

Talk at work

Interaction in institutional settings

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Dilemmas of advice: aspects of the delivery and reception of advice in interactions between health visitors and first-time mothers

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1 Introduction

The British health-visitor service is the largest single element of the UK community-nursing program, comprising some 9,300 qualified nurses (Cumberlege Report 1986: 10).¹ The health visitor's role, as described by the Health Visitors' Association (1985), is to be "fully and completely involved in the giving of advice and support but only indirectly in the treatment of illness, environmental control and the provision of practical help." As this broadly worded description suggests, health visitors have very wide-ranging professional responsibilities comprising the following: the detection and prevention of ill-health in the community; the identification of health needs in the community; health teaching; and advice and guidance in cases of illness and in the care and management of children (Council for the Education and Training of Health Visitors 1977). These responsibilities – in which advice giving plays a primary role – are necessarily discharged through verbal interaction with members of the community.

In this chapter, we examine the management of advice giving in interactions between health visitors and first-time mothers (primiparae) during the course of visits to the mothers' homes. In particular, we will focus on the first of these visits, which normally takes place about ten days after the birth of the baby and which is widely believed to be particularly significant for the subsequent relationship between mother and health visitor. Our objective is to describe

We would like to thank Steve Clayman, Paul Drew, David Greatbatch, Berry Mayall, Manny Schegloff, and Candace West for valuable comments on an earlier draft of this chapter.

some basic aspects of the advice-giving sequences that occur in these first visits. Specifically, (a) we will sketch the main ways in which advice giving is initiated with a particular focus on how the parties arrive at the point where advice giving is begun. (b) We will discuss the main ways in which advice is received over its course, focusing on the ways in which the advice may be accepted or resisted.

We emphasize that this chapter offers a relatively gross overview of the basic features of these advice-giving sequences and does so with reference to a particular social context – first visits to the homes of first-time mothers. More detailed analyses of the design and trajectory of advice-giving sequences will be dealt with in subsequent studies as will comparisons of the initiation, design, trajectory, and reception of advice in these visits with those occurring in later visits to the same first-time mothers and in visits to mothers who have already had at least one child. Finally, while the health visitors exhibited significant individual differences in their approach to advice giving, individual comparisons are also beyond the scope of the present chapter. Below, after a description of our data base, we begin our discussion with a brief overview of the health-visiting service.

1.1 *The data base*

The data on which the present chapter is based are drawn from a substantial corpus of self-administered audio-tape recordings by health visitors in a large industrial city in central England.² The health visitors recorded their first six visits to a range of mothers evenly divided between first-time mothers and mothers who had previously had one or more children. In all some seventy-five visits were recorded. This chapter is based on data from eight initial or primary visits to first-time mothers conducted by five different health visitors and occupying a total of 4.5 hours.³ These data contain some seventy instances of advice-giving sequences and, although any indications of a distributional kind should be treated with caution, we are confident that many of the main ways in which advice giving is managed in home visits are represented in the observations that follow.

1.2 *The health visitor service: a brief overview*

Health visitors, as Dingwall (1977: 21) has observed, “are a uniquely British contribution to the delivery of public health services.” They are fully trained nurses who work in association with general practitioners and community health centers. However, unlike community nurses in other advanced countries, health visitors do not perform routine nursing tasks and concentrate instead on illness prevention, giving advice on health and social problems and case finding for other more specialized agencies (*ibid.*).⁴ Although their range of responsibilities is, as noted above, exceptionally large, in practice they presently tend to concentrate their work in two main areas of need: families with children aged under five, who absorb about three-quarters of their time, and the elderly sick, who occupy another 10 percent. Their work is conducted through two major types of activities: (a) clinics focused on preventative aspects of health involving developmental assessments and immunization; and (b) visits to the homes of persons in some kind of need. As far as home visits are concerned, the largest proportion are made to mothers of new-born children, and it is these visits which are the subject of this chapter.

The British health-visiting service is distinctive in that, unlike other medical services in the United Kingdom and elsewhere, its provision is supply- rather than demand-driven.⁵ This characteristic is particularly prominent in relation to the health visitor's work with children. Health visitors have a statutory obligation to perform routine visits to all mothers with children under five regardless of whether these visits are requested or not.⁶ The supply-driven character of the service reflects the origins of the health-visiting service in the municipal sanitation movement of the nineteenth and early twentieth centuries. Strongly interventionist and directed towards working-class homes, this movement culminated in the development of a national sanitary inspectorate during the early decades of the twentieth century. The following quotation from the rule book of the Manchester and Salford Sanitary Association (*c* 1880) gives a flavor of the women inspectors' duties:

They must visit from house to house, irrespective of creed or circumstances, in such localities as their superintendents direct. They must carry with them the carbolic powder, explain its use and leave it where it is

accepted; direct the attention of those they visit to the evils of bad smells, want of fresh air and impurities of all kinds; give hints to mothers on feeding and clothing their children; where they find sickness, assist in promoting the comfort of the invalid by personal help ... they must urge the importance of cleanliness, thrift and temperance on all possible occasions. They are desired to get as many as possible to join the mothers' meetings of their districts: to use all their influence to induce those they visit to attend regularly at their places of worship, and to send their children to school.

(Clark 1973: 11)

Today, long after her incorporation into the national health service and with a statutory obligation embracing the health needs of children of all social classes, the modern health visitor still carries at least a whiff of that interventionist carbolic into the houses of contemporary mothers and their babies. Although the health-visitor organizations downplay this aspect of their role, the health visitors' access to the homes of young children gives their visits an unavoidable dimension of surveillance and social control.

The general significance of this surveillance role, which is widely oriented to by mothers,⁷ may be inferred from the fact that health visitors are the largest single source of information and referral in cases of child abuse and neglect in the United Kingdom (Dingwall, Eekelaar, and Murray 1983).

1.3 The home visit

Home visits occupy between a quarter and a third of health visitors' time (Clark 1981; Dunnell and Dobbs 1982). They begin when the new-born is about ten days old and the midwife has formally relinquished responsibility for the mother and baby. For the first month or so, and especially in the case of first-time mothers, they tend to occur on a weekly basis, subsequently diminishing in frequency in succeeding months.⁸

The home visit is an aspect of health-visitor (henceforth HV) practice that is largely hidden from public view. Its content and procedures have not been a focus of sustained social-scientific research in the past, nor have systematic principles of home-visiting practice been elaborated and taught as part of HV training programs. Insofar as specific interactional procedures for the conduct of visits are acquired in the course of initial training, they are

largely learned tacitly through apprenticeship to more experienced practitioners (Dingwall 1977).

Robinson (1982) has proposed that the knowledge base on which HVs rely – incorporating clinical and nutritional principles, epidemiology, child development, and psychological and sociological views of the person and the family within social processes – could sustain two alternative models of HV practice:

The first model is founded on a clinical, problem oriented base. The health visitor engages in a search for health problems through an "identification, diagnosis and treatment" process. Students are taught that a good relationship with clients is essential in order to gain acceptance for their special expertise in preventive health care ... The second model is founded on a relationship centred base. The client is enabled to engage in the self-identification of factors operating against his health and well-being and is encouraged to join with the worker in a programme of help.

(Robinson 1982: 24)

To date, however, no empirical studies have been developed to assess the extent to which these models influence HV practice.

Notwithstanding its importance, there have been relatively few attempts to study the home visit in any detail. Previous studies of HVs' activities have largely been based on diary keeping and other self-reporting methodologies and have concentrated on how HVs allocated their time among their different responsibilities and on statistical analyses of the topics and activities of the home visit (see e.g. Clark 1973; Watson 1981; Dunnell and Dobbs 1982). These essentially cross-sectional studies give little access to the interactional processes of health visiting and there is almost no published information that deals in detail with the events of the home visit.⁹

Studies of client perspectives on health visiting have tended to be small scale and present results which are piecemeal and fragmentary. In general, however, they indicate that mothers tend to prefer home visiting rather than clinics as a site for interaction with their HVs (see Bax, Hart, and Jenkins 1980; Orr 1980; Foxman *et al.* 1982), but, predictably, dislike it when visits occur unannounced (Orr 1980; McIntosh 1986). At the same time however a substantial proportion of mothers, particularly in social classes IV and V, see the HV service largely in terms of social control and surveillance and attempt to minimize contact with its representatives (*ibid.*). Most surveys suggest declining levels of satisfaction with the

HV service over time (Graham and McKee 1979; Field *et al.* 1982; Moss, Bolland, and Foxman 1982; McIntosh 1986) and indicate that mothers tend to remain unclear about the role and value of HVs (Hunt 1972; Moss, Bolland, and Foxman 1973; Orr 1980; McIntosh 1986). A number of studies have found that mothers evaluate their HVs largely in terms of personality characteristics and interpersonal style. These studies also indicate that mothers have a strong preference for friendliness and informality in HV conduct and that HVs are quite commonly perceived as excessively authoritarian and didactic (Political and Economic Planning 1961; Wilson and Herbert 1978; Blaxter and Paterson 1982; Foxman *et al.* 1982; McIntosh 1986).

Although advice giving has been a central feature of health visiting throughout the existence of the service, there has been relatively little systematic study of its provision. A study by Davison (1956) argued that, in contrast with social-service case workers, HV advice "is offered by her, not requested by her clients," and this view has been somewhat reinforced by anecdotal evidence from clients. As one of the latter, in an article published in *World Medicine*, observed, "they never really listen to you. Oh they appear to listen – but inside they have already pigeon-holed you and are just waiting for a gap in the conversation in which to give the appropriate advice" (Clark 1973: 6). Clark's time study of HV activities (*ibid.*: 69–73) found that advice giving was more frequent and more assertive in relation to physical health-care topics and where the subject was a young child. Finally, two studies of working-class mothers have dealt with reactions to advice giving. The mothers in Orr's (1980) study saw advice as something that should be "done without pushing," and this view was strongly reinforced in McIntosh's (1986) study of first-time mothers in Scotland, in which unsolicited advice was viewed as patronizing and was associated with considerable hostility. The mothers reported that they simply ignored much of this advice, particularly if it was associated with conflict of any kind (McIntosh 1986: 25–8).

1.4 The general character of the first visits

Of the visits that make up our data base, most represented the first occasion on which the mother and HV had met one another and,

although the mothers were expecting a visit from the HV at some time during the week of the first visit, all were unannounced.¹⁰ In a number of cases, third parties – husbands, grandmothers, or female friends – were present during the course of part or all of the visit and in some of these they were significant participants. The visits varied in length from fifteen minutes to just under an hour.

Although the visits are quite diverse, their content contains a number of common features. A large majority of topics were initiated and terminated by the HV in a basically 'segmented' process of topical progression (Button and Casey 1984; Sefi 1988). In visits where no third parties were present, the HVs usually began with inquiries about the mothers' experience of the birth and its immediate aftermath. Where third parties were present, they began by admiring the baby and dealing with topics that could be an appropriate focus of third-party participation.

Substantial parts of these first visits were occupied with three bureaucratic tasks: (a) getting face-sheet data about the mother and baby for the records of the clinic to which mother and baby will be attached; (b) getting consent signatures for immunization injections for diphtheria, whooping cough, tetanus, polio, and measles; and (c) explaining clinic procedures and the various subsequent health checks that mothers and babies will go through in the ensuing months and years. In a number of cases, explicit form filling for the creation of bureaucratic records formed a "backbone" to the visit: it was initiated early and was intermittently departed from in a range of topical excursions and returned to as the topical content of these excursions was exhausted. In others, the face-sheet data gathering was confined to a specific segment of the visit. The visits were substantially diverse in terms of their overall trajectories, the type and ordering of the topics raised and in terms of the "tone" or "rapport" achieved between the parties.

1.5 Advice giving and the problem of competence

There is ample evidence, both from survey data and from the materials that form the basis of this study, that during these first visits mothers primarily orient to their HVs as "baby experts" – persons with particular expertise on the health and treatment of babies – rather than as "befrienders" with whom they can share problems or

troubles that are not directly connected with problems of baby management. Moreover, HVs characteristically comport themselves as "baby experts" during these visits. Thus, insofar as the initial visits can come to involve more than a simple initiation of contact together with the collection of face-sheet data, both mothers and HVs treat its possibilities primarily in terms of a "service encounter" (Jefferson and Lee, this volume).

However, in these visits it is also clear that, to a greater or lesser extent, the mothers saw their knowledge, competence, and vigilance in baby care as an object of evaluation and, moreover, by a person with officially accredited competences to judge their conduct. This orientation emerged in a wide range of contexts but is transparently visible in the mothers' responses to comments in which the HV raises something that is apparently untoward, as in (1):¹¹

(1) [5A1:2]

- 1 HV: 'hh She likes it on her ba:ck does she.
 2 M: I j'st put 'er on there while I was
 3 gettin' the pram out.
 4 HV: [()
 5 HV: Yeh. 'Cos sometimes they can uh
 6 (0.5)
 7 M: choke. Ye h.
 8 HV: [Yeh. When they're on their back s.
 9 M: [Well
 10 she does like it on her ba:ck.
 11 HV: Ye:s. I think when it- when you- when you're
 12 lea:ving he:r
 13 (.)
 14 M: Ye: ah
 15 HV: [You ought to put her on her tummy
 16 real ly.
 17 M: [Yea:h, oh yeah

At the beginning of this sequence, the HV comments on the baby's posture using a question design (statement + tag question) that is built towards the supposition that the baby generally prefers to lie this way. Although the question does not overtly treat the baby's posture as problematic, it is noticeable that the mother's initial response (lines 2–3) downplays its significance. She depicts it as a brief and incidental part of her own earlier course of action and, by

implication, not as evidence of the baby's general preference. She then exhibits an awareness of a potential danger associated with this posture through her collaborative completion (line 7) of the HV's next turn (line 5). Thus it is only *after* the mother has displayed an alertness to the dangers implicitly raised in the HV's initial question that she then produces a revised response to it (lines 9–10) that acknowledges that the baby does in fact prefer lying on her back. Here then, the mother defers dealing with the HV's question "at face value" in favor of an initial response that shows her awareness of the dangers implicitly raised by it.

A concern for the judgmental possibilities inherent in these first visits is still more vividly illustrated by (2) below. Here an apparently casual observation by the HV "He's enjoying that isn't he" (presumably referring to some sucking or "mouthing" behavior by the baby) elicits contrastive responses from the baby's father and mother. While the father takes the remark at face value and responds with an agreement, the mother's response is notably defensive:

(2) [4A1:1]

- 1 HV: He's enjoying that isn't he.
 2 F: [°Yes he certainly is=
 3 M: =He's not hungry 'cuz (h)he's ju(h)st (h)had
 4 'iz bo:ttle 'hhh

Here the mother's initial response treats the HV's observation as implying that the baby may be hungry and, by extension, as possibly implicative of some failure on her part. She denies that the baby is hungry and goes on to produce an account that justifies her claim. Her response is one that treats the HV as someone who, whatever other functions she may have, is evaluating her competence as a mother.

This orientation towards the HV as someone who may stand in judgment on the mother's competence in child care suggests, and our data confirm, that requesting and giving advice during these first visits can be highly problematic activities. Any request for advice constitutes an admission of uncertainty about an appropriate course of action. Such a request may, further, imply or display that its producer lacks knowledge or competence concerning the issue at hand or is unable to cope with a problem without external

assistance. By the same token, it constitutes the recipient of the request as the knowledgeable, competent, and authoritative party in the exchange. Concerns with these issues of knowledgeability, and the "face" considerations they raise,¹² may be compounded when the requested advice concerns a baby for whom a mother has a direct responsibility to care in a knowledgeable and competent way and when the requestee may be viewed as someone who stands in judgment on her knowledge and competence in this matter.

Similar issues concerning the implications of advice giving for judgments of mothers' knowledgeability and competence in child care and related matters may also inhabit contexts where advice giving is volunteered or occurs unrequested. For the volunteering of advice may carry with it an assertion of the very same implications about the relative authority and competence of the advice giver and advice recipient that are acknowledged in contexts where the recipient requests advice. And such implications may be the more unwelcome because they are produced by persons whose claims – to knowledge and to rights to judge – may be effectively unchallengeable.

1.6 Advice giving during the first visit: preliminary observations

In examining patterns of advice giving during these visits we have focused on sequences in which the HV describes, recommends, or otherwise forwards a preferred course of future action. Our concern is with sequences in which the HVs were engaged in activities having an essentially normative dimension which, we propose, is central to advice giving as an activity.

In the majority of our advice sequences, advice was explicitly future oriented and was delivered in strongly prescriptive terms.¹³ This prescriptiveness emerged in a number of ways:

First, it appears in the language of overt recommendation:

[3A1:15] "I would recommend giving her a ba:th every da:y"

[4B1:16] "The hospital recomme:nd that she shouldn't start solids until she's (.) four months."

[1C1:31] "Well my advice to you: is that ... you firmly put her do:wn"

Second: advice was often couched in the imperative mood:

[3A1:24] "No always be ve:ry very qui:et at ni:ght."

[1C1:13] (The reference is to an eye infection)

"If you think they're pussie then you must use boiled wa:te:r"

Third: advice was often expressed using verbs of obligation:

[1C1:5] "And I think you should involve your husband as much as possible no::w"

[5A1:2] "when you're lea:ving he:r you ought to put her on her tummy really"

Less commonly, advice could be expressed as a "factual generalization," as in the following case, in which a mother's enthusiasm for disposable nappies (or diapers) is met with a generalization about the practice of other mothers, which amounts to a recommendation of reusable ones:

(3) [1C1:6] (Readers should note that the term 'terries' refers to a reusable cotton towelling nappy or diaper)

- | | | |
|----|-------|--|
| 1 | HV: | And uh <u>disposable</u> nappies are quite <u>easy</u> |
| 2 | | aren't they really no:w,= |
| 3 | M: | =They're a lot easier than the uhm (0.4) |
| 4 | | terries () aren't they yeah. |
| 5 | HV: | [Ye:s. |
| 6 | M: | They're easier to pu(t) on and <u>quite</u> simple= |
| 7 | HV: | =Mm |
| 8 | M: | You kno:w, |
| 9 | | (0.2) |
| 10 | HV: → | Lots of mums <u>do</u> : progress to thuh (0.8) |
| 11 | | terries when they're a bi:t older. |

In general, though, the HVs delivered their advice explicitly, authoritatively and in so decided a fashion as to project their relative expertise on health and baby-management issues as beyond doubt.

In examining patterns of advice giving during the first visit, we will first consider the main procedures by which advice giving is initiated in these visits and subsequently turn to look at some aspects of its reception.

2 The initiation of advice giving

In looking at initiations, it is useful to begin with advice which was directly or indirectly requested by mothers.

2.1 *Mother-initiated advice*

2.1.1 *Requests for advice*

Mother-initiated requests for advice are, in principle, the most straightforward in our data base. A request for advice establishes the relevance of subsequent advice giving in three important respects: first, it establishes the problem area for which advice is requested; second, it establishes the requester's uncertainty about some aspect of that problem area and her view of it as problematic; third, a request establishes her alignment as a prospective advice recipient and thereby legitimates the subsequent delivery of advice.

Mother-initiated requests for advice can take the form of simple question-answer sequences. Thus in (4) below, the mother designs her request for advice as a straightforward "open" question, thereby acknowledging ignorance as to how to proceed:

(4) [5B1:21] (The inquiry concerns the management of breast feeding)

- 1 M: → How long should I leave him on the other
- 2 side ()
- 3 HV: Until he's finished.
- 4 M: Guzzling away.
- 5 HV: Mm.. 'Till he's had that side really.
- 6 M: mYea:h.

However, even in their direct requests for advice, mothers were rarely prepared to acknowledge complete ignorance about an appropriate course of action.

More commonly, they managed their requests so as to display a measure of knowledge or competence in the management of their activities and thus to circumscribe the scope of the advice requested. One common procedure for achieving such displays involves embedding a proposal about an appropriate course of action within a question. This procedure was normally managed as a "closed" (yes/no) question – a format that was generally used to solicit support for the proposed course of action – as in (5) below:

(5) [1C1:29]

- 1 M: Shall I let her tell me when
- 2 she's hungry.
- 3 HV: Yes well that's sensible.

Here, rather than using a question format (e.g. "How often should I feed her") that would overtly acknowledge a lack of knowledge about how often to feed her baby, the mother's inquiry is one through which she portrays herself as having independent knowledge or understanding of how to proceed. The issue is thus treated as only residually problematic and the HV is merely invited to confirm the viewpoint embedded in the mother's inquiry.¹⁴ In this case, the HV's advice is limited to a fleeting confirmation.

However, this course of action carries a significant risk that the HV will reject the mother's viewpoint and thereby deny the competence and knowledge that is proposed with it. This risk is realized in (6):

(6) [3A1:15]

- 1 M: → I haven't bathed her yet. Is once a week
- 2 enough.
- 3 (0.7)
- 4 HV: We'll (0.2) babies do sweat a lot. (0.3) So
- 5 (0.3)
- 6 HV: So I would recommend giving her a bath
- 7 every day

Here the mother's inquiry describes a past course of action and proposes an appropriate interval for bathing her child. However, the HV's response indicates not only that the mother's proposal about how often a baby should be bathed is incorrect, but also that she has already failed to bath her child with a frequency that the HV judges to be appropriate. Notwithstanding these risks, however, most requests for advice were packaged as requests for confirmation of proposed courses of action.

In most cases, including the above, mother-initiated advice sequences emerged within topical environments that had already been established by HVs' questions. These contexts afforded a wide range of opportunities for mothers to display their knowledge and ability to cope with the problems for which they sought advice. Thus in the following case, rather than asking for advice outright, the mother details a problem connected with the taking of iron

tablets, expresses uncertainty about whether to continue with them, and offers a candidate solution to her problem.

(7) [5B1:14]

- 1 HV: Have you got some iron tablets I left.
 2 M: 'hh We:ll yes
 3 I ha:ve (.) 'cos uh 'hh uhm (0.5) I wasn't
 4 able to take them in pregnancy because they
 5 made me constipa:ted.
 6 HV: Ye:s.=
 7 M: =And I have had a fe:w over the last few days
 8 and it's happening agai:n.
 9 HV: Is it.
 10 M: → So I don't know whether to carry on or no:t.=
 11 → =Maybe have one every now and agai:n.
 12 HV: Ye:s. (.) I mea(n) i- you're ten point four:
 13 which isn't too ba:d.

Similarly in the next case, after the HV has raised the topic of family planning and suggested various sources of help including herself, the mother indirectly requests some advice about when to restart the pill (arrow 2) but only after she has shown that she has independently dealt with the family-planning issue (arrow 1):

(8) [4B1:7]

- 1 HV: 'hh And family planning you know you can get
 2 pregnant straight awa:y so if you wou:ld (.)
 3 like any: (.) help in that score you can
 4 always ask me: or see the G.P. or go to the
 5 family planning clinic.=
 6 M: 1→ =Well I- I've got some (0.4) things
 7 upstai:rs.
 8 HV: 'Oh well done.'
 9 M: 2→ But (.) when I've got to take them I
 10 do:n'know.
 11 HV: Well (.) uhm if you're not breast feeding
 12 there's no reason why you shouldn't start them
 13 when (.) she's four weeks.

In sum, the significant feature of requests for advice is that they directly and overtly establish a context in which advice can be relevantly given and they do so *in advance* of its actual delivery. Through requests, mothers can display an orientation to a state of affairs as problematic, describe the state of affairs and establish themselves as requiring some advice or direction about the course

of action they should take. However, this procedure, which involves an overt acknowledgment of some limitation in the mother's knowledge or competence as a carer, was not often adopted. Direct or indirect requests for advice amounted to no more than seven cases (approximately 10 percent of the total) in a set of interactions that, in total, occupied nearly 4.5 hours. Moreover, these requests were most commonly managed so as to preserve – as far as possible – the appearance of competence in baby management and related issues. Both the infrequency of these requests and their characteristic design suggest that mothers may be reluctant to request advice for fear that adverse judgments may be made about their knowledge or competence in baby management or mothering skills.

2.1.2 Soliciting advice by describing an "untoward" state of affairs

An alternative and more "cautious" procedure which mothers employed for soliciting advice was substantially more indirect. It consisted simply of detailing an untoward state of affairs which, without overtly requesting advice, they treated as potentially problematic.¹⁵ The following case, in which a mother and grandmother depict a condition of the new baby is prototypical in this respect:

(9) [4B1:22]

- 1 HV: Bonnets are worth ha:ving.
 2 G: 'hhh Her hai:r it
 3 seems a bit grea:s:y
 4 M: 'Yea: 'h.
 5 G: 'Every time we've
 6 wa:shed it=
 7 M: =Ye: a:h
 8 G: 'when we give her a little ba:th it
 9 looks lo:vely 'hhh=
 10 M: =b:y the end 'v-
 11 G: 'and by the end of 'th'da:y
 12 M: 'by-
 13 (.)
 14 M: by three o'clock in the afternoon it's all
 15 greasy on the to:p.=
 16 HV: =Is it?
 17 M: Yea:h she's a rea: 'I swea(t)uh.
 18 HV: → 'D'ju think she's ho:t.

- 19 ?G: She might be:
 20 M: Wul we keep 'e r wrappin' round er
 21 G: We keep 'er in that li- uh
 22 (0.5)
 23 M: and in this little nest [here that she's got.
 24 HV: Right.
 25 (.)
 26 HV: → Right. 'hh (It) might be that she's too hot.
 27 (1.2)
 28 ()
 29 HV: → Becuz this is certainly the- (.) the
 30 temperature of the hospital isn't it.=
 31 M: =Yea:h.
 32 HV: And is it the same throughout upstairs as
 33 we:ll.
 34 (0.2)
 35 M: We:ll I've got a little fire (.) upstairs
 36 HV: → I would
 37 → slowly bring the temperature do:wn to sort of
 38 → normal.

Here the mother and grandmother's collaboratively produced description of the baby's condition (lines 2–15) is apparently initially triggered (Jefferson 1978) by the conclusion of a previous advice-giving episode that culminates in the recommendation that "bonnets are worth having." The grandmother's initial comment about the baby's hair (lines 2–3) is collaboratively worked up into an extensive depiction of a sweating baby by line 18. However, while this description is developed as something noteworthy and possibly problematic, it is not associated with any overt request for advice. In this context, it is thus the HV who formulates a possible cause of the problem (at line 18) and, after a series of inquiries, proposes a remedy (lines 36–8).

In a range of other cases, too, the detailing of something untoward becomes an occasion for advice giving. The following sequence, which occurs just before (9) above, begins with the grandmother's "triggered" observation that the rain recurrently prevents her daughter from walking the new baby to the shops. While this state of affairs is reported as a "trouble," it is not depicted as a specific "problem" that requires advice. In particular, the grandmother offers no explanation of why the daughter has to return home when it rains. In this particular context, while there

may be a concern for the baby's welfare, there is also the possibility that the daughter does not like walking in the rain, or that she is anxious about her new baby carriage which, she has asserted a few turns earlier (data not shown), "goes funny" in the rain.

(10) [4B1:22]

- 1 G: 'hhh When she starts off walking ou:(t) it
 2 always seems to rai:n.
 3 HV: 1→ aO::h.=
 4 M: =Yea:h.
 5 G: Ge:ts half wa:y and 'as to come back.
 6 M: ()
 7 HV: 2→ Oh what a pity.
 8 M: Yea:h myea:h.
 9 HV: 3→ But if she's wrapped up well it won't do he:r
 10 any ha:rm
 11 M: (harm)
 12 G: No:.
 13 M: No: that's what they ()
 14 HV: 4→ [Babies loose a lot
 15 of heh- heat through their hea:ds
 ((continues with advice))

The HV's response to the grandmother's initial observations is one of simple affiliation: a sympathetically intoned "Oh" (arrow 1) in response to the grandmother's account of the rain and a subsequent empathetic assessment (arrow 2) in response to her account of its consequences. Subsequently, however, she shifts to a "baby relevant" treatment of the reported events (arrow 3) and continues by describing the baby's head as a major source of heat loss, an observation which culminates in the advice that "bonnets are worth having." Here, then, a general, and at best opaquely motivated, description of the irritations of the British weather is responded to in terms of its implications for the health of the baby and engenders advice giving as its outcome.

And in the following sequence, a minimally problematic reference also attracts advice giving.

(11) [3A1:14]

- 1 HV: Listen to your 'iccups. Just listen to your
 2 'iccups.
 3 B: ((hiccups))
 4 M: I know what cures those.

- 5 (.)
 6 M: More milk
 7 HV: {
 More
 8 {mi:lk is-
 9 M: { heh heh heh heh
 10 HV: Huh
 11 (0.5)
 12 HV: → Don't worry about hiccups. ((continues))

This fragment opens with the HV addressing a remark – in “baby-talk” register – to the baby. Whilst it is unclear whether this remark is intended as a means to draw the mother’s attention to the baby’s hiccups and thus to treat them as problematic, the mother nonetheless proceeds to describe what she proposes as a “cure” for the baby’s condition. Although the term “cure” formulates the baby’s condition as a “problem,” her subsequent depiction of it – “More milko” – is offered lightly and she follows it with laughter to which the HV briefly affiliates. Here, while the mother portrays herself as able to manage this situation, her formulation of it as problematic appears sufficient to engender advice giving, which the HV begins after a short pause.

2.1.3 Summary

A number of basic points about mother-initiated advice sequences can now be made. First, requests for advice are relatively infrequent in our data base of first visits. Second, mothers commonly manage them so as to portray themselves, as far as possible, as competent and knowledgeable about the issues they raise. Third, mothers may solicit advice, as in (9), by reporting or describing untoward states of affairs and without overtly requesting it. However, in such cases, the matters that are made explicit in overt requests – that something is viewed as problematic, the nature of the problem, and the need for advice – are, to varying degrees, left implicit. It is thus left to the HV to determine whether the described state of affairs embodies a genuine problem that warrants advice and/or whether the description is offered as a means of soliciting advice. Describing an untoward state of affairs is, at best, an indirect means of soliciting advice and such descriptions may be variously motivated. Advice giving, which treats such a description as a means of deploying a “problem” in search of a “solution,” is only one of a range of

possible responses and may represent a course of action that is unlooked for or undesired (Jefferson and Lee, this volume).¹⁶ In our data, the HVs tended to deal with such descriptions in terms of their relevance for health or baby-management issues and to respond with advice. Thus the report – or even mention (see (11) above) – of some problematic state of affairs may be sufficient to entrain the delivery of advice even in circumstances where it is unlikely that the report is being offered in search of advice. The readiness with which the HVs in our sample responded to such reports and mentions with advice indicates both their concern with any potential problem situation that may arise and their orientation to advice giving as a central task of these interactions.

2.2 Health-visitor-initiated advice

The vast majority of advice giving in our data base was initiated by HVs. Much of it arose from routine inquiries about baby- and health-related matters. In contrast to the mother-initiated advice sequences in which, by requesting advice, the mothers established both its relevance and its object, advice giving in the HV-initiated sequences often emerged prior to any clear indication that it was desired.

Below we show a range of the sequences through which the HVs initiated advice. These vary from relatively elaborate attempts to establish a “problem” – and thereby to construct a context in which advice could relevantly be offered – to cases in which no such attempt was made and advice was delivered to a completely unprepared recipient.

2.2.1 Stepwise entry in advice giving: developing a problem

We begin with cases in which a relatively complete series of steps in the construction of a “problem-requiring advice” are present. In (12) below, the mother’s response to the HV’s initial inquiry is indicative of a residual problem:

- (12) [1A1:10-11]
 1 HV: 1→ Is the co:rd eh:m (1.0) dry now.
 2 M: 2→ Ye:s it’s- (.) it weeps a little bit.
 3 HV: 3→ And what do you do:.
 4 M: {mYeah.)

- 5 M: 4→ I've got some of those mediswab^s
 6 HV: Uh huh
 7 M: 4→ an' I use
 8 4→ it to clean it with and I put a bit of
 9 4→ talcum (powder on)
 10 HV: 5→ Don't be frightened of uhr (.) the co:rd
 11 5→ because it's uhm (1.5) it uh nothing awful
 12 HV: 5→ will happen.
 13 M: Mm:
 14 HV: 5→ Uhm just make sure you clean right insi:de
 15 M: Ye:h
 16 HV: 5→ with (.) with the mediswabs.=Pull- pull it
 17 5→ apart with your fingers 'hhh and give it a
 18 5→ good (.) clean.
 19 (.)
 20 HV: 5→ And then put ye:r (.) sterile powder on.
 21 M: Ye:h.
 22 HV: 'nd if you need any more we can give you
 23 some more swabs.
 24 (.)
 25 M: Ri:ght.
 26 HV: Uhm (0.3) and what about- her bottom's
 27 alright?

The sequence is opened with the HV's inquiry "Is the co:rd ehm (1.0) dry now." The design of this inquiry – in particular, its explicit reference to the cord being "dry" – is managed so as to implicate an expectable or normal state of the cord, and thus gives the mother a standard against which to recognize anything that may be problematic in her own case. The mother initiates her response with a turn component ("Ye:s it's-") that is shaped to a trajectory that would assert that the cord is "fine" or "normal." However, she then revises this response so as to acknowledge that it is weeping "a little bit" (arrow 2) – a response that, in the context of the HV's inquiry, indicates an ongoing problem. The HV's second inquiry, "And what do you do:." (arrow 3), now accomplishes a range of tasks: first, it fixes the issue as problematic and requiring action; second, it moves the topical focus of the sequence from the problem to measures for its solution; third, it projects some detailing of her activities by the mother (arrow 4) to which the HV can relevantly fit appropriate advice on the course of action to be followed (arrow 5).

As noted above, this is a relatively extended "step-by-step" pro-

cedure which culminates in advice giving. The relevant steps may be summarized as follows:

- Step 1: HV: initial inquiry.
 Step 2: M: problem-indicative response.
 Step 3: HV: focusing inquiry into the problem.
 Step 4: M: responsive detailing.
 Step 5: HV: advice giving.

This "step-by-step" approach to the initiation of advice giving is further illustrated in (13):

(13) [IC1:39]

- 1 HV: 1→ And you feel- (0.3) you're alright ba:thing
 2 (.) her?
 3 M: 2→ I haven't bathed her ye:t.
 4 HV: Haven't you really.
 5 M: 2→ No:. She had a bath when she
 6 2→ came home from hospital (0.2) but I top and
 7 2→ tail her.
 8 HV: Ye:h=
 9 M: 2→ =but uhm: me mum's coming over tomorro:w (.)
 10 2→ and I'm gonna ba:th her in front of me mum
 11 2→ 'cos I'm (still) a little bi:t (.) you
 12 2→ kno:w ()
 13 HV: 3→ Did they show you how to bath
 14 3→ her (when you were in)
 15 M: They di:d but (0.9) I: (.) still
 16 4→ wasn't- I said to me mum you know wuh- when
 17 4→ you come over tomorrow would you sort'v give
 18 4→ me a ha:nd you know if I nee:d it.
 19 (.)
 20 HV: 5→ The main thing is: that you have the things
 21 5→ all together before you sta:rt.
 ((advice giving continues))

Here the HV's initial inquiry is built towards an affirmative, "no problem" response. However, the mother's reply indicates a potentially problematic state of affairs and the beginning of her – subsequently abandoned – account for not bathing her baby (lines 11–12) implies some uncertainty or lack of confidence about how to do it. The HV's focusing inquiry topicalizes this issue by asking whether the mother has been shown the procedure. It is noticeable that although the initial component of the mother's response

("They di::d but (0.9) I: (.) still wasn't-") is abandoned in favor of depicting her request to her mother (and through that depiction, an intimation of her needs), it is at least compatible with a continuing state of uncertainty about how to bath her baby. Subsequently, the HV begins to advise the mother how to go about the task.

Several significant features of this stepwise entry into advice giving may now be summarily noted. First, the relevance of advice giving is established in a successive process through which (a) a problem is unearthed and then (b) measures for its solution are topicalized through a focusing inquiry. By this means, the potential need for advice can emerge as the joint construction of the participants.

Second, the HV's focusing inquiry and the mother's response to it can enable the HV to develop her course of advice in a nonadversarial fashion and in a way that is fitted to the mother's account. For example, in (12), the mother's response to the HV's focusing inquiry enables the latter to build her advice so as to support and reinforce the mother's report of what she has been doing, rather than as a recommendation that would contrast with and implicate criticism of the mother's reported actions.¹⁷

However, third, the HV's inquiries are not managed in such a way as to determine clearly that the mother is ignorant or at fault. For example, in (12), although the HV's focusing inquiry and her subsequent advice imply that the mother may have failed to clean the cord in a satisfactory fashion, she does not attempt to establish this as a definite fact. Such an attempt would develop the interaction in an inquisitorial direction, while an overt finding that the mother's treatment of the cord had been at fault would be a problematic context within which to initiate a course of advice. Similarly, in (13), rather than attempting to have the mother overtly describe her anxieties or difficulties, the HV builds towards advice giving on the basis that the mother seems uncertain about bathing her baby. Thus, while advice giving may imply that the HV discerns a lack of knowledge or competence in the mother, the exact character of these deficiencies is left implicit.

2.2.2 Variations on the stepwise entry into advice giving

While (12) and (13) above represent a relatively extended step-by-step movement into advice giving, the sequence may be varied –

contracted or departed from – in a variety of ways. In what follows, we show an ordered series of such contractions and departures. Within this series, each contraction or departure involves a reduction in the amount of preparation for the consummatory advice-giving phase of the sequence and increases the risk that the advice, when it is finally delivered, may be redundant and/or undesired.

Variation 1

A minimal form of contraction in the sequence arises when a general inquiry gets a response from the mother that both indicates a problematic state of affairs (step 2) and volunteers some account of how she has dealt with it (step 4). In these sequences, the mothers' accounts of how they are dealing with the problem, while designed to display their competence and capacity to cope, nonetheless consolidate their view of the state of affairs they describe as a problem. Moreover, because they topicalize the matter of how to deal with the problem, these accounts establish interactional environments that are ripe for advice giving. The following instance is typical in this respect:

(14) [1C1:13]

- | | | | |
|----|-----|----|--|
| 1 | HV: | 1→ | Her eyes're oka:y. |
| 2 | | | (0.7) |
| 3 | M: | 2→ | They ge- th- they get a bit wee:py sometimes, |
| 4 | | 4→ | but that's normal isn't it. And I swab th'm |
| 5 | | 4→ | with wool with cotton woo:l. |
| 6 | | | (0.3) |
| 7 | HV: | 5→ | Ye:s if they- if they: (0.2) if <u>you</u> think |
| 8 | | 5→ | they're pussie. |
| 9 | | | (0.8) |
| 10 | M: | | Yea:h. |
| 11 | HV: | 5→ | then you must use <u>boiled wa:te:r</u> |
| | | | ((advice giving continues)) |

Here the HV's initial inquiry (arrow 1) gets a response that details a baby problem (arrow 2). Subsequently, the mother describes what she did to deal with the problem (arrow 4) and the HV initiates a course of advice in response to this account. In contrast to the "full" step-by-step sequence displayed in (12) and (13) above, the shortened sequence runs as follows:

Step 1: HV: initial inquiry.

Step 2: M: problem-indicative response.

+

Step 4: M: additional detailing.

Step 5: HV: advice giving.

This sequence is also realized in (15) below:

(15) [IC1:19-20]

- 1 HV: 1→ What are her motions like.
 2 (0.6)
 3 M: 2→ Uh: uh:m they're softer no:w because she
 4 2→ was a l'ttle bit constipated (0.2) a few days
 5 2→ ago:.
 6 HV: Mm hm.
 7 M: 4→ and the midwife advised me to put a teaspoon
 8 4→ of uhm
 9 (1.0)
 10 HV: brown | sugar
 11 M: 4→ | brown sugar in alternate feeds
 12 HV: I see.
 13 M: 4→ | and tha:t helped her an' they're a lot
 14 4→ softer no:w.
 15 (0.6)
 16 HV: 5→ Oh I don't think you nee:d (1.2) you kno:w=
 ((advice giving continues))

In these cases, then, the mothers' volunteering of how they dealt with the problem obviates the need for the HVs' focusing inquiries while nonetheless creating a topical environment in which advice giving may be initiated.

Variation 2

A further contraction of this sequence occurs when the HV's initial inquiry yields a problem and the HV proceeds to advice giving (step 5) without any focusing inquiry. In these cases the advice-initiation sequence runs:

Step 1: HV: initial inquiry.

Step 2: M: problem-indicative response.

Step 5: HV: advice giving.

as in (16):

(16) [IC1:30-31]

- 1 HV: 1→ And you're able to put her down in between

- 2 1→ fee:ds are you:.
 3 (1.0)
 4 M: 2→ No:: (0.4) She screams.
 5 HV: uhhhh hah hah | hah 'uhhhhhhhhhh
 6 M: 2→ | if I put her in the: | re.
 7 Fr: | hhehhhh=
 8 HV: =hah hah =
 9 Fr: =eh hnh
 10 (1.0)
 11 M: Ye:s.=
 12 HV: 5→ =Well it is important you kno:w tuh: (0.2) get
 13 5→ it into a rou:ti:ne (0.2) otherwise she'll get
 14 5→ so used to sittin' on your lap she'll want to
 15 5→ do it all the ti:me.
 ((advice giving continues))

In (16) the HV's initial inquiry again projects an affirmative "no problem" response. After a substantial delay,¹⁸ the mother briefly responds by depicting a possibly problematic state of affairs which is initially met with laughter from the HV. Subsequently, the HV proceeds directly to the initiation of advice.

A similar pattern emerges in (17). Here an initial inquiry about postnatal exercises is met with a response that indicates that while the exercises have been begun, the mother did not start them until relatively recently after her return home. The mother's subsequent elaboration of this observation is intersected with the initiation of advice giving.

(17) [IC1:33-34]

- 1 HV: 1→ Are you doing your exercises.
 2 M: 2→ Yes I've started to do them () no:w.
 3 2→ =I didn't do them 'till I come ho:me
 4 (.)
 5 M: 2→ You kno:w I uh
 6 HV: 5→ | I think it's quite important to uh
 7 5→ particularly yer tail exercises which you can
 8 5→ do: when yer just sitting do:wn
 ((advice giving continues))

Here the mother's response apparently indicates insufficient commitment to the postnatal exercises and creates sufficient doubt for advice about the exercises to be initiated. The HV's advice is designed to underscore their importance.

By contrast with the sequence types discussed previously, this

contraction significantly reduces the chance that the relevance of advice giving can be appropriately established prior to its delivery. First, since no description of how she is dealing with "the problem" is volunteered by the mother or requested by the HV, it may not be clear from the mother's initial response that she regards the circumstances she describes as significantly problematic. For example, in (17) the mother may have described an approach to her exercises which is, from her point of view, perfectly adequate. Thus what is treated as a "problem in need of advice" by the HV, may not be regarded in the same way by the mother.¹⁹

Second, in the absence of a description of the mothers' responsive measures, the HV has no assurance that the advice she gives may not be already known, and indeed acted upon, by the mother and her advice stands a serious risk of appearing inappropriate or redundant.

The choice between moving to a step 5 advice giving or a step 3 focusing inquiry is nicely illustrated in (18) below. Here, the sequence opens with a problematic noticing by the HV of the baby's jaundice that is strongly confirmed by the mother. At line 9, the HV begins a turn with "Well I think eh-" and abandons this beginning in favor of a focusing inquiry about where the baby has been during the day.

- (18) [3A2:1-2]
- 1 HV: We'll I think her (.) jaundice has faded a
 - 2 little bit but it hasn't (.) h₁asn't
 - 3 M: Gone
 - 4 HV: gone yet.=
 - 5 M: =No:: her eye:s especially if you notice her
 - 6 eyes when she opens them.
 - 7 HV: O:h.
 - 8 M: You can tell.
 - 9 HV: → Well I think eh- Has she been outs- outdoors
 - 10 he- getting plenty of light.
 - 11 (0.3)
 - 12 M: Well she's (.) been outdoors but I mean (0.5)
 - 13 I wrap her up so well and I always keep the
 - 14 hood up so that she doesn't get wi:nd (.)
 - 15 HV: Y₁es
 - 16 M: on her.=So: (.) not really.
 - 17 HV: I think you (know) (.) keep her near the
 - 18 window.=

- 19 M: =Okay.=
- 20 HV: =Keep her in light because um 'hh I thought it
- 21 really would have gone this week.

A comparison of the beginning of line 9 with the HV's subsequent advice delivery (line 17) strongly suggests that the HV was beginning a step 5 advice giving which she then abandoned in favor of a step 3 focusing inquiry. Insofar as the HV intended to recommend what she subsequently inquired into (that the baby be placed outdoors), the inquiry enabled her to avoid proposing a course of action which, it turns out that the mother has been cautious about (see lines 12-16). She was thus able to design her final advice in a way that was fitted to the mother's account and the weather conditions that the account details. Here then it is likely that the HV's reversion to a focusing inquiry served to avert the proposal of a contestable or inappropriate course of action.

Notwithstanding the various contractions of steps 3 and 4 of the movement into advice giving, all the HV-initiated advice sequences examined thus far have been developed after at least a *possibly problem-indicative response* (step 2) to a HV inquiry. In these cases, an initial problem-indicative response has provided for the relevance of the subsequent move into advice giving.

Variation 3

In a variety of cases in our data base, however, advice giving was initiated in the absence of a problem-indicative "step 2" response. In a small subset of these cases the HV sustains a "problem orientation" as the basis for advice giving by herself, detailing a possible or potential problem and then going on to offer advice on how to deal with it. For example, in the following instance, the HV follows a "no problem" response to her initial inquiry by first describing a problem that "might" arise (lines 8-14) and then offering advice on it (lines 14-15).

- (19) [4B1:3]
- 1 HV: 1→ 'hh And has your discharge lessened.
 - 2 M: 2→ Yeah.
 - 3 HV: Smashing. And it's sort of pinky brown.
 - 4 M: 2→ Yeah there's hardly anything there
 - 5 no w.
 - 6 HV: Lovely.=

- 7 M: =S_o
 8 HV: 5→ 'hh You might find if you start rushing
 9 5→ around as you're feeling so fit and 'hhh
 10 5→ gallo- walking up to the sh- (.) up to the
 11 5→ Cowley Centre and doing your shopping and
 12 5→ carrying heavy ba- (.) bags back 'nd things
 13 5→ you might find 'hhh that it- it gets a
 14 5→ little bit heavier in which case that's a
 15 5→ good sign tuh (.) slow down a bit.

The basic pattern in this sequence may be represented thus:

Step 1: HV: initial inquiry.

Step 2: M: "no problem" response.

Step 5: HV: advice giving on "possible problem."

This pattern is also exhibited in (20) below:

(20) [1A1:11]

- 1 HV: 1→ Uh:m (.) anything that w's worrying you at
 2 a:ll.
 3 (1.5)
 4 M: 2→ No: I don't think so?
 5 HV: 5→ When you're breast feeding you're passing
 6 5→ over some hormones to your baby.
 7 M: Ye:h.
 8 HV: 5→ So some ba- so me little girl babies do
 9 F: ((cough))
 10 HV: 5→ have (.) some (blood)
 11 (0.7)
 12 M: Oh:.
 13 HV: 5→ In fact there are- occasionally you do get a
 14 5→ little bit v mi:lk out of their breasts.
 15 M: 'hh Oh: ('hhh)
 16 HV: 5→ So that's as well to know if you remember that
 17 5→ in case you don't 'n' you know it (.)
 18 M: Mm:
 19 HV: 5→ alar:ms you.

In these cases, even though the mother's reply offers no overt warrant for advice giving – the (step 2) response is problem free – the HV provides such a warrant in association with the advice (step 5) by foreseeing a possible problem, one that "might" arise, or that happens to "some babies."²⁰

Variation 4

In our final variation on the basic sequence, even the warrant for advice giving found in (19) and (20) may be dispensed with. In the following cases, neither the HV's initial inquiry nor the mother's response to it is overtly problem oriented. The advice giving that ensues is thus delivered to an unprepared recipient – as in (21) below:

(21) [4B1:16]

- 1 HV: 1→ 'hh Now this (0.2) uh:m she started bottle
 2 1→ feeds from bi:rth.
 3 M: 2→ 'Yeah.'
 4 (2.2)
 5 HV: 5→ The hospital recomme:nd that she shouldn't
 6 5→ start solids until she's (.) four months.
 7 M: Four m-onths.
 8 HV: 5→ At lea:st.
 9 (.)
 10 HV: 5→ 'hhh Some babies don't even need to start
 11 5→ before six months (0.2) 'hh and really the
 12 5→ longer you can fob off solids the better for
 13 5→ he:r.

And in (22), a mother's "no problem" response to an inquiry about her baby's sleeping is accompanied by an elaborate description of her procedure for feeding the baby at night.

(22) [3A1:24]

- 1 HV: 1→ We:ll whu- uhh what is she: uh like at ni:ght.
 2 M: 2→ Uh:m (0.4) she's alright she kno::ws the
 3 2→ difference between night and da:y (.) and I
 4 2→ don't tend to stimulate her at all in (.) at night
 5 2→ time I jus:t get straight into the little
 6 HV: 2→ roo:m in the bed the re and (.) put her in
 7 2→ Yes Mm
 8 HV: 2→ with me: (0.2) and (.) she feg:ds and that's
 9 2→ it.=Not much (.) chatting or anything o:r
 10 HV: No.
 11 HV: 5→ 'hh No always be v:ry very quiet at
 12 5→ ni:gh:t. 'hh
 13 M: Mm
 14 (.)
 15 HV: 5→ Always uhm (0.4) on- have a dim li:ght.

- 17 M: Yeh.
 18 HV: 5→ And uhm (1.0) be v_g:ry qui_jet don't chat her
 19 5→ up at a:ll 'hh when you cha_nge her (.) change
 20 5→ as quickly as possib_le, without any
 21 M: Yeh
 22 (.)
 23 M: Yeh.
 24 HV: 5→ palaver.
 ((advice giving continues))

Here, notwithstanding the fact that the mother's account of her night-feeding procedures is, as it turns out, substantially identical with the HV's preferred procedure, the HV nonetheless elaborately advises her about appropriate practice and in terms that are very similar to those already used by the mother. In these last cases, advice giving is initiated on a unilateral basis without any basis in a previously depicted problem and, in (22) at least, it is clearly redundant.

2.2.3 Summary

We have now seen a variety of ways in which advice giving may be initiated in these first encounters between mothers and HVs. First, and relatively infrequently, mothers may request advice, thereby establishing the relevance of advice giving and their own prospective orientation as advice recipients. In overt requests for advice, identification of a problem area, the character of the problem, and a prospective alignment of the local roles of advice recipient and advice giver are usually achieved in a straightforward and natural way. As we have seen, the requests for advice that achieve these objectives are most commonly shaped as requests for confirmation of a proposed course of action. By this means, mothers display their own putative competence and capacity to cope with the problem for which they seek help and avoid the appearance of ignorance or incompetence which might arise from a simple request for information.

Second, the predominant form of advice initiation arises from HVs. In HV-initiated advice giving, by contrast with mother-initiated requests for advice, both the need for advice – and with it the prospective alignment of the mother as advice recipient – and the problem for which advice is sought are often less clearly estab-

lished. Most commonly, HVs initiate advice giving in the context of routine inquiries into a range of health and baby-management issues. These inquiry sequences may be arrayed on a continuum in terms of the degree to which a need for advice and its associated problem area are established prior to the initiation of advice giving. Within this continuum, the bulk of advice giving is initiated without an extended preparatory sequence. Indeed, the bulk of advice initiations falls close to the "unilateral" end of our continuum, in which the HV's initial question serves primarily to topicalize the issue for which advice is subsequently developed.

Across all these environments, the HV defines herself as a knowledgeable and authoritative "expert" *vis-à-vis* an advice recipient who is relatively ignorant or noncompetent. Although, as we have argued, HV-initiated advice sequences are almost always initiated without the mother's desire or need for advice having been definitively established, there is a wide range of variation in the degree to which advice giving is prepared for in advance of its actual delivery. However, a substantial majority of advice giving is initiated with only minimal preparation. The extent of this preparation, however, may strongly influence the subsequent reception of advice, to which we now turn.

3 The reception of advice

As we have already proposed, the initiation of advice giving carries problematic implications about the knowledge or competence of the intended recipient. A concern for these implications shapes both the design of requests for advice and mothers' conduct in sequences in which HVs move towards the initiation of advice. This concern is equally manifest in the reception of advice where, as we shall see, mothers tend to minimize the extent to which they acknowledge that advice has been "informative."

3.1 Receiving information

In ordinary conversation, the parties have a range of resources with which to receipt informing statements. Prominent among these are acknowledgment tokens (such as *mm hm*, *uh huh*, *yes*, etc.), which are normally used as "continuers" (Jefferson 1984b; Schegloff

1982); objects like *oh*, which treat the information as “news” for the recipient (Heritage 1984b); and “newsmarks” (Jefferson 1981a), which also treat prior talk as “news” and, to varying degrees, promote further informings. Some of the distinctiveness of these objects can be illustrated by reference to the following fragment, in which the component elements of an informing are receipted in a variety of ways:

(23) [Frankel:TC:I:1:2-3: simplified]

- 1 S: = 'hhh Uh:m:: .tch 'hhhh Who w'you ta:|k|ng
 2 to.
 3 ...
 4 ...
 5 G: I: wasn't talking to a:nybody. Bo-oth Martin'n
 6 I slept until about noo:n.=
 7 S: 1→ =O|h.
 8 G: 'hhhh An' when I woke up. I wanted to call
 9 my mother.
 10 S: 2→ Mm|hm
 11 G: 'hhhh An' I picked up the pho:ne. a:n' I
 12 couldn't dial out.'n I thought our phone was
 13 S: 3→ Oh: ().
 14 G: out'v order. 'n I-
 15 S: 4→ |Yeh.

In this segment, S's inquiry follows her report of repeatedly trying to telephone G and getting a “busy signal.”²¹ However, her inquiry, which presupposes that G has been talking extendedly on the phone, yields the report that this was not the case. This is “oh” receipted as “news” for S (arrow 1). Subsequently, G initiates a narrative whose first component is receipted as a narrative background with the “passive” or “continuative” acknowledgment token “mm hm” (arrow 2). As the narrative develops, G reports her discovery that she “couldn't dial out” and this component is “discovery” receipted by S with “oh” (arrow 3). Subsequently, G then reports her “first” and projectably incorrect thought (Jefferson 1986b) that her phone was out of order and this is receipted with an agreement-implicative acknowledgment token “yeh” (arrow 4). In this short segment, the various receipt items accomplish a range of distinctive tasks across the telling in progress, and they are selected to be appropriately responsive to the specific story segments as they emerge.

While this kind of variegated, segment-by-segment receipt of an informing rarely occurs in HV–mother interactions, the acknowledgment tokens deployed in (23), together with others detailed below, play a predominant role in the receipt of advice, to which we now turn.

3.2 Receiving advice

We begin by noting three main ways in which advice may be received.

1 *Marked acknowledgment*: Here mothers respond to advice in ways that acknowledge its character as advice and its informativeness for them. Marked acknowledgments normally convey acceptance of the advice offered.

2 *Unmarked acknowledgment*: Here mothers respond to advice in ways that avoid acknowledging it as informative and that avoid overtly accepting it. Although they do not involve the overt rejection of advice, we shall argue that unmarked acknowledgments represent a response form that is resistant to advice giving and that may imply rejection of the advice that is given.

3 *Assertions of knowledge or competence*: Here mothers respond to advice by asserting that they already know and/or are undertaking the advised course of action. While these assertions, like unmarked acknowledgments, do not reject the advice to which they respond, they are also resistant to its delivery and achieve this resistance by indicating that the advice is redundant.

Below, we consider each of these three main forms of advice reception in turn.

3.2.1 Marked acknowledgments

The pro forma “marked” advice receipt in our data base is *oh right* – the first *oh* component treating the prior advice as “news” for the advice recipient and adumbrating its acceptance (Heritage 1984b), the subsequent “right” component overtly marking its acceptance, as in (19):

(19 cont.) [4B1:3]

- 1 HV: Lovely. = 'hh And has your discharge lessened.
 2 M: Yeah.
 3 HV: Smashing. And it's sort of pinky brown.
 4 M: Yeah there's hardly anything the:re
 5 no_w.
 6 HV: _LLovely.=
 7 M: =S_o
 8 HV: 'hh You might find if you start ushing
 9 around as you're feeling so fit and 'hhh
 10 gallo- walking up to the sh- (.) up to the
 11 Cowley Centre and doing your shopping and
 12 carrying heavy ba- (.) bags back 'nd things
 13 you might fi:nd 'hhh that it- it gets a
 14 little bit heavier in which case that's a
 15 goo:d si:gn tuh (.) slow down a bit.
 16 M: → Oh right.

More elaborately, marked acknowledgments sometimes include partial repeats of key components of the prior advice:

(8 cont.) [4B1:7]

- 1 HV: 'hh And family planning you know you can get
 2 pregnant straight awa:y so if you wo:uld (.)
 3 like any: (.) help in that score you always
 4 ask me: or see the G.P. or go to the family
 5 planning clinic.=
 6 M: =Well I- I've got some (0.4) things
 7 upstai:rs.
 8 HV: _LOh well done.
 9 M: But (.) when I've got to take them I
 10 do:n'know.
 11 HV: Well (.) uhm if you're not breast feeding
 12 there's no reason why you shouldn't start them
 13 when (.) she's fou:r weeks.=On the da:y she's
 14 four weeks you can _Lstart them straight away.
 15 M: 1→ _LFour weeks.
 16 M: 2→ Ri:ght.=
 17 HV: =And then you'll be covered.
 18 M: Mm.
 19 G: ((cough))
 20 HV: Oka:y.=
 21 M: =Ri:ght.

In this sequence, the mother requests advice about when to restart the pill. The HV's advice, "four weeks," is initially presented in a

negatively formulated turn component "Well (.) uhm if you're not breast feeding there's no reason why you shouldn't start them when (.) she's fou:r weeks." The same basic information is then immediately re-presented in an affirmatively packaged turn component as positive advice. In the course of this second turn component, the mother acknowledges the specific advice element that responds to her previous inquiry with an overlapped repetition of "four weeks" (arrow 1) and a subsequent accepting "Ri:ght" (arrow 2) at the completion of the HV's turn.²²

A similar pattern of response also emerges in (6) below:

(6 cont.) [3A1:15]

- 1 M: I haven't ba:thed her yet. Is once a week
 2 enough.
 3 (0.7)
 4 HV: We:ll (0.2) babies do: sweat a lot.
 5 (0.3)
 6 HV: So I would recommend giving her a ba:th
 7 every da:y.
 8 M: 1→ Every da:y,
 9 HV: So that she gets used to it and sh- that's her
 10 little pl:aytime for he_r.
 11 M: 2→ _LOh ri:ght.

Here, the HV's contrastive recommendation of a bath "every day" is acknowledged by the mother with a repeat (arrow 1) and her elaborative continuation is receipted with a subsequent "Oh ri:ght" (arrow 2).

In only one case in our data base is "corrective" advice giving followed by an overt acknowledgment of error. This sequence is a continuation of (9) above and we pick it up at the point where the HV raises the question of whether a sweating baby may be too hot.

(9 cont.) [4B1:22]

- 1 M: Year:h she's a re:a_Ll swea(t)uh.
 2 HV: _LD'ju think she's ho:t.
 3 (G): She might be:.
 4 M: Wul we keep 'e_r wrappin' round er
 5 G: _LWe keep 'er in that li- uh
 6 (0.5)
 7 M: and in this little nest _Lhere that she's go:t
 8 HV: _LRi:ght.
 9 (.)

- 10 HV: Right. 'hh (It) might be that she's too hot.
 11 (1.2)
 12 (): ()
 13 HV: Becuz this is certainly the- (.) the
 14 temperature of the hospital isn't it.=
 15 M: =Yea:h.
 16 HV: And is it the same throughout upstairs as
 17 we:ll.
 18 (0.2)
 19 M: We:ll I've got a little fire:re (.) upstairs
 20 HV: I would
 21 slowly bring the temperature do:wn to sort of
 22 normal.
 23 (M): Ye,ah.
 24 (G): Yeh
 25 HV: A::nd
 26 (G): 1 → W' don't want her catching co:lds y' s' ee.
 27 HV: No:
 28 that's right (.) that's right it's
 29 so : difficult to deci:de
 30 G: ()
 31 HV: is, n't it.
 32 M: It could be.
 33 HV: 'hh But- but I think it- it's as bad tuh have
 34 HV: it too: hot as it is to have it too co:ld.
 35 G: 2 → (we probably (0.7) do over protect.)
 36 M: Yea:h.

Across the sequence of HV inquiries the mother and grandmother acknowledge the possibility that the baby may be too hot (lines 3–19). However, after the HV's recommendation that the house temperature be reduced and the mother's and grandmother's brief acknowledgment of the advice, the grandmother accounts for their actions in terms of the risk of the baby catching cold (arrow 1). It is only after the HV moves towards a further reassertion of her position that the grandmother interjectively acknowledges that they may have been in error (arrow 2).²³

The significant feature of these marked acknowledgments of advice is that they overtly receipt the talk to which they respond as *advice*. In different ways, their component elements – *oh* receipts, repetitions of key advice elements in prior utterances, *right* acceptances, and acknowledgments of error – respond to prior informings as “news” for the recipient and as containing information which

the recipient accepts and is prepared to act on. It is striking that these marked acknowledgments of advice are primarily found in environments in which the advice recipient has *already cast herself in the role of prospective advice recipient* by directly (e.g. [8] and (6) above) or indirectly (e.g. [9] above) requesting advice. In these cases, a request for advice – with its explicit or implicit acknowledgment of some deficiency in competence or knowledge – can permit marked acknowledgment and acceptance of the advice which follows without further loss of “face.” Moreover, such marked acknowledgment may be required from a recipient who, having requested advice, has now had that request fulfilled.²⁴ Marked acknowledgments of advice, however, are comparatively rare in the environment of HV-initiated advice. In the latter, the predominant form of receipt is unmarked acknowledgment.

3.2.2 Unmarked acknowledgments

Unmarked acknowledgments of advice giving characteristically involve such receipt objects as *mm hm*, *yeh*, and *that's right*. These objects stand in contrast to marked acknowledgments (such as partial repeats, *oh*, etc.) in two main respects. (a) They do not acknowledge advice giving as “news” for the recipient – indeed, receipts like *that's right* specifically propose that the recipient was already aware of the information offered as “advice,” while objects such as *mm hm* and *yeh* are, as already noted, primarily “continua-tive” in character (Jefferson 1984b; Schegloff 1982). (b) These objects do not constitute an undertaking to follow the advice offered. In short unmarked acknowledgments, while receipting the talk that constitutes an advice giving over its course, do not acknowledge or accept that talk as *advice*.

The use of this pattern of receipting was widespread in our data base. The following case shows the development of a sequence of advice giving from (22) above, in which the HV's advice largely repeated the mother's own account of her actions in feeding the baby at night.

(22 cont.) [3A1:24]

- 1 HV: 'hh No always be very very quiet at
 2 night. 'hh
 3 M: → Mm

- 4 (.)
 5 HV: Always uhm (0.4) on- have a dim li:ght,
 6 M: → Yeh.
 7 HV: And uhm (1.0) be vɛ:ry qui:et don't chat her
 8 up at a:ll 'hh when you change her (.) change
 9 as quickly as possi:ble, without any
 10 M: → Yeh
 11 (.)
 12 M: → Yeh.
 13 HV: palaver.
 14 (0.2)
 15 M: → That's ri:ght.
 16 HV: And (.) so she kno:ws that uh
 17 M: → (Yeh)
 18 HV: people aren't keen on me: at this: uhm (0.2)
 19 hou:r and uh once she gets that message it's
 20 M: → Yeh
 21 HV: a good thi:ng.
 22 (3.0)
 23 M: And she tends to settle do:wn straight awa:y
 24 at ni:ght
 25 HV: Mm
 26 M: I mean (.) sometimes during the da:y she'll uh
 27 (0.2) she'll scream for fi:ve minutes and then
 28 she'll go °off.
 29 HV: Mm
 30 (0.2)
 31 M: But uh
 32 (1.0)
 33 HV: (Yes)
 34 M: Y- you're alrigh: really a:ren't you.

In this datum, the mother receipts recognizably redundant advice with a series of unmarked acknowledgment tokens (arrowed). At the completion of the HV's advice giving, however, the mother permits a full three second pause to develop (line 22) without verbally acknowledging its completion and then proceeds with remarks (beginning at line 23) that indicate that the problem on which the HV's advice has been focused (the baby's sleeping at night) is not a significant one. In this case, then, unmarked acknowledgments over the course of an advice-giving sequence adumbrate a form of "passive resistance" to the advice-giving episode that is ultimately expressed as an implicit rejection of the relevance of the advice that was given.

This association between unmarked acknowledgments of advice giving and subsequent resistance is not particular to this datum. In (24) below, an extended pattern of unmarked acknowledgment is followed by a turn (line 37) that implies that the advice being delivered is redundant. The mother's initial turn in this datum represents the renewal of an earlier telling about problems in getting her baby to sleep. After a minimal affiliation with the trouble (line 3) the HV inquires into how she handled the problem – an inquiry which is a standard precursor to advice (cf. (12) above).

(24) [1A1:7]

- 1 M: B't last night she j'st wouldn't go o:ff.=I
 2 think she'd about two hou:rs till six o'clock.
 3 HV: O:h poor you.=So what did you do.
 4 ...
 5 ((17 lines of data omitted in which Mother and
 6 Father describe being up all night))
 7 ...
 8 HV: I think there's a danger when you are breast
 9 feeding that (.) especially at night when
 10 you're all sort of nice and cosy and wa:rm
 11 'hhhh that you do: (0.4) uhm (0.8) you know
 12 the baby feels so comf- comfortable and so
 13 content.
 14 M: Mm:
 15 HV: Uhm being cuddled an' (0.6) and sucking at
 16 your breast (0.4) that she falls asleep (.)
 17 she forgets about feeding
 18 M: Mm: ...
 19 HV: and falls to sleep without actually taking
 20 he:r hhh
 21 F: Mm.
 22 HV: uh required quantity.=
 23 M: =Yess.
 24 HV: and therefore you've got to (0.5) do your
 25 best to keep her awa:ke when she's actually
 26 M: 1→ Yea:h
 27 HV: feeding.
 28 (.)
 29 HV: 'hhhh Uhm (0.2) in ho:s:pital we encourage
 30 babies khhhhh 'hhh to keep awake by: sort of
 31 tickling the ba:ck of their neck or 'hh
 32 M: 2→ Mm::
 33 HV: tickling the soles of their feet.

- 34 M: 3→ Ye :s.
 35 HV: and not
 36 (.)
 37 M: 4→ They taught me (under the jaw) as well.=
 38 HV: =Yeh and not having them (.) mghm too wrapped
 39 up.
 40 (0.2)
 41 M: Mm.
 42 (1.0)
 43 HV: And uhm (.) I usetuh
 44 (3.2)
 45 HV: You've got to get as much of a bosom in her
 46 mouth ((continues))

In the advice delivery that follows (beginning at line 24), the mother responds with a series of unmarked acknowledgments (arrows 1–3) and then indicates (arrow 4) that she is already thoroughly aware of the advised procedure.²⁵ Subsequently, she retreats once more into (delayed) unmarked acknowledgment (line 41) as the HV continues. Shortly thereafter the HV shifts topic (lines 45–6). In this sequence, then, the mother's series of unmarked acknowledgments culminates in a response that, while confirming that she has heard and understood the substance of the HV's advice, specifically avoids treating it as "news" for her.

While we have so far proposed that unmarked acknowledgments are associated with subsequent resistance to advice, we may now note that they may be analytically treated as forms of resistance in themselves. Insofar as a would-be adviser shapes their talk as advice, then an appropriate form of receipt will involve the use of marked acknowledgments that treat the talk as advice. Unmarked acknowledgments, which do not involve such a treatment, are inherently resistant to the advice giving to which they respond regardless of what they adumbrate. This contrast between the two forms of acknowledgment is very apparent in the following sequence. The sequence opens with the HV's introductory remarks, which are hearably prefatory to the advice giving which follows. These remarks (lines 1–20) are appropriately "continuation" receipted (at lines 14, 18, and 20). Subsequently, however, a series of components of a lengthy advice sequence which generally favors immunization against whooping cough receive unmarked acknowledgments or no acknowledgments (arrowed 1), but the subsequent mention that the parents may defer making a decision about the

immunization receives marked acknowledgment (arrowed 2). The HV's later remarks in support of vaccination yield a return to unmarked acknowledgment (arrowed 3). Here the forms of acknowledgment are consistent with the tacit expression of the parents' resistance to making a quick decision about their child's vaccination. After this renewal of unmarked acknowledgment, the HV shifts the topic (arrow 4).

(25) [4A1:14-15]

- 1 HV: Have you thought about the immunisations yet.
 2 (0.5)
 3 F: Not really: 'ave we?
 4 M: No:.
 5 HV: The ones on offer are diphtheria (.)
 6 whooping cough (.) tetanus (.) polio and
 7 measles.
 8 (0.2)
 9 'hh And the: (0.3) health authority
 10 recommend (0.7) that unless there's a family
 11 history on (0.4) the immediate side your
 12 brothers and sisters or your brothers and
 13 sisters 'hh with a history of epilepsy.
 14 F: Mm.
 15 (0.2)
 16 HV: Uhm that's not febrile convulsions in babies
 17 but- but
 18 F: Mm.
 19 HV: proper epilepsy.=
 20 F: =Yes.
 21 HV: 'hhh Then there's no: reason fer: (.) a child
 22 not to have whooping cough.
 23 F: 1→ Mm.
 24 (.)
 25 HV: 'hh But if you decide (1.0) that you don't
 26 want him to have it (.) a little while ago
 27 there was a scare then you- it's entirely up
 28 to you nothing is compulsory.=
 29 M: 1→ =Mm hm.
 30 HV: but it is recommended that if possible (0.2)
 31 all of them are better than: (0.7) i- it's
 32 better to have them all than (0.5) uhm:
 33 (0.7) no:t.=
 34 F: =() ((to baby))
 35 HV: [whooping cough can be a killer in
 36 the baby under one.
 37 1→ (1.0)

- 38 HV: Uh:m (1.2) but it m- (0.2) maybe you'd like to
 39 have a think about it and=
 40 M: 1→ =Mm hm
 41 HV: uh:m talk it over with the doctor.
 42 1→ (1.0)
 43 HV: when you see him at clinic.
 44 M: 1→ Mm hm,
 45 (0.6)
 46 HV: You don't need to make a decision really
 47 before (0.2) 'hh before he's (.) three months.
 48 F: 2→ Thr ee months.
 49 HV: [which is when the first injections
 50 sta:rts.
 51 F: 2→ Ri:ght.
 52 (0.7)
 53 HV: And he might ask your families (0.7) whether
 54 they know (0.2) of- of- of any reason and
 55 indeed whether you yourselves had the whooping
 56 cough vaccine as children.
 57 F: Mm.
 58 HV: Uhm (1.2) in my eleven years I've never seen a
 59 reaction to it but people clearly have had
 60 reactions.
 61 F: 3→ Mm :
 62 M: 3→ Yeah.
 63 (0.2)
 64 HV: 4→ Uhm (.) he's lovely isn't he?

If unmarked acknowledgments may be analytically considered as involving advice resistance, then we should expect to find cases in which HVs orient to them as such. Such evidence is present in (25) above, where, after a series of unmarked acknowledgments culminating in no acknowledgment (line 37) of a series of turns advocating whooping-cough vaccination, the HV revises her position (at line 38) by proposing that the parents talk to the doctor about the issue and introduces the possibility of their delaying their decision. It is noticeable here that the father's marked acknowledgments of the HV's revised position only begin after she has overtly stated (lines 46–8) that the parents do not need to make an immediate decision.

A similar process in which unmarked acknowledgments are treated as advice resistant is visible in (26) below. Here, after a sequence of unmarked acknowledgments (arrowed 1) to her

repeated advice about keeping the baby on milk for the first four months, the HV shifts towards a position that suggests that the parents may wish to start the baby on solids earlier than this (arrowed 2). Unlike (25) above, however, this shift does not attract any marked acknowledgment and the HV subsequently shifts topic (arrowed 3). It may be noted that the sequence opens with a presequence about grandmothers that is later clumsily employed to preemptively discount them as an alternative source of advice about weaning babies.²⁶

(26) [4A1:13-14]

- 1 HV: And did you breastfeed him at a:ll?
 2 M: No:.=
 3 HV: =No he went straight on to the bottle.
 4 (5.2)
 5 HV: At this stage I don't know whether you've got
 6 grannies nearby.
 7 (1.0)
 8 HV: have you?
 9 M: One yea:h.=
 10 F: =(One [near Whitestone Close)
 11 HV: Yes.
 12 HV: Uh:m (0.2) 'hh The hospital at the moment
 13 recommend that you don't start solids (.)
 14 until (0.4) four months.
 15 (.)
 16 HV: [and that's a long way off.
 17 F: 1→ Mm.
 18 M: 1→ M-m hm,
 19 HV: ['hh But you might well- somebody might
 20 recommend that you do: (.) and indeed if he-
 21 if he (.) becomes a big baby you might well
 22 need to give him a little bit before (.)
 23 four months but 'hh if it can be avoided=
 24 F: 1→ =Mm.
 25 HV: milk is the only thing he needs really (0.2)
 26 or water between feeds.
 27 M: 1→ Mm hm.
 28 HV: A:nd (1.0) he can have (0.7) uh juice
 29 M: 1→ Mm hm,
 30 HV: about six weeks on.
 31 (0.7)
 32 HV: Uh:m (0.3) but I think just milk is all he
 33 needs really.

- 34 M: 1→ Mm hm,
 35 HV: Uh:m
 36 F: E's not a (water) baby are you?
 37 (.)
 38 HV: 2→ But if you do decide you want to start him on-
 39 2→ on solids then that's- that's fine (0.6) uhm
 40 2→ and I'll (0.2) help you if I can.
 41 M: Mm hm,
 42 HV 3→ Anything (.) you ought to know.
 43 (1.0)
 44 HV: Uh:m
 45 (4.0)
 46 HV: 3→ And then at eight weeks (.) he has his first
 47 developmental check

As already noted, unmarked acknowledgments, in the way that they avoid receipting advice as advice, constitute a form of resistance to its delivery. However, the resistance which they offer is essentially "passive." Unmarked acknowledgment does not involve the *rejection* of advice. Moreover, the fact that the advice is resisted is not stated outright, nor are the grounds on which it is resisted made overt. As we have seen, some, but not all, advice-giving sequences that involve unmarked acknowledgments culminate in some rather more overt expression of resistance at their conclusion. Unmarked acknowledgments are common in sequences in which advice has been initiated by the HV, and we suggest that they are well fitted to a social context such as these home visits, in which a mother may be able to do little or nothing to stem the flow of advice, where the HV is treated as having "rights" to advise on aspects of health and where the mother may not overtly reject the advice that is offered.

3.2.3 Assertions of knowledge and/or competence

Earlier in this chapter, we proposed that during these visits from the HV, mothers are concerned to display their knowledge, competence, and capacity to cope with matters concerning their babies' health. We proposed that this concern may underlie the relative infrequency of overt requests for advice during these first visits and that it informed the design of their requests for advice. We also suggested that similar issues may inhabit sequences in which advice is initiated by HVs. For the HV's initiation of advice may imply

that the mother is ignorant or otherwise unable to cope with the matters raised in the delivery of advice. The mothers' preoccupation with these implications is vividly illustrated by a number of sequences in our data base in which the mothers respond to advice giving with some assertion of knowledge or competence.

A preliminary sense of this preoccupation may be developed from the following datum, which is a continuation of (14) above:

(14 cont.) [1C1:13]

- 1 HV: Her eyes're oka:y.
 2 (0.7)
 3 M: They ge- th- they get a bit wee:py sometimes.
 4 but that's normal isn't it? And I swab th'm
 5 with wool with cotton woo:l,
 6 (0.3)
 7 HV: 1→ Ye:s if they- if they: (0.2) if you think
 8 1→ they're pussie,
 9 (0.8)
 10 M: Yea:h.
 11 HV: 1→ then you must use boiled wa:te:r with a
 12 M: 2→ [Yeah I
 13 2→ kno:w
 14 HV: 3→ little bit of salt i:n. (.) One teaspoonful of
 15 3→ salt to a pint of boiled wa:te:r (0.5) or
 16 3→ half a teaspoon to half a pint. (.) Oka:y?
 17 M: 4→ [°Oh
 18 4→ right I wi:ll do that () . °
 19 () : 'hhh
 20 (0.3)
 21 HV: 5→ And then you: (0.3) use clean cotton wool one
 22 5→ swab for each ey:e.
 23 M: °Alri:ght.°
 24 (.)
 25 M: 6→ Yeh I do that now. (0.2) I use a separate
 26 6→ thi:ng (0.2) with a bit of wa:rm warm water.=
 27 HV: =Mm.
 28 M: The- Not so much that I >y'know< to worry
 29 abou:t jist a little bit (in 'er ey^e) it's
 30 HV: [Mm
 31 M: sticky: (0.4) ('er eye)
 32 (0.7)
 33 HV: Ye:s (.) we:ll (.) tha:t is pretty usual.

In this sequence, the HV details the procedure for treating mild eye infections. It is notable that each component of her advice is acknowledged by the mother in terms of whether or not she already

knows what to do. Thus the first possible completion of the HV's advice – which ends at the recommendation “then you must use boiled wa:te:r” (arrow 1), is met by an assertion of knowledge (arrow 2). By contrast, the continuation of this advice that incorporates the reference to salt and an instruction as to quantity (arrow 3) is responded to with a marked acknowledgment and an undertaking to follow the advice (arrow 4). The final component of the HV's advice, which concerns using a separate swab for each eye (arrow 5), is initially met with an acquiescent “Alri:ght,” which is then revised by the mother's subsequent assertion that this is what she does already (arrow 6). Across the segments of this advice giving, then, the mother deals with each segment in terms of an underlying concern to display her knowledgeability wherever possible.

A similar concern to display knowledgeability or competence emerges in the next several cases where, in each case, after an initiation of advice giving (arrow 1), the mother responds by indicating that she is already aware of and/or has already dealt with the matters that are in the course of being raised (arrow 2). In the first three of these cases in particular, it may be noted that the competence assertions occur very “early,” that is, at or near the first point at which advice is recognizably being initiated.

(15 cont.) [1C1:19-20]

- 1 HV: What are her motions li:ke.
- 2 (0.6)
- 3 M: Uh: uh:m they're softer no:w because she
- 4 was a l'ttle bit constipated (0.2) a few days
- 5 ago:.
- 6 HV: Mm hm,
- 7 M: and the midwife advised me to put a teaspoon
- 8 of uhm
- 9 (1.0)
- 10 HV: brown [sugar
- 11 M: [brown sugar in alternate feeds
- 12 HV: I s:ee.
- 13 M: [and that helped her an' they're a lot
- 14 softer no:w,
- 15 (0.6)
- 16 HV: 1→ Oh I don't think you need (1.2) you know:w=
- 17 M: 2→ =(1) stopped doing it no:w.=

(11 cont.) [3A1:14]

- 1 HV: Listen to your 'iccups. Just listen to your
- 2 'iccups.
- 3 B: ((hiccups))
- 4 M: I know what cures those. (.) More milk [o
- 5 HV: [More
- 6 [mi:l:k is-
- 7 M: [heh heh heh heh
- 8 HV: Huh
- 9 (0.5)
- 10 HV: 1→ Don't worry about (h)iccups.
- 11 M: 2→ Ye:ah I know (.) she ha:s them nearly every.
- 12 HV: [()] [()]
- 13 HV: Does sh e.
- 14 M: 2→ [fee:d.

(10 cont.) [4B1:22]

- 1 G: 'hhh When she starts off walking ou:(t) it
- 2 always seems to r ai::n.
- 3 HV: [aO::h.=
- 4 M: =Ye:ah.
- 5 G: Ge ts half wa:y and 'as to come ba:ck.
- 6 M: [()]
- 7 HV: Oh what a pity.
- 8 M: Ye:ah myea:h.
- 9 HV: But if she's wrapped up well it won't do he:r
- 10 any ha :rm
- 11 M: [(harm)
- 12 G: No:.
- 13 M: No: that's what they ()
- 14 HV: 1→ [Babies loose a lot
- 15 1→ of heh- heat through their hea:ds
- 16 (0.3)
- 17 HV: 1→ 'hh so:=
- 18 G: 2→ =Well she's alwa:ys got a hat on ()

(16 cont.) [1C1:30-31]

- 1 HV: And you're able to put her down in between
- 2 fee:ds are you:.
- 3 (1.0)
- 4 M: No:: (0.4) She screams.
- 5 HV: uhhhh hah hah [hah 'uhhhhhhhhhh
- 6 M: [if I put her in the: re.
- 7 Fr: [hhehhhh=
- 8 HV: =hah 'hah =
- 9 F: =eh hnh

- 10 (1.0)
 11 M: Ye:s.=
 12 HV: 1→ =Well it is important you kno:w tuh: (0.2) get
 13 1→ it into a rou:ti:ne (0.2) otherwise she'll get
 14 1→ so used to sittin' on your lap she'll want to
 15 1→ do it all the ti:me.
 16 M: 2→ Well she di- that's what (.) I did in
 17 2→ hospital: uh I realise (about) my mistake no:w
 18 2→ but you (can't) keep them qui:et. I- (in fact)
 19 2→ I don't like ()=
 20 HV: 1→ =Well my advice to you: is that when she's had
 21 1→ a cuddle and you've changed her and you've fed
 22 1→ her and she's brought her wind up (1.2) that
 23 1→ you firmly put her do:wn.
 24 M: 2→ I've started.
 25 HV: O_:in her ow::n.
 26 M: 2→ I did it this mo:ning.

And in the following case, an inquiry which raises a problem about cats (arrow 1) is preemptively dealt with at its first possible completion (arrow 2). The mother's subsequent recycle of her response (arrow 3) is met with advice (arrow 4) to which she, in turn, responds with a repetition of her previous response (arrow 5):

(27) [1C1:44]

- 1 HV: 'hhh Two cats.
 2 M: We've got three: actually.
 3 HV: Oh goodness.
 4 (1.0)
 5 HV: 'hhh What d'they think of the baby.
 6 (1.0)
 7 M: u- Uhh they j's have a little sniff and they
 8 look at 'er when she cri:es but that's about
 9 i:t.
 10 (0.2)
 11 HV: 1→ You don't think they'll ever (.) jump up in
 12 1→ the pra:m or anything (like that).
 13 M: 2→ I've got a cat-net.
 14 HV: ()
 15 M: 3→ [Well: (0.4) I've got the cat-net and I'm you
 16 3→ know I'm here all the ti: me.
 17 HV: 4→ [hh I think if
 18 4→ you've got three cats it might be a good idea
 19 4→ to have a cat-net.
 20 M: 5→ Yeh I've got one I've definitely got one
 21 HV: (Beau-)

- 22 M: 5→ anyw a:y
 23 HV: 6→ [Yes because uh (.) there's always the
 24 6→ danger they might be attracted uh (.) 'hh and
 25 6→ sit on the (1.0) sit in there for warmth.
 26 M: 7→ That's it when I go upstairs I put it on
 27 7→ you know.=
 28 HV: =Mm.
 29 M: 7→ But >I mean< I- when I'm in the kitchen I can
 30 7→ sort'v see: you know.
 31 (1.0)
 32 HV: What a lot of cats.=How did you get three cats
 33 then.

Here, after the mother's third attempt to establish the fact that she has a cat-net (arrow 5), the HV develops her advice with an account of why cat-nets are necessary (arrow 6) and this is met by the mother with an elaboration of her earlier claim that she has the matter in hand (arrow 7). Subsequently, the HV initiates a shift of topical line.

In a number of these sequences, what starts as HV-initiated advice giving ends as a competence struggle. It is notable, in our data base at least, that once the HV has committed herself to a course of advice giving she may be reluctant to abandon it. In each of the following instances, which exhibit continuations of the data shown above, the HV persists in advice giving (arrow 3) in the face of competence claims (arrow 2). Thus in (15), the HV's continuation of advice giving (arrow 3) does not acknowledge the mother's assertion (arrow 2) that she has already stopped doing the advised-against procedure (putting brown sugar in the baby's feed to alleviate constipation).

(15 cont.) [1C1:19-20]

- 1 HV: 1→ Oh I don't think you nee:d (1.2) you kno:w=
 2 M: 2→ =(I) stopped doing it no:w.=
 3 HV: 3→ =You shouldn't do it u:h (1.0) as a
 4 3→ regular thi ng otherwise it would be
 5 M: [Ooh no:.
 6 HV: 3→ ba:d for her tee:th.
 7 M: It was just a couple of da:ys and it
 8 helped (her).
 9 (1.5) ((Tearing Paper))
 10 HV: Good.

Similarly, in (11), the HV persists in advising the mother, despite the latter's claim that she is not concerned about the baby's hiccups.

(11 cont.) [3A1:14]

- 1 HV: 1→ Don't worry about (h)iccups.
 2 M: 2→ Ye:ah I know (.) she ha s them nearly every.
 3 HV: ()
 4 HV: Does sh e.
 5 M: 2→ fee:d.
 6 HV: 3→ Yes. Well you can always put them do:wn the-
 7 3→ you don't have to keep nursing them for- 'hh

In (10), the HV's advice-adumbrative observation that babies lose a lot of heat through their heads, culminates in the advice that "bonnets are worth having" despite the baby's grandmother's interjection that the baby always has a hat on.

(10 cont.) [4B1:22]

- 1 M: No: that's what they ()
 2 HV: 1→ Babies loose a lot
 3 1→ of heh- heat through their hea:ds (0.3) 'hh
 4 1→ so:=
 5 G: 2→ =Well she's always got a hat on ()
 6 HV: 3→ b- Bonnets are
 7 3→ wo:rth having.

And in (16), the HV's advice that the mother "firmly put her do:wn" is augmented through three syntactically continuous accretions (lines 6, 8, and 10) despite the mother's interjected claims (lines 5 and 7) to be doing just that.

(16 cont.) [1C1:30-31]

- 1 HV: 1→ =Well my advice to you: is that when she's had
 2 1→ a cuddle and you've changed her and you've fed
 3 1→ her and she's brought her wind up (1.2) that
 4 1→ you firmly put her do:wn,
 5 M: 2→ I've started.
 6 HV: 3→ O: in her ow::n,
 7 M: 2→ I did it this mo:ning.
 8 HV: 3→ preferably not right by you:
 9 (0.8)
 10 HV: 3→ and you can check her every (1.0) fifteen
 minutes ((continues))

In the cases shown above, the HV's do not abandon advice giving in the face of the mothers' claims to knowledge or competence.

Moreover, in sustaining their advice giving, they sequentially delete the mothers' claims to competence. This conduct underscores other dimensions of the generally unilateral character of advice giving in these first visits and it suggests that, on occasion, the HVs may take little account of the mothers' claims to competence even when those claims are made clearly and assertively.

3.2.4 Summary

In this section, we have examined three major ways in which the reception of advice may be managed. While our data base contains only one instance in which advice is overtly rejected, only one class of receptions – marked acknowledgment – involves the full-fledged acceptance of advice *as advice*. The others – unmarked acknowledgment and competence assertions – in their different ways involve resistance to advice giving. Competence assertions resist advice through the claim that its content is already known and/or acted upon by the mother who, in this way, seeks to reject any implication of incompetence or lack of knowledge that may be carried by the initiation of advice. Unmarked acknowledgments, which receipt advisory talk but without acknowledging or accepting its character *as advice*, constitute a form of "passive resistance," whose motivation may remain opaque. In a substantial number of cases, unmarked acknowledgments were followed by more overt expressions of resistance to advice giving that challenged its relevance or informativeness to advisees.

4 Discussion

Taken as a whole, three facets of the advice-giving sequences in our data base of first visits are particularly striking. The first is the predominantly unilateral character of the ways in which the HVs both initiated and delivered advice. In the substantial majority of cases, the HVs began to deliver advice in the absence of any clear indication that it was wanted and, in a further substantial body of cases, in the absence of any clear indication of a "problem." In a large number of cases, little attempt seemed to be made to fit the advice giving to the particular interactional circumstances from which the advice emerged and, in many of them, it is difficult to resist the impression that the HVs would have initiated advice

giving no matter how the mothers responded to their inquiries. Secondly, there was little effort to accommodate advice giving to the circumstances of individual mothers and, in particular, to acknowledge their competences and capacity for personal decision making. Indeed, in most of the cases in which the mothers asserted their knowledge of competence in some facet of health or baby management, their assertions received no acknowledgment or minimal acknowledgment and, in a number of cases, were positively resisted. Third, in this context it is significant that fully three-quarters of all the HV-initiated advice met with either passive or active resistance. While it is not possible to extrapolate from the mothers' conduct during the course of advice giving to their subsequent decisions about whether to follow the advice or not, their reception of it suggests that much of the advice may have been counterproductive.²⁷ The responses of the mothers in these sequences may perhaps be aptly summarized by the Scottish mothers in McIntosh's study, who observed:

I don't like the health visitors. I mean, it's no' like help or advice – they *tell* you. It wisnae, "Maybe you should do this," it was, "You *should* do this." Y'know, "You're doing it all wrong." That's how I never went to the clinic. I was sick o' bein' bossed about.

She keeps tellin' me, "Do this, do that." It makes ye feel like a moron, that yer no' capable o' lookin' after yer baby. It undermines yer confidence. Ah always feel guilty after she's been as if ah've been doin' everything wrong. It makes me mad. Ah don't say anything at the time, ah just mutter a few oaths when she's gone.

(McIntosh 1986: 26)

These mothers' accounts of the authority relations assumed in advice-giving sequences and the passive resistance with which this assumption is met ("Ah don't say anything at the time") appear to encapsulate the predominant pattern of advice giving and advice reception that emerges from our data.

In considering this pattern, we are left with the problem of explaining why it is that our HVs persisted in this – apparently unproductive – process of self-initiated advice giving. Although, in the present context, responses to this problem can only be speculative, a number of possibilities suggest themselves.

We begin, first, by recalling Robinson's (1982) contrast between a clinical problem-oriented approach to health visiting associated

with a medical background and an approach based on the clients' identification of their own health needs, which might be favored by those whose training originates in social-work contexts (see Baldock and Prior 1981). HVs are, as previously noted, trained nurses – often with extensive clinical and hospital experience. This training and experience may incline them towards, in Robinson's (1982) terms, "an identification, diagnosis and treatment" approach to mothers rather than one in which mothers are encouraged to take the lead in defining their needs.

While this possibility is certainly attractive, it cannot by any means carry the whole burden of explanation. A preliminary analysis of interactions involving the same HVs with experienced mothers (with one or more previous children) suggests that, with these mothers, the HVs were less ready to initiate courses of advice unilaterally and more prepared to acknowledge the knowledge, experience, and competence of the mothers. This evidence, though yet to be fully developed, suggests that the "nursing background" of the HVs, while a possible factor in their orientations towards the first-time mothers, is by no means a factor that influences them to engage in unilateral advice giving regardless of who they are dealing with.

A second consideration arises out of the recognition that our findings are based on data involving interactions with first-time mothers who, in the nature of the case, are inexperienced in dealing with young babies. Much of our advice-giving data is consistent with the possibility that the HVs took up a "pessimistic" or "defensive" stance with respect to the knowledge and competence possessed by these mothers. This stance has a number of aspects.

First, with respect to issues which the mothers treated in some way as problematic, the readiness with which the HVs proceeded to advice giving suggests that they started from the "pessimistic" presumption that the mothers would, at best, have limited competence to deal with the problem. This presumption might also have "defensive" aspects insofar as the HVs are organizationally accountable for the health and welfare of both mother and baby and, in some subsequent context, may desire to assert the adequacy of their conduct with respect to some problem. Second, the HVs' readiness to engage in unilateral advice giving is also consistent with "pessimistic" presumptions about the knowledge of first-time

mothers. Specifically, the HVs may believe that first-time mothers are unable either to recognize that they have a problem or, relatedly, to anticipate or imagine the range of problem contingencies to which they may become subject. And, to the extent that they take such a view, the relative lack of mother-initiated requests for advice – documented in this study – may confirm them in it. Such a perspective may encourage HVs to offer anticipatory or preemptive advice that addresses such contingencies before they are recognized or before they arise.

Third, the HVs' "pessimism" about the mothers' knowledge and competence may be matched by a correspondingly high valuation of their own expertise. Mayall and Foster (1989) have shown that HVs are confident in the superiority of their own knowledge base regardless of whether its origins were lay or professional in character. These survey-based findings are matched in our data where the HV's advice giving was marked by a significant tendency to assert their own authority and expertise over against the mother and other lay sources. This tendency is perhaps most particularly marked on the occasions in which they declined to acknowledge the independent knowledge and competence which the mothers attempted to display.

A final set of considerations arise from the broad and somewhat nebulous character of the HV role. It will be recalled that the HV role is centrally defined in terms of the provision of advice rather than in terms of direct practical nursing assistance and that the HV is nonetheless obliged to visit the homes of mothers with young children. Home visits conducted on this obligatory basis and in a context in which HVs have no practical nursing responsibilities must inevitably raise what might be termed the "ticket of entry" problem – the issue of what the recognizable purpose or point of home visits might actually be. This problem is one which may exercise both mother and HV alike and it may emerge with particular force on the occasion of first visits. As we have noted, a number of studies suggest that many mothers, rightly or wrongly, believe that home visits are conducted primarily for surveillance and social-control purposes. Regardless of the extent to which the HVs are aware of this belief or themselves recognize and accept this purpose, they are nonetheless confronted with the task of endowing their unsolicited visits with some basic (perhaps alternative) sense

of purpose. The delivery of advice, to the extent that it sustains the parties' sense that the HV desires to be useful to the mother, may contribute to a resolution of this "ticket of entry" problem.

It is here, however, that the central dilemma of advice giving may reach its apotheosis. For advice giving must ordinarily constitute the advice recipient as being of at least doubtful knowledge or competence. As we have seen, rather than establishing that mothers definitely lack specific knowledge or competences in relation to health or baby-management issues, HVs tend to act on a presumption of systematic doubt about the mother's abilities. There are good interactional reasons for this. First, the inquiries that might be necessary to establish the mothers' knowledge or competences could readily undermine "rapport" between the parties and may focus attention on just the surveillance aspects of these visits that HVs may be most anxious to have disattended. Second, efforts at a clear determination that a mother is specifically ignorant or incompetent on some matter will, if successful, tend both to humiliate the mother and to sour the context in which the subsequent advice is delivered. Conversely, where the outcome of those inquiries is the finding that the mother is specifically knowledgeable and competent, the basis on which advice can appropriately be given will be undermined. In this case, the result of detailed inquiry would be the loss of the "ticket of entry" that advice giving represents.

Thus, insofar as HVs deploy advice giving as a central "ticket of entry" to mothers' homes, they may tend to initiate advice in contexts where the recipient's desire or need for advice is uncertain. Paradoxically, the HVs' need to make herself useful may result in the delivery of advice in interactional contexts where, at best, it is of indeterminate value to the recipient and, at worst, it is resented and resisted by her. The ultimate dilemma of advice giving as a ticket of entry may be that it can only be bought by spoiling the ball game.

Notes

1. These figures are presented in terms of "full-time equivalents" and thus the actual number of nurses working in the health-visitor service is rather larger than this figure.
2. Audio-recording was selected both because it was a straightforward technique for data collection to be used by the health visitors themselves and because video equipment and the additional persons who

- would be required to operate it would have constituted an intrusive distraction in a delicate setting. The audio-record, however, has significant drawbacks. It is impossible to determine the spatial arrangement of the parties to the interaction and, on many occasions, the possibly important nonvocal activities of the parties. The significance of certain aspects of the audio-record is rendered equivocal by these lacunae. In developing our observations, we have avoided data manifesting these difficulties.
3. In the original data-collection process an attempt was made to restrict the social class of the mothers in the sample to IV and V. In the event, our sample is more broadly spread and incorporates persons with a wide range of occupations, including self-employed business persons, white-collar employees, skilled, semi-skilled, and unskilled manual workers, and persons who, at the time of the visits, were unemployed.
 4. See Robinson (1982) for a summary account of the historical background to this unusual division of labor between health visitors and other community nurses, and Donzelot (1980) for an account of the ideological background of health visiting.
 5. See, for example, Foster (1988) for a comparison of this feature of the British health visitor's role with her opposite number in France – the *puericultrice*.
 6. Although the health visitor has a statutory obligation to cater to the health needs of all children, she does not have a statutory right of entry into the parental home. In practice, however, the accountability of denying entry to the health visitor renders such a right unnecessary.
 7. A range of studies from the 1960s onwards (e.g. Political and Economic Planning 1961; Cartwright 1979 cited in Robinson 1982; Graham 1979) have suggested that some mothers perceive health visitors in terms of a surveillance role. McIntosh's (1986) study of a working-class sample of mothers' attitudes to the health-visitor service showed that the majority of first-time mothers viewed the health visitors' role primarily in surveillance terms (McIntosh 1986: 15). Such outlooks occasionally emerged as a more-or-less overt feature of the interactions that form the data for this chapter.
 8. For example, in our data base home visits were made on a weekly basis for the first month and subsequently on a monthly basis.
 9. Indeed Dingwall (1977: 91) has observed that the complexity of the home visit vitiates the value of timing studies.
 10. Although the HV service stresses the value of establishing contact with mothers before the birth of a baby and efforts are normally made to do so, only one HV in our sample (HV no. 5) had in fact made contact with her two first-time mothers prior to the first recorded visit.
 11. The speakers in this and the data extracts that follow are labeled as follows: HV = health visitor; M = mother; F = father; G = grandmother; Fr = friend.
 12. In Brown and Levinson's (1987) terms, advice giving threatens both

the positive face and negative face of the advice recipient. The recipient's positive face is threatened by the advice giver's implication that the recipient is not knowledgeable or competent concerning the matters that are advised upon. The recipient's negative face (desire to be unimpeded) is threatened by the obligation to follow the course of action recommended by the advice giver.

13. See Ervin Tripp (1976) and M. H. Goodwin (1991) for an analysis of directive forms. West (1990) describes similar features in the design of physicians' directives, though she also finds differences in their design that are strongly patterned by gender.
14. This procedure for requesting advice is not, of course, restricted to these materials. In the following datum, G has called E for a recipe for Tacos. Her initiation of the request is designed to show some knowledge of the relevant ingredients (arrowed):

[NB:IV:2:R]

- G: → 'hhhhh So e- d'you nee:d you need uh
 → hhamburger don't chu.
 E: → 'hh Ye:u:us? e n y uh need
 G: → [E n]
 E: → [some: u h :
 G: → [s- 'hh] sh:r edded lettuce?
 E: → Shredded lettuce en CHEE::SE?

15. See Drew (1984) for a discussion of other cases of reportings in which the relevance or implications of the reportings are left implicit. Drew notes that "the way in which an event is portrayed in a reporting establishes the relevance of a particular kind of involvement/co-participation by the recipient through some conventional tying between the kind of occasion/activity and a relevant action by the recipient" (1984: 149, n. 10).
16. As it turns out, in both (10) and (11) the offered advice is resisted, see pp. 404–5.
17. For a related discussion of a context in which a professional seeks to build an interactional environment in which the delivery of professionally expert information will not conflict with the lay perspective, see Maynard (this volume).
18. See Jefferson (1989) for an account of the distribution and "standard maximum" length of pauses in conversation.
19. We do not intend to imply in this paragraph that more complete stepwise approaches to advice giving always eventuate in appropriately designed giving. In (15), for example, while it is apparent that the mother presents the child's problem as past and presents her approach to it as the product of advice from another health professional, the HV nonetheless initiates advice giving.
20. In (20), the advice giving may be stimulated by intimations earlier in the visit that the mother is considering abandoning breast feeding.

21. See Pomerantz (1980) for a further discussion of this segment.
22. It may be noted that the mother's additional use of "right" at line 21 to acknowledge acceptance of the HV's advice after her acceptance has been resolicited (at line 20) is further evidence that "right" is a standard, but "minimal" form of marked acknowledgment for the acceptance of advice.
23. It is notable that this overt acknowledgment of past error is made by the grandmother rather than the mother. The grandmother does not have direct responsibility for the child's welfare and, moreover, is "experienced" and may have little to prove with respect to her competence in child-raising practices. Moreover, her account is couched in terms of conscientious, if misplaced, concern for the baby's welfare during a cold English winter.
24. For a parallel argument with respect to the receipt of answers to questions, see Heritage (1984b).
25. We particularly note here that the mother asserts that she was "taught" this procedure rather than, for example, "told about" it. The term "taught" here conveys not only that she was told about it, but that she learned the procedure or otherwise "took it on board."
26. This presequence illustrates a recurrent anxiety among the HVs in our data base about alternative sources of advice. In the following sequence, the HV receives no response (arrow 1) to a two-component advice delivery. Subsequently, she moves to undercut the baby-food packet as a source of advice about feeding (arrow 2).

[1C1:29-30]

HV: Don'(t)- (0.2) I think it- (.) it's sensible to
 (1.0)
HV: you know tuh- (0.2) to use your common sense
 and give 'er what what you think she need:s.
 1→ (0.3)
HV: 'h'h If she's (.) 'hh happy: (.) she's not
 being sick (0.6) she's not screaming the
 place do:wn >you're doing the ri:ght thing.<
 1→ (0.5)
HV: 2→ Don't take any notice of what it says on the
 packet an' how many ounces (.) per how many
 (.) weeks.

Here it is noticeable that the HV's elaboration of her first piece of advice is designed in terms of a three-part list format (Jefferson 1990) which is often used in talk designed to persuade (Atkinson 1984; Heritage and Greatbatch 1986). The failure of this advice component to get any response may be implicated in the HV's subsequent move to deny the value of the baby-food packet as a source of direction for the mother – a move that was possibly foreshadowed with her initial turn

- beginning "*Don't*-" that was previously abandoned in favor of the subsequent, more constructive advice.
27. This is the clear conclusion of McIntosh's (1986) questionnaire-based study of first-time mothers' responses to their HVs. See McIntosh (1986: 60) and Carter *et al.* (1986) for a more general review.