Chapter Eleven

DISCOURSE ANALYSIS: BEYOND FREUD

Ever since Freud, the question has arisen of how a discourse
should be understood. How do we interpret discourse? What
can be assumed and what are the bounds on derived meaning?
The fragmented nature of normal discourse is presented. Then,
four modes of interpretation of patients' speech are offered
along with a discussion of elicitation and its effect on speech.
This includes such matters as resistance to therapy.


The stunning force of Freudian interpretation burst upon the 20th
century revolutionizing our perception of human behavior. Ulti­
mately, it affected psychiatry, psychology, literature, the graphic arts,
and, eventually, society itself by forcing reexamination of family structure,
including the child's obligations to the parent and the blaming of the
parent for the child's insecurities, obsessions, and transgressions. All of
this occurred because of Freud's mode of interpretation of discourse.

It is not too much to say, for instance, that Bateson's double bind
theory could not have been formulated without a prior belief in Freud­
ian analysis, nor, of course, would we have the interpretive methodologies
of Harry Stack Sullivan, Harold Searle, Silvano Arieti, Ernest Jones,1 or
the now popular Lacan. All such interpreters depend upon the basic
Freudian assumption that language at no level necessarily means what it
says. Interpretation derives not from the actual words and grammar as
used by nonpsychotic patients, but from reference to beliefs about Oedi­
pal bonds, castration fears, homosexual panic, and even paranoia induced
by feelings of inadequacy. Lacan roots his interpretations in the linguistics of de Saussure, but still employs a Freudian model of the uncon­
scious to which the psychiatrist is supposed to be talking. He envisions a
dialogue between the Other, the analyst, and the Other, the patient's
subconscious (Holloway 1977, 1978; Haskell 1978). Psychosis is believed
to stem from avoidance of intolerable feelings.
Analysts differ considerably in their treatment of schizophrenia, ranging from Rosen’s belief in uncovering “vivid and shocking interpretations of a primarily oedipal nature,... [he] bypass[es] the ego and... communicate[s] with the unconscious id material” (pp. 149–150). Analysts were trained by other highly respected senior analysts, so to speak, who offered interpretations of the patient’s speech based upon his or her view of what caused the neurotic or psychotic illness. Although all such analysis emanated from Freudian theory, individual analysts departed from this theory to a greater or lesser degree (Hallowell and Smith 1983).

One issue has been the mode of analysis to follow in treating schizophrenics. Analysts perceive themselves as teachers and their mode of analysis is aimed at teaching the patient to cope. Hallowell and Smith (1983, pp. 149–156) summarize some of these methods and the rationale behind them. Some analysts believe that their task is to restore defective ego boundaries. This resulted in an “intrusive, even persecutory style [of analysis] (p. 150). Others believe in entering the patient’s psychotic world and then by building trust, help the patients to reintegrate themselves into the world left behind by the psychosis.

The relative validity of any and all of these beliefs about therapy is not the issue here. The issue here is solely the differences in orientation of various analysts and analyzers of discourse, because these lead to very different kinds of interpretations of what a patient has said. It is the relationship between analysis and theoretical positions that have to be examined. We have already seen that interpretation is based upon various strategies, and that these strategies include our ascribing intention to the speaker. We also consider mutual histories of interactors. The influence of theory and of being in a therapeutic setting, then, are important determinants in analysis.

All Freudian or post-Freudian theories rest upon a view of the dynamics of mind and speech that cannot be verified by overt observation or by experimentation. One either believes them or one does not. This doesn’t mean that they are valid or not valid. It is just that they are not provable by the usual scientific procedures. There is no way to disprove Freud or his followers, including Lacan, but there is no way to prove that they are correct either. Ultimately, one believes or not according to one’s intuitive sense that psychoanalysis strikes a responsive chord. Those who do not intuit this may be, as the analysts claim, simply denying what is true, burying it, even perhaps resisting treatment.

Linguistics itself did not offer many guides to interpreting even nor-
mal discourse to Freud or his contemporaries. In fact, psychoanalysis predated linguistics by decades in realizing that language must have some kind of deep structure as well as surface forms. Psychoanalysis also predated linguistics by decades in realizing that the encoding of a message is dictated partly by the speaker’s intent, and the meaning a hearer derives depends on the intent that he or she ascribes to the speaker in formulating that message. Until relatively recently, linguists rested semantics upon the flimsy undergirding of sentence grammars and the doctrines of separation of linguistic levels, and that was when meaning was considered at all.

Under the aegis of philosophers of language like Austin and Searle and linguists themselves like Lyons, Fillmore, and Halliday, the context-sensitive view of language finally offered some alternate procedures for analysis. We can make a case nowadays that matters of justifiable interpretation, even of metaphor, seem to be bounded by rules and strategies, so that we are justified in speaking of the grammar of the discourse. It is time to reexamine Freudian inspired modes of psychoanalytic interpretation in the light of our new understandings, not with the view of invalidating psychoanalysis, but to enhance its insights by providing a firmer base upon which to ground interpretations, and, in some cases, to provide alternate interpretations.


Psychiatry and its sister disciplines generally downplay the public and social nature of language. Rather, language is treated as a private system which each person can and does use pretty much as he or she wishes. Typically, meaning of a discourse is taken to be holistic with little or no attempt to justify it on the basis of actual syntax or lexicon used. Meaning is assigned to the discourse as a whole according to the analyst’s perception of the patient’s intent; thus, discourse is taken as a strategy, a cryptic rendering of a person’s real, hidden meaning. Imaginative exegesis, as in literary analysis, is admired, and certain analysts, such as Freud or Searles, are often used as guides to interpretation of given utterances because of their acknowledged superior ability to see into the true meaning of discourses. The Seeman and Cole analysis of Carrie’s speech, presented below, is an example.

Linguistics also acknowledges that each person’s language is, to some degree, unique. It has long been said that, ultimately, we each speak an
idiolect, as well as a dialect of a language. However, the idiolect arises because individuals may have learned a few rules of language somewhat differently from others, and because words and even syntax can change over a person's lifetime. Still, idiolectal variation refers to language being used to convey messages to others. For instance, several of my students say and write "concern to" rather than "concern with." This use of to seems to be spreading virtually person by person and students even from the same region differ, some keeping the older with, and some not. At this point in time, we can only say that there is idiolectal variation of the particle used with the verb concern.

We must not assume that the flow of linguistic understanding always proceeds from linguistics to psychiatry. Sometimes the reverse is true. Long after psychiatry, for instance, linguistics has finally begun to consider the roles of motivation and presupposition in meaning, as well as implication derived from both roles.

Still, there are definable differences in orientation between psychoanalytical and linguistic analyses of discourse. It bears repeating that linguistic analyses proceed from actual words combined with actual syntax, and their relation to social context. Implicitly or explicitly, utterances are judged as normal or deviant, idiolectal or dialectal. Linguists are primarily concerned with uncovering regular rules and strategies for conveying meaning; why, for instance, "It's cold in here" may be construed as a command to close a window, or "You live on 56th Street" may be heard as a question (e.g., Ervin-Tripp 1972; Labov and Fanshel 1977; Goody 1978). Such a concern with rules and strategies entails another assumption, that we are all using language, or trying to, in pretty much the same ways (e.g., Searle 1975, pp. 63, 73; Austin 1962; Lyons 1977, p. 735.) Problems naturally arise when language is clearly not being used correctly, when it deviates from linguistic norms. Such speech often cannot be understood by usual decoding strategies. Typically, linguists have treated such error by comparing it to normal production, assuming that the speaker intended to use language so that it could be understood, but that normal production processes have been disrupted (e.g., Fromkin 1973; Clark and Clark, 1977, pp. 211-215; Buckingham and Kertesz 1974; Chaika 1974a, 1977). In such instances, extraordinary measures are employed to gain understanding, but these are based upon normal decoding practices.

Four separate discourses will be presented here, each resulting from data collected in different ways and upon different assumptions, and
each interpreting those data according to somewhat different constructs. The first is based upon poetry as a mode of communication between therapist and patient (Hallowell and Smith 1983). The second, Labov and Fanshel (1977), analyzed five therapeutic episodes between a therapist and her patient in the light of strategies of ordinary conversation, developing what they call a **principled elaboration** of meaning.

In what is perhaps its most shaky premise, classic psychoanalysis guarantees that the analyst can never be successfully proven wrong. According to this theory, the more one denies that one meant what the therapist says one meant, the more one really meant it. For instance, if an analyst tells a woman that she is consumed by penis envy, the more she says she isn’t, the stronger her envy is presumed to be. Her denial constitutes proof of her neurosis. The same is true of the man who denies that he is consumed by Oedipal desires. As a concommitant of this premise, analysts speak of the period of resistance, a period of time during which the patient evinces resistance to the therapeutic situation. There is, undeniably, a period that can be called resistance, but I suspect that there are many reasons for resistance, and, in some instances, it is not real resistance at all.

We now examine interpretations of speech data from three patients. These data were elicited in three different ways: squiggles, an ordinary therapeutic interview, and unbounded conversation.

### Squiggles and Therapy.

Hallowell and Smith, being highly influenced by Arieti’s compassionate view of the psychotic’s unbearable sadness and loss, developed a mode of analysis in which they adapted a game of squiggles as a way of offering the patient the therapist’s ego as a bridge, but one which also allows the therapist to “enter the metaphor of the patient’s world.” The *squiggles* game consisted of the therapist or patient providing a verbal opener, and the other responding with a short line. Some of these rhymed, some did not, but the result in each instance presented formed a joint dialogue cast into poetic form, as in:

1A. Th.: They said I am a hopeless case  
    Pt.: Not I, a member of the human race, in disgrace  
    Th.: I wish they wouldn’t say that  
    Pt.: In a nonjoking way  
    Th.: It makes me
Pt.: Suspicious
Th.: And angry and sad
Pt.: Which aren't the strongest emotions I've had
Th.: The strongest are
Pt.: Composed of these
Th.: Combined into
Pt.: Something I don't want to feel
Th.: Something like
Pt.: Rage, but not quite
Th.: Also like
Pt.: An intense feeling

The patient's rhyming here is controlled, fits the meaning of the entire squiggle. This patient had unusual facility with language, writing superb poetry. He fits the pattern of the negative symptom psychotic, speaking little. He presented poems both on the day of admission and the next day, but did not talk (Edward Hallowell, personal communication). What is noteworthy about these squiggles is that they provide a structured enough frame so that a dialogue can proceed without the patient's becoming derailed. The therapist is able to constrain the topic, and, at the same time, to allow the patient free expression. This constituted an opening for therapy itself “... the more personal, affective part of it, especially in the beginning, was contained in the squiggles” (Hallowell and Smith 1983, p. 143). Hallowell's skill in presenting the right kinds of openers for the patient himself must not be overlooked.

Hallowell and Smith do not give any extraordinary interpretations of what the patient has said in these squiggles. They take 1A as a straightforward expression of his feelings. Similarly, he expresses his need to cut off feeling, in

1B. Pt.: Nothing lasts forever
Th.: No one lives that long
Pt.: Not on earth
Th.: Sometimes I want to get away
Pt.: Into the body of a robot
Th.: No feelings there. Just safe steel
Pt.: No way to get hurt or die
Th.: Sometimes I want to die
Pt.: To live in heaven forever
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Th.: Where people stay with you
Pt.: And never leave
Th.: Leave, leave, leave
Pt.: I wish my feelings would leave sometimes
Th.: But they stay
Pt.: And haunt

(pp. 143–144)

The degree to which squiggles could be applied to all patients has not been determined, but, given the results in this case, it certainly seems promising.


In Chapter 5 we saw that Forrest interpreted the following as being a metaphorical way to express what it is like to be schizophrenic:

2. Doctor, I have pains in my chest and hope and wonder if my box is broken and heart is beaten... (Maher 1968 cited in Forrest 1986)

Forrest believes that all language is metaphor (1976, p. 296), that schizophrenic speech is especially poetic and that associational chaining is a way of affirming the “right of choice which exists in thought and language,” of “look [ing] for extra connections in words... to firm up the connection between ideas we feel are related” (Forrest 1965).

Such an explanation ignores the fact that normal speakers do not firm up connections between ideas by uttering glossomanic chains. Rather, the many modes of effecting cohesion firm up those connections as do the ways that sentences are made to fit to a topic.

Another example of chaining, here a response to a question, is here reprised:

   Hay day. Help! I just can't. Need help. May day. (Cohen 1978, p. 29)

As explained earlier, several patients named the disc in question as being either clay-colored or salmon-colored. Cohen, a psychologist oriented towards behaviorism, explains chaining responses as in 3 as resulting from “anticipation of social punishment contingent upon the emission of a sampled response (1978, p. 21). He says that schizophrenics cannot effectively reject punishable responses to referents, they... break the perseverative cycle by shifting to different referents. One way to do
this is via chaining.” He admits that “ultimately” their responses become “remote from the original referents and from the listener’s standpoint, seriously tangential to the conversational context.” Given such an explanation for the cause of schizophrenic speech, there is, of course, no reason to search for meaning in sequences of chaining, and, indeed, Cohen does not.

In terms of behavioral theory, however, it is puzzling how the chaining can proceed from a need to avoid punishment, since the first sentence is the most correct, and, indeed, the only correct one. It is the phenomenon of chaining itself which is incorrect. Furthermore, as Cohen himself admits, the chaining always moves further away from a correct response. Hence, according to behavioral psychology, no chaining should ever occur because it leads to the very punishment that Cohen says the patient is trying to avoid by chaining.

Also, Cohen’s explanation rests upon a belief that the patient has actively chosen this means to avoid punishment. Since other examples of chaining do appear in the literature, and appear as examples of speech especially pathognomonic of schizophrenia, his explanation assumes that schizophrenics as a group are very likely to choose this behavior for avoiding punishment.

The problem is that the chaining is bizarre precisely because there seems to be no normal speech behavior like it. Certainly, this is not the kind of speech behavior one calls upon to avoid punishment. Thus there is no possibility it has been learned, except, perhaps those unfortunates who have been hospitalized for long periods with SD schizophrenics. Cohen offers no proof that his patients have “learned” to speak this way. Although I have heard anecdotal evidence that some psychotics have learned to “speak schizophrenic” as a result of hospitalization, I have yet to find hard data to support such a possibility. Even if someone does present such data, it would still beg the question of why only schizophrenics seem to speak this way whether through learning from other schizophrenics or from internal speech difficulties.

If it were an isolated instance, or if it were reported only of members of one social group, however defined, we can explain it as a learned response. Rather, it is reported only of schizophrenics, and of schizophrenics who come from all social classes and nations, and who speak a great many different languages. Since there is no evidence that it is or even can be learned, the natural assumption is that it is caused by the disease. This conclusion is bolstered by the fact that schizophrenics
typically create glossomanic chains only when they are being schizophrenic. If they chain deliberately to avoid punishment, why don't they do this when they are in remission? It seems to me that the schizophrenic condition itself is responsible for the chaining.


Labov and Fanshel (1977) provide an exceptionally detailed and perceptive analysis of a therapeutic situation involving a girl named Rhoda, an anorexic in conflict with her mother. The mother is a clever manipulator of discourse and Rhoda has to learn to deal with her by some means other than starving herself to death. In the segment described here, the mother has left Rhoda to take care of their shared home while she, the mother, is taking care of Rhoda's sister's children, staying away too long, thus interfering with Rhoda's schooling. Rhoda cannot cope, but to admit this overtly to her mother would be yielding to her mother's opinion that Rhoda is not capable, an opinion fatal to Rhoda's desire to prove her worth by proving she can cope. This power struggle between Rhoda and her mother is complicated by Rhoda's anorexia. It is this last which is being directly treated, with the therapist trying to allow Rhoda to see that her refusal to eat is, indeed, a power play.

Labov and Fanshel (1977, p. 53) demonstrate that one of the specific characteristics of the therapeutic situation is that both patient and therapist are presumably working towards making explicit those propositions which underly the problem leading to the therapy. As we have seen, in any situation, part of the meaning derived comes from the personal history of the interactors. Labov and Fanshel, Kreckel (1981), and Sanders (1987) all stress the relationship between the richness and accuracy of interpretations and extensive mutual interaction. Labov and Fanshel (1977, pp. 351–352) stress that one cannot interpret individual texts by themselves, noting that they collected many conversations in which one interpretation seemed correct, but that somebody who knew the interactors better than they was able to show that it was not. For example, a seminar was shown a video of a married couple conversing. At one point, the wife remarked that blood was thicker than water, whereupon the husband turned his head away. The members of the seminar assumed that the husband was angry because the wife had implied that her relatives were more important than he. One viewer knew the parties in question, however; consequently, he was able to give quite a different interpretation of this scene. Knowing
the family dynamics, he demonstrated that the wife was complimenting the husband, indicating that he was as much blood to her family as she was because he shared her concern for them. When the husband turned away, far from being in anger, he was being modest, turning aside when complimented.


As a working guide towards establishing what a given patient is referring to, Labov and Fanshel isolated potential conflicts between Rhoda and her mother. They operated under the assumption that anorexics stop eating as a way of defying authority, in this instance, the mother. As they emphasize, nobody knows how to make someone eat if they don't want to. Whether or not all anorexics become that way as a defiance of authority, such as may be embodied in a mother, I do not know, but that Rhoda had a severe problem dealing with her mother is undeniable. As the section shows, one evidence of that is her strategies for mitigating requests to her mother.

Labov and Fanshel isolated several topics that Rhoda refers to which clearly are causing conflict. One way one can tell that these are central to Rhoda's conflict is her direct mention accompanied with the implied request for approval,

4. I don't . . . know, whether . . . I—i think I did—the right thing, jistalittle situation came up. . . . an' I tried to uhm. . . well, try to . . . use what I—what I've learned here, see if it worked” (p. 363)

She goes on to explain that her mother, as in the past, has gone to her sister Phyllis's house to babysit, leaving Rhoda at home to care for the house, a task which Rhoda finds too difficult as she is also attending school. The opener, “I don't know whether I did the right thing,” means “did I do the right thing?” It is a way of asking for confirmation, otherwise why mention it at all, much less mention it with a disclaimer that shows doubt? She does understand clearly that the sessions are to teach her to deal more effectively with her mother.

Labov and Fanshel isolate several recurring propositions in Rhoda's therapeutic session, a partial list of which is (not their words):

- The patient should gain insight into his or her own emotions.
- One should express one's needs and emotions to relevant others.
- Rhoda's obligations are greater than her capacities.
- Rhoda is a student who has a primary responsibility to study.
Labov and Fanshel term these, respectively, the propositions of \{INSIGHT\}, \{S\}, \{STRN\}, and \{STUD-X\} (notation theirs). By isolating these propositions, they often can relate comments in the therapeutic interview to these, showing how frequently they are alluded to as well as justifying their interpretation of what she meant. For instance, 4 above refers to the propositions of \{INSIGHT\}, \{S\}, and \{STRN\} as the situation that came up was her mother's remaining at Phyllis's house too long, leaving Rhoda to cope at home and what Rhoda did was call her mother. She had the dual task of letting her mother know that the mother was shirking her responsibility and that Rhoda herself could not cope. What made this especially difficult is that Rhoda did not want to mention that she couldn't cope because part of the conflict with her mother was that the mother felt that Rhoda was not competent.

Clearly, the propositions become identified through a series of interviews Labov and Fanshel (1977, p. 149) insist that any abstract structures that the therapist claims should be equally available to a native speaker. What they are saying is that the strategies for interpretation in a clinical setting are not different from those in ordinary interactions. The difference is that, in daily interacting, much of what is said is evanescent, simply reacted to. Certainly, interactors do remember prior dealings with each other and judge others' motives or worth on that basis. In the therapeutic situation, participants ruminate on the entire history of the sessions themselves, correlating them with the patient's personal history and present situation as revealed in the course of therapy. Still, normal modes of analyzing speech are not abandoned even in psychotherapy.

These normal modes do include such matters as taking into account the ways that preconditions for making statements lead us to interpret. We have already seen that a statement will evoke a response of an answer to a question if the conditions for questioning are met. Labov and Fanshel demonstrate that elaboration of comments must be principled, verifiable by appeal to ordinary language behaviors. They provide detailed arguments for their interpretations and stress that to expand the full meaning of an utterance, including what was not overtly stated, one must draw upon the whole body of shared knowledge that can be recovered from all the therapeutic interviews. These should include conversations between the therapist and client. This, of course, mirrors the meaning that we get in ordinary daily interactions. If we presume different strategies in the therapeutic situation, we are in the strange position of asserting that once one retreats behind the therapist's door, all normal speech practices are subject to idiosyncratic change.
As we have seen, part of the meaning of any linguistic production is constrained by the intent or motive we attribute to the producer. Truly, the purpose of the therapeutic interview certainly helps determine the topics of conversation and what is made of them, but the strategies for understanding what is meant from what is said are quite ordinary. As we saw in Chapter 6, it is rarely appropriate for somebody to say absolutely everything he or she means. Because so much meaning is hinted at rather than directly encoded we usually have to expand on what is said to get the actual meaning. This expansion constitutes a derivation of meaning. As such, it includes the kinds of “filling-in” of omissions of repetitions already seen, knowledge of utterance pairs and other discourse devices, reference to topic at hand, all of the modes of inference we have seen, references to context, even kinesics and paralinguistics.

Labov and Fanshel maintain that expansion can be open-ended, but their own explanations remain quite close to the bone. If we confine our interpretation to what can be expanded from given utterances, we do find natural bounds. What does happen—and should—is that subsequent interviews might call for reinterpretation of previous ones. The important thing is that expansions derive from the ordinary meanings of what has been said, not from a preexisting theory of what someone must be meaning.


In traditional psychoanalysis, we frequently saw the antithesis of the give and take we call conversation. There was no negotiation of meaning. Rather, the therapist told the analysand what the latter meant. If the analysand objected or misunderstood, then he or she was considered to be in a stage of resistance. This ended when the analysand finally accepted the therapist’s interpretations and learned to utilize the same terminology as the analyst.

Labov and Fanshel (1977, pp. 34, 306) depict a patient as resisting therapy by denying the strength of her emotions as well as by not following the therapist’s advice. Thus, for instance, they assume that when Rhoda says she was bothered she was using a euphemism for the truth, that she was angry. They consider such euphemizing to be a mitigation of her real feelings, hence, to be a way of resisting therapy. This conclusion is reinforced because she precedes bothered by just, a further mitigator. The patient, Rhoda is being treated for anorexia, a result apparently of the power play between her and her mother.
They also claim that an even more extreme form of resistance is for a patient to resort to saying nothing at all, something which Rhoda also does at certain times, admitting that in a therapeutic situation, unlike ordinary conversations, the therapist is “... sometimes able to say more definitely what another person feels than that person can say himself.” This can be extremely threatening of course. Traditionally it has been assumed that the patient cannot yet admit the truth because his or her feelings would be too intolerably intense if he or she did. This is undeniable, but there may be other reasons for such resistance as well. The operative term here is as well. It seems to me that there can be several reasons for apparent resistance and that they may operate concurrently, serially, or singly.

It seems to me that an alternate reason that patients may resist is that they do not agree with the analyst’s interpretation of their feelings, feelings which patients certainly must know since only they can feel them. Labov and Fanshel (pp. 62–64) term these A-events, events known to the speaker but not necessarily to another. At times, a patient might refuse to talk because the analyst persists in attributing feelings that are A-events to the analysand. Then, the analysand, not being believed, simply doesn’t talk. Notice that this is not necessarily the cause of resistance. It is only possibly the cause. On the one hand, the analysand may be seen as simply not being ready for such truths, thereby resisting the analyst. On the other hand, the analyst may be wrong.

Labov and Fanshel (p. 36) also comment on the fact that psychoanalytic terms like

“interpretation,” “relationship,” “guilt,” “to present oneself,” “working relationship,” and so on

are used primarily by the analyst in this situation because the patient they are studying is not as “mature” as many analysands. This lends credence to a suspicion I have long harbored that some of what is called resistance is unfamiliarity with the discourse rules of the therapeutic interview.

Another possibility is that the patient has not yet learned the jargon of analysis. Clearly, one goal of analysis is to teach the analysand to label his or her feelings with the distancing terms of analysis. There is no a priori reason to label one’s relationship with one’s mother as a “working relationship” or to say of one’s persona that one “presents oneself as...” Language is eminently paraphrasable, as we have seen.
There are other ways that patients have to learn how to have therapy. Wooton (1975, p. 70) cites a good example

5. Patient: I'm a nurse but my husband won't let me work.
   Therapist: How old are you?
   Patient: Thirty-one this December.
   Therapist: What do you mean, he won't let you work?

Here, the patient answers the psychiatrist's first question as if it were bona fide, a real-world question. The psychiatrist was not really asking her age, however. He was trying to lead her to see that she should be making up her own mind, that she is old enough to do so. The patient did not yet realize that the goal of the therapist's questions are rarely factual information. Rather, they are intended to aid in a process of self-discovery.

In sum, resistance—or what appears to be resistance—is not necessarily a unitary phenomenon. The patient may not yet be able to handle the power of emotions that would surface if he or she admitted something, or the patient genuinely does not feel what the analyst says he or she should be feeling, the patient may be uneasy in the situation having been made to feel that he or she is a fool in prior sessions, or that the patient either hasn't yet figured out what the analytic jargon is or has not yet figured out the modus operandi of the therapeutic session.


The traditional explanation for resistance, that it would prove too painful for the patient if he or she got too close to the truth, is probably also valid. There are truths too painful for many of us to acknowledge even outside of the therapeutic situation. It is well-known that many social routines are couched in a mitigating fashion. For instance, rather than saying, “Shut the door!” to one of our colleagues, we would more likely couch the command as a request, even a pleading one, like “Please shut the door” or, “Would you please shut the door?” Similarly, language abounds in other kinds of mitigating words and phrases commonly used to soften assertions, such as “I may be wrong, but…”; “This might sound silly, but…”

Labov and Fanshel are very aware of mitigation used both in softening assertions, as above and in reporting one's feelings as well. They give an exceptionally apt example (p. 96) while demonstrating that a rule of
interaction could be called the “rule of overdue obligations.” This is alluded to whenever one reminds another of something that should or should not have been done. Therefore, Rhoda phones her mother and asks, “When do you plan to come home?” rather than, “When are you coming home?” If she had not used the word plan (p. 50), her question to her mother could have been taken as a challenge, meaning, in effect, “You belong at home and you’ve been staying at my sister’s long enough.” The word plan makes it sound as if the mother not only has full authority to do as she wishes, but that it is she, not Rhoda, who is determining the length of the stay (Labov and Fanshel p. 50, 96.) Not only has Rhoda avoided challenging her mother by mitigating with plan, but she has also downplayed her own need to have her mother home. That is, Rhoda tries to mitigate the fact that she cannot indeed cope without her mother.


The therapeutic situation does provide its own special contexts, including an uncovering of personal histories that do impinge on meaning. As we have seen, all utterances are abbreviations for meaning in that they assume certain cultural and personal shared knowledge, as well. The question arises of when extraordinary measures are justified in interpreting a discourse. Remember that only some schizophrenics display structurally abnormal speech, and of those, most use structurally normal speech when not in the throes of a schizophrenic bout. We are entitled to adopt extraordinary measures only when speech is clearly deviant in structure. Then exegesis must proceed on the basis of similarity of sentence structure to normal possible productions and only to the extent that such matchings can be made. If the speech is nondeviant in structure, then, in the absence of strong case history or contextual clues, it should be interpreted in the same way as a nonschizophrenic person’s would.

If the context simply does not fit what has been said, then one is justified in searching further for special meanings. If what is said is structurally abnormal, then one must try to compare it with the closest linguistic structure that seems to fit the situation. One can be guided by the voluminous research on the forms of slips of the tongue and speech produced by those with known injuries to the brain. If it still cannot be understood, we must admit simply that we don’t know what the subject was trying to say. If the utterance appears to be structurally normal, but is highly obscure, we might still suspect disruption in communicative
ability, including such problems as lapses in the ability to monitor another's reactions, to paraphrase what one has just said so that the hearer can understand, or to judge what is necessary to provide in order to allow the co-conversationalist to hone in on what one is trying to communicate. None of these skills in inconsiderable, and all are requisite to successful comprehension.

As an illustration of the above points, it is fruitful to consider a virtually classic case of psychoanalytical interpretation, in this instance guided by the tenets of Harold Searles. This particular case was chosen for illustration because the authors of the study discussed below, Mary Seeman and Howard Cole (1977), were unusually explicit in delineating why they interpreted as they did (Chaika 1981). They presented the discourse of Carrie, a twenty-nine-year-old diagnosed schizophrenic, along with their gloss of that discourse. It must be emphasized that their interpretations are quite solidly in the tradition in which they were trained and, within that tradition, their analysis was both sensitive and sound.

It must be emphasized that, at the time of Seeman and Cole's investigation, there was little reason to delve into the linguistic literature on discourse analysis. With the exception of Labov and Fanshel's groundbreaking study which was published the same year as Seeman and Cole's, the linguistic literature was largely hobbled by sentence grammars. Discourse considerations were still being labeled pragmatics. Linguistics at that point was just beginning to show its efficacy and relevance to psychiatric research. There are psychiatrists and clinical psychologists who still doubt the value of an interloping researcher from the field of linguistics. If nothing else, however, the comparison presented here at least shows how far one's assumptions can take one in what one comprehends.

Seeman and Cole's (1977) analysis was chosen because the authors were unusually explicit in showing exactly what they were interpreting, how they interpreted it, and why. Also, felicitously, they provided comparative data which examined the speech of one patient produced under the same conditions within the same experimental context. This provided a sharpness of focus so that the central issue of how a discourse should be interpreted would not be lost.

They used as their authority the analyst Harold Searles, a practice dating from Freud. That is, they applied Harold Searles' guide to what a schizophrenic means given the nature of the illness to what Carrie
actually said in the interviews. In contrast, Carrie’s utterances are here compared with those gathered from ostensible normals in naturalistic settings. This comparison suggests that Carrie’s speech, for the most part, is nondeviant, therefore, in my judgment, not amenable to extraordinary interpretation.

We have already seen that there is high interjudge reliability as to the schizophrenicity of some discourse (Maher, McKeon, and McLaughlin 1966). Nancy Andreasen’s widely used diagnostic criteria rest primarily on such shared perceptions of speech.

Seeman and Cole apparently address themselves to the well-known fluctuation of schizophrenic speech disability. They (p. 283) explain that “interpersonal intimacy” is threatening to schizophrenics. The purpose of their study was to “illustrate with verbatim speech samples the daily progression of change” showing that the patient becomes more and more disorganized in her speech as intimacy increases. To this end, they devised an ingenious study in which they had Carrie meet with a first-year medical student, John, for daily discussion of neutral topics such as fashions and learning a foreign language (Seeman and Cole 1977, p. 284). In their article, the authors present excerpted samples from the corpus they obtained. The capital letters represent Seeman and Cole’s own numbering of the speech samples.

They judge this monologue as being inscrutable, saying that she [Carrie] switches topic constantly, talks in riddles and ambiguities, abandons the rules of grammar so that it is impossible to know what she is referring to (Seeman and Cole 1977, p. 289).

(A) [Carrie’s discourse]
You know what the experiment is geared to find is how vulnerable, I guess, and you know, if you get close to this person and how you feel about it and some pretty basic questions like it may have something to do with psychiatry, I don’t. I’m beginning to think psychiatry is rather old-fashioned, you know there are young people on Yonge Street selling books about, I don’t even how to label them, but there are new ways for man coping with the environment and the

[Seeman and Cole’s commentary]
The whole segment can be taken to mean: Do you like me, and if you do, that puts me in an intolerable position. And if you don’t, that’s unbearable. There seems to be no solution.
people in it. And I haven't got into that but, I don't know I, I just, like, you have your set ways of doing things and you're in control. You know and you're talking about yourself personally yesterday, you know, and I walked out of here yesterday and I didn't really have any feeling at all. It was kind of like a release. I like people to confide in me, but, like, where is it going? What, it must serve some purpose, I don't have any theories about it. All I know is what I do get involved with people and it usually ends the same way I, I become very angry and you know something, well not always, but I always get taken, I get sucked in, you know, and I, I was just immobilized last night I didn't accomplish anything and here again today I, I haven't accomplished anything and I thin it's a hang-up I have got with you but I, I don't think I'm alone maybe maybe it's your hang-up too, I, I really don't know. But I do get involved in, with and when someone tells me I want to help out, and I want also to give something of myself like I'm older than you like I would like to give you some of my own insights and I, I don't know if it's appropriate what are we talking about what is it we're talking about? We're just talking about relationships and they're different, you're a man and I'm a woman and I guess I identified a bit with your girlfriend because I've done that with my boyfriend.

(B) Yeah, I don't like this book, uhm, there's a dictionary that I was thinking of buying. It's 75 cents. I might This means: I could be like the dictionary bright, compact and precise, but why should I put out such an
buy it just for my own use but it's very compact and it's just it's yellow and red, you know, it's very compact and precise. It's too bad in a way. I was, I was thinking of buying it but you know, I kind of resented having to pay out money you know.

(C)... time when I first moved into the house, my landlord and landlady had me down to dinner and I was using the living language course which is different and I was using the words of (Italian) and going along with it. But that was when I first moved in. They haven't invited me down for dinner for a while, and I when I get angry at someone I just shut their language out the way I shut them out, you know, and it's reflected in the way I shut them out, you know, and it's reflected in the way I'm learning it.

(D) I think I became jealous of the relationship the landlady has with the lady on the second floor. They seem to be really good friends, you know, and I feel kind of out of it. Sometimes I get awfully mad in my room listening to them talk, you know, and I was sure she, they were talking about me one day, that much I know, I can pick up when I'm being talked about.

effort? I don't know if you're worth it. The displacement and identification with an inanimate object is characteristic of Carrie (cf. Searles p. 122) "... it is nonhuman roles which predominate, more than any... human ones in the life of the child who eventually develops schizophrenia."

Both passages (C) and (D) seemed out of context to John and he could not comprehend the vehemence with which they were spoken. Carrie seems preoccupied by the question of how important John is to her. As in the dictionary segment she seems to be wondering whether he is worth the effort. This makes the suspiciousness of the last two segments understandable. To quote Searles again (p. 125) “That the paranoid individual experiences the plot... as centering on himself is in part a reaction to his being most deeply threatened lest he be as insignificant as outside everyone else's awareness, as he himself, with his severe repression of his own dependent feelings, tends to regard other individuals as being (1977, pp. 287-288).


Carrie's words seem to mean something quite different from Seeman and Cole's translation of them. This, in itself, does not necessarily invalidate the interpretations, however. It is well-known that the force or meaning of an utterance may be quite different from the literal meaning of the words used, but when this occurs, we can point to general discourse practices.
In contrast, the Freudian theory of communication assumes that virtually anything a patient says is subject to special interpretation and that this interpretation can be given only by those with specialized training. These interpretations differ greatly from whatever the ordinary meaning would be. Moreover, there is no check on what the analyst says the utterance means. In such a system, yes can mean "no," good can mean "bad," boy can mean "girl," and "there's a dictionary I was thinking of buying..." can mean "I could be like the dictionary..." Certainly, what people say is not always what they mean. Certainly, much of what people say means something quite different from what it literally says. However, the problem still remains of what constitutes a normal and usual decoding of someone else's speech, what constitutes a justifiable construing and what does not. Examination of discourse under a wide variety of conditions has provided us with some guidelines for determining what is and what is not a justifiable rendering of another's meaning. Before considering these, however, let us look at the properties of normal spoken discourse as this impacts on the question of is and what is not deviant.


Discourse analysis by linguists or philosophers is based upon the speech of normals. By normal, I mean usual, unremarkable, not apparently deviant because of drugs, illness, injury, or other incapacitation. Notice that normal can also refer to the deaf or those who stutter or lisp, as these populations may still both give and get meaning by usual strategies. The question is, what constitutes normal speech? We have already seen that laypersons mistake written language as being real language, not being aware that normal oral language is loaded with hesitations, false starts, and errors. The ear somehow smooths these out in ordinary conversations, so that when written transcripts are produced of actual speech, the effect on many people is that they think the speech is abnormally disjointed or defective.

Seeman and Cole overtly claim (p. 288) that they interpret her speech as they do because she is a schizophrenic. Their reasoning seems to be "Since Carrie is diagnosed as a schizophrenic, her speech is schizophrenic, and should be interpreted according to special rules of schizophrenic discourse as explicated by interpreters like Searles. "Such a belief regards all the speech produced by a diagnosed schizophrenic to be deviant, and,
therefore, to necessitate interpretation by other than normal means. The reason for my assumption that Seeman and Cole would consider anything said by a diagnosed schizophrenic to be aberrant, therefore liable to exceptional interpretation, is that all the samples they present of Carrie's speech are quite normal and easily interpreted by normal decoding strategies. That is, there is no other a priori reason to assume that Carrie is saying anything more of less or different than what her sentences would mean if produced by a normal.

Compared to spontaneous speech at, say, an academic seminar, Carrie's speech, as reported in Seeman and Cole (1977), is remarkably lucid and well-formed. "Spontaneous speech in the raw can be very raw indeed" (Clark and Clark 1977, p. 260). The more difficult the ideas to encode, the rawer the speech" the more false starts, filled and unfilled pauses, erroneous lexical choices, and assorted slips of the tongue. If each phrase, so far as it goes, is of normal structure, if each slip of the tongue is explicable in terms of that structure, and all is subordinated to an inferable topic appropriate to the occasion, then the speech is most likely normal (Chaika 1974, 1976, 1977; VanDijk, 1977: 121, 134.) Language is so constructed that encoding of ideas need only be exact enough so that hearers can infer what is meant. There are many kinds of difficulty which can lead to raw speech: complex ideas, embarrassing, exciting, or controversial issues.

For instance, consider this passage from a speaker who is embarrassed or uneasy speaking to the police

6. P: Do you know the names of any of these boys?
C: Ahh, gee, I hate—I do? One of them, but I don't like to say anything, you know. (Sharrock & Turner 1978)

C apparently starts to say that he hates to finger any of the boys. Before completing the construction, however, speaker breaks off to ask "I do?" as if he didn't know any of the offenders. Then, apparently realizing that the "I hate" implied an admission of knowledge that could not be counteracted by the innocent sounding "I do?" he answers the policeman's question admitting that he does know one of them, finishing with the statement he started with, that he hates to give evidence.

The pause-laden speech in 7 arises from what appears to be happy excitement from two males talking about an exciting subject, racing cars:
7. 'N challenge Voodoo to a race. I mean the hell with drag strips you gotta have ten thous'n bucks ready t'spec—hh I wanna build a street machine... It's a 55 Chevy. It's bright orange, and it has—it had hhu lemme tell y'about this car. Hh a three twunny seven Vet in it uhyih an' if wiz, uh, hh dual quads, hh hadda full roller cam [pause] four speeds hydrostick... (Jefferson, 1978, p. 237-238)

In 7, an intrusive thought disrupts the speaker's sentence “... ready t'spe—hh I wanna build a street machine.” Here the break was right in the middle of a word. Later, he stops after has, changes its tense to had, then still doesn't tell us what it has or had. Instead he starts all over with “lemme tell y'about this car.” The if in “... an if wuz uh...” seems to be a normal slip of the tongue explicable by the phonetic similarity between it and if.

Raw speech is not hard to find even from brilliant academics who make their living by talking. In 8, we see a sample of spontaneous speech about a complex subject (slashes indicate false starts):

8. As far as I know, noone has yet done the/ in a way obvious now and interesting problem of [pause] doing a/in a sense of structural frequency study of the alternative [pause] syntactical uh/ in a given language, say, like English, and how/what their hierarchical [pause] probability of occurrence structure is. (Reported in Clark & Clark 1977, p. 260) (from Maclay & Osgood 1959, p. 25)

Twice here the speaker starts to utter a noun phrase and twice changes his mind after selecting the article, first the and then a.

The literature on discourse analysis abounds with samples of normal speech like the three above. Here they are discussed only as a yardstick by which to measure Carrie's speech. Unfortunately, Seeman and Cole did not indicate in their data information about pausing or false starts. If that information were deleted from the above segments, or, alternatively, if slashes or [pause] were inserted in Carrie's speeches, then the similarity of her speech to the normal samples would be evident. A closer examination of where these occur in the normal speech, along with a more detailed analysis of Carrie's, might further indicate the essential normalcy of her discourse.

If we assume11 that Carrie's speech did contain pauses such as those in the three samples of normal discourse above, then we see her speech is quite normal. One reason we might assume this is that the researchers made no reference to her evincing pressured speech, the term used for
manic and schizophrenic speech that has no pausing and no false starts, nor is there evidence of glossomania, which is typically produced with no pausing before the chained segments. Since pausing and false starts indicate planning stages in speech, that which does not contain them appears to be essentially unplanned speech, speech on automatic pilot, so to speak.

Pausing during encoding of thoughts (i.e., putting them into words) with or without pause fillers like *uhh, hu, mmm, you know,* and the like is normal as is making false starts and slips of the tongue (Fromkin 1973). Pausing occurs at the beginning of major constituents in sentences (e.g., Boomer 1965; Goldman-Eisler 1958; Rochester, Thurston, and Rupp 1977) and represents a planning of what is to come next. It is easy to see why such pauses might increase as encoding difficulty increases. It is also easy to see why speakers disrupt their own sentences. They start to say one thing, preplanning to the end of, say, a clause, then realize that their wording is not felicitous. Thus they pause, replan, and start over.

Evidence for such planning stages comes from such phenomena as slips of the tongue. These most often are an anticipation of a word selected during the planning stage (Lashley 1951) or selection of another word that belongs in a set with the intended word (Fromkin 1973; Chaika 1977) or a normal intrusion (Dell and Reich 1977) caused by disruption in the context. Like pausing, slips seem related to planning and increase with excitement and embarrassment.

[12] What Does Carrie Mean?

One thing to note in the samples of normal speech above is that each of the fragments can be restored by English speaking hearers. That is, based upon what they know about English and the American culture, hearers can with a good degree of certainty, fill in what has been left out or correct what has been mis-said. No one needs training in this skill (Gleitman, Gleitman, and Shipley 1972). It comes from being a human being who has learned a language. This is what is meant by *normal decoding strategy.* It is the tacit understanding that people can do this which leads to testing procedures such as the Cloze test which has been used to analyze schizophrenic speech (e.g., Salzinger, Portnoy, and Feldman 1978). Being able to decode imperfect speech allows people to understand young children, those with foreign accents or speech impediments, as well as speech produced under noisy conditions. A second thing is
that all the speech in the above discourses, including errors and false starts is subordinated to a general topic, an important feature of normal discourse (VanDijk 1977, p. 122; Chaika 1974, p. 275).

Carrie, in common with many younger speakers today, uses “you know” as a pause filler. Goldman-Eisler (1961) says that fillers increase with heightened emotions. We can see why her emotions may be heightened when we consider her situation. Examining Carrie’s speech in the light of the well-known fact of the imperfect nature of ordinary conversation, it does not seem so incoherent. Indeed, applying the twin tests of reconstructability and subordination of utterance to topic to Carrie’s speech reveals it to be quite normal. Assuming that it is, it is possible to come up with an unstrained gloss of what she meant. Carrie appears excited and embarrassed in (A) above when she says

You know what the experiment is geared to find is how vulnerable, I guess, and you know, if you get close to this person and how you feel about it and some pretty basic questions like it may have something to do with psychiatry, I don’t. I’m beginning to think psychiatry is rather old-fashioned, you know there are young people on Yonge Street selling books about, I don’t even how to label them, but there are new ways for man coping with the environment and the people in it...

Her embarrassment is quite justified since she is telling a medical student in a psychiatric hospital that she doubts the efficacy of psychiatry. This constitutes a challenge (Labov and Fanshel 1977, pp. 96–98), which they define as

... a speech act that asserts or implies a state of affairs that, if true, would weaken a person’s claim to be competent in filling the role associated with a valued status.

They stress that this does not necessarily mean that the person challenged will suffer an actual loss of status. The challenge is to the claim alone.12

To tell people who have authority by virtue of position and education that they do not know what they are talking about is supremely difficult for those of lower status, normal or not. It seems to me that the operative words in Labov and Fanshel’s definition are valued status. By virtue of such status, one should be immune from criticism from subordinates. One decides how one fulfills the higher role. That is part of what it means to have valued status. Parents, for instance, are considered to have the right to rear their children as they see fit. The child has no right to tell the parent how the parent should behave. Only “spoiled brats” do
that. Often adolescents, as part of their ascent into adulthood, do challenge their parents and other adults in authority. This marks their imminent entry into adulthood, a valued status.

Labov and Fanshel (1977, pp. 124–125) analyze Rhoda’s challenge to authority. Like Carrie’s challenge, hers was very indirect, but still heard as a challenge. As part of her complaint that her mother has stayed too long at her sister’s home, she says “Look—uh—I mean y’been there long enough.” Labov and Fanshel interpret the *look* as a way of calling her mother’s attention to the fact that Rhoda’s needs aren’t being met. It seems more overt a challenge to me. Saying “look” warns the other that one’s patience has worn thin. This always signals a challenge. The correctness of this interpretation is demonstrated by the especially softened language following the *look*. First there is the weakening pause. This is followed by the hesitation marker *uh*. Then comes the softened phrase “I mean,” and then the rest of the challenge. It is a challenge because a child ordinarily has no right to tell her mother how long to stay anywhere. A major goal of Rhoda’s therapy has been to teach her to stand up to her mother. Even so, she challenges by indirection.

Comparing Rhoda’s challenge with Carrie’s, we see a great deal of similarity. Rhoda has been taught through therapy to stand up to her mother. Carrie has not been taught to stand up to her therapist. To the contrary, she is expected to respect his authority. Not surprisingly, her challenge to his superior status, shows even more indirection and hedging than Rhoda’s did. There has been a great deal of evidence amassed which demonstrates that women have more difficulty than men in criticizing or challenging, especially in male-female situations; therefore, they hedge their remarks more than men (Lakoff 1975; Eakins and Eakins 1978, pp. 23–52, 66–72). Considering these factors, we are reasonable in expecting Carrie to have many hesitations, false starts, and filled or unfilled pauses in the situation eliciting her speech.

Actually, the comparison of her speech with that of normal males above shows she is no less fluent than they are (as has been already noted).

As with the normal speech presented above, Carrie’s false starts are readily retrievable. Although she appears to be switching topics constantly, her adherence to a general topic and the movement within it seem normal in every instance especially when we add dashes to indicate probable false starts, and repunctuating to indicate new sentences whenever they occur, using the usual convention of periods followed by capitals.
I'm beginning to think psychiatry is rather old-fashioned. You know, there are new—there are young people on Yonge St. selling books about—I don't even know how to label them, but there are new ways for man coping with the environment and the people in it. And I haven't go into that but—I don't know—I- I just like, you have your set ways of doing things and you're in control.

As she starts to explain why psychiatry is old-fashioned, Carrie stops after *new*. Apparently, a word like *ideas* was intended, or, as appears later, *ways*. The reason for the hesitation seems straightforward enough. She is not sure of the label, and, when she does get the notion coded, it is with a whole sentence, "there are new ways for man coping with the environment and the people in it." However, she cannot get all this out until she has invested these ways with the authority of other people, young people and books. In a society which values both youth and newness, to claim that youths have new ways, and in a society which values the printed word over the spoken, to note that youths and books are promulgating new ways, gives the new ways more sanction than if they were something that Carrie, a woman and a mental patient, dreamed up. To have just continued talking about the new ideas or ways would have placed too much of the blame on Carrie herself. Besides, the appeal to authority is always more convincing. Just look at the references in scholarly articles even for quite mundane and self-evident notions. If someone else said it or wrote it, it makes it better than if we have stated it all by ourselves.

Carrie herself explains why she stopped after *about*. She doesn't have a ready label for the concepts which in her opinion are rendering psychiatry old-fashioned. What is important is that the discourse strategy she employs, a false start, followed by "I don't even know how to label them," is entirely usual, one we have all probably used at one time or another. Common paraphrases are "I forget it/his/her/ name." "I don't know the word for it," "you know what I mean," or even "whatchamacallit."

The next set of false starts is especially interesting.

And I haven't got into that but,—I don't know I,—I just,—like, —you have your set ways of doing things and you're in control. You know—and you're talking about yourself personally yesterday,—you know,—and I walked out of here yesterday and I didn't really have any feeling at all. It was kind of like a release. I like people to confide in me,—but,—like,—where is it going?

These, as a set, imply that she disagrees with the student and the psychiatrists that he is representing. Again, this is a normal strategy, a
way of letting the other person know that you disagree without your actually doing so in overt words. The passage may look disjointed, appearing as it does in an orthography which normally admits of no false starting, but when read aloud, it does not sound particularly disjointed.

It is significant that the hesitations and false starts cluster at the point at which one would expect Carrie to be stating that she is disillusioned with psychiatry. “I haven’t got into that but…” seems like a normal entry into “the new approaches that might be better than psychiatry,” or some such paraphrase thereof. Instead, Carrie stops after the but, the word which leads one to expect a disclaimer. Then she demurs with the feminine “I don’t know” (Lakoff 1975, pp. 15–17) which has the effect of softening any assertion. She starts giving her opinion again, saying “I,” then starting all over again with “I just.” This just is similar in force to the preceding but which initiated this string of false starts. It announces that she holds an opinion different from the establishment’s as if she were trying to say “I just don’t believe in you anymore.” This is not to say that those were necessarily the next words she intended, but that the just in the given context does have the force of a disclaimer, and she has previously voiced doubt about the efficacy of psychiatry. She stops short of having to put herself overtly on the line, although she has signaled enough for us to infer what she is getting at.

The like following the false start “I just” is often used in precisely the way Carrie uses it to mean “what follows is not a direct expression of what I mean, but I’m finding it difficult to say exactly what I mean.” In one afternoon’s office hours, I collected these samples, all from female students, all in far less socially precarious positions than Carrie.

9. I don’t know, but—like, I can’t get my act together ever since I got back from Spain.
10. Yeah, like—it’s interesting, y’know
11. …-like,—now I got rid of him, like—I dunno I just feel—I found myself.

What Carrie does is most interesting, and most skillful. She has set her hearer up for criticism of psychiatry; then, without really giving that criticism, she tells John, “You have your set ways of doing things.” That is, even if other things are better, you’d not be likely to change your mind. “And you’re in control” seems to mean just that. He is in control of the situation and himself. Interestingly, the authors themselves stress the
businesslike air of the student (p. 284) confirming Carrie's perceptions.

The thesis of the Seeman and Cole paper is to show how Carrie's speech becomes more disorganized as she feels the "intimacy of the daily meetings" (p. 289). In a large sense, this is undoubtedly true. Intimacy makes Carrie dare to question her therapists, but the daring does not extend to her speaking her mind openly. Surely, there is veiled meaning in her words, but the kinds of veiled meaning and the ways she expresses it seem wholly usual and normal, conforming to regular discourse strategies. She is cognizant of social situation, and, contrary to expectation (Rochester and Martin 1977; Rochester, Martin, and Thurston 1977) gives the listener ample information to know what she is referring to.

Unlike the passages just discussed, the rest of Carrie's speech is straightforward if one decodes it as one would normal speech. Her topic at the outset of (A) is the experiment in which she is a participant. She is correct that this experiment is to see if her speech becomes disorganized as the topic become more personal. Seeman and Cole (p. 284) had told her this. In other words, as Carrie says, the experiment is to see how vulnerable she is. She is also correct in assuming the experiment has something to do with psychiatry. This is the lead-in to the indirect, but recoverable critique of psychiatry that we just saw. As part of this critique, she complains that the previous day's session left her devoid of feeling, like a release of tension, a common enough aftermath of a talk session, but she still doesn't see the purpose of the sessions.

She continues the monologue with the unfortunately common human plaint that she is always the loser in human relations. This does not seem to be an inappropriate switch as she is talking about the relations with John. The previous night after the, to her, pointless gab fest, she could not get anything done, nor does she feel that her talking that day has any purpose. She wants to help the experimenters out by participating. Also, being older than John, she feels that she should be giving him insights, but does not know if that would be appropriate, nor, actually, what she and John are talking about. Here I must point out that Carrie is not being particularly obtuse. Nowhere in the transcription is there any indication that John has responded to anything she has said. Apparently, he just lets her rattle on. This constitutes a highly abnormal situation. Normal conversation consists of turn taking (Sacks 1967–71; Jefferson 1978). Even very normal confident people find it upsetting to be in a situation where they are supposed to be carrying on a conversation and the other person doesn't carry the ball. If one adds to this normal
discomfort, the social convention that it is up to the female to draw the male out and to keep the ball rolling in social situations, especially in one-on-one occasions like dates. Carries' speech is all the more normal. The situation she finds herself in with John is the same as if she were his girlfriend. In short, John's failure to take his rightful turns in the conversation such as answering Carrie's questions forces her to fill up the silence with a monologue. She is obeying normal everyday conventions of our society when she does so.

Carrie's comments about the dictionary are also amenable to quite ordinary meaning rather ordinarily phrased. These occur in the context of her attempts to teach John a foreign language (Seeman and Cole 1977, p. 287). Many people have ambivalent feelings about buying books and her wording about this ambivalence seems unremarkable.

Carrie's feeling that the landlady and the other tenant are talking about her (passages C and D) may be paranoid, but the structure of the language she uses to express that feeling is perfectly normal. It is puzzling, however, that John could not comprehend the vehemence with which Carrie's complaint was spoken (p. 287). Even normal people get angry if they feel that they are being snubbed for no good reason, and even normals are jealous of friendships between people who exclude them.

Many might object that as a schizophrenic, Carrie's speech must be interpreted differently from that of normals. In other words, the diagnosis determines the meaning. If she had not been diagnosed as schizophrenic, then her words could be taken to mean something entirely different from what they mean in light of a diagnosis. In essence, those who feel that the prior diagnosis determines the mode of interpretation claim that they are among those with a key to it, a key supplied by Freud, Sullivan, Searles, or another analyst.

In contrast, my interpretations of Carrie's speech depend on the assumption that anyone using English is using it in the same way as normals do provided it has normal structure. There may be deviant schizophrenic speech just as there is deviant aphasic speech or heavily accented speech or imperfect toddler speech. However, all such speech, if interpretable at all, is interpretable only if the hearer can match the deviation with the nearest possible rules which produces an utterance appropriate to the given context (Clark and Clark 1977, pp. 211-215).

John Searle (1975, p. 63, 73) says that one assumes that someone speaking to us is cooperating in the conversation so that his/her remarks
are intended to be relevant. This does not mean that speakers don't lie, do not use language metaphorically, or do not use one utterance to imply something different from what is said. Speakers do all of these things but lying, metaphor, and implicature are all rooted in normal uses of language and the shared conventions of speakers of a particular language. For instance, when someone lies, he or she depends on the hearer's understanding of the lie to mean what it normally does. That is, the lie does not consist of unusual uses of the words in the utterance. To the contrary, it depends upon a normal reading of the words. If Max says, "I didn't cut the meat with a cleaver" when in fact he did, the lie is not in the negative -n't. The lie works only if the hearer interprets -n't as usual, as a denial.

To assume that some conversations must be interpreted by extraordinary means is to assume that the incredibly complex sets of rules which enable us to handle human language, both as a system in itself and as a social system, can be wholly altered by one class of persons, the mentally ill. As John Searle (1975, p. 67) said in a somewhat different content, "... an ordinary application of Occam's razor places the onus of proof on those who wish to claim these sentences are ambiguous. One does not multiply meanings beyond necessity." Nor, I hasten to add, does one claim idiosyncratic meaning when conventional meaning is retrievable by conventional means and fits the social context.

Then, too, to assume that schizophrenics abandon the usual meanings of words without clear evidence such as semantic anomaly raises some very sticky questions. If the schizophrenic's meaning can be so very far removed from normals, how does anyone know what the schizophrenic means? At what point in a patient's illness does one suspend the normal rules of decoding and substitute the schizophrenic ones? At what point in remission does one abandon the schizophrenic interpretations and go back to the ones shared by other speakers? Or is the schizophrenic's speech always governed by the rules of schizophrenia? If so, should these rules be applied retroactively, say, perhaps, to five years before the visible onset of illness? Or does one start interpreting differently at the precise moment when schizophrenic illness is diagnosed?
Notes

1 Jones also had a great impact on literary criticism by psychoanalysis of such figures as Hamlet, claiming, for instance, that Hamlet was suffering from a severe Oedipus complex.

2 A major problem with this view of language is that it seems improbable that language could have evolved as a means of an intensely personal system of communication to be utilized to express cryptically one's unconscious thoughts. Language had to have been developed as communication in social relations, and there is no actual evidence that it has evolved further to act as Freud and his followers assert.

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4 The literature on aphasias and normal speech errors report errors made because of intrusions of related words. In normals, however, these never take the form of chaining of related words, and in aphasia, if chaining does happen, it is rare. It is not a usual occurrence as it is in speech disordered schizophrenics.

5 I am aware of studies by Singer and Wynne and others that tendencies towards glossomania can be found in close relatives of schizophrenics and in those at risk for the disease, but this means that whatever causes schizophrenia causes the glossomania. Not all schizophrenics can be shown to come from such families, however, nor has it been shown that all members of schizogenic families create associational chains. The enormous literature on language acquisition does not offer any parallels to children learning to speak in such a deviant fashion. Rather, it has been shown that they speak like their peers. Children from families of foreign speakers do not themselves speak with a foreign accent.

6 They actually couch these as "X's obligations..." and use the masculine pronoun as in "his capacities." It is very obvious that they are speaking of Rhoda. In general, however, Labov almost always uses the masculine pronoun as generic to include a female even when he is speaking of a female.

7 Such mitigators seem to be used more by women than by men, although men in the weaker position in an interaction may use them as much as women (O'Barr 1982; Lakoff 1972, 1975).

8 Actually, their investigation and subsequent articles about it must have taken place well before the publication date.

10 The manual languages of the deaf have been shown to be structured remarkably like oral languages and they make slips-of-the-hand in a manner parallel to slips-of-the-tongue. Likewise, the deaf may suffer from aphasia in which case they make analogous errors to the speech errors of hearing aphasics. I know of one bit of anecdotal evidence that schizophrenic deaf patients may produce the counterpart to oral gibberish in their sign language.

11 Perhaps it should be noted that I have had personal correspondence with Dr. Seeman about her studies of Carrie and she did not contradict my assumption that Carrie's speech had pausing and false starts.
The reader should be aware that Labov and Fanshel provide a detailed and precise anatomy of what constitutes a challenge and why, along with precise mathematically precise rules to characterize challenges and the other speech events that they explain. It must be remembered that their book is not so broad in its presentation as this one is, but their work makes up for breadth in depth. In this work, space does not permit a full rendering of their rules. Nor would a nonlinguist necessarily find these of practical help. However, and this cannot be stressed enough, their careful attention to proving what something can reasonably be assumed to mean is invaluable, and this can be understood without re-creation of their meticulous set of rules. In this book, I present their methods and conclusions only, but I urge the reader to dip into their work.

Societies vary greatly in this matter. Americans and Canadians typically feel that one must “keep the ball rolling” with chitchat, but in other societies, such as many Native American ones and the working-class Irish in Belfast, long silences are perfectly companionable (Chaika 1989, p. 107).