Reconfirming normality:
The constitution of reassurance in talks between
midwives and expectant mothers

Margareta Bredmar and Per Linell
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1. Introduction

1. Normality and preventive health care

Notions of normality have a firm place both in people’s ordinary life-worlds
and in the scientific sphere. From an everyday life perspective, normal
conduct is moral in nature, and its norms are interactionally acquired and
sustained, as Goffman (e.g. 1967) has persuasively argued. Normality is
also something which can be associated, by a Foucauldian argument, with
normalizing judgment, disciplinary power and social control. Accordingly,
Swann (1990) talks about doctors, psychotherapists, teachers, police
officers, and others as the “normalisers” of our time.

In the social sciences, notions of normality have been discussed for a
long time. They have also had a prominent role in many professional prac-
tices based on applications of social and psychological sciences. Variation
in social and psychological phenomena are assumed to take the form of a
“normal” distribution in the statistical sense (cf. the bell curve). Hacking
(1990) argues that notions of normality were taken over from physiology
and medicine by the social sciences, a move attributed (by him) to Auguste
Comte. “The word [i.e. normal] became indispensable because it created a
way to be “objective” about human beings” (1990: 160). This appears to be
what medical (and other professional) discourses take for granted.

Taken together, these two perspectives imply that the concept of nor-
mality, despite the modern effort for “objectivity”, has retained something
of a double nature, one dimension bordering on moral aspects (that which
is to be expected from a responsible person, i.e. what kind of conduct is
regarded as desirable, proper, correct, “normal” etc.) and the other on sta-
tistical/scientific (e.g. medical) aspects (that which is predicted on statisti-
cal grounds, the ordinary, frequent, typical, average, standard). The multi-
dimensional semantics of “normality” (and related concepts like abnormality
and risk) becomes discursively very complex in all those settings in which professionals and lay people, together but often in separate ways, must recontextualise abstract scientific knowledge so as to make it relevant for the individual case with all its idiosyncratic properties (cf. Linell 1998).

Clinical practice characteristically involves the application of notions of normality and deviation to the individual case. Statistically based knowledge, which is rendered meaningful only at an aggregational level where variations within a population are treated together, does not apply straightforwardly to the individual case. Whereas individual patients are often faced with an all-or-nothing choice ("am I sick or not?") statistical definitions (in epidemiology etc.) imply scalar dimensions ("this value might indicate an increased risk of X"). The issue is complex also because a specific person may have "normal" values, and yet these values could actually be dysfunctional or abnormal in his or her case, due to some specific factors that are relevant just there-and-then for him or her. The reverse is of course also possible.

1.2. The clinical framing of normality and pregnancy

Professional-lay interactions are often quite complex in their framings. Many health care contexts must be balanced between one framing of finding out and talking about medical information and another one of giving support, reassurance and advice to clients and patients. In comparison with doctors’ discourse, nurses’ talk can be expected to be more (but by no means entirely) geared towards the latter needs (in a frame of caring?). We will be concerned here with one such clinical practice, the encounters between midwives and expectant mothers within public maternal health care (MHC). In Sarangi and Roberts’ terms (Introduction, this volume), this is an institutional context, in which professional knowledge is accommodated and recontextualised into clinical, i.e. institutional, accounting practices.

Our specific topic in this paper is the role of ‘normality’ in midwife-expectant mother (“M-EM”) talks, and especially in certain kinds of discursive episodes. Normality, we argue, is used as an organising principle for the understanding of pregnancy. Normality considerations are involved at least at two different levels: (1) pregnancy in general as a normal (biological and social-psychological) process, and (2) the individual woman’s pregnancy as a normal case.

On the first point, the whole process of pregnancy is constantly referred to by midwives as “normal”, “natural”, “healthy”, and not as an illness-like state that calls for special treatment. Women should lead their normal life during pregnancy. This stance is a culture-specific one; other cultures and periods of history have argued, for example, that pregnant women are brittle creatures requiring special protection or that they are impure and should temporarily withdraw from social life (cf. Olin-Lauritzen 1990).

Understanding of normality, Giddens (1991) argues, are challenged particularly in significant and “fateful” moments in life. In spite of the emphasis on normality, pregnancies are unusual, perhaps even unique, events in the lives of most modern women. And despite the emphasis on health and normality throughout pregnancy, our data on M-EM talk (Bredmar 1999) exhibit characteristic changes in how the expectant mother and her development are described in different phases of her pregnancy. If one looks at the ways the woman is talked about across the encounters, there is a transformation from a social person (in the beginning), to a body and a birth canal (when approaching delivery), and then back to a woman with a social (and sexual) identity (in the post-delivery check-up talks, which includes a sort of “restoring a life-as-normal framework”; Silverman’s 1994: 432, term).

In this paper, we will look at how, in M-EM talk, the concept of normality is used as a pivot and an objective for specific discursive episodes dealing with the individual woman’s pregnancy. For an expectant mother, it is of course of vital importance that her pregnancy evolves in a “normal” way. Having a child with congenital anomalies is strongly consequential for the sort of life that the woman, her partner and family can expect to live in the future. No wonder then that almost all the women, as witnessed by interviews in our corpus, express their concern, and attend the optional services of the maternal health care to get adequate medical check-ups and to get support and reassurance in their “fateful” project of giving birth to a healthy child. Taking advantage of the services of the midwife becomes in itself part of normality, the normal way (in both senses of the term ‘normal’) of handling one’s pregnancy.

2. Data

The data to be used in this paper are drawn from a Swedish project on naturally-occurring encounters between midwives, who are qualified nurses working within preventive maternal health care (MHC) units, and expectant mothers, who pay regular visits to these units. Preventive maternal health care is a service provided to pregnant women in Sweden. The purpose of this community service is primarily to give personal and pro-
fessional advice and assistance to women, but it naturally also affords health authorities some opportunities to check and control progression and conduct during pregnancy. Taking advantage of these community MHC services is optional, but a large majority of women (95% according to national statistics) do it.

At the time when our data were collected (in the years 1990–93), a woman (in the community studied) could see her midwife up to fifteen times during her pregnancy. (Recent cuts in Swedish maternal services have now brought down the number to about ten.) In our data, the first visit usually takes place in the tenth or eleventh 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: inskrivningssamtal). It is followed by a series of visits, the last one taking place after parturition.

In our study, ethnographic fieldwork has been conducted at nine different MHC centres, and a large number of interviews with women clients and midwives have been made. The core data, however, are the taped-recorded (and observed) midwife-pregnant woman encounters (at times with fathers also present). There are two sets of such data, both of which will be drawn upon in the present paper: one corpus of 30 booking interviews and another corpus of 10 longitudinal series involving ten different individual women appearing in (in each case) six different encounters with the midwife. The following occasions were strategically selected to be representative of different stages in the evolution of pregnancy:

(i) the booking interview (in the 10th or 11th week of pregnancy),
(ii) one encounter in weeks 19–22, and then:
(iii) in week 30;
(iv) in weeks 34–35: this encounter also includes an examination by (and talk with) a doctor, who is either a specialised gynaecologist or a general practitioner (the ordinary doctor of the primary health care clinic);
(v) in weeks 37–38 (close to parturition), and
(vi) a post-parturition check-up (6–8 weeks after parturition).

In this paper, we focus on explicit or implicit references to ‘normality’ in the M-EM talks. We shall also take a special look at how midwives deal discursively with situations in which deviant symptoms or test results have been obtained. We will concentrate on two sequence types, both of which recur massively in our data, across the six stages outlined above:

a) Symptom-exploring sequences, where the midwife (M) asks the expectant mother (EM) how she is. These are sequences of describing and exploring various subjective symptoms that EM has had or could be expected to have.

b) Test assessments: sequences in which physical (or physiological) measurements and test results are reported and assessed.

3. Symptom-exploring sequences

We will first turn to episodes that explore subjective symptoms and experiences. Example (1) is a sequence which occurs right at the beginning of the booking interview (cf. lines 1–2):

(1) (TemaK:BM6:1:1) (EM: primigravida)"²

1 M "yeah, as I said, you are welcome here
2 EM mm. "Thanks"
3 M and eh (0.8) (§-) this is your first pregnancy,
4 yes
5 EM "yes it is.
6 M and how are you then?
7 EM I feel a bit sick, actually
8. M okay.
9 EM "I feel"
10 M that’s not so unusual
11 EM yes, it goes up and down, I don’t know if it-
12 M [no
13 M no. mm. it’s another type of feeling sick than
14 when you’ve got a stomach flu
15 EM mm
16 M the best way to ( ) keep it in check, that’s eating
17 EM "yeah"
18 M or drinking water.
19 EM but I feel awfully peckish an’ at the same time I
20 don’t want to but I still must.
Sometimes she suggests a symptom, such as "feeling sick", while in other encounters (as in (1)), it is the pregnant woman who does it (l. 7). Once an expected symptom has been confirmed by the woman, the midwife might declare that the symptom sounds "fairly normal". In one case (not shown here), for example, it turned out that EM had felt excessively tired, something which M countered by saying that "you may feel tired now". EM then disclosed that she had been close to fainting, which led to an episode, in which M, towards the end, said that during early pregnancy, one’s blood pressure falls. The medical statement about the blood pressure was thus used for normalisation purposes, the midwife once again confirming that the symptom experienced was not to be seen as abnormal. The temporal dimension (now/later) was again exploited; discomfort now is normalised in terms of a better outcome in the future.

Symptom-exploring sequences occur in all encounters, not just in the booking interview. Here is an extract from an encounter in EM's twentieth week of pregnancy:

(2) (TemaK:B13:2:1–2) (EM primigravida)

(The excerpt comes soon after the initial greeting sequence; the parties have agreed upon which week of pregnancy EM is in)

1 (5.0)
2 M how are you?
3 (1.5)
4 EM well:, I am fairly fine, "I guess".
5 M you are.
6 EM yes.
7 M "hm" (0.3) now (.) you’ve started to feel movements of the foetus?
8 EM "yes"
9 M "for how" long (0.3) have you felt them?
10 EM well, I have felt it for a couple of weeks.
11 M mm
12 EM though it’s more now in the [last--]
13 M [it’s more evident now, yes.
14 EM "yes"
15 M ((to F)) perhaps you have felt it too?

After checking that this is the woman’s first pregnancy (line 3), M immediately asks her how she is (l. 6). Note, in this example, the and-prefacing, which shows that this is an agenda-bound question, rather than merely a ritualised opening (Heritage and Sorjonen 1994). EM replies that she feels sick now and then (though she sort of minimises the problem: "a bit sick") (l. 7), and M explains that this is not unusual (l. 10), whereupon the two discursively explore the symptoms for a while. M clearly implies a normality assessment, when she describes the type of "feeling sick" (l. 13–14) as something different from an accidental and pathological state ("stomach flu"). She then proceeds rapidly to a routine-like description of symptoms and possible remedies (l. 21–38), an account of the “ordinary” (i.e. normal), without much notice of EM’s particular perceptions (e.g. l. 19–20). The (sub)episode ends with M saying that it will get better (l. 38). Thus, M repeatedly builds her reassurance argument on a contrast between the present (it is normal, “not so unusual”) (l. 10), to feel bad now) and the future (later on, you will feel normal, “it gets better” (l. 34), which “is always comforting” (l. 38)).
As we can see, M is here interested in whether EM has felt any incipient movements of the foetus (l. 7–8). EM confirms this, but it is M who then (l. 17ff.) provides more substantial statements about how it feels or what will be sensed later on. These descriptions are given in generic terms; M talks about how things develop in pregnancies in general, rather than refers to the individual woman’s actual case. Her discursive means for doing so include the use of the present tense ("it’s like this"); "it becomes", "it [i.e. the baby] does somersaults", etc, instead of the perfect tense used about the individual pregnancy: "have you felt?, l. 7, 9, 15), impersonal constructions (l. 36: "it is pleasant to feel"), the generic pronoun "one" (l. 37), and at times the qualifier "usually" (l. 36). Indeed, EM too adopts the generic perspective for a while, referring to herself by "one" (l. 42, 44), before the two personalise the descriptions at the end of the excerpt (l. 45–46). EM sums up the short episode by saying that now she really feels that she is pregnant (l. 42, 46), and the two mutually confirm their understandings of this. In other words, EM is confronted with descriptions of sensations and experiences of pregnancy, and she is given frequent opportunities to agree with these characterisations. EM’s own experiences are being reconfirmed in the dialogue, and she is reassured that she is “normal”. M positions herself in the role of somebody who is both an expert on the subject matter and a fellow woman; for example, she describes the foetal movements in detail, but she does so using rather mundane vocabulary (l. 17–38).

There are several things that could be said in the way of general observations on the symptom-exploring sequences. We must be content with pointing out a few recurrent features.

The sequences are almost always initiated by the midwife who asks her client “how she is” already in the very beginning of the booking interview. (Such questions reappear in the ensuing encounters, though she may then also ask how the woman “has been since last time” or how she experiences the present stage of her pregnancy.) It is interesting that the expectant mothers sometimes seem to treat the opening question “how are you?” partially as a ritual one, as if taking it to be an extension of the greeting sequence, despite the fact that the midwife often formulates the question so as to mark its character of being an item belonging to her professional agenda, as is shown by the following examples of midwives’ ways of formulating the question in the booking interviews:

(a) *and*-prefaced question: *å hur mår du då?* “and how do you feel then?” (ex. (1), l. 6),

(b) prefacing the “how are you”-question with “let’s see”, i.e. indicating the introduction of a (new) agenda point: *ska vi se, hur mår du??*
(c) conflation of "pre'-question with the core question: ja ska börja fråga hur du mår? "I'll start by asking how you are",

(d) positioning the "how are you"-question after an episode-initial question like hur känns de att va gravid då? "how does it feel being pregnant, then?"

(e) lexical choice of mår in hur mår du? "how do you feel?", rather than other variants which are common in ritual post-greeting sequences, e.g. hur e de? lit. "is it?" (i.e."how are you doing?"") hur står de till? "how are things?"

(f) stress on mår in hur mår du? "how do you feel?"

(g) addition of clitic då "then" hur mår du då? "how do you feel then?" (ex. (3), l. 1 below) (still with stress on mår)

(h) addition of bra "well" in mår du bra? "do you feel well?"

(i) expanded formulation: du mår bra eller känner känner du () inga symptom? "you feel well, or you don't (?) sense, any symptoms, do you?"

Some of these devices more clearly signal the agenda, especially (a)–(c), but all of them seem to serve to establish the frame of talking about the pregnancy as such (rather than just indulging in introductory small talk). Typically, the woman's response consists in her mentioning a single symptom, perhaps after first claiming that she is just fine. That is, when the midwife asks "how are you" ("how do you feel", "how have you been") in the beginning of the encounter, this is often countered by an answer like "not so bad" or "quite well", or some single symptom is mentioned and often belittled. While this kind of response has a certain ritualistic ring (cf. above), it also contributes to co-constructing a frame of normality. The conduct is reminiscent of what some patients do in ordinary medical consultations, when they give this kind of reply to the doctor's first question (Frankel 1995: 239). Yet, these same patients, according to Frankel, may present many serious symptoms later on in the same encounter. In M-EM talk, it may, similarly, be revealed that the woman has indeed had a number of troubles.

After the initiating question-answer exchange, the discourse takes the form of a symptom-eliciting sequence, like a short history-taking in a health check-up, in which the parties collaboratively bring up some real or potential troubles. Often, the midwife produces proposals or guesses (as in extract (2)) of what perhaps has happened to the woman. She formulates a number of descriptions in such a way that a confirming answer is presumed. This provides the woman with descriptions in which she could recognise her own situation and thus get reassured that she is experiencing what pregnant women normally do. The symptoms mentioned, described or discussed are such that they, under different circumstances, could have been thought of in a framework of illness or disease; not feeling well, having swollen legs or aching breasts, putting on much weight, being enormously tired etc. In this kind of M-EM discourse, however, these features are treated as, or transformed into, something which is not abnormal, not deviant and not alarming but quite normal. It seems as if the midwife manoeuvres to get into a dialogically constituted position where she can say that things are quite normal. This normality statement is delivered as an assessment, and can be heard as a mini-diagnosis rather than as just an exit from a topic.

So, these symptom-exploring sequences (and sometimes their sub-sequences too) regularly end by the midwife's saying "that's normal", "it's quite normal", or sometimes with other wordings, for example, "it usually is like that", "it's natural", "that's not unusual". But this is not always the case. Though it seems almost obligatory that the midwife asks "how are you?", in some cases 'normality' is never explicitly mentioned. Rather, one can get (usually fairly brief) sequences, in which the two parties seem to tacitly and mutually agree on what is to be expected and that the mother-to-be fits this pattern. Excerpt (3) may be seen as such an example:

(3) (TemaK:BM7:1:1) (EM has had several pregnancies before)

(Excerpt taken from the very beginning of the booking interview)  

1 M how are you then?  
2   (0.5)  
3 EM I'm fine.  
4 M you're fine.  
5   ()  
6 M yes  
7   ()  
8 EM a bit tired.  
9 M yeah. but it's-() sort of part of it, yeah.  
10 EM yes it is.  
11   (2.0)  
12 M but it's no more than you think you can cope with.  
13 EM no, I can.  
14 M mm.  

((end of topic))
Here, EM first responds to the "how are you?" question by saying that she is fine (l. 3), thus conforming with patterns described above. When M leaves opportunities (micropauses, lines 5, 7) for EM to expand, she suggests tiredness as a symptom (l. 8). M points out that this is "sort of part of it" (l. 9), and suggests that it is something EM "can cope with" (l. 12), implying that it can be made part of normal life. So, in the frequent cases where "normality" is not explicitly mentioned, it still seems to be taken for granted by both parties. In parties' (often short) symptom-exploring sequences, normality is arguably present as a tacit framework for understanding what they are talking about. This implicit treatment naturally occurs more often with women who have experienced pregnancy before.

4. Reporting of measurements and test results

Consider first example (4). M has used a measuring-tape to measure the distance from the pubic bone to the upper limit of the uterus, which can be felt as a sharp edge on the woman's body. This is called the symphysis-fundus ("S-F") measure, and it is a way of measuring, somewhat indirectly, the growth of the foetus.

(4) (TemaK:B8:2:26)

(M is pointing to the curve on the diagram)

1 M mark you out on this curve
2 (7.0)
3 you are about down here somewhere, yeah [0.2] then
4 EM [mm]
5 it depends also a little on how big one is in
6 oneself, you see, cause if you have an increased
7 layer of fat then you measure that too, y'know
8 EM mm
9 M so you end up down here
10 EM mm
11 M you are just below the so-called average curve but
12 [.] it should sit here in between, y'know [.]
13 EM [mm] somewhere, [.] so you are totally normal [.]
14 OK.
15 EM
16 M assessing the size
17 EM mm
18 M [\*mm\*]
19 (1.2)
20 M then the baby should follow its own curve, whether
21 it is up here or one is down here, the main thing
22 is that it follows its own growth curve, cause it
23 is unique for each baby, y'know.
24 EM yes, if one should end up outside here, what would one [do then]?
25 M [well, if we- if it starts here an'] ends up
26 [he or such like, then (1.2) then it is a bit
27 noteworthy, then we must check it up what is that
28 caused by, then
29 EM then you may have got too much flu-amniotic fluid.
30 M for example, yeah.
31 EM mm

((a few more turns on the same topic))

In (4), M is talking while plotting the woman's S-F value onto a diagram, i.e. a preprinted form, where one finds already a so-called 'normal' (or 'medium') curve marked out together with a zone of permissible normal variation above and below this curve. So this graphic representation is a medical device in which normality is already inscribed; the individual woman's values can be put quite concretely there and inspected with regard to what is considered normal. In (4), M notes (l. 11) that "you are just below the so-called medium curve". In l. 14 follows the assessment: "you are totally normal". So M first describes and reports the value, then makes an assessment of normality. Note, incidentally, that in l. 24, it is EM who asks about possibly deviant values, about what happens if somebody "ends up outside" of the normal range. M simply responds that that would be "noteworthy, we must check it up" (l. 26–27), whereupon EM, rather than M, is the one who proposes an explanation (l. 29). This is met by a minimal response on the part of M, with no mention of any risk factor either to the mother or to the child. We will later return to the observation that aspects of transgressing the normal range tend to be treated in a minimal or mitigated manner in the midwives' discourse.

In many cases, the midwife describes how the S-F value is measured, while actually doing the measuring. The actual measuring is often discursively closed by the midwife declaring that the value is "usual" or "quite normal", or "looks fine" etc. Later in the interactions, similar assessments of normality recur, as the midwife marks the value on the diagram (as in
This pattern occurs massively in the data; first, a report on the baby's growth (as indirectly evidenced by the S-F value), then a normality assessment.

Other measurements are reported and then assessed in rather similar ways. Such tests and measurements include urine tests, blood (haemoglobin) tests, measuring the woman's weight and blood pressure, listening to the baby's heart (measuring its frequency, using a special device (Sw "doppler")), and sometimes a few other things. Whether the actual measurements are carried out during the verbal interaction or prior to it, results are always and routinely reported and commented upon. Therefore, we argue, these testing and measuring procedures actually function as a resource for routinely creating opportunities for normality assessments. Indeed, tests and result reports punctuate the whole pregnancy, since the timing of visits is organised around weeks of pregnancy considered suitable with regard to tests/assessments. The reporting of test results is an example of a routine performed as a "creative accomplishment" (cf. Zimmerman 1992). In and through being routinely repeated at each and every visit and, at the same time, being regularly delivered in a personalised form, test assessments constitute moments for reconfirming normality of the individual woman's progression throughout the pregnancy.

5. Coping with deviant values

Even though only a few examples have been given here, we can assert that there is a massive emphasis on normality in our M-EM talks. But this makes one may wonder how midwives report deviant values. The answer is that they try to discursively neutralise unexpected deviations. For example, the midwife sometimes produces one or several arguments why one need not take a certain deviant value so seriously. She may suggest that there are a number of alternative 'natural' explanations for the value received on this particular occasion. In other cases, midwives leave the deviant value aside and talk instead about positive indicators, or they simply avoid further talk on the matter. We will now turn to two examples that illustrate these strategies. Again we have chosen reportings of S-F values, although there are examples of other deviant test results in the corpus as well.
Returning to example (5), the deferred report format combined with the absence of a normality assessment can naturally be heard as suggesting that the value is not entirely unproblematic. Accordingly, EM makes a comment which implies an understanding on her part that the value was too low (l. 9–13: "but I think myself that I've grown..."). M's uptake of this is in the form of minimal acknowledgements (l. 12, 14). M later concedes that the S-F value does indeed fall outside the normal range (l. 18–20). The inclusion of a mitigator here ("so to speak") seems to indicate her reluctance of being entirely bald-on-record. Furthermore, she recontextualises discursively the deviant value as something of a detail of her bureaucratic routine of record-keeping (l. 20–23), and fails to comment on its medical significance. Instead, she chooses to mention some other things which are positive (l. 27–28, 33–34, 38). Incidentally, notice that M starts this with "and" (l. 27), when, perhaps, we could have expected "but". The use of "and" implies that the prior information was not really negative. Nevertheless, what M does is to arrange for EM to come back for one or two extra check-ups, which is definitively outside of normal routines.

This cannot be seen in the extract.

In general, midwives seem to avoid talking about potentially alarming situations as something to worry about. They tend to ameliorate or neutralise their negative features. Often, mitigation or avoidance strategies are deployed. Let us look at one more example:

(7) (TemaK: B7:3:4) (EM primigravida)

(Earlier in the encounter, EM has talked about putting too much weight and about the fact that she now eats very little. When M starts measuring the S-F value, the parties talk about EM's premature contractions)

M do you have them often?
(1.2)
EM well eh hh
(0.5)
M or is it sort of when you lie down an'
(0.5)
EM [ah:
EM yes
(0.2)

Here, M reports the value without any interjacent talk (l. 3), and she communicates the normality explicitly several times (l. 4, 8–9).

(6) (TemaK: B10:2:4–5) (EM primigravida)

M an' then I measure on the upper part, where is your
uterus? it goes approximately here exactly
vertically, (1.0) an' it's seventeen centimetres
an' it usually is about that, an' next time it's
perhaps twenty

EM mm
(2.5)
M so it is quite normally sized, it grows as it
should
then it's perhaps above all ([.] "in the evenings")
[yes
(0.3)
cause that ([ ) you may have, y'know, [so wi- in a
[mm
changed position an' ([ ) such like, you shouldn't
[mm
have anything regular, and they shouldn't cause
you (0.5) harm, "an' it should--'
((M is measuring W's tummy))
(1.2)
twenty-seven! you are today, I think, that doesn't
make such a ([ ) "big difference
(1.0)
"if I measured it correctly"
(1.5)
"an' twenty-six you were last time"
(1.5)
did it grow too little then?
( )
what?
grows too little now then
no not too little, "big but--" (0.7) I didn't say
that, (0.8) "but it doesn't grow--", well, but here
"it's bigger", (0.7) "twenty-eight".
(3.0)
I thought you were so big up there, but it is
maybe a little bigger (1.0) on this side after all.
((M goes over to another activity))

Where the excerpt starts, EM has brought up her premature contractions. Although this can be a serious cautionary sign, M prefers to normalise the situation (l. 12: "you may have [them]", i.e. under certain circumstances). When she then reports the S-F value (l. 19), her first reaction is that there was not much of difference since last time (l. 19–20). EM asks a question which can be heard as alarmed (l. 26). Since M's mind seems occupied elsewhere, i.e. with repeating the actual measurements (compare the delayed repair initiation in l. 28), EM repeats her question (l. 29). Again, M does not say that there is something to worry about. Her speech delivery is, however, filled with pauses and subdued utterances (l. 30–33); she seems to move out of and back into her conversational role, by mixing half-self-talk-like speech (see sotto voce parts of lines 30–32), produced while continuing the actual measuring, with louder parts designed to answer EM's query (l. 30: "I didn't say that"). In this case, M may be heard to break the frame, giving off some information which might be heard as expressing concern and worry. However, this concern is never explicitly lexicalised; it is shown (through prosody and paralanguage) rather than said (in so many words). After the strip of talk shown in (7), M proceeds immediately to the next task (listening to the baby's heart beat). But it is reasonable to argue that, in this example of evasive discourse, despite M's denial ("did it grow too little?" "I didn't say that"), there is a certain collusion between M and EM about implicit meanings of concern and worry.

Some of the cases dealing with deviant values are close to another sequence type, that of the 'anxiety stories', of which the corpus includes a few cases. There is no space for going into these in real detail here. The point of such a story (or story-like argumentative sequence), however, is that the woman brings up worries based on what she has heard about some female friend's accident, misfortune, terrible delivery, or the like. The woman is worried that she might become subject to similar things, because (she thinks that) her symptoms are similar to what her unfortunate fellow woman had. Such cases usually give rise to long episodes, in which midwives regularly try to recruit arguments why this need not be the case, or is in fact quite unlikely (cases are not parallel, there are alternative explanations of troubles etc.). In dealing with anxiety stories too, midwives seem to use "the normal" as an interpretive framework in cautiously limiting, mitigating or downgrading the relevance and applicability of possibly intimidating, narrative components and implicit arguments in women's stories.  

6. Concluding discussion

For the expectant mother, the project of coping with a pregnancy and carrying this through to a successful end, saving her own health and social life and giving birth to a healthy child, is a major undertaking, in most cases taking place only a few times (or perhaps only once) in her life time.
For her, uncertainties and anxieties need to be eliminated or at least alleviated; she wants to be told that she is doing fine. In post-interviews, the women in our study give voice to such views in their explanations of why they so regularly go to the primary health care centre. Conversely, providing support, reassurance, knowledge and good advice is for the midwives at the heart of their communicative tasks.

The communicative project to provide and receive reassurance and support, and to reconfirm experiences of being healthy and normal, is largely a common, collaborative undertaking for the two parties. For example, our excerpts have shown how both of them frequently orient to normality. Heritage and Lindström (1998), in their study of British health visitors talking with recent mothers, talk about an effort for “maximal affiliation between the concerns and experiences of the two women” (p. 433). Though not so conspicuous in the sequence types selected for analysis in this paper, affiliation is in general a prominent feature in our data; there are frequent episodes in the M-EM encounters characterised by second assessments, collaborative completion of turns, shadowing, and sequences of mere confirmations (Linell and Bredmar 1996: 368). Arguably, affiliative strategies support the promotion of reassurance and normality. At the same time, the encounters are asymmetrical in several respects; the parties have only partially shared background knowledge, the professional midwife is the one who has got the specialized competence, expertise and professional responsibilities, and the woman/client is “just” the person whose “case” is at stake. The asymmetrical patterns of participation, with the midwife often in the dominant role, asking questions and giving information, give her ample opportunities to communicate her views on pregnancy. At the same time, she often uses a colloquial vocabulary (cf. excerpt (2)), and the two women often mutually confirm their perceptions and assessments. Indeed, the midwife seems to employ a subtle combination of interactional dominance and affiliative strategies to enact a discourse of normality.

But the midwife’s task in her professional encounters with women within the clinical practices explored here is actually dual:

- a comprehensive communicative (or conversational) project: to talk with the woman about various matters,

- a medical task of health surveillance and control (which is in principle of a non-communicative nature): to check up the biological process and, if necessary, take necessary measures.

Ultimately, both these are of course subordinated to the overall medical and social responsibilities of preventive health care. A similar duality can be seen in other nursing tasks. Heritage and Lindström (op. cit.: 401) talk about the health visitor’s “dual role of advisor and evaluator”.

Reassurance, and reconfirmation of the normal, is central to the conversational project. Normality is a frame of understanding, a perspective, which parties try to adopt in their dialogue. It works as a resource for midwives, and for the entire institution of maternal health care, in their interaction with clients, for the interpretation and reinterpretation, construction and reconstruction, of variations, deviations and changes in the pregnancy as state and process. ‘Normality talk’, as described in this paper, must be seen as one discursive resource among others to provide support, affiliation and solidarity within the midwife’s communicative project. This kind of talk exhibits a recurrent use of expressions like “this is quite normal”, “fine”, “OK”, “as it usually is”. The midwife reassures the mother-to-be that she is doing fine, and that everything is quite normal. She proposes descriptions of pregnancy symptoms that the woman could recognise and feel at ease with. Each discursive episode tends to be organised so that a positive normality assessment becomes possible towards the end, where it is often explicitly expressed or at least implicitly presupposed.

That which is deviant in the individual woman’s conditions is not explicitly talked about as something abnormal, alarming, or worrying. Deviant values tend to be discursively neutralised, minimised or at least mitigated by the midwife (while she carefully makes notes of them in the case-book). One reason why midwives refrain from talking about deviations as indicating illness or disease is undoubtedly that they are not legally empowered (as doctors are) to make and deliver diagnoses (recall the midwife’s “I didn’t say that” in (7)). But the point of belittling deviance in discourse arguably also has a communicative goal, that of not upsetting the other unduly. Similar findings have been reported elsewhere. Bad news in general must be communicated with delicacy (Maynard 1997). Strong (1979) proposes that in many health care situations, normality is communicated explicitly, but abnormality only indirectly or implicitly. Adelsvärd and Sachs’s (1996) study of nurses counselling male clients who are subject to risks through heightened cholesterol values shows that high values were communicated with mitigation. Leppänen (1998), in a study of Swedish district nurses visiting patients in their homes, shows that bad test values (pulse, blood sugar) are reported with delayed delivery (rather than an elliptic bald-on-record report, as in the case of good values), with mitigation (and stressing positive aspects), and often with attempts to explain
the values as due to accidental circumstances; the aim seems to be to
“inform without causing worries”.

Although the midwife does not upset the expectant mother with information about risk symptoms, she does take down notes discreetly and refers the woman to extra check-ups and control visits. Thus, the conversational task may oblige the midwife to downplay the importance of certain symptoms, whereas her medical, non-communicative project forces her to carefully watch the very same symptoms and take the necessary measures.

A pregnancy always involves risks. Therefore, midwives, just like many other health care professionals within preventive care, are faced with a dilemma, giving information and calling for action vs. not upsetting clients (Adelswärd and Sachs 1996). Talk in M-EM encounters is geared towards the latter; it is clearly not centred around ‘risk’, at least not explicitly. Midwives orient to potential worries by invoking ‘normality’ instead, something which can be most clearly seen in their dealing with situations involving deviant values. We noted earlier that clinical practice in general involves transformations, ‘recontextualisations’, from statistics to the individual case. Such recontextualisations are clearly dependent on the overall activity type and its purpose; in our M-EM talks, individual worries are mitigated by the midwife’s emphasis on normality and her exploitation of the notion of variation within a population. By contrast, in e.g. Adelswärd and Sachs’s (1998) genetic information talks, which deal with risks of developing diseases such as hereditary cancer, or getting babies with congenital diseases, ‘risks’ are made central to the discourse, and they are discursively transformed into properties pertaining to, almost as if embodied within, individual human beings. Accordingly, different clinical contexts vary greatly with respect to how potential risks are talked about.

We would like to end with a couple of discourse-theoretical points. We have seen that the midwife’s conversational project (what she tries to achieve in and through talking with and to women, i.e. reassurance) and her medical control task are intertwined in subtle ways. The task of medical monitoring has communicative reflections too. First, it does result in written notes to be entered into the files (but these have not included in this study). Secondly, it gives rise to particular indirect discursive manoeuvres in the conversations (and this we have seen in the data cited here). In the terms of Tannen and Wallat (1993), midwives balance and combine different framings in their discourse. The problem of combining the conversational and medical projects, establishing reassurance and confidence vs. gathering information about medical measures and symptoms, must be somehow solved in the creative accomplishments of actual interaction. Medical information is assembled as well as delivered by the midwives in their talk with the expectant mothers, but this must be done with caution: informing must not cause worries. In at least some cases of potential risks, this is enacted with a subtle balance of withholding potentially upsetting information and, at the same time, keeping track of noteworthy symptoms.

This brings us to a more general analytic point. Hak (this volume) has brought attention to the ‘talk bias’ in many discourse-analytic approaches; professional work practices, he points out, go beyond what is recordable as talk data (see also Sarangi and Roberts, Introduction, this volume). We have pointed especially to one feature of professional work, i.e. establishing reassurance and confidence and reconfirming normality, which is largely done in and through talk. It is hardly conceivable without the verbal interaction between professional and client, and this is a strong argument for the place of discourse analysis within the studies of the professions (and more widely within the social sciences). But our case also corroborates Hak’s point. Midwives do other things when they see their clients than pursuing conversational projects; in particular, they carry out medical surveillance tasks. Moreover, the conceptions of normality and pregnancy are not based entirely on information exchanged through talk. This is true of the professional experts, the midwives, but most probably also of the expectant mothers; they do not express all their thoughts in the conversations, nor do they derive all their knowledge from them. Exploring these issues is, however, a much larger task than we have taken on in this paper; we have been concerned with the nature of the communicative projects that midwives share with the expectant mothers.
Appendix

Transcription conventions

The transcripts follow usual conventions, but note the following points:

[ ] (left square bracket) on two adjacent lines indicates the onset of simultaneous talk

\underline{word} an underlined vocalic syllable nucleus denotes a focal stress within the prosodic phrase

(words) within parentheses indicate that the correctness of transcription is uncertain

(\texttt{xxx}) within parentheses denote undecipherable word(s)

\texttt{^words^} denote talk produced on in-breath

\texttt{°words°} denote talk in sotto voce

\texttt{*words*} denote talk produced with laughter in the voice

\texttt{\_\_\_\_} denotes laughter

\$\$\$\$\$ denotes throat clearing.

(1.2) denotes a timed pause in seconds and tenths of second

(\_\_\_\_) denotes a micro-pause (less than a quarter of a second)

Extracts (Swedish original)


1 M "ja som sagt\textsuperscript{o}, du e välkommen hitt
2 EM mm. \textsuperscript{o}tack\textsuperscript{oo}
3 M och-eh (0.8) (\$\$\$\$\$) de e din första graviditet,
4 de här, ja
5 EM =ja, de å de.
6 M å hur mår du då?
7 EM ja mår lite ilia, faktist
8 M jaha
9 EM "känner ja\textsuperscript{o}
10 M de e inte så gvanlit

11 EM ja, de åker upp å ner, ja vet inte, [de--
12 M [nå
13 M nåä. mm. de e ett- annan typ av illamående ån när man
14 har maginfluensa
15 EM mm
16 M de bästa sättet å (.) hålla de i schack, de e å åta
17 EM \textquoteleft ja\textquoteright
18 M eller dricka vatten.
19 EM men ja blir så jättesugen å samtidit så (.) vill ja
20 inte men ja måste ändå.
21 M nå. jus\textquoteleft de. jüs\textquoteleft de. å sen e de viktit att man håller
22 mättiderna
23 EM mm-hm
24 M att man åter regelbundet. (0.5) [så brukar man må
25 EM [mm
26 bättre också, de kanske du märker nän gång att (.) åter
27 du inte (.) lunch på den tiden du brukar så mår man
28 sâmre.
29 EM mm
30 M \textquoteleft ja\textquoteright (0.3) så de s- ska man tänka på, om inte annat se
till att man har en banan eller nåt å stoppa \textquoteleft ej vi\textquoteright
31 den tiden
32 EM (ha me sej om man jobbar)
33 EM [precjs. (.) så brukar de bli bättre. (.) å sen e de ju
34 M [mm
35 EM så här att-eh de håller inte på så hela tid\textsuperscript{en}. utan de
36 EM [nå
37 EM blir bättre, de e ju allit en tröst.

38 (2) (TemaK:B13:2:1–2) (EM primigravida)

1 (5.0)
2 M hur mår du?
3 (1.5)
4 EM joo-o, ja mår väl ganska bra "tron ja\textsuperscript{o}."
5 M de gör du.
6 EM ja.
7 M "hm" (0.3) nu (.) har du börjat känna fosterrörelser?
8 EM "ja"
9 M "hur sä" länge (0.3) har du känt dom?
10 EM jaa, ja har känt de ett par veckor.
11 M mm.
12 EM fast de e mér nu på [sista--
13 M [de e tydliare nu, ja.
14 EM "ja"
15 M ((till F)) du kanske har känt också?
16 F jaa.
17 M för de e ju så att vartertider gär så blir de
tydliare å tydliare. de första e ju (.) svårt å stjä om
18 de e fosterrörelser. [de de e så lite [så de kan
19 EM ["ja" [mm
20 F [mm
21 EM "ja"
22 F mm
23 EM ja precis
24 M de e svårt å urksilja va [va som de å.
25 EM [ja
26 EM ja
27 M sen blir de ju mer å mer tydlik så kommer ju (.) att
den slår kyllerbyttron i magen å att den buffer liksom
28 me armar å ben å (.) å de här blir starkare å
29 EM [mm
30 M starkare, den väcker (.) ger mer å mer rörelser ifrån
31 EM [mm
32 EM "sej" (.) eller dom känns av mer å mer
33 EM [mm
34 EM "ja"
35 EM "ja"
36 M de brukar eh upplevas rätt så skönt, trevligt de här när
37 M man (.) känner dom här rörelserna
38 EM "jaa"
39 M ja, de blir ju mer påtagligt.
40 EM "ja".
41 M "de gör de".
42 EM man känner ju verkligen att man å gravid nu
43 M ja
44 EM de gjorde man inte riktigt fgrut.
45 M du gjorde inte de.
46 EM näe. men nu känner ja att de å, "märks".
47 M ja

(3) (TemaK:BM7:1:1)
1 M hur mår du då?
2 
3 (0.5)
4 EM ja mår brå.
5 M du mår brå
6 (.)
7 M jaa
8 (.)
9 EM lite trött.
10 M ja. men de- (.) liksom hör till, ju.
11 (2.0)
12 M ja, de gör de.
13 (2.0)
14 M men de e inte mér ån att du tyckre de e hanterbart.
15 EM ja, de å de.
16 M mm.

(4) (TemaK:B8:2:26)
1 M "prickan dey på den här (.) kurvan" .
2 
3 (7.0)
4 EM du ligger ungefär (.) hår nånstans, ja, [(0.2) sen
5 EM [mm
6 beror de också lite grann på hur krafti man e i sej
7 själv, va. för här man ett ökat fettlager så mäter man
8 EM mm.
9 M så du hamnar (.) hår under.
(5) (TemaK:B6: 5: 5) (EM primigravida)

10 EM mm.
11 M du ligger strax under den så kallade mgdelkurvan men
12 [.] de ska ligga här emellan, va [.] någonstans,
13 EM mm [mm
14 (.) så du ligger helt normalt (.)
15 EM ha
16 storleksbedömningen.
17 EM m[m
18 M [“mm”]
19 (1.2)
20 M sen ska barnet då följa sin egen kurva, om den sen
21 ligger här uppe eller man ligger här nere, huvudsaken e
22 att (.) de följer sin egen tillväxtkurva, för de e
23 individuellt för varje barn ju.
24 EM aa, om man då skulle hamna utanför här va gör [man då då?]
25 M [ja om vi-
26 M om de börjar här å hamnar här uppe liksom, då (1.2) då
27 e de lige anmärkningsvärt. då måste vi kolla upp va
28 beror de på, då.
29 EM då kan man ha fått för mycke vatt- fostervatten.
30 M till exempel, ja.
31 EM mm

11 (1.0)
12 M [mm
13 EM [mycke stöorre
14 M mm
15 EM de [ser ja på kläderna.
16 M [få se, <trettigta å trettigen>
17 (3.0)
18 <nu gör ja> (.) f-faktist så hår att i å me att du
19 hamnade under den här (.) nedre normalkurvan s’att sätja
20 [(0.2) så sätter ja ett mijns där, å de ber- de betyder
21 EM [jaa
22 bgra så att du ligger under den streckade linjen, de e
23 [de e s’att om du undrar varför- va de g ja skrivar
24 EM [jaa
25 för nånting
26 EM [jaa
27 M och hyvet e ju helt klart fixgrat, de ligger ju väldit
28 (.) väl (0.2) [förankrat
29 EM [ner
30 (0.2)
31 M mm[m
32 EM mm
33 M (0.2).hh fosterjud har dom räknat här ser ja å
34 skrivar U Δ, betyder utan anmärkning. [(0.3) ja räknar
35 EM [jaa
36 de inte utan ja--
37 EM bara lys[nar
38 M [(bara att) de låter brag. mm.
39 (2.0)
40 och trettigt
41 (2.0)
42 åh:me: ((låter::)) uftraljud visar lijet barn som växer,
43 hade Anette skrivit. [(.) å relativt lijten (.)
44 EM mm
45 fostervattenmängd
46 M jaa
(6) (TemaK: B10:2:4-5) (EM primigravida)

1. M 
å så mäter ja på den övre delen, var har du
livmodern? den går ungefär i lodrätt plan precis.
(1.0) å de e sjutton centimeter å de bruvar de va
ungefär, å nästa gång e den kanske
2. EM

tjuge.°
3. M
mm
4. (2.5)
5. M
så de e helt normalstort, de växer som de ska.

(7) (TemaK:: B7:3:4) (EM primigravida)

1. M
har du de gifta?
2. M
(1.2)
3. EM
jaeh e hh
4. (0.5)
5. M
eller å de så här typ [när du lägg::er dej å--
[æ:h:
6. EM
ja
7. (0.2)
8. M
då e de väl kanske framför allt då [(.) "på kvällen"
9. EM
ja
10. (0.3)
11. för då () får du ju ha [så här i vi- ändrat () läge
12. EM
[mm
13. å-- ()
14. (1.0)
15. EM
[mm
16. å sånt. du ska ju inte ha nå' regelbundet, å de ska
17. inte (0.5) göra gnt. å de ska--° ((M mäter magen))
18. (1.2)
19. tjuguest ° å du ida tycker ja. de va inte så: () "stor
20. skillnad°
21. (1.0)
22. °om ja har måttit rätt°
23. (1.5)
24. °å tju gospel va du sjest°
25. (1.5)
26. EM
har de växt för lije då?
27. ()
28. M
va?
29. EM
växer för lije nu då
30. M
"nå inte för" lije, °men--° (0.7) de har ja inte
31. sagt. (0.8) "men den växer inte--", ja men här å den
32. större° (0.7) "tjuagta°.
33. (3.0)
34. ja tyckte du va så stor där upppe, men den e väl lite
35. större (1.0) på den sidan i alla fall.

Notes

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2. For discussion of the concepts of 'frame' and 'framing', see Goffman (1974), Tannen/Wallat (1993), and MacLachlan & Reid (1994).

3. In total, the corpora comprise 99 recorded and transcribed M-EM talks. Ten different midwives are involved.

4. Excerpts are given first in (relatively close) English translations, then in Swedish originals. The numbering of lines in the English translation have been adapted so as to correspond as closely as possible to that of the Swedish counterpart. The initials used are: M = midwife, EM = expectant mother, F = father (who is present in a minority of encounters). Indented initials are used
to mark off listener support items (rather than turns at talk); such items do not interrupt the speaker's turn (for example, in (1), lines 34, 36, 38 are one continuous turn by M, accompanied by listener support items by EM (lines 35, 37)).

5. There are often several cycles of similar arguments. For example, excerpt (1) is followed by more talk (left out here due to space limitations), in which M takes up the symptom of swollen breasts, which EM feels familiar with, and that episode is eventually closed by M asserting that this is something quite common (and hence normal) (expressed in generic terms: "they (i.e. the breasts) do so (i.e. get swollen) quite early", Sw. de gör dom tidit), and that it usually gets better.

6. Within a week after encounter B6:5 (cf. excerpt 5), the EM (B6) had an extra ultra-sound examination and an additional visit to her doctor.

7. I.e. the contractions.

8. Incidentally, EM was hospitalised later in the same day, due to strong contractions.

9. Heritage & Lindström (1998), in their study of British health visitors, report a somewhat similar case, albeit of a woman who has already given birth but does not think she acts like a good mother, since she does not feel much love for her child. Here too, the nurse takes pains to "ameliorate the case.

10. Cf. various documents regulating preventive maternal health care (Bredmar 1999). Rules and regulations describe the tasks of health surveillance. At the same time it is strongly recommended that the midwife work "in a psychosocial manner".

11. See e.g. excerpt (4): l. 4, 19.

12. These health care contexts, in which risks are oriented to in some way or another, are different in several respects. One is the obvious difference in legal entitlements between doctors/geneticists and nurses. For a more comprehensive discussion of these and other differences, see the comparative analysis in Linell et al. (forthc.).

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