: Russell Sage Foundation.

Livingston, E. (1987) Making Sense of Ethnomethodology. New York: Routledge and Kegan Paul.

Lynch, M., Livingston, and Garfinkel, H. (1983) "Temporal Order in Work Laboratory Work" in
in K. Knorr-Cetina and M. Mulkay, eds., Science Observed: Perspectives on the Social Study of Science. London: Sage Publications.

Lynch, M. (1993) Scientific Practice and Ordinary Action: Ethnomethodology and social studies of Science. Cambridge: Cambridge University Press.

Lynch, M. (1985) Art and artifact in laboratory science: A study of shop work and shop talk in a research laboratory. London: Routledge and Kegan Paul.

Lynch. M. (1983) "Accommodation Practices: Vernacular Treatments of Madness." *Social Problems.* 31:2, 152-164.

Mauss, M. (1939) "A Category of the Human Mind: the notion of person; the notion of self" in M. Carrithers, S. Collins and S. Lukes, eds., The Category of the Person. Cambridge: Cambridge University Press.

Mauss, M. (1979) [1950] "The Notion of Body Techniques, Classification of Body Techniques, Biographical List of Body Techniques, General Considerations" in Sociology and Psychology: Essays. London: Routledge & Kegan Paul.

Maynard, D. and Clayman, S. (1991) "The Diversity of Ethnomethodology." *Annual Review of Sociology.* 17:385-418.

McCallum, D. (1998) "Dangerous Individuals: Government and the Concept of Personality" in M. Dean and B. Hindess, eds., Governing Australia: Studies in Contemporary Rationalities of Government. Cambridge: Cambridge University Press.

McKnight, J. (1980) "A Nation of Clients?" *Public Welfare.* Fall:15-19.

McQueen, D. (1989) "Thoughts on the Ideological Origins of Health Promotion." *Health Promotion.* 4:4, 339-342.

McLeary, R. (1977) "How Parole Officers Use Records." *Social Problems.* 24:5, 576-589.

Meehan, A. (1993) "Internal police records and the control of juveniles: politics and policing in a suburban town." *The British Journal of Criminology.* 33:504-24.

Mercer, J. (1973) Labeling the Mentally Retarded: Clinical and Social Systems Perspectives on Mental Retardation. Berkeley: University of California Press.

Merton, R. (1957) Social Theory and Social Structure. Glencoe: The Free Press.

Mesch, G. and Fishman, G. (1999) "Entering the system: ethnic differences in closing juvenile criminal files in Israel." *Journal of Research in Crime and Delinquency.* 36:2, 175-93.

Mitchell, J. (1984) "Case Studies" in R.F. Ellen, ed, Ethnographic Research. London: Academic Press.

Mitchell, J. (1983) "Case and Situation Analysis." *The Sociological Review.* May:187-211.

Miller, P. (1987) Domination and Power. London: Routledge and Kegan Paul.

Miller, P. and Rose, N. (1990) "Governing economic life" in *Economy and Society*. 19:1, 1-31.

Monnickendam, M., Yaniv, H. and Geva, N. (1994) "Practitioners and the case record: patterns of use." *Administration in Social Work*. 18:4, 73-87.

Morawski, J.G. (1994) Practicing Feminisms, Reconstructing Psychology: Notes on a Liminal Science. Ann Arbor: University of Michigan Press.

Morawski, J.G. (1988) "Impossible Experiments and Practical Reconstructions: The Social Bases of Psychologists' Work" in J.G. Morawski, ed., The Rise of Experimentation in American Psychology. New Haven: Yale University Press.

Morawski, J.G. (1988) "Introduction" in J.G. Morawski, ed., The Rise of Experimentation in American Psychology. New Haven: Yale University Press.

Myers, F., Ager, A., Kerr, P. and Myles, S. (1998) "Outside Looking In? Studies of the Community Integration of People with Learning Disabilities." *Disability and Society*. 13:3, 389-413.

Nettleton, S. (1997) "Governing the Risky Self: how to become healthy, wealthy and wise" in A. Petersen and R. Bunton, eds., Foucault, Health and Medicine. London: Routledge.

Nirje, B. (1969) "The Normalization Principle and its Human Management Implications" in Changing Patterns in Residential Services for the Mentally Retarded. Washington DC: Presidential Commission on Mental Retardation.

Oliver, M. (1996) Understanding Disability: From Theory to Practice. London: Macmillan.

Osborne, T. (1993) "On liberalism, neo-liberalism and the 'liberal profession' of medicine." *Economy and Society*. 26:4, 345-356.

Parsons, T. (1951) The Social System. New York: The Free Press.

Parton, N. (1994) "'Problematics of Government', (Post) Modernity and Social Work." *British Journal of Social Work*. 24, 9-32.

Perrow, C. (1986) Complex Organizations: A Critical Essay, 3rd Edition. Glenview, IL: Scott-Foresman.

Perrow, C. (1967) "A Framework for the Comparative Analysis of Organization." *American Sociological Review*. 32:2, 194-208.

Pollner, M. and Goode, D. (1990) "Ethnomethodology and Person-Centering Practices." *Person Centered Review*. 5:2, 203-220.

Postman, N. (1982) The Disappearance of Childhood. New York: Vintage Books.

Power, M. (1997) The Audit Society: Rituals of Verification. Oxford: Oxford University Press.

Prior, L. (1988) "The architecture of the hospital: a study of spatial organization and medical knowledge." *The British Journal of Sociology*. Vol. 1, 86-113.

Procacci, G. (1978) "Social economy and the government of poverty." *Ideology and Consciousness*. 4:55-72.

Prottas, J. (1979) People-Processing: The Street-Level Bureaucrat in Public Service Bureaucracies. Lexington, MA: Lexington Books.

Radford, J. (1994) "Intellectual Disability and the Heritage of Modernity" in Disability is not measles: New research paradigms in disability. North York, Ontario: Roeher Institute.

Rapley, M., Kiernan, P. and Antaki, C. (1998) "Invisible to Themselves or Negotiating Identity? The Interactional Management of 'Being Intellectually Disabled.'" *Disability & Society*. 13:5, 807-827.

Rhoades, C. (1986) "Different Organizational Models for Self-Help Advocacy Groups that Serve People with Developmental Disabilities." *Journal of Rehabilitation*. Fall.

Robillard, A. (1999) Meaning of A Disability: The Lived Experience of Paralysis. Philadelphia: Temple University Press.

Rose, N. (1999) Powers of Freedom: Reframing Political Thought. Cambridge: Cambridge University Press.

Rose, N. (1999b) [1989] Governing the Soul: The Shaping of the Private Self. London: Free Association Books. Second edition.

Rose, N. (1998) "Governing Risky Individuals: The Role of Psychiatry in New Regimes of Control." *Psychiatry, Psychology and Law*. 5:2, 177-195.

Rose, N. (1996a) Inventing Our Selves: Psychology, Power and Personhood. Cambridge: Cambridge University Press.

Rose, N. (1996b) "Psychiatry as a Political Science: advanced liberalism and the administration of risk." *History of the Human Sciences*. 9:2, 1-23.

Rose, N. (1994) "Expertise and the Government of Conduct." *Studies in Law, Politics, and Society*. 14, 359-397.

Rose, N. (1985) The Psychological Complex: Psychology, Politics and Society in England 1869-1939. London: Routledge and Kegan Paul.

Rose-Ackerman, S. (1999) "Mental Retardation and Society: The Ethics and Politics of Normalization." *Ethics*. 93:1, 81-101.

Ross, R.T. et al. (1985) Lives of the Mentally Retarded: A Forty Year Follow-Up Study. Palo Alto: Stanford.

Rothman, D. (1971) The Discovery of the Asylum: Social Order and Disorder in the New Republic. Glenview, IL: Scott, Foresman.

Rothman, D. J. and S.M. Rothman (1984) The Willowbrook Wars. New York: Harper and Row.

Sacks, H. (1992a) Lectures on Conversation, Vol. 1, edited by G. Jefferson. Oxford: Blackwell.

Sacks, H. (1992b) Lectures on Conversation, Vol. 2, edited by G. Jefferson. Oxford: Blackwell.

Sacks, H. (1987) "On the preferences for agreement and contiguity in sequences in conversation" in G. Button and J. Lee, eds., Talk and Social Organization. Cambridge: Cambridge University Press.

Sacks, H. (1975) "Everyone has to lie" in M. Sanches and B.G. Blount, eds., Sociocultural Dimensions of Language Use. New York: Academic Press.

Sacks, H. (1972) "On the analyzability of stories by children." in J. Gumperz and D. Hymes, eds., Directions in Sociolinguistics. New York: Holt, Rinehart and Winston.

Sacks, H., E. Schegloff and G. Jefferson (1974) "A simplest systematics for the organization of turn-taking in conversation." *Language*. 50:4, 696-735.

Schegloff, E. and H. Sacks (1974) "Opening up Closings" in R. Turn, ed., Ethnomethodology. Harmondsworth: Penguin.

Schegloff, E. (1982) "Discourse as an interactional accomplishment: some uses of 'uh-huh' and other things that come between sentences" in D. Tannen, ed., Analyzing Discourse: Text and Talk. Washington, DC: Georgetown University Press.

Schegloff, E. (1987) "Between Macro and Micro: Contexts and Other Connections" in J. Alexander, B. Giesen, R. Munch, and N. Smelser, eds., The Micro-Macro. Berkeley: University of California Press.

Schutz, A. (1970) On Phenomenology and Social Relations Chicago: University of Chicago Press.

Scott, W. (1992) *Organizations: Rational Natural and Open Systems, 3rd Edition.* Englewood-Cliffs, NJ: Prentice-Hall.

Selznick, P. (1948) "Foundations of the Theory of Organizations." *American Sociological Review.* 13:25-35.

Siperstein, G. (1992) "Social Competence: An Important Construct in Mental Retardation." *Mental Retardation.* 96:4, iii-vi.

Silverman, David (1998) Harvey Sacks: Social Science and Conversation Analysis. Oxford: Oxford University Press.

Simpson, M. (1998) "Just Say 'No'? Alcohol and People with Learning Difficulties." *Disability and Society.* 13:4, 541-555.

Simpson, M. (1996) "*Normalization* and the psychology of 'mental retardation.'" *The Sociological Review.* 44:1, 99-118.

Simpson, M. (1995) "The Sociology of 'Competence' in Learning Disability Services." *Social Work and Social Sciences Review.* 6:2, 1995-96, 85-97.

Smandych, R. (1999) Governable Places: Readings on governmentality and crime control. Aldershot: Dartmouth Publishing.

Smith, D. (1990) Texts, Facts and Femininity: Exploring the Relations of Ruling. London: Routledge.

Smith, D. (1978) "K is mentally ill: the anatomy of a factual account." *Sociology.* 12:1, 25-53.

Star, S. (1983) "Simplification in scientific work: an example from neuroscience research." *Social Studies of Science.* 13:205-228.

Stockholder, F. (1994) "Naming and Renaming Persons with Intellectual Disabilities" in Disability is not measles: New research paradigms in disability. North York, Ontario: Roeher Institute.

Stone, D.A. (1984) The Disabled State. Philadelphia: Temple University Press.

Stroman, D. (1989) Mental Retardation in Context. Lanham, MD: University Press of America.

Taylor, S. (2001) "The continuum and current controversies in the USA." *Journal of Intellectual and Developmental Disability.* 26:1, 15-33.

Taylor, S. (2000) "You're Not a Retard, You're Just Wise." Disability, Social Identity and Family Networks." *Journal of Contemporary Ethnography.* 29:1, 58-92.

Taylor, S., Bogdan, R. and Z. Lutfiyya (1995) Eds., The Variety of Community Experience: Qualitative Studies of Family and Community Integration. Baltimore: Paul H. Brookes.

Thomas, D. (1982) The Experience of Handicap. London: Methuen.

Traweek, S. (1988) Beamtimes and Lifetimes: The World of High Energy Physics. Cambridge: Harvard University Press.

Treece, A., Gregory, S. Ayres, B. and Mendis, K. (1999) "'I Always Do What They Tell Me To Do': choice-making opportunities in the lives of two older persons with severe learning difficulties living in a community setting" *Disability & Society.* 14:6, 791-804

Trent, J. W., Jr. (1994) Inventing the Feeble Mind: A History of Mental Retardation in the United States. Berkeley: University of California Press.

Valverde, M. (1998) Diseases of the Will: Alcohol and the Dilemmas of Freedom. Cambridge: Cambridge University Press.

Van Velsen, J. (1967) "The Extended-case Method and Situational Analysis" in A.L Epstein The Craft of Social Anthropology. London: Tavistock.

Waksler, F. (1991) "Dancing when the music is over: A Study of Deviance in a Kindergarten Classroom" in F. Waksler, ed., Studying the Social Worlds of Children. London: Falmer Press.

Watson, R. (1992) "Introduction" in Text in Context: Contributions to Ethnomethodology. New York: Sage Publications.

Wehmeyer, M. and Schwartz, M. (1998) "The Relationship between Self-Determination and Quality of Life for Adults with Mental Retardation." *Education and Training in Mental Retardation and Developmental Disabilities.* 33:1, 3-12.

Weiss, M. (1997) "For Doctors' Eyes Only: Medical Records in Two Israeli Hospitals." *Culture, Medicine and Psychiatry.* 21:3, 283-302.

Wheeler, S., ed., (1969) On Record: Files and Dossiers in American Life. New York: Russell Sage Foundation.

Wieder, D. (1974) Language and Social Reality: The Case of Telling the Convict Code. The Hague: Mouton.

Wing, L. (1989) Hospital Closure and the Resettlement of Residents. Aldershot, UK: Avebury.

Wolfensberger, W. (1995) "Social Role Valorization Is Too Conservative. No, it is too radical." *Disability & Society.* 10:3, 365-368.

Wolfensberger, W. (1989) "Human Service Policies: The Rhetoric Versus The Reality" in L. Barton, ed., Disability and Dependency. London: Falmer Press.

Wolfensberger, W. (1969) "The Origin and Nature of Our Institutional Models" in R. Kugel and A. Shearer, eds., Changing Patterns of Residential Services for Persons with Mental Retardation. Washington, DC: President's Committee on Mental Retardation.

Wolfensberger, W. (1972) Normalization: The principle of normalization in human services. Washington, DC: National Institute of Mental Retardation.

Woodill, G. (1994) "The Social Semiotics of Disability" in Disability is not measles: New research paradigms in disability. North York, Ontario: Roeher Institute.

Wrigley, J. (1989) "Do Young Children Need Intellectual Stimulation? Experts' Advice to Parents, 1900-1985." *History of Education Quarterly.* 29:1, 41-75.

Yates, J. (1989) Control through communication : the rise of system in American management. Baltimore : Johns Hopkins University Press.

Yeatman, A. (2000) "Who Is the Subject of Human Rights?" *American Behavioral Scientist.* 43:9, 1498-1513.

Yeatman, A. (1998) "Interpreting Contemporary Contractualism" in M. Dean and B. Hindess, eds., Governing Australia: Studies in Contemporary Rationalities of Government. Cambridge: Cambridge University Press.

Young, D. and Quibell, R. (2000) "Why Rights are Never Enough: rights, intellectual disability and understanding." *Disability and Society.* 15:5, 747-764.

Zimmer, L. and Jacobs, J. (1992) "The business of drug testing: technological innovation and social control." *Contemporary Drug Problems.* Spring.

Zimmerman, D. (1969a) "Tasks and Troubles: The Practical Bases of Work Activities in a Public Assistance Organization" in D. Hansen, ed., Explorations in Sociology and Counseling. New York: Houghton-Mifflin.

Zimmerman, D. (1969b) "Record-Keeping and the Intake Process at a Public Welfare Agency" in On Record: Files and Dossiers in American Life. New York: Russell Sage Foundation.

Zola, I. (1983) Sociomedical Inquiries. Philadelphia: Temple University Press.

Zuboff, S. (1988) In the Age of Smart Machines: The Future of Work and Power. New York: Basic Books.