Reconstructing Topical Sensitivity:  
Aspects of Face-Work in Talks between 
Midwives and Expectant Mothers 

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_Sensitivity in Conversation_

When people meet and talk about various topics, whether in institutional encounters or in the private spheres of everyday life, their communication is not a matter simply and only of efficient and rational information transfer about anything that might be present in their minds. Rather, speakers follow a rationality informed by moral choices: “all verbal behavior is governed by social norms specifying participant roles, rights and duties vis-à-vis each other, permissible topics, appropriate ways of speaking and ways of introducing information” (Gumperz, 1982, p. 165).

A _sensitive_, or interactionally _delicate_, topic may be defined as one that cannot be addressed directly or explicitly by the speaker without endangering the interactional harmony of the encounter by threatening the listener’s face (and therefore also the speaker’s own face). Sensitive topics are primarily those with “moral” implications, that is, they often touch upon interlocutors’ responsibilities for leading their lives in good or bad, acceptable or blameworthy ways. The interactional treatment of morality and delicate topics have a strong affinity with issues of mutual face preservation discussed by Erving Goffman (e.g., 1955, 1959, 1983, p. 28). One can talk about both a positive face-need (to present oneself and to cast others as, e.g., competent and socially likeable) and a negative face-need (to want to be unimpeded). For example, if an expectant mother is invited to have an HIV test, there is an implied threat to her negative face both by the mere fact of the tests and by the impositions that would follow a positive test result.

Brown and Levinson (1987), arguing largely along Goffmanian lines, pointed to the tension in interaction between the two opposed poles of positive politeness (being authentic, genuine, involved, immediate, sincere) and negative politeness (being considerate, tactful, respectful, discreet). Sensitive, potentially face-threatening topics generally cluster toward the latter, and have been found to be expressed in more indirect and implicit ways, with more deference and negative politeness, than topics that are more neutral with respect to moral implications. We use indirectness (of expression) as a cover term for various kinds of "expressive caution" (cf. Silverman, 1994a), defined as any type of deviation from a straightforward ("bald-on-record"), immediate (e.g., nondeferred), explicit, and unambiguous expression of the things and issues meant (including their implications).

In health care there are two major kinds of sensitive topics.¹ Both occur in maternal (prenatal) health care (MHC) talk and are well represented in our data. One category is lifestyle-implicating topics, that is, those that concern modes of living for which the addressee (normally the patient or client) can be held responsible. In our case, these are the topics of smoking and drinking habits, and sexually transmitted diseases. The other recurrent category of sensitive topics in health care contexts is those that relate to serious diseases and disabilities with strongly intimidating aspects, potentially affecting life and death. In our data, these are primarily issues concerning malformations of the fetus/baby, which, in turn, entail issues of serious moral choice, that is, abortion.

Topics such as sex, illness, and dying are difficult to address in ordinary conversation, and they were found to be sensitive also for participants in the institutional contexts of AIDS counseling sessions, as studied by Peräkylä and Silverman (Silverman & Peräkylä 1990; Peräkylä & Silverman, 1991; Peräkylä 1993; Silverman, 1994a, 1994b). We will see how such topics are dealt with in a seemingly much less threatening context, namely, that of routine visits by newly pregnant women to midwives working in primary (preventive) health care units.² We argue that the clinical frame may be seen as involving efforts to remove some of the moral concerns from the delicate topics, and yet the participants' actual handling of the topics as "sensitive" reinvokes the moral dimension all over again.

Data

Our data are drawn from a project on authentic encounters between midwives, who are qualified nurses working within preventive MHC units, and expectant mothers, who pay regular visits to these units. Preventive MHC is a service provided to pregnant women in Sweden. The purpose of this societal service is primarily to give personal and professional advice and assistance to women, but it naturally also affords health authorities with some opportunities to check and control progression and conduct during pregnancy. It is optional to take advantage of these communal MHC services, but a large majority of women (95% according to national statistics) do it.
At the time when our data were collected (in the years 1990–1993), a woman could see her midwife as many as 15 times during her pregnancy. (Recent cuts in Swedish maternal services have now brought the number down to about 10.) In our data, the first visit usually takes place in the 10th or 11th week of pregnancy, and involves a good deal of history-taking and information transfer by the midwife. This talk is commonly called the booking interview (Swedish: *inskrivningsamtal*). It is followed by a series of visits, the last one taking place a few weeks or a month after delivery. A couple of these appointments also include an examination by (and talk with) a doctor (either a specialized gynecologist or a general practitioner, the ordinary doctor of the primary health care clinic).

In our project, ethnographic fieldwork was conducted at nine MHC centers, and a large number of interviews with women clients and with midwives and other personnel were conducted. The core data, however, are the tape-recorded (and observed) midwife–pregnant woman encounters. There are two corpora of such data, one of which is used in this article. It consists of 30 booking interviews, that is, the first encounters between the individual women and their midwives.

The booking interview serves to acquaint the expectant mother with the midwife and with the routines and norms of the MHC. The midwife takes in a considerable amount of information about each woman, and this information is entered on a form with preprinted slots. The midwife also communicates information about what is going to happen at different stages of a “normal” pregnancy, particularly with regard to what the different visits to the MHC center will involve. The client receives some printed brochures, and times are fixed for some of the future visits. The overall *phase structure* of the booking interview is as follows:

(a) Greetings
(b) Midwife) asking W(oman) “how she is,” and the ensuing (usually chit-chat type) conversation
(c) Information collection: M filling in W’s case-book, posing specific questions, and then entering W’s answers on the preprinted form
(d) Instructing W to call the hospital to fix a date for the upcoming ultrasound examination (to be done in Week 12)
(e) Taking W’s blood pressure
(f) Informing about the AFP test
(g) Informing about the routines (opening hours, working schedules) of the MHC center
(h) Talking about blood tests to be taken after the interview
(i) Agreeing on times for later visits to the MHC center
(j) Various issues (optionally brought up by W)
(k) Closing the session

The order of these subactivities may vary slightly. In particular, the talk on the blood tests (h) may sometimes occur earlier, after (d), (e), or (f).

The topics of the booking interview are largely agenda-bound, that is, they are predetermined, and many points correspond to items on the printed form. The general context, the medical-institutional character of the situated activity, and
the predefined agenda will therefore provide a frame in which topics, which are sensitive by mundane standards, could be broached in a rather "mechanical" or "bureaucratic" way, along with other nonsensitive topics. We see that, nonetheless, they are treated differently from these other topics.

In our data, there are three different topics that are almost always brought up in the interviews and that may be candidates for sensitivity. These are (1) a lifestyle issue, the woman's smoking and drinking habits; (2) tests for sexually transmitted diseases (syphilis, HIV); and (3) a "dreaded" issue implicated by the AFP test. The AFP test is used as an indicator of serious anomaly or malformation in the fetus, and this topic will then bring up the morally loaded issue of abortion. These three topics belong to rather different domains, and in the booking interviews they belong to different frames and contexts; in terms of the aforementioned phases, they occur in (c), (f), and (h), respectively. Accordingly, they exhibit both features that are common to all of them and other features that distinguish between them.

The Expression of Sensitivity

Analyses of conversational episodes pertaining to the three topics just mentioned yield an array of eight features of indirectness and mitigation, which we can interpret as signs of sensitivity. These features range from phonetic and prosodic features of delivery over various grammatical, lexical, and sequential properties of discourse to aspects of contextual embeddings. We now proceed to a systematic account of these observed features of indirectness, and illustrate them through the use of selected excerpts from the three domains. These features are pausing and other perturbations of delivery, reduction of topic prominence, deferral of topic introduction, limited depth of topic penetration, use of special (mitigating) vocabulary, restrained interactional style, use of neutralizing activity contexts, and use of neutralizing cognitive contexts (frames).

Pausing and Other Perturbations of Delivery

Pauses, especially if nondeliberate, may be characterized as a perturbation of a smooth delivery of information and argument. As is shown in the literature (Schegloff, 1980; Peräkylä, 1993; Weijts, Houtkoop, & Mullen, 1993), predelicate sequences often involve such features as hesitations (filled and unfilled pauses), abandoned utterance attempts and renewed turn beginnings, self-repairs, topicless introductory turns (let's see then), and so on. Such disfluency features also serve to delay the introduction of the delicate issues. In our data they are characteristic particularly of the syphilis and HIV episodes:

Example 1

(Tema K:BU4: Episode on rubella/syphilis/HIV; M = midwife, W = pregnant woman, in this case expecting her first child)

(M returns to the printed form)

1 M: ehm then let's see, (.) German mneasles, do you
2 know if you had that?
3 W: no; I haven't, but on the other hand I am ( ).
4 M: [mm vac.
5 W: of course vaccinated *right*
6 M: we must see to it that the vaccination has taken on
7 too
8 W: mm mm
9 M: () chrm you could stay away from hugging spotty
10 children *before*
11 W: *yeah. hh*=
12 M: *=we know* () this answer. (2.0) then we'll take ()
13 a test, also a blood test (1.0) where one can see ()
14 that () so that you haven't got syphilis
15 ()
16 W: I see ([(Swedish: jaha)]
17 M: this, you see, is something we take on everybody,
18 () an' I haven't yet found anybody
19 W: *no:*=
20 M: =in all these years
21 (1.0)
22 M: HIV. (0.3) we will test.
23 W: mm
24 M: it's optional, d'you want to do that?
25 W: yes, it's *it ca*=
26 M: ==(that) I take, you know, in the same prickling when
27 I now () when I do it on you, right?
28 W: mm
29 M: so it won't be anything () extra
30 W: * no*
31 ([(M turns the page, 3.0)]
32 M: then I talked about ultrasound

In Example 1 the midwife informs the woman about three blood samples. We note that she uses the topic of the rubella test as an introduction to the whole block of tests for which she seeks W's consent. When, in lines 12–14, she moves on to the syphilis test, she does not say, for example, straightforwardly "syphilis we will also test" (let alone, in analogy with lines 1–2, "syphilis, do you know if you have [had] that?"); instead, her approach is slow and stepwise, replete with pauses and with some repetitions. Such perturbations and signs of guardedness are quite typical, and distinguish the syphilis and HIV topics from the adjacent rubella topic. In this case, the word "HIV" is produced in the beginning of a turn (line 22), but it is surrounded by pauses and followed by some verbal material ("we will test").

In the following excerpt, the beginning of a fairly long episode on the AFP test, we see the midwife producing quite a lot of pauses:

Example 2 (TemaK: BUI: Episode on AFP: W expecting her first child)
((previous topic: appointment dates))
1 M: mm. (0.7) yes, then I thought I should inform you
2 as well that (0.5) in week sixteen, () then you'll
3 have an opportunity to take a () blood test
Pauses, if consciously planned, may express cautiousness and guardedness in approaching the sensitive topic. Non-deliberate pausing, too, may indicate some resistance toward introducing face-threatening topical aspects directly. Both of course lead to deferring the direct expression of sensitive aspects.

In addition to pauses in introductory sequences, pauses typically occur just before and/or just after the keyterm, that is, the expression most unambiguously naming the sensitive topic (see Table 1). Although it is certainly commonplace that there is a hitch in speech delivery before keywords (speakers often seem to hesitate a little before finding or deciding on which word to use), pauses and hitches are particularly frequent and salient in our data, especially considering the fact that midwives are involved in carrying out routine activities. The pre-keyterm pauses are perhaps more convincing evidence of the speaker’s addressing the keyword as delicate than are post-keyterm pauses, which could be interactionally driven (solicitation of acknowledgment, re-establishing eye contact, etc.). Yet, a pause after the keyword(s) may also be heard as an attempt to let the intimidating information sink in. On this point, however, there seems to be a competing, partly opposed, strategy available, namely, to move on quickly without dwelling on the sensitive point (this is addressed further later). Virtually all the midwife’s turns in Example 2 are replete with pauses. There are micropauses in the introduction (e.g., Example 2, lines 6–9) and some longer pauses in the “dreadful” description (Example 2, lines 20–22, 24, 26). Another significant feature is M’s (apparently) strategic use of lowered volume. This brings us to our next point.
Table 1: Some properties of midwives' strategies for presenting some topics (incidence in percentages)

<table>
<thead>
<tr>
<th>Topics</th>
<th>AFP (n = 30)</th>
<th>Rubella (n = 21)</th>
<th>HIV (n = 30)</th>
<th>Syphilis (n = 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pauses in introductory sequence*</td>
<td>27</td>
<td>24</td>
<td>27</td>
<td>21</td>
</tr>
<tr>
<td>Pauses before or after keyterm†</td>
<td>23</td>
<td>10</td>
<td>63</td>
<td>58</td>
</tr>
<tr>
<td>Prekeyterm utterance segment‡</td>
<td>70</td>
<td>52</td>
<td>87</td>
<td>63</td>
</tr>
<tr>
<td>Postkeyterm utterance segment§</td>
<td>50</td>
<td>57</td>
<td>60</td>
<td>74</td>
</tr>
<tr>
<td>Proxy topic ¶</td>
<td>100</td>
<td>76</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Quick retreat from topic¶</td>
<td>47</td>
<td>24</td>
<td>90</td>
<td>95</td>
</tr>
</tbody>
</table>

* A sequence was positively coded if it contained at least two pauses (micropauses or longer).
† Note, however, that HIV and syphilis topics often do not have an introductory sequence of their own: they are introduced through the "safe" topic of the rubella test (see text).
‡ A sequence was positively coded if it contained at least one pause before or after the key expression.
§ Any verbal material except hesitation markers like (Swedish equivalents of) uh, ehm, and so forth.
¶ Compare Footnote d.
These notions are explained in the text under "use of neutralizing cognitive contexts" (p. 369).
In the remaining cases (24%), M asks directly about rubella or immunity against rubella.
A quick retreat must not contain any additional remark on the topic.

Reduction of Prominence

One strategy for diminishing the face-threat of some topics seems to consist of reducing the perceptual or cognitive salience of their corresponding expressions. For example, lowering the volume to sotto voce, thereby perhaps also switching to another voice quality, may be a way of indicating the delicacy of a particular issue. We find it particularly in the AFP test episodes, when (some) midwives start to lead up to mentioning particular malformations (as in Example 2, lines 7-8, 10).

Another feature quite frequent in our data is that of syntactic embedding; the use of some verbal material before and/or after the particular delicate or threatening keyterm. To see this point, let us first introduce an example of an episode that is quite different in that it involves morally relatively neutral topics. Consider the following sequence from the dialogue accompanying the filling in of the form:

Example 3 (Temak K: BÅ5:6. Sequence from information collection by M; W expecting her first child)
1  M: "then I'll go through different diseases an'such.<
2  W: "diabetes, you haven't got that, have you?
3  W: "no.
4  M: "urinary tract or kidney disease?"
In contrast to the HIV episodes, the keyterm (usually a noun, explicitly identifying the topic) is here routinely introduced by M straight on (and it is, of course, taken as such from the printed form). In most cases, like in Example 3, the woman will give short negative answers, which receive no overt verbal responses from the midwife, who, instead, moves on quickly through the list of items, without much ado. The rubella, HIV, and syphilis tests are also three items that make up a small list (corresponding to a specific subsection on the printed form), and yet there is ample evidence that they are not treated in the same way. Typically, the keyterms HIV and syphilis do not come first in a turn (or even turn-constructional unit); they tend to be preceded, and/or followed by, other, often rather empty, verbal material. We saw this in Example 1. Example 4 shows something of the same:

Example 4  (Tema K: BU8: Episode on rubella/syphilis/HIV; W has children from before)

previous topic: tallness and weight. W talks with her little child, M leafs through papers, clears her throat. No talk for about 15 seconds)

1  M:  "let's see her" "then we'll fill in these blood tests we're gonna take." then I guess they checked up HIV last time you were pregnant?

2  W:  mm.

3  M:  but that's something one repeats.

4  W:  "yeah exactly".

5  M:  you have nothing against that?

6  W:  no.

7  M:  in the same way we check up "syphilis too".

8  W:  yes=

9  M:  =German measles on the other hand, that you were immune against, so that's OK, you know

10  W:  mm

11  M:  so that we-- "we need not" (.) that you can't change anything on that, right?

12  W:  "^no^" (((W talks to her child, pause for 7 seconds, then a new topic)))

8  W:  "no".
This episode is a rather exceptional case in terms of its absence of pauses (but note M’s local use of lowered volume; Example 4: lines 1–2, 9). Yet, rubella is again treated differently from HIV and syphilis. In this case, however, we have a woman whose immunity to rubella is known from her previous pregnancy, but HIV and syphilis are different and must be checked again. Note, though, how the rubella test is used as an exit, a means to retreat rather rapidly from the topic of testing for the sexually transmitted diseases.

There seem to be embeddings of sensitive material at several structural levels. At the level of turn-constructional units, we find the use of prekeyterm or postkeyterm utterance segments, which allow the speaker to avoid having the (threatening) keyword (usually a noun) stand out as the perceptually salient first or last word of the utterance. At a somewhat higher level, we find the use of a “safe” topic, the rubella test, used as an entrance (as in Example 1) and/or an exit (as in Example 4) to the topic of venereal diseases. In the following we encounter other ways of embedding delicate topics in suitably neutral contexts.

Deferral of Introduction

Some of the aforementioned methods serve to defer the introduction of the sensitive topic. Another method to achieve deferral is the use of presequences (Scheglof, 1980; Heritage, 1984, pp. 265ff.):

Example 5 (TemaK: BÅ8: Episode on AFP test; W has children from before)
(5.0)
1 M: AFP, did you take that last time?
2 W: no.
3 M: what are you going to do this time?
4 W: no, I think I’ll stick to this.
5 M: yes, but then I write abstains here.
6 W: yeah.
7 (11.0)

In our data, presequences are characteristic primarily of the AFP topics; for instance, Example 2, line 1: “I thought I should inform you,” and Example 5, line 1: “AFP, did you take that last time,” and Example 6, line 1, following. The syphilis and HIV episodes may exhibit similar features (Example 4, line 1: “we’ll fill in these blood tests we’re gonna take”). The use of pre-acts, which we can see as a kind of sequential embedding (cf. the uses of syntactic embedding, discussed in the prior section), may serve the purpose of indicating the delicate character of that which is going to be introduced later on (Scheglof, 1980, pp. 131 ff.). Peräkylä (Silverman & Peräkylä, 1990, p. 308; Peräkylä, 1993, p. 303) observed this feature in counseling sessions.

Limited Depth of Penetration

If the sensitive topic is sometimes approached slowly, indirectly, or gradually, the degree of penetration is also often limited, and parties, in our case led by the
midwife, soon start retreating. This is especially salient in the malformation/abortion issue. As we noted before, the AFP test is a major method in screening pregnant women for fetal anomalies, and it implicates serious moral considerations. However, if the midwife finds out that the woman knows about the test and knows what stance she will take, the midwife will invariably, as in Example 5, move on without any penetration of the topic at all, thus avoiding the implicated moral issue completely. Example 6 is just a little more explicit:

Example 6  (TemaK: BU10: Episode on AFP: W has children from before)  

(4.0)  
1 M:  AFP, did you take that last time?  
2 W:  well, that I don't (know)  
3 M:  that was this thing with the chi . . . having an open  
4 W:  well that  
5 M:  spinal hernia  
6 W:  well that I took (2.0) I probably took  
7 all the tests, ((laughter))  
8 M:  (xx) yes, you did.  
9 W:  mm  
10 M:  that was good.  
11 W:  ^yeah^  
12 M:  the offer stands of course.  
13 W:  mm  
14 M:  and one doesn’t take it until preg the sixteenth  
15 pregnancy week so there will be  
16 W:  that I want to take (^anyway^)  
17 M:  mm  
18 W:  ^yeah^  
19 M:  () then you’ll get a new appointment when you’ve  
20 been to the doctor's check up  
21 W:  yes  
22 M:  so we’ll take it in week so it’s fairly important that  
23 one takes it in week sixteen you know  
24 W:  mm  
25 M:  so that there won’t  
26 W:  ^yeah^  
27 M:  be any change on that.  
((new topic))

In some cases, the AFP gives rise to a long episode. In Example 2 we saw the start of such an episode; Example 7 is almost a direct continuation of the sequence in Example 2:

Example 7  (TemaK: BU1; see Example 2)  

32 M:  hh. ehrm yeah, so that one has then an opportunity to  
33 take such a test.  
34 W:  mm.  
35 M:  now I should of course also tell you that this is  
36 of course terribly unusual, both these things
it is, isn’t it.

yes, it is, so that it is so to speak *nothing* which ()

no

happens ofen, but it is terribly unusual

*yes exactly*

*yes*. and it is completely optional if you want to take it.

(0.3)

whereabouts

hh

d’you take “it”?

it’s a common blood sample that I (.) take here

((M shows where on her arm the sample is to be taken))

take it here then.

mm=

=mm.

but one takes it in week sixteen.

m-hm

mm. (0.5) so you can then (.) read through this brochure,
or ehm (.) slip at home then, and- ah (0.3) then you
can (.) tell me (.)

mm

when you come to the doctor then, if you want to take

the test “or not”.

*yes exactly*

mm. what I think perhaps is important that is I think

that one (.) goes one step further what do I do if I get a-

(

yes.

that one has so to say (.) thought it over a little bit, so

that one won’t take a test that one actually doesn’t hh

*want*

mm"

(0.3)

to know, right

mm

(1.0)

so th- (.) but talk about it at home an’—

mm

(2.0)

then you’ll see.

*yes*'

*mm*. that (brochure) you’ll have (.) also then.

mm.

((M goes on to leaf through papers, then a new topic))

Whereas morally indifferent topics can be approached head-on, the topical episodes of morally sensitive topics are quite different. The co-text for the AFP test and its implied issues is tests and examinations that the MHC "offers." The footing is clearly that of information delivery, but such information could of
course be heard as a (delicate) way of providing advice. The strategy used by the midwife usually involves a preparatory action, "have you heard about AFP?" Only if this is met with a negative answer, or an answer indicating uncertainty, does the midwife go further into the issues. This naturally happens more often with women who have had babies before.

If we generalize across the AFP episodes of the whole corpus, we can discern an approach phase, a central phase, and a retreat phase. The approach phase is characterized by indirectness (in the sense of deferral). For example, preparatory sequences are common; metacommunicative pre-acts (Example 2, line 1: "I thought I should inform you about"; also, "I am going to ask you about"; "do you know anything about") are used to signal in advance that a certain topic will be broached, a certain type of sensitive question will be posed or sensitive information given, and so on. This gives the woman an opportunity to prepare herself, and it gives M (and W) a chance to withdraw promptly, if possible. In fact, midwives regularly take the chance not to go into the matter if the women say that they are familiar with the test and that they know what they want to do. Even if the woman is very laconic on the matter, the midwife accepts this without probing the issue (Example 5).

In most cases, the episode develops into a central phase, defined as the sequence in which parties get maximally close to the (sensitive) topic. In many cases the central phase is characterized by limited degrees of concreteness, precision, and depth of penetration. Often there are abstract and vague references and anonymizing strategies; the talk is temporarily at a general level, rather than addressed to the individual woman; compare the use of "one" (Swedish: man) rather than "you" (Swedish: du): "if one has heightened values" (Example 2, lines 6–7), "one can then also" (Example 2, line 17), "one has an opportunity" (Example 7, line 32). Ways of retreating from the sensitive parts are often hinted at, and, if possible, also exploited. In some cases, the dreadful aspects and moral implications are avoided altogether.

Accordingly, we can say that parties, led by the midwife, prefer to leave the central phase rather quickly and move into a retreat phase. The retreat can sometimes be very rapid, with M posing questions in forms that allow for short replies on the part of W. In other cases, however, when the intimidating topic has been penetrated, there is a need to neutralize negative and threatening aspects, if these have been brought up. This calls for a longer retreat. In Example 7, M takes some pains to assure W that the malformations are "terribly unusual" (Example 7, lines 36, 40).

The morally loaded issue dormant in the AFP episodes is of course that of a possible abortion (medical reasons for abortion becoming relevant if the test indicates increased levels of AFP). Although this issue is explicitly brought up in those cases in which the midwife goes into describing the possible malformations involved, it never happens that the midwife asks for a particular stance from the woman (at the stage of the booking interview), nor do the women ever overtly speak their minds on this point.
Compared to the AFP episodes, those on smoking and drinking exhibit a rather different form. Let us look at three cases of varying extension, Examples 8–10:

Example 8  (Tema K.BU5: Episode on smoking and drinking: W expecting her first child)

((straight from previous topic, housing, no pause))

1 M:  d’you smoke?
2 W:  *no*
3  (3.0)
4 M:  ehm (.) drink alcohol?
5 W:  *no*
6  (.)
7 M:  never?=
8 W:  ="no"
9  (3.0)
((new topic))

Example 9  (Tema K: BM3: Episode on smoking and drinking: W has children from before)

((1.0))

1 M:  well, an’then (.) d’you smoke by the way?
2 W:  no
3  (0.5)
4 M:  "your alcohol habits?"
5 W:  well, they are "awfully moderate" (laugh)
6 M:  they are, yes.
7 W:  "yes?"
8 M:  once in a while or--?
9 W:  well, now that I am pregnant, then I am naturally completely abstinent, of course
10 M:  you are, right?
11 W:  yes
12 M:  mm. then I put down never then. an’you-- >we have talked, haven’t we, about your-- we talked about it last time<
13 W:  yes
14 M:  >this thing about temporary abstinence and that this< (that is so well worked into)
15 W:  yes it would never occur to me
16 W:  no, if you don’t take (.) headache tablets (i.e., aspirin)"
17 W:  no
18 M:  then you shouldn’t drink anything either
19 W:  no
20 M:  (\\textit{M laugh}) (.) then that is fine.
Example 10  ([Tema K: BM6: Episode on smoking: W expecting her first child]
\((\text{previous topic: W's overweight})\))
(2.0)
1 M:  "yes, that's it", "an' then", d'you smoke?
2 W:  yes, unfortunately.
3 M:  about how much then?
4 ()
5 W:  "one package per day".
6 M:  "one package per day", (0.5) that was pretty much.
7 W:  "mm".
8 M:  =mm
9 (0.3)
10 W:  I've tried to reduce since I did my test at home then, but I
11 M:  I can't manage you see, I can't do it.
12 ()
13 W:  mm. do you feel stressed from (.) feeling that now I must
14 M:  quit, or?
15 (0.5) yes, it's hard, it feels hard
16 W:  'cause you know one (.) one knows, one has heard so much
17 M:  mm mm
18 W:  [if it isn't--] an' clearly, =twenty cigarettes is (.) a whole lot, you know
19 M:  mm
20 (0.3)
21 W:  so that (.) if you (.) tried--
22 (0.3)
23 M:  yes, most (.) of all (.) I would of course want to be able
24 (.) completely straight, (.) over, (.) yes
25 W:  I can't quit once for all
26 M:  that I can't manage
27 W:  that you can feel
28 (0.5) no, no, no, I know that it is like that, "actually".
29 (.) (discussion goes on for about 30 more turns)

In Example 8, M introduces smoking bald-on-record whereas the midwives in Example 9 and Example 10 display a few features of indirectness. The question in Example 9, line 1, is embedded between "an' then" and "by the way." The use of "and (then)" prefacing in Example 9, line 1, and Example 10, line 1, indicates that the questions have a routine or agenda-based character (Heritage & Sorjonen, 1994), and this marking may somewhat contribute to diminishing moral implicativeness. We also note the lowered volume used in Example 9, line 4, and Example 10, line 1; it seems as if the midwife in Example 10 anticipates that the woman is a smoker (her voice quality may be a reliable symptom). The typical pattern of the smoking and drinking episodes, however, is that the midwife poses the basic questions rather straightforwardly, without any previous pauses.
or other perturbations and without prekeyterm utterance segments; the keywords are taken directly from the form; “do you smoke?”; “your alcohol habits?” (the latter typically in this elliptical form). If these questions receive clear “nos” from the woman, the topics are typically left without further comments; Example 8 is a case in point. If the woman hesitates just a little before answering “no,” a few reminders by the midwife are usually forthcoming. In Example 9, the woman does not hesitate, but prefaces her response with a weak Swedish ja (here translated as “well” in Example 9, line 5) and then concedes that she drinks alcohol moderately, before she, after a follow-up question by the midwife, assures the midwife that she does not drink at all during her pregnancy (Example 9, lines 9–10). In such cases, the midwife would still mention the desirability of “temporary abstinence” (Example 9, line 17; using an abstract coinage that means, in literal translation, “point abstinence”; Swedish: punktmycket) and then leave the issue. In cases like Example 10, when the woman admits that she does smoke a number of cigarettes per day, or that she may drink a glass of wine now and then, a discussion usually evolves in which the midwife issues the “recommendations” by the MHC (“we issue a recommendation of temporary abstinence”; Swedish: vi gör ut och rekommenderar . . .) and expresses some cautious moralizations. The general pattern of the episodes is this: first ask for information about W’s habits, then either leave the topic (if W provides unambiguous, negative answers), or explain what the MHC wants.

Midwives are clearly aware that their recommendations imply an intrusion into private lifestyle. (On this point, one may compare recommendations on other non-lifestyle-related issues, such as the prescription of iron tonics, which, in our data, never involves any face-preserving measures on the part of midwives.) In some talks, the midwives explicitly mention that they are “aware that they cannot set limits” and that they do not want to evoke feelings of guilt with regard to (especially) smoking habits. So, if midwives try to educate and control, they do it in a mitigated manner. The desiderata of the MHC with regard to women’s conduct are often expressed in terms of mitigated recommendations, rather than straightforward requests. Thus, the force of prescriptions is downgraded; a recommendation of “temporary abstinence” is a fairly limited intrusion into the woman’s lifestyle (midwives do not say “we think you should not drink at all”).

Use of Special (Mitigating) Vocabulary

Other strategies for warding off face-threats and avoiding embarrassment include the use of vague or abstract expressions, circumscriptions and euphemisms, mitigators, attenuations, and various qualified “weak” expressions (cf. Drew, 1992, p. 503). Speakers often prefer such expressions to naming the things talked about bald-on-record. Rather than being indiscreet, speakers leave it to their addressees to draw conclusions about things meant and implied. For example, Macintyre (1982) mentioned gynecologists’ use of initiations like “Let’s have a look down there,” and Weijts et al. (1993, pp. 304ff) found the same, as well as an excessive use of pronominal expressions in referring to sexual organs and activities. Such features appear sometimes in our data too, even if they may not be
particularly salient in the episode types considered in this article. Note however, abstract, and somewhat clumsy, coinages like "temporary (point) abstinence." In asking about drinking habits, midwives regularly use the abstract noun "your alcohol habits?" rather than "do you drink anything?" which would have focused on the personal agent and her conduct more directly. In one case (not quoted here), in which the midwife first addresses the woman more personally on the matter, she immediately corrects herself, thus taking immediate measures to re-establish the anonymization.

Restrained Interactional Style

The two last paragraphs point to the role of vagueness and incompleteness of discourse on sensitive topics. Another characteristic of the interactional style is the asymmetrical pattern, with the midwife providing information, without too much penetration, and the expectant mother responding, often rather minimally. This is actually quite noteworthy, because there are other episodes in the booking interviews where the two women interact in rather different ways. Consider a spate of talk like Example 11, where the two women indulge in a more symmetrical exchange:

(3.0)

1 M: >(d you think it's been) tough, this thing?<
2 (0.5)
3 W: mm, very tough.
4 M: yes, it's natural. ^yeah^ 
5 W: mm
6 M: yeah
7 W: it was the third time, you know.
8 M: yeah exactly.
9 W: yeah=
10 M: ^=yeah^
11 ()
12 W: yes it was-- it was perhaps not so (.) tough the thing
13 itself uh (0.5) well, it was one got tired from the
14 treatment then
15 M: mm
16 W: but- uh (0.5) that waiting then was I going to have
17 my period or--
18 M: yeah exactly
19 W: mm
20 M: "I see"
21 W: ^yes^. (.) so, mentally it has been tough
22 M: yes, it must be almost even tougher when one (.)
23 keeps trying anyway so to speak
24 W: yes (0.3) ^yeah^. that's uh (2.5) no, it's been terrible,
25 I think ([(light laughter)])
26 M: mm mm
27 W: so that was the last try, then I thought never anymore.
28 M: yes then it--
29 W: [it must be as it may this time, that is (0.5)
30 I go just 'cause I (.) sh- [should do it]
32 M: [should do] it (laughs)
33 yes yes, but it is kind of nice to have that attitude
34 for it's a little--
35 W: [yeah, perhaps that's] why it--
36 M: it works, right?
37 W: yeah
38 M: *yeah*
39 W: *yeah* *so that it--
40 (0.5)
41 M: 'cause it's a terrible-- I think terribly much lies (0.3)
42 perh- terribly much but it can surely be terribly much
43 on the mental plane if
44 W: mm
45 M: how one succeeds
46 W: mm
47 M: and so on
48 W: mm. I think so too.
49 M: so that uh (.) yeah: (0.5) but it's nice
50 W: yeah
51 M: mm.

((M starts asking about housing conditions))

Note here features like the upgrading in second assessments (Example 11, lines 1, 3: "tough," "very tough"; lines 21, 22, 24: "tough," "even tougher," "terrible"), collaborative completion of turns (e.g., lines 35–36), overlapping turns (lines 29–35), shadowing (e.g., lines 31–32), and sequences of mere confirmations (lines 8–10, 37–39, 49–51). By contrast, in the case of morally delicate topics, the two interlocutors do not engage in lightheartedness and they seldom go into details.

Yet, along with paralinguistic strategies for mitigating face-threatening messages such as pausing, sotto voce, and perturbations of delivery, one might expect the use of laughter, which has often been shown to alleviate face-threats (cf. Jefferson, 1985; Adelswärd, 1989). Beck and Ragan (1992) found that patients and nurses often key their talk with laughter and jokes during actual gynecological examinations, and Aronsson and Rundström (1989) found doctors bracketing sensitive talk by using a joking mode when they issued lifestyle recommendations to child patients and their parents. Neither of these latter phenomena is common in our data, however. 14

Use of Neutralizing Activity Contexts

Discourse cannot be understood without analyzing its contexts. Turning now to contextual resources, we note the following aspects of indirectness. 15 Under this heading we may assemble several, partially hierarchically ordered, contexts.
First of all, the institutional encounter itself is of course a particular type of context, partly clinical and medical in character, which makes it different from an everyday-life context. In part, the institutional context may be regarded as an environment created partially to make it possible to talk professionally about issues which are not naturally talked about in everyday life. On the other hand, midwives (and other [para]medical personnel) seem to try to create an informal atmosphere, so as to partially reconstruct a more everyday-life type of conversational frame. One may think of the communicative genre as one in which the midwife, together with her interlocutor, seek a compromise between a professional neutrality and a more conversation-like affiliative stance. In Fairclough’s (1992, p. 205) terms, we can talk about the “conversationalization” of a type of institutional discourse.

Secondly, one may exploit particular activity types or phases in the encounters. For example, among conversational activities one may mention types of information collection being administered by the professional in going through a form. This generates a kind of highly constrained, routine-like interaction, in which specific questions are often posed in sequences of elliptical formulations that allow for short answers (cf. Example 3). With this specific kind of interactional footing, delicate issues might be smuggled into a “neutral” context (cf. Silverman & Peräkkylä, 1990, p. 309). In our case, this is true of smoking and drinking, but not of HIV and syphilis.

Another strategy may be to exploit the specific footings of situations in which the medical professional pursues a physical examination of the patient. In this kind of situation, the patient has already been stripped of some of her personal integrity, and she is in fact often partly undressed, and the doctor or nurse may then insert a few pertinent questions and comments, as if it were in the background of the physical manipulations.16 Our data for this article do not include any physical examinations, though, except for taking a patient’s blood pressure (for other findings from the more comprehensive corpus, see Bredmar, in press).

A third, and somewhat related, strategy is simply to sneak in sensitive topics in phases that may be regarded as marginalized in the encounter as a whole. There is a tendency for the HIV and syphilis test topics to be relegated to inconspicuous phases, that is, rather late in the encounter, when, one may perhaps assume, all important things have already been dealt with. This squares well with the results of Weijts et al. (1993) on the topic of sex in gynecological consultations.

Use of Neutralizing Cognitive Contexts (Frames)

Under this rubric, we also find a number of different phenomena. Most of them concern the discursive re-framing of issues, that is, one tends to bring up the delicate topics within frames that are not in themselves morally loaded. Thus, we observed how HIV and syphilis, in our data, are never talked about as diseases, let alone as morally implicitive phenomena (cf. note 11). Instead, they are always topically framed as targets of blood tests. We could say that the topic of the tests stands proxy for the more delicate topic (accordingly, the term proxy topic). The issue of anomalies and potential abortion is obligatorily introduced through the practical frame (or proxy topic) of taking a blood sample.
Another strategy in the discourse is the deployment of anonymization ("we," "the MHC"); compare what Drew and Heritage (1992, p. 30) termed "the self-referring we [used] to invoke an institutional over a personal identity." A related strategy in our data is the invocation of routines, that is, practices applied to everybody (although the individual woman may decline to take the tests involved). In our data, a sensitive issue is sometimes framed as if it were of no concern for the individual woman, and instead something forced upon the individuals by the need to check the state of health in the Swedish population. A characteristic feature of Example 1 is the midwife’s immediate comment (line 17) that the test “is something we take on everybody.” Thus, the testing has nothing to do with any suspicion in the specific case (cf. also Example 1, lines 13–14, cast with the negative presumption: “a blood test where one can see that you haven’t got syphilis”).

Three Sensitive Domains: Similarities and Differences

The three types of sensitive topics are different in fundamental respects. The smoking and drinking topic is concerned with a lifestyle, which the woman, and indirectly the MHC, can influence, and hence it becomes rational to discuss appropriate conduct during pregnancy. The syphilis and HIV topics are also potentially lifestyle-related, but little can be changed here, at least not within the scope of the current pregnancy. The topical complex of fetal anomalies and possible abortion implied by the talk on the AFP test does not involve lifestyle issues; we are faced with something for which the individual cannot be held responsible. On the other hand, these topics involve a rather frightening future perspective and lead to the morally loaded question of what decision the woman would take on the issue of abortion.

There are also other premises and conditions that distinguish the discursive treatment of the three topics. The context for the smoking and drinking issue is a rather early phase in the conversation, in which the midwife goes through the case-book, that is, there is a printed form to be filled in. The syphilis and HIV episode, on the other hand, sometimes occurs in a late phase of the encounter, as if it was some insignificant matter that the midwife had forgotten to deal with before. It is related to the form (the consent by the woman to take the tests is entered there) and is always introduced in the frame of obligatory tests to be taken.

These differences lead to distinct ways of managing the topics in the discourses. The major patterns can be summarized as in Table 2. Briefly, we can say that the topics of smoking and drinking are characterized by an immediate approach, a mitigating vocabulary, and a limited depth of penetration. The latter aspects are what indicates sensitivity. The bald-on-record approach may have to do with the fact that the issues involved are routinely raised in many types of health care talk these days. By contrast, HIV and syphilis are not talked about in most doctor consultations, and here they are introduced through a reframing and
Table 2: Typical patterns of indirectness and mitigation and their incidence in three kinds of sensitive topics in midwife-pregnant woman talks

<table>
<thead>
<tr>
<th></th>
<th>Smoke/Drink</th>
<th>HIV/Syph</th>
<th>AFP (Mall/Abortion)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduced volume</td>
<td>no</td>
<td>yes/no</td>
<td>yes</td>
</tr>
<tr>
<td>Pausing</td>
<td>no</td>
<td>yes</td>
<td>yes/no</td>
</tr>
<tr>
<td>Perturbations of delivery</td>
<td>no</td>
<td>yes</td>
<td>yes/no</td>
</tr>
<tr>
<td>Syntactic embedding</td>
<td>no</td>
<td>yes</td>
<td>yes/no</td>
</tr>
<tr>
<td>Presequences</td>
<td>no</td>
<td>yes/no</td>
<td>yes</td>
</tr>
<tr>
<td>Limited depth of penetration</td>
<td>yes</td>
<td>yes</td>
<td>yes*</td>
</tr>
<tr>
<td>Mitigating vocabulary</td>
<td>yes</td>
<td>no</td>
<td>yes/no</td>
</tr>
<tr>
<td>Elliptic Q-A sequence</td>
<td>yes</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Inconspicuous phase</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
<tr>
<td>Practical reframing (proxy topic)</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Anonymization</td>
<td>yes</td>
<td>yes</td>
<td>yes/no</td>
</tr>
</tbody>
</table>

*Limited depth of penetration occurs whenever possible, that is, when the woman says she knows about the test.

delayed approach. The same is true of the issue of malformation and possible abortion. There, the presence of presequences is particularly noteworthy.

There are additional common features. With respect to morally loaded aspects, there is a general preference for avoidance, a reluctance to detail accounts or to penetrate issues. The issues are anonymized; they are talked about as handled by the MHC in general, rather than by the midwife herself. Downgrading also applies to some descriptions (“it is very unusual” about anomalies, thus reducing the range of applicability of the description). Peräkylä (1993) likewise found counselors generalizing and anonymizing descriptions and prescriptions, and mitigating the applicability of dreadful descriptions (upgrading their conditionality: “if it were to happen . . .”). At the same time, such similarities may conceal differences. For example, mitigations have a rather different meaning in prescribing lifestyle as compared to estimating the likelihood of a birth defect.

Moral aspects are also typically recontextualized by the institution. Rather than being couched as moral in nature, they are framed as issues of what is medically appropriate. Sometimes, the medical aspects too are backgrounded, in favor of practical aspects. This pattern is perhaps most clearly shown in the case of the AFP test and its background and implications. The course of progression is nearly always this:

1. First practical aspects: information about how and when blood tests are taken.
2. Then medical aspects: describing the anomalies that may be indicated by heightened levels of AFP.
3. Last moral aspects: the dilemma of deciding on abortion is explained. This order may be a natural and logical one, but it is still a significant fact that the moral issues are backgrounded, deferred, and never brought to a climax.
Conclusion

Sensitivity in conversation has been treated in terms of tact (Leech, 1983), face-threats and politeness strategies (Brown & Levinson, 1987), sequential properties of structurally dispreferred responses (especially within Conversation Analysis), and so on. Here we relate it to moral implicativeness, and we take indirectness to be its overt expression. Sensitivity is therefore related both to accountability (what the speaker can be held accountable, or responsible, for; Battny, 1993) and reportability (what topics can be freely reported on, or not).

Indirectness has been shown to have many different shapes. Many of them can be understood in terms of the speaker’s distancing himself/herself and his/her interlocutor from the delicate or “dangerous” issues involved. For example, sensitive topics are often gradually approached, only partially penetrated, and quickly retreated from in many episodes. Given that speakers may be said to have several voices or identities available (Bakhtin, 1986; Wertsch, 1991), anonymization may be understood as the speaker’s attempt to not speak in his/her personal identity (rather, the midwife is the representative of the MHC system), and to speak as if the topic did not directly concern the individual other (anonymization, Peräkylä’s “universalistic approach,” 1993, p. 305). Other means to distance oneself from one’s own and the other’s person include the collective construction of depersonalizing situations with less conversation-like footings, for example, those involving the use of technology or the manipulation of the body.

Another possibility of distancing oneself from sensitive topics lies in the exploitation of the participation framework of a multi-party encounter. For obvious reasons this is not available in a dyadic situation like ours. However, Aronsson (Aronsson & Rundström, 1989; Aronsson, 1991) has shown, in studies of pediatric consultations featuring a doctor, an allergic child, and his/her parent, how physicians may address sensitive topics to the child when they are actually targeted at the parent. 7 Peräkylä’s studies of participation framework in his AIDS counseling session data showed that a counseling team could avoid addressing delicate questions to the client directly in basically two different ways. Either the co-counselor could request the main counselor to ask the client a sensitive question, thereby relieving the main counselor of the burden to act as principal and author (in Goffman’s, 1981, terminology) of the sensitive question. Another possibility sometimes used was for the counselor to ask the co-client, a close relation accompanying the client (a spouse or a girl/boy friend) first to tell her/his views on topics dealing with the (HIV-positive) client’s experience; only then was the latter himself addressed on the same issue (Peräkylä & Silverman, 1991).

One way of neutralizing sensitivity is to reconstruct it within new frames or contexts (cf. Peräkylä, 1993, p. 306). As we have argued, the establishment of institutional contexts may be taken to function as a means to provide opportunities for talking about sensitive issues in neutral contexts, with neutral professionals having no personal interests involved. One aspect of the treatment of moral issues in such contexts is their recontextualization (and reinterpretation) in the direction of a framing of practical, administrative, or technical considerations. For example, Adelswärd (in press) described this “de-moralization” in interviews with conscientious objectors, and modern judicial procedures exhibit
the same phenomena (Linell & Jönsson, 1991). A similar tendency can be seen in the present data, for example, in reconstructing sensitive issues in terms of medical appropriateness ("temporary abstinence"), practical business (taking blood samples), and so forth.

The institutional context in our recorded talks involves several features that seem to warrant a more neutral treatment of sensitive issues. Yet, the actual performance shows that the issues are still sensitive, with (it seems) their moral implications lurking below the surface. Indeed, the exploitation of some of the specific contextual features just referred to contribute to making the issues stand out as special, that is, as delicate or sensitive. Parties try partly to avoid the morally loaded aspects, and in doing just that, that is, exhibiting partial avoidance, they reconstruct the moral loadedness. Bergmann (1992), in his study of "veiled morality" in psychiatric interviews, made a similar point with respect to vagueness; if the psychiatrist describes an event in an indirect and vague way, he/she makes the event "embarrassing, delicate, morally dubious" (1992, p. 154) precisely by speaking about it in this indirect way. In a similar vein, Scheglof (1980, p. 143) noted in the discursive treatment of delicate issues that it is "not so much a matter of 'masking the delicateness' as of 'doing masking of the delicateness', which is not masking at all." In our case, the institutional contexts seem to be arranged in order to recontextualize issues as nonsensitive, and yet parties reconstruct topics as sensitive in and through their conversational conduct. Sensitivity becomes both a precondition for and a product of indirectness in discourse.

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Notes

1. Not all sensitive aspects in discourse are exclusively topical in nature. Some are more endogenous to the discursive interaction as such, in the sense that certain moves or illocutionary actions may be face-threatening in themselves. For example, orders, inquisitive questions, or threats and other imposing moves are often interpersonally delicate, apart from the fact that their topics are often sensitive too. At a general level, Linell and Rommetveit (in press) talked about "discourse-internal ethics" as an intrinsic moral dimension of human discursive interaction.

2. Politeness strategies in health care encounters were treated by Aronsson and Larsson (1987), and Larsson (e.g., Larsson, Johanson, Säljö, & Svärdssudd, in press) described in later studies how lifestyle issues, relating particularly to smoking and drinking, tend to be talked about in indirect, vague, or incomplete ways. Aronsson and Rundström (1989) pointed to the use of pauses, hedges, diminutions, and other
indirectness types in doctors' presequencing of lifestyle critiques and potentially face-threatening advice. Weijts et al. (1993) described the exercise of "expressive caution" (Silverman, 1994a), represented by delays, avoidances, and depersonalizations, in talk on sexuality during gynecological consultations. Conversational strategies to approach morally implicative issues in health care were also treated in Heritage’s studies of health visitors (Heritage & Seif, 1992; Heritage & Lindström, in press).

3. We disregard here the fact that a prior telephone contact occurred in some cases. Also, some of the women had met their midwives during one or several previous pregnancies. The 30 booking interviews are divided among 10 “young” women (ages 17–24), 10 “middle-range” women (ages 25–32), and 10 “older” women (over age 32). Eight of these were first-time mothers, the other 22 had delivered at least one child before (and had also gone to a MHC center before). The other data corpus is longitudinal; 13 women were followed through pregnancy, and in each case six encounters were observed and tape-recorded. These 13 women were all expecting their first child, so the total number of primigravidae in the entire corpus was 21. Six different midwives appeared in the 43 booking interviews.

The whole project deals with how the participants construct, or reconstruct, views of the pregnancy, the projected childbirth and the circumstances connected with these events, and how these topics and understandings are differently talked into being in the course of the progressing pregnancy. Issues like solidarity talk between women (in spite of the institutional environment), the role of medical technology as a resource for promoting understanding, and the prevalence of the notion of normality in these talks are treated in other studies. For a full documentation of the entire corpus, see Bredmar (in press).

4. Alpha-fetoprotein (AFP) is produced by the fetal liver and is passed via the amniotic fluid through the placenta into the mother’s blood circulation, where it can be measured. The maternal serum AFP screening is not in itself a diagnostic test. Other tests (ultrasound, amniocentesis) are used to diagnose suspected fetal anomalies (see Katz Rothman, 1993, p. 236).

5. Other sensitive topics may occur in individual talks, for example, cases of prior abortions, previous problematic deliveries and their circumstances, and issues of malformation and abortion may sometimes surface in other contexts than the AFP test. Likewise, information about problematic marital life or social networks may occasionally make topics like residence and housing conditions (an obligatory topic) morally delicate. However, these types only occur in a few isolated cases.

6. Excerpts are close English translations of Swedish originals. We use standard transcription conventions (such as brackets for overlapping speech, * * for sotto voce speech, and ( ) for a micropause), but note also the following points:

underscore = marks (the stressed syllabic nucleus of) a foically stressed word
** = laughter in the speaker’s voice while pronouncing the words enclosed
>< = accelerated tempo (relative to surrounding talk)
^ ^ = words pronounced on in-breath
-- = utterance fades out, usually with a prosody indicating that the speaker leaves it unfinished

7. The Swedish lay term for “rubella” is röda hund, which is consistently used in the talks. A literal translation of the term would be “red dog.” It is translated here by “German measles.”

8. These tests formed part of the screening procedures undertaken on pregnant women when our investigation was carried out. In the last phase of our data collection, syphilis screening had been dropped.
9. The rubella test as an entrance is, not surprisingly, more common with first-time mothers (ninth time mothers are usually known to be immune), but the correlations between discursive strategies and first-go/ninth-time pregnancy seem otherwise less pronounced in our data than could be expected a priori.

10. In general, our results on this point corroborate those of other researchers, for example, Larsson et al. (1994, in press), who have found that topics like smoking and drinking (and sex-related issues) are usually touched upon only superficially, in spite of their potential importance in primary health care.

11. The discursive treatment of HIV and syphilis (in our data) do not seem to involve euphemisms or mitigated substitutions, but note that both words (HIV, syphilis) are rather clinical in nature. Sex is never mentioned in the episodes involved. Note also that midwives almost invariably talk about “HIV” or “HIV positiveness”; only exceptionally do they mention “AIDS,” that is, the (dreadful) illness.

12. Vagueness and incompleteness as face-preserving techniques (Brown & Levinson, 1987) have been described for many communicative genres. For example, Marková (1989) analyzed semantic indeterminacy, as well as unfinished sentences and other kinds of incompleteness, in dialogues between patients and therapists as strategies for handling emotionally difficult topics, and Bergmann (1992) showed how euphemistic descriptors are used by psychiatrists to describe events with discretion.

13. It is undoubtedly a significant factor that our data involve only women. Features of indirectness have sometimes been considered as a gender-based indicator of female conversation. Moreover, the two persons of each dyad in our data are, in general, more equal in status than are, for example, a doctor and his/her patient. Because we lack a commensurable corpus of conversations with male doctors (or midwives!) we must, however, abstain from exploring the gender dimension here.

14. The longitudinal corpus includes some instances, as when the topic of sex is raised by the midwife in the postdelivery checkup encounter, for example:

TemaK: B8:6:7

1 M: it feels good down there? did you try intercourse?
2 ((The translation “down there” in line 1 is a free one;
3 the Swedish original was i underlivet “in the womb”))
4 W: =no, we haven’t done that.
5 M: =you haven’t done that, no.
6 W: I forgot how to do it, I say (laughs)
7 M: (laughs loudly) *you have to take a course* (laughs, 2.0)
8 W: >he said that, *when we talked about it earlier*, an’then he
9 said,< (0.3) *you can tell her this* we thought of quitting,
10 now that we have got a child. *and* see what she says,
11 (laughs)
12 M: *yes* (laughs)
13 W: yes, right, we (xx)
14 M: there’s no point any longer, you say (laughs)
15 W: *no* (laughs)
((shift of topic))

15. Actually, textual and contextual features are heavily intertwined in discourse, and hence the taxonomy used here is a considerable simplification. We have chosen to be a bit inconsistent in dealing with anonymization, largely a matter of wording, addressing it under the heading of “Use of Neutralizing Cognitive Contexts.” For a general discussion of contexts in discourse, see Linell (1995).
16. Larsson et al. (1994) mentioned that the issue of self-examination of the breasts, a sensitive issue bordering on other topics with sexual overtones, tends to be broached during the physical examination phase. Interestingly, the related issue of mammography is not as sensitive, judging from Larsson's (admittedly limited) data. Mammography, on the other hand, is associated with technology (see later discussion under "Use of Neutralizing Cognitive Contexts").

17. Our ethnographic data, however, have documented a case where the midwife addresses, in a joking mode, a 6-year-old boy accompanying his (pregnant) mother with the question: "Well, Charlie, how's mother doing on smoking?"

18. Whether this is due to strategic choice or to psychological-emotional factors, or both, is something that can hardly be determined on the basis of our data.

References


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