

Motherhood, Medicine, and Morality: Scenes From a Medical Encounter

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As Bergmann (1998) observed, morality in discourse emerges at two levels. First there is the moral order *of* interaction. As Goffman (1955, 1983) recognized, the interaction order is a social institution and it is, as he also maintained, a moral order constructed of institutionalized rights and obligations. Second, there is the moral order *in* interaction: the moral worlds evoked and made actionable in talk. These moral worlds are also institutional worlds, but their reality, though evoked in talk, is not confined to it. “Motherhood” and “medicine” are worlds of this second kind.

In this article, we examine some moments in the course of informal medical encounters in which motherhood and medicine collide and intertwine. Such collisions and intertwinings are, in a sense, ubiquitous in these conversations. Within them, motherhood, medicine, and morality are also yoked to the interaction order that is inflected and given a

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particular accent by the medical context of the encounters. Conduct that is face threatening or offensive in ordinary conversations between peers or acquaintances, and that might ordinarily be sanctioned as offensive, is commonplace in these interactions. Also, where sanctions are in fact deployed, their content and severity is conditioned by this context.

In this article, we sketch some aspects of the talk that takes place between first-time mothers and British community nurses ("health visitors" or "HV") during the course of the nurses' visits to the mothers' homes. We first focus on data from the first of these visits that normally take place about 10 days after the birth of the baby. The unobtrusive but insistent enforcement of a range of obligations by the medical professionals is characteristic of these visits (Heritage & Sefi, 1992). Subsequently, we look in more depth at some moments in which the morally problematic nature of certain experiences and emotions is more explicitly taken up and dealt with in these encounters.

"Morality" per se is not, of course, a primary topic of these conversations. As Bergmann (1992) and Linell and Bredmar (1996) observed, medicine often involves a systematic subordination of moral issues to more instrumental or technical medical considerations. Yet, as in other types of conversation, these medical encounters are drenched with implicit moral judgments, claims, and obligations. Consider the following datum, in which the HV begins the activity of soliciting face sheet data¹ from an unmarried mother who is living with her boyfriend in her mother's house. The boyfriend is not present at this interaction. (The speakers in this and the data extracts that follow are labeled as follows: Health Visitor = HV; Mother = M; Father = F; Grandmother = G; Friend = Fr.)

(1) (4B1:5)

HV: Uh:m (0.8) .hh now first the particulars they want to know th' baby's father's a:ge.

Consider the lexical choice that the HV makes to refer to the child's father. In principle, this choice represents a selection from at least the following terms: *husband*, *father*, *boyfriend*, as well as the choice that was, in fact, made, *baby's father*. It will be apparent that one of these terms, *husband*, might not be appropriate in this context, and the most appropriate term, *boyfriend*, which would acknowledge the child's illegitimate status, seems to be the term being avoided. Of the remaining terms, *baby's father* seems to work at formulating the connection between

the recipient of the question (the mother) and the person being inquired about, in a distanced, "bureaucratic" fashion. Indeed, this bureaucratic formulation is provided for by the design of the question that indicates that it is "they" (the designers and users of the face sheet) who want the information (Heritage & Sorjonen, 1994). Here then the HV distances herself from the question she is asking—and thereby orients to it as intrusive, but she also avoids the "immoral" ("boyfriend") formulation of the father's relationship to the mother—a formulation that could express some acceptance of that relationship.² Here, in a lexical selection, bureaucratic state surveillance and morality collide: The HV's morally distanced reference ("th' baby's father") is wrapped inside a formulation with which she distances herself from the bureaucracy (the "they" who "want to know"), and this in turn is a vehicle for managing a moral distancing from the household she is entering for the first time.

However, if morality is ubiquitous in these encounters, these data are of interest for the ways in which particular moral themes—involving health and pain, the obligations of looking after young children, family relationships, the roles of husbands and other family members, the appropriateness (or otherwise) of particular feelings toward the new arrival, and so on—are dealt with. However, the medical or quasi-medical context of the interactions gives these themes a particular inflection. Although the mothers may have particular outlooks and beliefs about how their children should be looked after, they are confronted by medical professionals who have socially sanctioned rights to "know better" about how their obligations should be discharged. It is in this inflection that morality is normally subordinated to medicine, and motherhood is addressed with a form of disciplinary power that is partially masked by this subordination (Foucault, 1980).

THE DATABASE

The data on which this article is based are drawn from a substantial corpus of self-administered audiotape recordings by HVs in a large industrial city in central England.³ The HVs recorded their first six visits to a range of mothers evenly divided between first-time mothers and mothers who had previously had one child or more. In all, some 75 visits

were recorded. This article is based on a cross-sectional analysis of data from eight initial or primary visits to first-time mothers conducted by five different HVs and on a longitudinal analysis of all six visits involving a single mother-HV pairing.⁴

THE HV SERVICE: A BRIEF OVERVIEW

The British HV service is the largest single element of the U.K. community nursing program comprising some 9,300 qualified nurses (Cumberlege Report, 1986, p. 10). The HV'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, HVs have very wide ranging professional responsibilities comprising 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. Unlike community nurses in other advanced countries, British HVs 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.⁵

The British health visiting service is distinctive in that, unlike other medical services in the United Kingdom and elsewhere, its provision is supply driven rather than demand driven.⁶ This characteristic is particularly prominent in relation to the HV's work with children. HVs have a statutory obligation to perform routine visits to all mothers with children under 5 years, regardless of whether these visits are requested or not.⁷ The supply-driven character of the service reflects the origins of the health visiting service in the municipal sanitation movement of the 19th and early 20th centuries. This movement was highly interventionist and was anchored in a sense of mission that bordered on a moral crusade. The following quotation from the rule book of the Manchester and Salford

Sanitary Association (c. 1880, as cited in Clark, 1973) conveys something of the openly moralist stance of this movement:

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. (p. 11)

Although this explicit moral focus has all but evaporated with the HV's incorporation into an instrumentally oriented national health service, there remains a—perhaps irreducible—residue of ambivalence concerning the dual role of advisor and evaluator that is commonly attributed to the HV role (McIntosh, 1986).

MOTHERHOOD AND THE PROBLEM OF COMPETENCE

There is ample evidence, both from survey data and from our data, 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 (Sefi, 1988; Heritage & Sefi, 1992). 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 & Lee, 1981).

However, in these visits it is also clear that, to a greater or lesser extent, the mothers see their knowledge, competence, and vigilance in baby care as an object of evaluation and, moreover, by a person with officially accredited competencies to judge their conduct. This orientation

emerged in a wide range of contexts but is transparently visible in the mothers' responses to volunteered HV comments on matters that may seem equivocal as in (2) following:

(2) [5A1:2]

- 1 HV: .hh She likes it on her back does she.
 2 M: I j'st put'er on there while I was gettin' the pram out.
 3 HV: ()
 4 HV: Yeh. 'Cos sometimes they can uh
 5 (0.5)
 6 M: choke. Ye-h.
 7 HV: Yeh. When they're on their backs.
 8 M: Well she
 9 does like it on her back.
 10 HV: Ye:s. I think when it- when you- when you're leaving
 11 he:r
 12 (.)
 13 M: Ye:rah
 14 HV: You ought to put her on her tummy real-ly,
 15 M: Yea:h, oh
 16 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 toward 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 (line 2) 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 6) of the HV's next turn (line 4).⁸ Thus it is only after the mother has displayed an alertness to the dangers implicitly raised in the HV's initial question that the mother then produces a revised response to it (lines 8–9) that acknowledges that the baby does in fact prefer lying on her back. Here then, the mother defers a direct response to the HV's question until after she has shown that she is aware of the dangers implicitly raised by it.

A concern for the judgmental possibilities inherent in these first visits is still more vividly illustrated by the following in (3). 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. Whereas the father takes the remark at face value and responds with an agreement, the mother’s response is notably defensive:

(3) [4A1:1]

HV: He’s enjoying that isn’t he.

F: Yes he certainly is=

M: =He’s not hungry ’cuz(h)he’s ju(h)st (h)had ’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.

MOTHERHOOD AND MORALITY

In general, the HVs treat the mothers in this data rather in the ways that Strong (1979) observed in his study of pediatric clinics: as properly motivated, but possibly incompetent, carers for their babies. The nature, extent, or quality of their *motivation* is scarcely ever addressed directly but rather is treated as a presupposition of the advice and exhortation that the HVs offer. By contrast, the mothers’ competence is not presupposed. In what follows, we sketch some sequences of interaction that deal with two dimensions of the mothers’ competencies: (a) their capacities as *perceivers* of their children’s needs and abilities and (b) their capacities as competent *actors* in the management of their children’s welfare. Both elements—perception and action—are treated as competencies for which mothers, in particular, are morally accountable.

Mothers' Competence as Perceivers

We begin with the following sequence that occurs within the first recorded minute of the HV's encounter with this family.

(4) (1A1:1)

- 1 HV: .hh I'll show you these notes that we write,
 2 (1.0)
 3 HV: You can both see them just so that you (.) can see what
 4 I'm doing,
 5 (0.2)
 6 HV: .hh These uhm (1.0) are the notes that I carry arou(t)
 7 with me:.
 8 F: Mm hm,
 9 HV: And I (0.2) I uh record your baby's progress on he:re.
 10 (0.2)
 11 HV: .hhh [So that uhm (.) I want to know when she's doing
 12 M: [°(Oh)°
 13 HV: new things when she smiles and when she (.) .hh uh:m
 14 you know she's holding her head up better: .hh I want
 15 you to notice if she: (.) .hh can see: .hh You
 16 probably can no- .hh-h
 17 F: [Mm
 18 HV: Do you sort'v=
 19 F: =Oh [y- she's always looking arou:nd uhhhh
 20 HV: [kno:w already whether she can see:.
 21 F: (Yeah she's tryin')
 22 (0.2)
 23 HV: Pardon?
 24 F: And she's trying to lift 'er head'(p).

In this rather Foucauldian scene, the parents are first instructed about the nature of observations that the HV will be making (in the discussion of the "notes that we write," lines 1–9), and then instructed (lines 11–16) as to what they should be looking for in their baby's progress. The first two items (smiling and holding her head up) are presented as exemplifications of the "new things" the HV wants to record. The third item is syntactically disjoined from these: "hh I want you to notice if she: (.) .hh can see:" and the HV then proceeds to a more direct inquiry about this.

The first, subsequently abandoned, attempt is shaped as an “indirect question” (“You probably can no-”) that is then reshaped as a direct inquiry: “Do you sort’v kno:w already whether she can see:.” The parents are noticeably cooperative in responding to this question. The father’s interjective response (line 19) anticipates the HV’s reformulation of her inquiry and his subsequent responses (lines 21 and 24) elaborate on it in some detail.

Other responses to this type of question are also relatively prompt and detailed.

(5) (1C1:10)

- 1 HV: .hh What does she do: so fa::r tell me.
 2 (0.2)
 3 HV: Does she uh:=
 4 M: =She- she looks arou:nd a- (.) a lot no:w ’nd I mean
 5 I’ve got- in the bedroo:m I’ve got mobiles and things’n’
 6 she looks up tuh those and likes watching those.=
 7 HV: =Does she:.
 8 (): unhhh└hh
 9 M: └And uhm she knows muh voice no:w.
 10 HV: Oh lovely.=How do you know that.
 11 (1.0)
 12 M: We:ll
 13 (0.7)
 14 (): whu└h-
 15 M: └when I was round me mum’s yesterda:y muh mum’s
 16 to::ld me mum w’s talking to me: and I ca:me over an’
 17 I spo:ke to ’er and then she turned around at (.) me:
 18 I kne:w she knew that (0.2) it was my voi:ce you kno::w
 19 (0.3)
 20 HV: └°Mm hm°
 21 M: └mum- even me mum said “oh she knows your voi:ce.”
 22 (1.0)
 23 M: And she focuses quite we:ll.=She did right from day one
 24 you know w- uhm I’ve noticed (0.2) with a lot of babies
 25 their eye(s)’re all over the place. .hh Her eyes do it
 26 a little bit but (0.6) not too ba::d.
 27 (1.0)
 28 HV: °Yeah.°

Here the mother's description of her child's vision is documented with details about the child's activities and their motivation. After the HV's newsmark (line 7), she begins describing a second aspect of her child's perceptual capacities. In this case, though, it is noticeable that, after the HV asks for evidence that the child recognizes her mother's voice (line 10), the mother's detailing becomes "defensive" when, having described her observations of an incident in which her child recognized her voice (lines 15–18) and got no uptake from the HV (line 19), she then cites a more experienced observer of children (her own mother) as independently corroborating her account.

Similarly, in (6), an inquiry about when the baby was last weighed elicits not only the baby's last recorded weight but also a contrast with the baby's birthweight and a—possibly to be elaborated—account of the child's feeding that is abandoned (lines 14 ff.) in the face of no uptake from the HV.

(6) (1C1:15)]

- 1 HV: She's enjoying that isn't sh-e.
 2 M: └She i:s.=
 3 HV: =When did you have her weighed la:st?
 4 (0.3)
 5 M: Uh Saturday an' she wa:s (.) seven and a ha:l:f.
 6 (0.7)
 7 M: And when she was bo:rn she was six (0.6) nine and three
 8 quarters °so she's put on quite a bi:t.°
 9 (0.5)
 10 HV: Lovely.
 11 M: But she enjoys 'er bo:t:tle (.) an' she takes five
 12 ounces.
 13 (1.0)
 14 M: Don't you.
 15 (.)
 16 M: Mm:?
 17 (1.2)
 18 HV: Are you feeding her on Cow and Gate.

Although the elaborated detailing that displays the parents' determination to show their capacity (and obligation) to perceive the progress and needs of their children is relatively commonplace in this data, it is

not universal. In the following datum, the HV continues the topic of the baby's developing abilities (inquired into at lines 1–9) into an anticipation of his future achievements. At lines 15 and 16 in this extract, the mother and father each produce an utterance designed to agree with the HV's suggestion that they'll be "amazed" at the child's progress and they do so nearly simultaneously. However, whereas the mother's agreement refers to the development of children in general ("They learn so quick don't they"), the father refers to their experience of their own child's progress ("We have noticed hav'n't w-"). Although the father's utterance exhibits a commitment to noticing their own child's behavior and development, the mother's response does not.

(7) (4A1:2)

- 1 HV: Does he look around?
 2 F: Oh y_{eh}
 3 M: └He is starting to.=Yeh.
 4 HV: A_{nd} does he fix on you?=
 5 M: └Yeh
 6 HV: =Does he look at you?
 7 F: └Mm mm
 8 M: └Yeah.
 9 HV: Lovely.
 10 M: (hn)
 11 HV: It's amazing, there's no stopping him now, you'll be
 12 amazed at all the di_{ff}erent things he'll start doing.
 13 F: └(hnh hn)
 14 (1.0)
 15 M: Yeh. They └learn so quick don't they.
 16 F: └We have noticed hav'n't w-
 17 HV: That's right.
 18 F: We have noticed (0.8) making a grab for your bottles.

It is noticeable that the mother's response avoids taking up the "novice" position in an "expert–novice" relationship that the HV's remark might be seen as expressing. The father, by contrast, agrees with the HV's remark by asserting that they have already and independently noticed their child's rapid development. Significantly, although the father (putatively the junior partner in the family's child care arrangements) appears eager to show their competence in noticing the details of their child's

behavior, the mother's response in this sequence avoids any indication that she will hold herself accountable to the HV for the supply of such details.

However, this same couple—who were also involved in the defensive discussion of whether their baby was hungry in (3) earlier—engage in a quite assertive and collaborative display of their capacity to recognize their baby's needs in a subsequent return to the topic of feeding.

(8) (4A1:3)

- 1 M: We know when 'e wants a feed 'cos 'e's mou:thing for it
 2 └you know hih hih hih
 3 HV: └Yes
 4 F: Oh 'e goes frantic
 5 M: Yea(heh) └heh heh heh
 6 F: └don' 'e
 7 F: 'E goes frantic.=
 8 HV: =And you'll soon be able to able to distinguish between
 9 his cries of (0.3) .hh hunger and his cries of wanting
 10 attention.=
 11 M: =Ye:ah └I think that's what 'e wanted this time 'cos
 12 F: └(°Mm hm°)
 13 M: 'e's certainly no-t hungry
 14 F: └Oh: no::.=
 15 HV: =No:
 16 F: .tch You're not 'ungry are you mate

In sum, the HVs in this database require parents to display a commitment to a kind of “perceptual regime” as part of their tasks of parenthood: This includes detailed knowledge of their baby's activities and history as well as an orientation to the prospect of events and developing skills to come. On the occasions in which it is invoked, this requirement formulates the relationship between the HV and the parents in expert–novice terms. The parents generally display a corresponding commitment to this regime, which they orient to as a “character and fitness” test that examines their knowledge, vigilance, and motivation in relation to the care of their baby. There are, however, hints in the data that where two parents are present—and one of them can, by hanging back in the discussion, somewhat decline this role—it can be the one who, by convention, is the more responsible and accountable parent, the mother, who does so.

This generally constructive orientation to tasks of perception is not paralleled when we turn from perception to action.

Mothers' Competence as Actors

Almost all the sequences in these first visits that touch on appropriate activities in baby care are permeated with pending advice—the central charter and manifest function of the health visiting service. Advice giving, of course, also invokes the expert–novice relationship discussed earlier and also, more strongly than “perceptual” topics, implicates the kinds of judgments of the mothers’ competencies that surface in (2) and (3) mentioned earlier. In delivering advice, the HV’s assertions of competence and authority are strongly formulated:

Using speech act verbs of explicit advice and recommendation:

[3A1:15] I would recommend giving her a bath 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

Using 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 boi:led wa:te:r

Using modal verbs of obligation:

[1C1:5] And I think you should invol:ve your husband as mu:ch as possible no::w

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

Whether based on their own authority as experts or on external medical authorities such as “the hospital,” 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.

The mothers’ orientation toward the HV as someone who may stand in judgment on their competence as actors is also expressed in their approaches to advice giving. Heritage and Sefi (1992) found that less than 10% of the advice-giving sequences in these early encounters were

initiated by mothers. Both the frequency and design of these initiations suggest 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, 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 person to whom the request is made 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 in which advice giving is volunteered or occurs unrequested. 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. Also, 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.

ADVICE GIVING AND MORALITY

Within the context of these general observations, four basic points on the role of morality within the advice-giving process should be sketched. They represent a significant contrast with the very overt role of explicit moral formulations described in several other contributions to this special issue.

First, the normative background of advice giving that we could formulate loosely as the mother's obligation to act at all times in "the best interests of the child" is almost never explicitly thematized but rather is treated as presuppositional to the talk. The following is the only case

in the database where a mother's obligation to her child is explicitly raised. Here the HV, who has become alerted to the mother's inclination to terminate breast feeding, makes an "Nth" pitch in favor of continuing with it:

(9) (1A1:25)

- 1 HV: And you're quite happy about breast feeding,=You're not
 2 having second thoughts about it?
 3 (0.3)
 4 M: Oh I was last night.
 5 HV: Were you really.
 6 M: (0.5)
 7 M: We:ll (but I-) I dunno:.
 8 HV: → I'm- I'm su:re it's the best thing for your ba-by.
 9 M: └mYeah.
 10 (.)
 11 HV: You know it's uh (.) it's certainly cheap(hh)est
 12 ┌huh huh
 13 M: └Oh yea:h.=
 14 HV: .hhhh Uhm and it's such a shame when you've got lots
 15 of milk you kn-ow
 16 M: └Yea:h
 17 HV: └and uh you're giving her a bit of
 18 immunity and you- (.) you're very close to her when
 19 you're breast feeding.
 20 (0.6)
 21 HV: Sometimes Dad feels a bit left out do you?

As noted, this case—with its overt formulation of breast feeding as the “best thing for your baby”—is exceptional. It is the only case in over 90 episodes of advice giving during the first visits. Even here it is heavily buttressed by practical and technical medical justifications. In the remainder of our data, by contrast, the moral imperatives subtending the field of HV–mother interaction remain an unthematized system of constraints that *implicitly* structure the advice, claims, and counterclaims that make up the discourse about baby care in these encounters.

Second, just as in Strong's (1979) pediatric data, HVs rarely engage in actions that explicitly challenge the mother's capacities or motivation

for baby care. In (10) following is the most extreme case in our database though, as will be apparent, it is hardly a powerful "challenge."

(10) (1A1:21)

- 1 HV: Were you a uhm (1.5) what (1.0) uh: (.) you were a
 2 nurse at the Royal.
 3 F: Ye_eh
 4 M: └─Yea:h.
 5 (5.2)
 6 HV: Uhm (.) an S.E.N..
 7 M: Ye(p).
 8 (2.2)
 9 HV: Are you going to go back.
 10 F: Mm hm
 11 M: Yea:h
 12 F: ((sniff))
 13 M: I've taken maternity leave.
 14 HV: ([)
 15 M: └─I'm due to go back in Marrch.
 16 HV: → And who will look after (.) Ann-Marie.
 17 M: I was goin' back on nights.
 18 HV: I see.
 19 M: I wanted to 'ave a go at a couple of nights to see if
 20 we could (.) you know manage between us,
 21 HV: Yes that's a good idea?
 22 M: 'Cos we don't really want anybody else looking after
 23 'e_er
 24 HV: └─No:=
 25 M: =you know if we can 'elp it.
 26 HV: No:.
 27 M: We (.) said that before
 28 F: Mm hm=
 29 M: =I even fell pregnant didn't we:.
 30 F: (pt) .hhhh Ye:h- hhhhhh

Here the HV's question is one which, in the way that it anticipates a problem that is still some months away, may implicate some doubt about the extent of the parents' foresight and by extension, perhaps, their motivation and concern for their child's welfare.⁹ It is also noticeable

that, in her response, the mother portrays her plans to go back to work as premised on her and her husband's determination to look after the child themselves—a determination formed with maximum foresight in that it was, as she portrays it, formed prior to her becoming pregnant (lines 27–29). Other challenges to the mothers' competence in our database are still less explicit than this case.

Third, HVs do not normally engage in overt criticisms of the mothers' baby care practices.¹⁰ The following—although evidently a mildly formulated correction—is among the strongest cases of error formulation in our data set (grandmother = G).

(11) (4B1:24)

- 1 G: .hhh Her hai::r it seems a bit grea:s-y
 2 M: Yea::h.
 3 G: Every
 4 time we've wa:shed it=
 5 M: =Ye-a::h
 6 G: when we give her a little ba:th it looks lo:vely
 7 .hhh=
 8 M: =b-y the end'v-
 9 G: and by the end of -th'da:y
 10 M: by-
 11 (.)
 12 M: by three o'clock in the afternoon it's all greasy on
 13 the to:p.=
 14 HV: =Is it?
 15 M: Yea::h she's a re:a-l swea(t)uh.
 16 HV: → D'ju think she's ho:t.
 17 G: She might be:.
 18 M: Wul we keep 'e-r wrappin' round er
 19 G: We keep 'er in that li- uh
 20 (0.5)
 21 M: and in this little nest here
 22 HV: Ri:ght.
 23 M: that she's go:t.
 24 (.)
 25 HV: → Ri:ght. .hh (It) might be that she's too ho:t.
 26 (1.2)
 27 (): ()

- 28 HV: → Becuz this is certainly the- (.) the temperature of the
 29 → hospital isn't it.=
- 30 M: =Yea:h.
- 31 HV: And is it the same throughout upstairs as we:ll.
 32 (0.2)
- 33 M: We:ll I've got a little fi::re (.) ┌upstairs
 34 HV: → └I would slowly
 35 → bring the temperature do:wn to sort of no:r:mal.
- 36 M: Ye-ah.
 37 G: └Yeh
- 38 HV: A::nd
- 39 G: → W' don't want her catching co:lds y' s-ee.
 40 HV: → └No: that's
 41 → right (.) that's ri:ght it's so difficult to deci:de
 42 → is-'n't it.
 43 G: └It is really.
- 44 HV: → .hh But- but I think it- it's as ba:d tuh have
 45 HV: → i-t too: hot as it is to have it to co:ld.
 46 G: └(We probably (0.7) do over protect.)

Here the mother's and grandmother's collaborative deployment of a problem with a sweating baby (lines 1–15) is gradually diagnosed by the HV as a problem of overheating (lines 16, 25, 28–29) and a recommendation to reduce the ambient temperature in the house. It is noticeable that the (implied) criticism of the overheating is addressed by the HV in terms of a parallel between the temperature of the house and the hospital (lines 28–29), thereby suggesting a rationally founded and well-motivated basis on which the (over)heating has been arrived at. Notably, this whole sequence—with its mild criticism—is produced in response to a request for advice.

Fourth, mothers almost never explicitly reject the advice they are given. The following is the only case in the database in which a rejection emerges. This young mother's friend (Fr) is co-present during this exchange in which an incipient "discipline" or "training" problem emerges.

(12) (1C1:31)

- 1 HV: And you're able to put her down in between fee:ds
 2 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 Fr: =eh hnhh
- 10 (1.0)
- 11 M: Ye:s.=
- 12 HV: =Well it is important you know tuh: (0.2) get it into a
- 13 rou:ti:ne (0.2) otherwise she'll get so used to sittin'
- 14 on your lap she'll want to do it all the ti:me.
- 15 M: Well she di- that's what (.) I did in hospital: uh I
- 16 realize (about) my mistake no:w but you (can't) keep
- 17 them quiet. I- (in fact) I don't like ()=
- 18 HV: =Well my advice to you: is that when she's had a cuddle
- 19 and you've changed her and you've fed her and she's
- 20 brought her wind up (1.2) that you firmly put her do:wn,
- 21 M: I've started.
- 22 HV: O:n her ow::n,
- 23 M: I did it this mo:rnig.
- 24 HV: preferably not right by you:
- 25 (0.8)
- 26 HV: and you can check her every (1.0) fifteen minutes
- 27 if she ()
- 28 M: She had a cry for twenty minutes this morning
- 29 HV: Did she:?
- 30 M: (then she:) went to slee:p.
- 31 HV: Mm. 'Cuz she has to lea:rn that uh (0.7) she can't
- 32 M: ()
- 33 HV: uh be with you a:ll the ti:me.
- ..
- .. ((13 lines of transcript omitted))
- ..
- 47 HV: .hh No: I think it's a very important right from the
- 48 beginning to be fi:rm with 'em.=I(f) you firmly put
- 49 'em down you: TELL 'em (0.8) bedti:me an' I'm
- 50 not pickin' you: up so you can: (0.5) you know:w=
- 51 M: =Tha: t's i:t.
- 52 HV: do what you li:ke (.) and I'm goin' off to

- 53 (1.0) uh:m
 54 (0.7)
 55 M: → Oh I wouldn't let 'er cry too: lo:ng you kno:w.=
 56 HV: =No:.
 57 M: → I mean (0.2) half an hou:r (0.5) y'know I- like
 58 → you sa:y you look- you check them.
 59 HV: Oka:y well th'n I mean (0.5) (let her tr- (0.3) cry-)
 60 if she's- if she's sounding re:ally desperate well
 61 then you pick her up

Here, at the end of a strongly contested “competence struggle” (Heritage & Sefi, 1992)—lines 12–33—in which the HV’s advice is met with consistent efforts by the mother to portray herself as in command of the situation, the mother is eventually brought (at lines 55, 57–58) to reject a still more extreme formulation (lines 47–50, 52) of what she should do.

If these cases represent parameters of explicitness, the majority of “action competence” oriented sequences involve beneath-the-surface strugglings in which, where possible, the mothers strive to show that they have displayed vigilance in child care and have competently responded to problematic situations. Here is a sequence in which the baby’s eyes have been problematic:

(13) [IC1:13]

- 1 HV: Her eyes're oka:y.
 2 (0.7)
 3 M: They ge- th- they get a bit wee:py sometimes, but that's
 4 normal isn't it? And I swab th'm with wool with cotton
 5 woo:l,
 6 (0.3)
 7 HV: 1→ Ye:s if they- if they: (0.2) if you think they're pussie,
 8 (0.8)
 9 M: Yea:h.
 10 HV: 1→ then you must use boiled wa:te:r wi:th a little
 11 M: 2→ |Yeah I kno:w
 12 HV: 3→ bit of salt i:n. (.) One teaspoonful of salt to a pint
 13 3→ of boi:led wa:te:r (0.5) or half a teaspoon to half a
 14 3→ pint.
 15 (.)
 16 HV: 3→ Oka:y?
 17 M: 4→ |(^Oh right I wi:ll do that () .°)

- 18 (): .hhh
 19 (0.3)
 20 HV: 5→ And then you: (0.3) use clean cotton wool one swab for
 21 5→ each ey:e.
 22 M: °Alri:ght.°
 23 (.)
 24 M: 6→ Yeh I do that now. (0.2) I use a separate thi:ng (0.2)
 25 6→ with a bit of wa:rm warm water.=
 26 HV: =Mm.
 27 M: The- Not sò: much that I >y'know< to worry about:t jist
 28 a little bit (in 'er ey:e) it's sticky: (0.4) ('er eye)
 29 HV: L Mm
 30 (0.7)
 31 HV: Yes: (.) we:ll (.) that: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), although only after the HV has pursued response (at line 16) following the mother's failure to produce an immediate response (at line 15). 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” that 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 whenever possible.

In sum, these interactions embody a massive and systematic subordination of moral evaluation to a discourse based in practical and technical-medical reasoning (Linell & Bredmar, 1996). However, as Bergmann (1992) suggested, suppressed moral discourse can leak into, inhere in, or even suffuse these medical ways of talking in unacknowledged ways. There are occasions in which the defensiveness of the mothers' responses formulates the absence of moral evaluation by the HVs as a kind of “withholding”

of moral judgment. In this way, moral considerations are circuitously reintroduced into the talk as its liminal subtext.

A Deviant Case: Advice Seeking on a “Morally Contaminated” Issue

As we have noted, the mothers in our data set rarely request advice and, on the whole, avoid personal disclosures. However, there are exceptions and in this section we examine a series of sequences in which a mother discloses that she does not feel much love for her child. These sequences are taken from the second and fourth visits in the six-visit series. Before turning to episodes from these visits, we consider some of the literature on mothering and motherhood as it pertains to our data.

Feminist scholars criticize the tendency to treat motherhood as an exclusively natural biological category. Oakley (1993) argued that the term *mother* refers to “both the capacity for biological reproduction and the exigency of social reproduction—child bearing as opposed to child-rearing” (p. 83). Kitzinger (1978) stated that “a great deal of what we take for granted as ‘natural’ in mothering is not natural at all, but a product of culture” (p. 9). She also stressed that mothering is a capacity that is gradually achieved and that childbirth is thus just a point in the “process of becoming a mother” (p. 161), and this theme is echoed by Oakley (1981).

These arguments resonate with ethnomethodological work that has shown how “natural” attributes are socially achieved (Garfinkel, 1967; West & Zimmerman, 1987). In the study of Agnes, Garfinkel (1967) described the social management practices associated with sexual status—a category that is usually treated as quintessentially natural. Garfinkel argued that, although sexual status is socially achieved, it is overwhelmingly treated as “natural.” However, this naturalness is oriented to within a moral framework. Persons who, from the collectivity’s point of view, are not “normally sexed” are treated as wrong and sinful even by individuals like Agnes who do not fit neatly into the male or female dichotomy (cf. Heritage, 1984). There is an important dialectic here. Appeals to “nature” are among the strongest types of moral justification, and to determine that something is “unnatural” can constitute a very strong form of moral condemnation. Claims of naturalness are thus often, paradoxically, constitutive of moral evaluations.

Our data involve an instance consistent with these observations. In it, motherhood and the appropriate feelings associated with mothering are treated within a developmental “natural” idiom. The parties treat the development of maternal feelings as natural but, when the relevant feelings seem not to emerge, they are concerned about this outcome as unnatural and morally “wrong.” Thus, in acknowledging that she does not have the proper feelings for her child, our mother brings up a problem that she treats both in terms of “normal development” and in terms of morality.

Our analysis centers on how this moral problem is introduced, depicted, and resolved. The parties’ treatment of the problem has a broad trajectory consistent with that described by Jefferson (1988) for “troubles telling” in which

the parties start out at an interactional distance appropriate to their routine conversation, become gradually closer, arrive at an intense intimacy as the trouble is focused upon, and then return to a more distant relationship as they re-engage with business as usual. (p. 419)

We argue, in line with Linell and Bredmar (1996), that as the interactants progressively enter into the mother’s problematic feelings as a “trouble” and as a part of the moral realm, the HV tends to abandon the idiom of technical and medical advice giving in favor of a more autobiographical and experiential approach in which she directly addresses the mother’s experience. We use the term *documented empathy* to describe this kind of experiential matching. To provide a context for our analysis of this and other practices, we first briefly characterize the entire series of visits between this mother and her HV.

Like most of the first visits in the larger database from which this series of visits was drawn, the first visit was mostly occupied with bureaucratic tasks such as obtaining the vital statistics of the baby, registering the baby for immunizations, and explaining the schedule of health checkups for the baby (Heritage & Sefi, 1992). The HV physically examined the baby during this visit and gave some advice on basic baby care. She also asked the mother about her birth experience and advised her on postpartum care. The proper care of baby and mother was also the main topic of the second visit. The mother is slightly more forthcoming in this visit than she was in the first. In this visit, the mother volunteers for the first time that she does not yet have strong feelings for her baby. Between the second and third visit the baby got a chest infection, and the mother had mastitis. The proper care for these medical problems occupied a great deal of the third visit. The

fourth visit provides the focus for our analysis because it is here that the mother's difficulty in bonding with her baby is most explicitly dealt with. Initially the interactants discuss the baby's current sleeping and feeding schedule. The mother acknowledges that the baby's erratic daytime schedule is taking a toll on her, and this leads to more extended talk about the emotional difficulties of mothering. The mother is still expressing concern that her baby does not properly settle between feedings during the fifth visit. This visit is much shorter than the other visits as the mother is on her way out when the HV arrives. The baby's feeding is also extensively discussed during the sixth visit. After briefly examining the baby, the HV recommends a medication for colic. Future concerns, such as day care, are also discussed during this visit.

The ensuing analysis has been divided into three episodes. As we move from Episode 1 to Episode 3, the mother's depiction of her relationship with her baby becomes increasingly serious. In the first episode (taken from the second of the six visits), she presents her problem within a natural, developmental idiom and downplays its importance. In the second and third episodes (from the fourth of the six visits), she increasingly abandons this idiom and expresses more anxiety about her situation. The HV's responses match this development, and she tends to respond in increasingly experiential terms as the mother moves from the natural to the moral realm.

A Moral Problem: Episode 1

The following sequence is the first time the mother discloses that she is not yet connecting with her baby. She offers this information in response to a query by the HV (line 1). This query is done in the midst of a number of mothering activities—changing and nursing the baby—and it is uttered with a raised voice over the baby's crying. Given this context, the HV's question could be heard to address the mother's ability to cope with the practical challenges of mothering.¹¹ However, the mother chooses to respond in terms of her emotional state.

(14) Episode #1 [3A2:27]

- 1 HV: >Do you think you've settled very quickly into motherhood,<
 2 M: Uhm (1.2) ye::s I suppose so (I mean)

- ((7 lines of data omitted in which Mother tends to the
· baby.))
·
- 10 M: I still feel I've got to sort of really grow to:, (1.5)
11 ehm pt .h feel that she is my ow:n and rea:ily
12 (1.2)
13 HV: Mm:,
14 M: love her lots
15 (.)
16 M: I mean I like he:r and I think she's wonderful'n (0.6)
17 but I don't feel "ohhh look at m-y ba:by"
18 HV: No,
19 M: .h It doesn't really worry me cause I know it'll come
20 with ti:me.=
21 HV: =It does yes.
22 M: But ehm-
23 HV: Yeah. .h Well when I first had mi:ne I couldn't stand
24 the sight of him?
25 M: °Heh heh heh,°
26 HV: (.hh W'l-) 'e wasn't exactly pretty looking he had .h
27 some forceps marks all over his head,
28 M: Oh lo:rd ((wavering))
29 HV: (It was all) sort
30 of a weird shape you kn-ow,
31 M: Yes
32 HV: Huh huh huh huh huh .hh
33 M: pt
34 HV: ehm But pt e-hm it's something as you sa:y that does come,
35 M: ((to baby)) The:re ()
36 M: Yeah,
37 HV: And it's eh it's when they start responding to you when
38 they a-re
39 M: That's right.
40 HV: ehm they're looking forward to you they're looking out
41 for you and you find then that you know you can feel
42 quite wa-rm towards them,
43 M: Yes
44 HV: .hh but I think the first weeks ((clears throat)) pt they

- 45 take a lot out of you and and nothing is,
 46 M: Nothing is- that that's right there's no feedback

Although the mother's response is given in second position, she is nonetheless the one who introduces the morally sensitive issue of maternal bonding. She introduces this issue in a natural and normalizing idiom. In stating that "I've got to sort of really grow to:", (1.5) pt .h feel that she is my own" she depicts the desired feeling as one that naturally will come with time. The mother portrays herself as somewhat distant from the baby (lines 10–11, 14, and 16–17), hesitating in "pre-delicate" fashion at lines 10 and 12 before describing particular feelings that she depicts as absent. Having stated that she still has to learn to love her baby "lots," the mother then retracts a little (line 16) but contrasts her moderate feelings with a position that is depicted and vocally animated (via an "exaggerated" softness and breathiness in the delivery) as an excessive infatuation ("I don't feel 'ohhh look at my ba:by:'"). This line is perhaps the peak moment of disclosure in this episode.

Subsequently, the mother begins to exit this disclosure sequence via an optimistic projection in lines 19–20 that once again emphasizes the naturalistic or developmental framework of her situation. It is this projection that the HV takes up and agrees with (line 21). She then normalizes the mother's feelings by describing similar feelings that she had toward her own child (lines 23–24, 26–27, and 29–30). The HV initiates an exit from the sequence by explicitly agreeing with the mother's earlier optimistic projection (repeating the same words, line 34)¹² and thereafter moves to a less empathetic and a more objective and professional perspective in advising about how mother-child relationships in general develop (lines 37–38, 40–42, and 44–45). Within this segment, she implicitly lowers the mother's expectations by using the words "quite warm," rather than "love" or "affection," to describe the onset of maternal feelings. The sequence ends with explicit agreement from the mother in line 46 and an effort at collaborative completion of the HV's unfinished utterance.

The predominant tone of this segment is naturalizing and developmental. The extent of the HV's "documented empathy" is relatively minimal and does not quite match the mother's experience.¹³ There are two key differences between the mother's and the HV's tellings. First, whereas the mother emphasizes her lack of emotional closeness with her baby, the HV stresses her dislike of the physical appearance of her baby. Second, the HV provides an external reason for her dislike (the forceps

marks). Such an account is not available to the mother. The HV's story is thus not fully analogous to the mother's, although she initially abandons her "professional" stance in dealing with the mother's anxieties. An extended exit to this sequence is initiated by the mother's return to an optimistic projection (lines 19–20) and the HV's subsequent support for that position within, first, an experiential and, subsequently, a professional frame of reference.

As noted earlier, the mother and baby fell ill between the HV's second and third visit. The treatment of the illness occupied most of the third visit. We therefore now turn to the fourth visit, where the mother's feelings toward her baby are once again addressed.

A Moral Problem: Episode 2

The HV's query (line 5) in the next episode emerges after, and can be understood as a pursuit of, a weak agreement that the mother produced after the HV had positively evaluated the mother's early postpartum experience (lines 1–4). When the mother does not immediately respond, the HV probes with "do you feel as though you have or j'st". Unlike the query in line 5, this probe, especially the turn-ending "or j'st," is built for a possible disagreement (Lindström, 1995). In questioning the mother about her feelings, the HV preserves the validity of her own evaluation in lines 1–4 (she does not address whether the mother has "come through with flying colors" or not, but rather whether she feels as though she has).

(15) Episode #2 Part 1 [3A4:4]

- 1 HV: Ah: .hh and- you know the next six weeks you'll find
- 2 things so much easier .hh and you've come through this
- 3 first six weeks with flying colors may I sa:y huh
- 4 └huh huh
- 5 M: └Yea:h,
- 6 HV: Haven't you.
- 7 (.)
- 8 HV: Do you feel as though you have or j'st-
- 9 M: Not really- I don't know perhaps I expect too much of
- 10 myself.
- 11 HV: Ah

- 12 M: And perhaps I expect too much of Phoebe as well I you
 13 know I expect her to be a perfect baby and every time she
 14 does something that's (0.5) <not brilliant> I (.) think
 15 that this is the start of bad things to come you know and
 16 I really worry about that and get all uptight °and°,
 17 HV: .hhh Well there's no such thing as the perfect mother
 18 and there's no such thing as the perfect [baby.
 19 M: [babie:s
 20 HV: .hh And we're all different, (0.2) .hh but you really
 21 have done very well this first six weeks it's your
 22 first baby, .hhh=
 23 M: =°M└m°
 24 HV: [And you've coped exceedingly well I mean how can I
 25 .hh impress on you [just how well you've coped, .hh
 26 M: [°Mm°
 27 HV: and I wouldn't be saying that if I thought otherwise.
 28 M: Mm:
 29 HV: You have coped very very well.

In contrast with the previous episode, the mother does not present her problem in terms of a lack of feelings that will come. Instead she indicates that her experience of motherhood has not met her expectations, although simultaneously acknowledging that these expectations might be too high (lines 9–10 and 12–16). The HV's response in lines 17–18, which asserts that there are no perfect babies or mothers, agrees with the mother's criticism of her own perfectionism and is thus hearably reassuring in intent. She then goes on to reassure the mother in very explicit terms, using very strong evaluations: "you've coped exceedingly well I mean how can I .hh impress on you just how well you've coped, .hh and I wouldn't be saying that if I thought otherwise. You have coped very very well."

In the ensuing segment (not included on our transcript) the HV suggests some medical and social reasons why this mother has had a more difficult time than most. She then reverts (in the next transcript) to the idea that the mother has set herself too high standards and claims that this is "a common failing of nurses." Because the mother also is a nurse, this is hearably designed to establish a link between the experiences of the two women. The mother agrees with this observation. The following (16) shows the remainder of this sequence.

(16) Episode #2 Part 2

- 1 HV: Nobody was worse than me I may _{say.}
 2 M: _{Heh heh heh}
 3 HV: Huh huh huh huh .hhh
 4 M: Mm
 5 HV: I was a typical case of somebody who knew everything,
 6 (.)
 7 HV: Didn't I _{heh heh heh .hh}
 8 M: _{Heh heh heh}
 9 HV: And now I realize th't, .hh I have to learn every da(h)y
 10 _{hhh .hhgh} And take days as it comes and not ehm .hh
 11 M: _{Mm}
 12 HV: (0.4) but it took me years to- to get to that frame of
 13 mi:nd
 14 M: M_m hm
 15 HV: _{where I could .hh} say well you know I don't think I
 16 handled that very well and just accept it you know just
 17 eh shrug your shoulders to a certain extent.
 18 (2.4)
 19 HV: But having said that I think that ehm pt nurses are on
 20 the (ball) like that.=In the long run you see you just
 21 .hhh you ehm you do achieve a lot because you have these
 22 high _{ideals.}
 23 M: _{Mm}
 24 HV: .hh But if the ideals .hh are really (0.5) >getting on
 25 top of you< then of course you won't achieve so much.
 26 M: Mm=
 27 HV: =You have got to sort of .hh not- not °worry so much°.
 28 M: (°Mm°)
 29 HV: Just try try and take things a little bit e:hm easier
 30 .hh let things flow over your head a bit

In this segment the HV gives an extended discourse on the moral lesson to be learned from this. She begins this by speaking of her own experience (lines 1, 5, 7, 9–10, 12–13, 15–17). She then restates her prior generalization that this is a professional shortcoming of nurses (lines 19–20) and ends the sequence by directly addressing this mother: “You have got to sort of .hh not- not °worry so much°. Just try try and take things a little

bit e:hm easier .hh let things flow over your head a bit.” As in Episode 1, there is an effort to build shared experience, but a relatively nonintimate form based on external professional characteristics. We also note that the mother attempted to place part of the blame for her situation on her baby’s behavior (see Excerpt 15, lines 12–16). The HV resists this, focusing instead on the vulnerabilities of the mother’s psychological or motivational mind-set.¹⁴

A Moral Problem: Episode 3

The next episode is the most complex data we deal with in this article. We have therefore divided it into four segments that we discuss separately. The first of these segments begins with the mother’s response (line 4) to an optimistic projection (line 1) by the HV that within the next 6 weeks either the baby will become less demanding or the mother will be able to better cope with the baby regardless of its behavior. The mother continues (lines 4–5) by initiating a “serious troubles” telling in which she assesses her own experience of motherhood:

(17) Episode #3 Part 1 [3A4:9]

- 1 HV: And (e-) you know eh one or other will ha-ppen
 2 M: └Yeah
 3 (1.8)
 4 M: I just feel really (s- I dunno) cheated I feel “oh I’m
 5 not enjoying this at all and I should be.”
 6 (.)
 7 M: And when I take her to see people and .hh there’s one
 8 friend of mine who is desperate to have a baby,
 9 HV: Mm
 10 M: She’s got one already but she’s (.) quite infertile (0.5)
 11 and she picks up Phoeb- “Oh isn’t she beauti-ful”
 12 HV: └Yes well
 13 she is
 14 M: and () you see her going all gushy
 15 HV: Yes
 16 M: └And I think well I should be like this I should be
 17 feeling th’t .hh “oh isn’t she wonderful-” I mean I-
 18 there’s sometimes I look at her and I think she’s

- 19 pretty (good) you know, but none of this
 20 HV: └Mm
 21 M: real sort of (.) "oh: I can't bear to not look at her
 22 for five minutes" you know,
 23 (0.6)
 24 M: Ehm (0.2) I don't know I feel really (0.6) as if: (.)
 25 >I'm not her mother at all< (and) as if (.) somebody
 26 else is going to come along knock on the door and say
 27 "right I'll take her home now thank you."
 28 (1.0)
 29 M: And (0.8) I suppose it'll come later but I jus-,

As noted, this episode opens with an optimistic projection by the HV that either the baby will improve or the mother will adapt better regardless of its behavior (line 1). After a pro forma agreement, the mother rejects this projection with a progressively more serious rendition of her emotional bond with her child. In lines 4–5, the mother states she feels “cheated” and then assesses her experience of motherhood against what she invokes as the norm: “oh I’m not enjoying this at all and I should be:.” When the HV does not immediately respond to this assessment, the mother upgrades her position by describing a situation in which another woman showed very strong feelings (“going all gushy,” line 14) toward her baby. This woman is not introduced as a “normal” person but as “someone who is desperate to have a baby.” Nonetheless, the mother treats this woman’s expressed feelings as a contrastive “benchmark” (Smith, 1978) against which to evaluate her own: “And I think well I should be like this I should be feeling th’t.” The mother then progressively describes her own relationship to her baby in increasingly dissociated terms, moving from “I think she’s pretty good” to “I feel really (0.6) as if: (.) >I’m not her mother at all< (and) as if (.) somebody else is going to come along knock on the door and say ‘right I’ll take her home now thank you.’” This evocation of a concrete but imaginary process by which someone will come to retrieve the baby constitutes a very strong acknowledgment of estrangement. Faced with no immediate uptake to this depiction, the mother offers a most minimal, and “trailed off,” optimistic projection: “I suppose it’ll come later but I jus-.”

The sequence continues as follows:

(18) Episode #3 Part 2

30 HV: .hh Well it- it- can I assure you that I felt just like

- 31 that with my first one.=And it does come later.
 32 M: └Yeah
 33 HV: .hhh But it's (.) easy to say "yes it will come later."
 34 M: That's r₁ight,
 35 HV: └I think (e-) falling in love with your baby
 36 is sometimes instantaneous. └.hh And sometimes takes
 37 M: └Mm:
 38 HV: a long time .hh and I think when you've had a difficult
 39 (.hh)labor that it takes longer be₁cause you know y-
 40 M: └Yeah
 41 HV: physically and mentally you're exhausted when the baby
 42 is there .hh and really I used to (0.2) wake up °and
 43 think "that dratted baby is crying (ag(h)ain. hh)"°
 44 M: Yeah.
 45 HV: n I'd think "oh:." (0.2) scream and go ma:d.
 46 M: Mm.
 47 HV: And um pt .h it was: (.) he was well over six weeks
 48 before I felt any- you know └.hh
 49 M: └Yeah
 50 HV: WELL GRADUALLY .hh (as 'e-) the more he smiled at me
 51 you kn₁ow the more I felt "oh well └s- perhaps he's not
 52 M: └Yeah └s ri:ght
 53 HV: s(h)o b(h)a(h)d a(h)ft(h)e(h)r a(h)-ll huh huh huh .hh
 54 M: └That's right.

At lines 30–31, the HV responds to this telling. The initial component of her self-interrupted turn-beginning could be heard to be going toward the subsequently realized "it does come later" (line 31). However, she interrupts this unit in progress and begins to introduce her own experience as a mother as a basis for her assertion. With this self-editing, the HV shifts from a professional to a personal basis on which to address the mother's concerns. That this shift as a kind of "afterthought" is also perhaps evidenced by her later retrospective comment that it is "easy to say 'yes it will come later'" (line 33).

After glossing her own experience in lines 30–31, the HV offers some more professionally oriented generalizations about maternal bonding (lines 35–36 and 38). Like the advice she offered in the first segment discussed in this section of the article, these generalizations are constructed within a developmental and naturalistic idiom. After suggesting

the birth experience as a general factor impacting maternal bonding,¹⁵ the HV shifts back to her own experience (lines 42–43, 45, 47–48), returning to a claim she made in an earlier visit (see Excerpt 14, lines 23–24) that she had not initially bonded with her child. This allows her to assert on the basis of her own personal experience as a mother what she had earlier asserted merely as a professional generalization in the first of these problem segments (cf. Excerpt 14, lines 37–38 and 40–42): namely, that the baby's increasing responsiveness evokes maternal bonding.

In comparison with the first episode (14), this time there is a better match between the mother's telling and the HV's "documented empathy." In the previous episode, the HV only briefly invoked her bonding problems and seemed to explain them away in terms of the baby's appearance. In this episode, by contrast, the HV comes close to depicting her own situation as having been more serious than the mother's. In stating that it took well over 6 weeks before she bonded with her child, the HV renders the mother's disposition toward her 6-week-old baby as less out of the ordinary. The mother responds to the HV's account by agreeing (lines 52 and 54) with the generalization that is implied. It is noticeable, in this account, that the HV's dawning affection for her child ("oh well he's not so bad after all") is not depicted in strongly emotional terms, and it is lightened by laughter that the mother, strikingly, does not join (for a similarly lukewarm depiction of maternal affection, see Excerpt 14, line 42).

The third part of this episode, which the mother begins by disavowing any danger to the baby arising from her emotional state (lines 55 and 57–58), is shown as follows:

(19) Episode #3 Part 3

- 55 M: I mean I'd never do anything awful to her 'cause I-
 56 HV: └Mm
 57 M: I mean I care for her and look after her and make sure
 58 she's clean and ()
 59 HV: └Yes
 60 HV: Well you do she is beautifully cared for .hh
 61 M: But I'd uh (1.5) I just haven't got that (.) gushing
 62 loving feeling yet,
 63 HV: Well I think again in the next six weeks .hh you will
 64 .hh eh start to get it.
 65 M: Mm

- 66 HV: Um (1.0) but it may be slow to come (0.4) and I think
 67 you have got to be patient with yourself.
 68 M: Mm
 69 HV: .hh I know that it is I used to think well I've handled
 70 a lot of children and and you have as well?
 71 M: Mm
 72 HV: And so ehm why I am I you know being s- sort of
 73 apathetic about my own (0.4) but in fact ehm .h I love
 74 him very dearly now that he is thirty-one hhhh HUH HUH
 75 HUH HUH HUH HUH HUH
 76 M: Promise it doesn't t(h)ak(h)e that long.
 77 HV: HUH HUH .hh Oh no it doesn't no .hh
 78 M: (Heh heh heh .hh)
 79 HV: No I w- you know between six weeks and three months
 80 pt .hh I think the baby develops so much intellectually
 81 you know they .hh they eh responding to you more and
 82 more every day and (0.4) that process of falling in
 83 love with the baby and the baby falling in love with
 84 you.
 85 M: Mm
 86 HV: Through eye-to-eye contact and chatting her up a-nd ehm
 87 M: Mm^o
 88 HV: nursing her and cuddling her (0.4) comes gradually,

The mother's initial and volunteered disclaimer (line 55) supports our earlier point that caregivers (and mothers in particular) continuously orient to the evaluative dimension inherent in these interactions. The HV responds by first acknowledging the mother's statements (lines 56 and 59) and then upgrades her response by complimenting the mother on the care of the baby: "she is beautifully cared for." The mother then de-escalates the seriousness of her disclaimer by returning to her feelings: "I just haven't got that (.) *gushing* loving feeling yet." The term *gushing* reinvokes an earlier use of the term (Excerpt 17, line 14) in which it was used to depict excessive feeling from a woman who was "desperate to have a baby." Here, the reuse of the term *gushing*, with its connotations of excess, contributes to the sense of de-escalation and may further represent a first effort at sequence closure, contingent perhaps on the mother's recognition that her earlier disclaimer has "gone too far." The HV's response, with its explicit reinvocation of the 6-week period as one

of adjustment, addresses the mother's effort at closure and modulates into an optimistic projection that is tempered by a slight expansion of the time period in which bonding can expectably take place (lines 66–67).

Subsequently, the HV again shifts to her own experience as a mother (lines 69–70 and 72–75). Explicitly underscoring the similarity between her own and the mother's experience as health professionals (lines 69–70), the HV portrays her uncertainty about her own "apathy" about her child (lines 72–73). She then continues by jokingly implying that it took over 30 years before she developed real affection for her child. The mother responds to this by pleading in a "smile voice" that the HV "promise that it doesn't take that long" (line 76). The HV's laughter in the ensuing turn suggests that she appreciates the humor implicit in the mother's turn. This notwithstanding, she shifts from a joking to a serious response by telling the mother when and how she can expect her maternal feelings to evolve (lines 79–84, 86, and 88). This last bit of advice can also be heard as an embedded instruction on how the mother ought to interact with her baby.

In the last part of this episode, the HV overtly addresses the moral dimension associated with the issue of maternal bonding.

(20) Episode #3 Part 4

- 89 HV: pt .hh But I can remember (0.8) sitting on the bed
 90 cuddling him and thinking (0.8) "we:ll you know I got
 91 more out of cuddling somebody else's baby sometimes,"
 92 M: Mm:
 93 HV: Mm?
 94 (0.3)
 95 M: That's right.
 96 HV: Yeah?
 97 M: Oh that's alright. <That's reassuring.
 98 (0.5)
 99 M: |heh heh heh
 100 HV: |No I- I mean I really did feel that .hhh and I remember
 101 telling it eh- saying to somebody that I felt like this
 102 and of course this was years ago when you didn't discuss
 103 such things you know,
 104 M: |No that's right.
 105 HV: .hhh And this person being absolutely horrified and
 106 telling me I was an unnatural mother,
 107 pt

- 108 (0.2)
 109 M: And that made you feel even worse,
 110 HV: Oh yeah that really got me(h) hhhh w(h)ound up I c(h)an
 111 t(h)ell you,
 112 (0.5)
 113 M: No:
 114 HV: I was careful not to say it to anybody else for years
 115 after that.
 116 (0.8)
 117 HV: Yeah .hh but I think now it's all acknowledged and out
 118 in the open and it is so (.hh) normal to be like this
 119 especially when you had ehmm pt a rough time.

The HV begins by upgrading her previous identification with the mother's feelings by relaying that she felt cold to her own child by comparison with other children she worked with professionally (lines 89–91). This observation reciprocates the mother's earlier assertion that she doesn't feel as if she is her baby's real mother (Excerpt 17, lines 24–25). The mother acknowledges the HV's disclosure with a neutrally intoned continuer (line 92). Subsequently, she explicitly aligns with the HV (line 95) and expresses her appreciation of the HV's telling as "reassuring"—a metacommunicative observation that incipiently undermines the mutuality of the sharing experience that the HV is undertaking in favor of a more professionally oriented task focus. After a short silence, both women address this: the mother with a short laugh (line 99), the HV by renewing and upgrading an assertion of the genuineness of her experience.

This sets the stage for the final escalation of the HV's account (lines 100–115) in which she describes a friend's negative reaction to her disclosure of similar feelings that the mother has disclosed to her. This sequence culminates in the acknowledgment by both women that these feelings are widely, if erroneously, regarded as unnatural and inappropriate.

The HV begins this sequence by starting to describe how she told someone else about her feelings. At lines 102–103, she interrupts the narrative with a scene-setting generalization about the period and its social conventions and then resumes with a general description of the friend's reaction as "absolutely horrified" and, in indirect reported speech, the explicit statement that she was an "unnatural mother." Through this narrative, the HV brings a profound level of moral (self-)condemnation to the conversational surface. This is strongly responded to by the mother

with an empathetic increment to the HV's turn ("And that made you feel even worse,") which anticipates the HV's report of her reaction to the "horrified" response. The HV consolidates the mother's response with a report of a psychological reaction (being "wound up") that strongly echoes aspects of the mother's concerns and setting them in a context of historical retrospect. This sets the scene for an exit to the sequence, which the HV accomplishes by a renewed normalization of the mother's experience and a relativization to the historical past of the reactions she reported. Overall, this sequence involves maximal affiliation between the concerns and experiences of the two women (Jefferson, 1988).

The HV's narrative, then, is done fully in the interests of normalizing the mother's parallel experiences. The "horrified" external condemnation of the HV—who has passed on to a fully loving relationship with her son—is used as a resource to bond with, and reassure, a currently uncertain mother in a similar circumstance. The reported reaction that she was "an unnatural mother" is available, now contexted as an ignorant reaction from the historical past, as a resource to contrast with the HV's personal and experiential certainty that this mother's situation is not "unnatural" or even unusual. The HV drives the moral point home further with a final coda in which she renews her earlier invocation of the period to relativize this reaction and to normalize the mother's experience and reduce her feelings of abnormality and isolation by reference to contemporary standards in which these feelings are understood to be normal, and "it's all acknowledged and out in the open."

Discussion

Sefi (1988) observed that the conduct of health visiting can be based on two possible models:

1. In the "baby expert" model, the HV operates in terms of a technical basis of clinical knowledge with which she advises and directs the conduct of mothers toward their babies.
2. In the "befriending" model, the HV establishes a shared experiential base with the mother, affiliates with her problems, and suggests possible courses of action.

Although many of the encounters we have studied embody elements of both approaches, it is clear that the "baby expert" approach is the dominant one and represents the "ticket of entry" for home visits (Heritage & Sefi, 1992).

Within this approach, moral issues do not ordinarily reach the conversational "surface," despite the fact that many of the issues addressed within the "technical idiom of medicine" have significant moral dimensions. It is against this background that the "deviant" case considered in this article (in which the moral issue is directly addressed) is a significant one.

The problem of emotional bonding raised by the mother is a well studied problem in medicine and psychology and, as we have seen, the HV initially tries to address it in terms of broad generalizations. After a certain point, however, the HV is brought to address what might be termed the *phenomenology* of the mother's experience: her dramatic uncertainty about her feelings and her inability to project how they will alter. It is at this point that the HV invokes her own experience as a mother as a resource with which to chart the likely future of this mother's relationship with her baby. As the process of sharing experience takes hold, the technical or medical idiom that has informed the women's interaction thus far falls away, and the moral dimensions of mothering and of the feelings associated with mothering assume a greater prominence.

Although we do not know whether this aspect of the interaction "solved" the mother's problem, the mutual acknowledgment of shared difficulties in bonding with their babies and of the moral stigma associated with this problem may well have served to make the mother feel less isolated in her predicament. We find it inescapable that the direct sharing of experience in this situation is an activity suffused with moral content, although both its moral qualities and their management are quite distinct from cases in which moral concerns are explicitly argued over or treated as rationalizations or as objects of analysis or contemplation.

NOTES

- 1 Facesheet data include background social information such as the number, age, and sex of family members, their employment information, and so forth.
- 2 Compare the following sequence:

(5A1:8)

- HV: (pt) °N(h)o:w° jist need a little bit of (0.3)
 information on the insi:de.=You're both British.
 (0.6)
- M: Yeah.=

- HV: °Yeh.°
 (2.8)
 HV: → What's your boyfriend's name?
 M: Nigel.
 HV: Nigel.

On lexical choice as an index of “institutional” tasks and orientations, see Drew and Heritage (1992) and Heritage (1997).

- 3 Audio recording was selected both because it was a straightforward technique for data collection to be used by the HVs 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.
- 4 In the original data collection process, an attempt was made to restrict the social class of the mothers in the sample to semiskilled and unskilled manual workers. In fact, our sample is more broadly spread and incorporates persons with a wide range of occupations including self-employed businesspersons; white-collar employees; skilled, semiskilled, and unskilled manual workers; and persons who, at the time of the visits, were unemployed.
- 5 See Robinson (1982) for a summary account of the historical background to this unusual division of labor between HVs and other community nurses and Donzelot (1980) for an account of the ideological background of health visiting.
- 6 See, for example, Foster (1988) for a comparison of this feature of the British HV's role with her opposite number in France—the *puericultrice*.
- 7 Although the HV 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 HV renders such a right unnecessary.
- 8 Readers should note that the danger that the HV and mother address in this interaction, which took place in 1982, is no longer thought to be of primary significance. Modern pediatric practice advocates that babies should sleep on their backs, stressing that this position reduces the risk of death from sudden infant death syndrome.
- 9 There is a transparent effort here to “detoxify” the question with an *and*-preface. See Heritage and Sorjonen (1994) for details.
- 10 As Heritage and Sefi (1992) noted, the stepwise initiation of advice in these data is generally designed to avoid the explicit formulation of error.
- 11 The transition to motherhood could be a particularly salient issue for this mother as she worked outside the home before the birth of her child.

- 12 On lexical or phrasal repeats as relevant to topic closures, see Schegloff (1995), especially the section on sequence closing sequences.
- 13 Here we note in passing that it is problematic even to refer to these two women as "HV" and "mother" when dealing with this and later sequences in which both parties emphasize common aspects of their experience as mothers.
- 14 This resistance to blaming the baby is evident elsewhere in our data. Consider for example the following segment in which the HV interrupts the mother in the arrowed line to normalize a behavior by the baby that the mother has depicted as excessive:

- 1 M: It's just- I don't know (0.5) Phoe- (0.5) she- (0.5)
 2 When she's awake I (imagine) her that if I feed her
 3 and lie her down and (0.2) she should be happy and
 4 HV: Mm
 5 M: content.
 6 HV: Mm
 7 M: But she'll lie down for five minutes on the floor and
 8 then she'll get bored or whatever and start squeaking
 9 so I have to pick her up and (usually take her around)
 10 HV: Mm
 11 M: (And talk to her)
 12 HV: Yeah
 13 M: And she just seems to want to be with me all the time,
 14 HV: Yeah
 15 M: And clinging of me and
 16 (0.2)
 17 HV: → Well they do at this stage,
 18 M: Mm:=
 19 HV: =Mm:

- 15 Although they are explicitly targeted to this mother, these factors do not accurately reflect the mother's experience as she had reported it in previous visits. For example, she claimed to have enjoyed the birth in the first postpartum visit.

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