SANNI TIITINEN

Supporting Parenthood in Interaction

A conversation analytic study of maternity and child health clinics

To be presented, with the permission of the Board of the School of Social Sciences and Humanities of the University of Tampere, for public discussion in the Lecture Room Linna K 103, Kalevantie 5, Tampere on January 10th, 2015, at 12 o’clock.

UNIVERSITY OF TAMPERE
SANNI TIITINEN

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Acta Universitatis Tamperensis 2009
Tampere University Press
Tampere 2015
The originality of this thesis has been checked using the Turnitin OriginalityCheck service in accordance with the quality management system of the University of Tampere.
Acknowledgements

At last, the end of my journey as a doctoral student is so close to its final destination that it is time to look back and thank all those people who have made this journey possible with their support.

Johanna Ruusuvuori has been my supervisor since I started to do my Master’s thesis. Johanna has taught me a great deal on conducting CA and also on doing research in general. I am truly grateful for her dedication to working together on our articles, the countless number of insightful comments that she has made on the analyses, and her sensibility and encouragement during those times that I have doubted my abilities as a researcher. Thank you, Johanna!

This dissertation is a part of the research project ‘Preventive healthcare in maternity and child health clinics’. Johanna Ruusuvuori, Pirjo Lindfors and Riikka Homanen, thank you for letting me join in the project, of which the encouraging and warm atmosphere has supported my development into a researcher, starting from being a Master’s student and a research assistant and finally a doctoral student. I want to acknowledge especially Riikka’s effort as she has collected the vast majority of the projects’ video-recordings and thus, the data that I use in this dissertation. Thank you also to Aku Kallio and other research assistants as well as Master’s students who have participated in transcribing the projects’ data.

I am deeply grateful for the institutions that have made it financially possible to work as a doctoral student and to publish this dissertation: With the four year funding provided by the Finnish Doctoral Program in Social Sciences (SOVAKO) I have been able to concentrate on my work without interruption. The School of Social Sciences and Humanities at the University of Tampere has been my home institution during these years and it has also provided financial support for finalising the dissertation as well as for a conference trip and proof-reading of the dissertation. The Scientific Foundation of the City of Tampere funded the publication of the dissertation.

In addition to funding, SOVAKO has offered me an important community in the form of the Graduate School of Language, Action and Social Interaction in which I have enjoyed many insightful scientific discussions as well as amusing free time. Thank you Mikko Kahri, Timo Kaukomaa, Inka Koskela, Hanna Rautajoki,
Jenni-Mari Räsänen, Mika Simonen, Melisa Stevanovic, Emma Vanhanen, Liisa Voutilainen and Elina Weiste as well as the teachers Ilkka Arminen, Kirsi Juhila and Anssi Peräkylä. A special thanks to Elina for introducing me to formulations, watching and discussing data together and most importantly, thank you for your friendship!

During the first years of my doctoral studies I participated in the seminar group on interaction and cultural studies supervised by Ilkka Arminen and the seminar group on family and childhood studies supervised by Anja Riitta Lahikainen and Ritva Nätkin. Thank you to the supervisors and participants of these seminar groups for all their helpful comments and support. During the last years of my doctoral studies I attended the seminar group of social psychology supervised by Johanna Ruusuvuori. Thank you Johanna, Aija Logren, Aku Kallio, Miia Männikkö and Julia Katila for the splendid seminars!

I have also enjoyed participating in the data sessions organised in the University of Tampere and I want to thank all the participants for the great opportunity to learn and do CA together. Thank you also to Anssi Peräkylä and his doctoral students for letting me to participate in their data sessions and seminar in the University of Helsinki.

The pre-examiners of this dissertation, Celia Kitzinger and Anssi Peräkylä provided insightful and encouraging comments which helped me to finalise my dissertation. Thank you to Celia also for agreeing to act as my opponent!

Thank you also to Elizabeth Stokoe for helpful comments on an earlier version of the manuscript of this dissertation. In addition, during these years many people have commented on my texts, data and presentations in various PhD-courses and conferences which I have attended, and I want to express my gratitude for them.

My sister Kaisa and my parents Sari and Raimo have always been supportive with my studies and provided an environment in which I have been able to practice analysing everything! My parents also made it very easy for me to study in Tampere while living in Kouvola by being always ready to offer me a place to stay when I was visiting Tampere. Finally, thank you to my husband Kalle for being there for me and reminding me that there are also other things in the life than a doctoral dissertation!
Abstract

This dissertation analyses the ways in which parenthood is supported in interaction in maternity and child health (MCH) clinics. Two points of view are addressed: 1) how fathers’ parenthood and their participation in interaction is supported compared to mothers; and, 2) when parents have potential problems, how parenthood is supported through an orientation to talk about problems in a particular way. To analyse these questions I use samples of video-recorded MCH encounters between public health nurses and parents as data (33 encounters in total) and apply conversation analysis as the method. The dissertation consists of a summary and three scientific articles which present the analyses.

The analyses focus on the interactional practices related to both engaging parents in the interactions and producing parenthood during the encounter. First, I present the ways in which parents are engaged in talking about issues concerning them both in maternity clinic encounters and in talking about their own and their children’s problems. Second, I demonstrate that, and how, the public health nurse’s practices of a) designing questions about parenthood in a way that suggest particular responsibilities for each parent and b) regulating parents’ participation roles in the encounter, invoke presuppositions of gendered parenthood. I also show that these gendered presuppositions can be negotiated and deviated from. In addition, I demonstrate the relevance of the public health nurse’s gaze direction in relation to both engaging parents in the interactions and producing parenthood.

The study highlights the benefits of detailed analysis of actual interaction in MCH clinics in order to gain knowledge of the minute practices in and through which the basis for supporting parenthood is built. The results are discussed in relation to previous studies of participation roles in multi-party health care settings and of facilitating talk about problems. I also suggest practical implications for family support in MCH clinics: a) the interactional practice of speaker selection by gazing and the questionnaire on psychosocial issues can be used to engage fathers in interaction, b) when questions to fathers are used to engage them in the discussions, attention must be paid to the question design, and c) the practice of topicalising by formulating the problem-relevant features of the parents’ problem-indicative talk and gazing at the parents gives them space to elaborate on their potential problems.
Tiivistelmä


Analyysit keskittyvät vuorovaikutuskäytäntöihin, jotka liittyvät sekä vanhempien vuorovaikutukseen osallistamiseen että vanhemmuuden tuottamiseen vastaanottojen aikana. Ensiksi esittelen tapoja, joilla vanhempia osallistetaan keskustelemaan molempia vanhempia koskevista asioista sekä heitä ja heidän lapsia koskevista ongelmista. Toiseksi osoitan, miten terveydenhoitajien käytännöt liittyvät a) vanhemmuutta koskevien kysymysten muotoiluun siten, että niissä ehdotetaan tietynläisiä velvollisuksia kullekin vanhemmalle, ja b) vanhempien osallistajaroolien säätelyyn, tuottavat oletuksia sukupuolittuneesta vanhemmuudesta. Osoitan myös, että näistä sukupuolittuneista oletuksista voidaan neuvotella ja poiketa neuvolavastaanottoilla. Lisäksi osoitan, että terveydenhoitajan katseen suunta on merkityksellinen sekä vanhempien osallistamisen että vanhemmuuden tuottamisen kannalta.

Aitojen vuorovaikutustilanteiden yksityiskohtaisen analysoinnin avulla saadaan tietoa hienovaraisista käytännöistä, joissa ja joiden kautta vanhemmuutta tuetaan neuvolavastaanottoilla. Tuloksia tarkastellen suhteessa aiempiin tutkimuksiin, joissa käsitellään tapoja, joilla tuotetaan osallistajaroolen monenkeskisissä terveydenhuollon vastaanottotilanteissa ja helpotetaan ongelmista keskustelemista. Ehdotan myös käytännön sovelluksia vanhemmuuden tukemiseen neuvolavastaanottoilla: a) terveydenhoitajat voivat tukea isien osallistumista keskusteluihin osoittamalla heille puheenvuoroja katseen avulla sekä käyttämällä kyselylomaketta, jolla kartoitetaan perheet psykososiaalista tilannetta, b) on syytä kiinnittää huomiota kysymysten muotoiluun, kun isien osallistamiseen käytetään kysymyksiä, ja c) kun keskustellaan vanhempien esiintuomista ongelmista, terveydenhoitaja voi antaa vanhemmille tilaa jatkaa mahdollisten ongelmien kuvaamista formuloimalla ongelmiaan liittyviä tekijöitä vanhempien edeltävästä puheesta ja katsomalla vanhempia.
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Article 1


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Article 2


[Reprinted from Patient Education and Counseling, 89/1, S. Tiitinen & J. Ruusuvuori, Engaging parents through gaze: Speaker selection in three-party interactions in maternity clinics, 38–43 Copyright (2012), with permission from Elsevier]

Article 3


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1 Introduction

In this dissertation I analyse the ways in which parenthood is supported in interaction in maternity and child health (MCH) clinics from two points of view: 1) how the parenthood of both mothers and fathers is supported, and 2) how parenthood is supported when parents have potential problems. While previous studies of family support in MCH care have to a large extent focused either on clients’ and professionals’ perceptions of the services or on the effectiveness of various interventions (see review by Tiitinen, Homanen, Lindfors & Ruusuvuori 2014), this dissertation analyses the interactional practices in and through which support for parenthood is actualised.

In Finland, MCH clinics have an important role in promoting families’ well-being, as almost all expectant parents and families with children under six years old use the services (Hakulinen-Viitanen, Pelkonen & Haapakorva 2005: 21; Klemetti & Hakulinen-Viitanen 2013: 326). The clinics focus on monitoring the health of the pregnant woman and the development and growth of the child, as well as on giving psychosocial support to all family members. Explicit aims and principles guiding the work at clinics include supporting families through potential problems as early as possible, and acknowledging not only mothers but also fathers as clients. (MSAH 2004: 20–23; Klemetti & Hakulinen-Viitanen 2013: 16–20.) Using the method of conversation analysis, I describe in detail interactional practices and phenomena that seem to relate to these aims and principles of MCH care.

The dissertation consists of five chapters. In the introductory chapter I outline the settings and focus of the dissertation. The second chapter presents previous literature on interaction in MCH care and healthcare encounters. In the third chapter I present the data, the research questions and the conversation analytic method. The fourth chapter gives a summary of the research results, which are further discussed with regard to the previous literature in the fifth chapter.
1.1 The context of the study: maternity and child health clinics

MCH clinics are an established public service with the primary aim of ensuring and promoting the health and well-being of the foetus, the pregnant woman and the whole family during the pregnancy (Klemetti & Hakulinen-Viitanen 2013: 16), and the health and well-being of the child and whole family after the baby is born (MSAH 2004: 20). The first clinics were introduced in the 1920s (Korppi-Tommola 1990: 63–65), and the provision of MCH services became a statutory duty for municipalities in the 1940s (Siivola 1985: 92; MSAH 2013: 8). The utilisation rate of the services was very high by the beginning of the 1960s (Siivola 1985: 96), and it has remained high since then: today almost all expectant parents and families with children use the services offered by the clinics (Hakulinen-Viitanen et al. 2005: 21; Klemetti & Hakulinen-Viitanen 2013: 326). One of the central original aims of the clinics was to reduce infant mortality (Korppi-Tommola 1990: 63–64; Turpeinen 1987: 393–399), but the focus has widened from the somatic health of the expectant mother and baby to encompass the psychosocial well-being of the whole family (see Klemetti & Hakulinen-Viitanen 2013: 16; MSAH 2004: 20).

The use of MCH services is free and voluntary (National Institute for Health and Welfare, NIHW 2014a). However, visiting the clinic – or having a doctor’s check-up elsewhere – is a requirement for receiving the maternity grant (a package of baby care equipment, clothes and the like, or a lump sum of €140) (The Social Insurance Institution of Finland 2012). On the basis of her ethnographic study in MCH clinics, Kuronen (1993: 46–49) has also pointed out that public health nurses see the use of the services as parents’ responsibility – that is, it is regarded as their moral duty to visit the clinic.

The broad aims of MCH services are regulated by the Healthcare Act (1326/2010), and a related decree (338/2011) regulates the content of health examinations and guidance. The Ministry of Social Affairs and Health (MSAH 2004) and the National Institute for Health and Welfare (Klemetti & Hakulinen-Viitanen 2013) have also published more detailed guidelines on the aims and principles of the services, and also on work practices such as the tasks to be completed during each visit. According to the guidelines, a woman expecting her first child should be offered at least nine check-ups during the pregnancy; during subsequent pregnancies she should be offered at least eight check-ups (Klemetti & Hakulinen-Viitanen 2013: 102). The first encounter after the initial contact at phone is scheduled at eight to 10 weeks of pregnancy, and the closer the due date, the more frequent the appointments (ibid.: 103). After the child is born, there are
at least 10 visits to the clinic during the first 18 months, and then a check-up once a year until the child is six years old (MSAH 2004: 127, 313). The majority of the encounters in MCH clinics are with a public health nurse. In addition, a few encounters both during the pregnancy and after the baby is born are with a doctor. (Klemetti & Hakulinen-Viitanen 2013: 103; MSAH 2004: 127.)

The official guidelines include a list of tasks to be completed during each visit, ranging from particular topics for discussion and guidance and examinations to development tests and vaccinations (Klemetti & Hakulinen-Viitanen 2013: 103–107; MSAH 2004: 130–157, 313). A recent online handbook for child health clinics lists the content of each encounter, dividing it into stages: before the check-up, preliminary information, check-up, health counselling, and end of check-up (NIHW 2014b). The encounters usually begin by interviewing clients about their current concerns. For example, a general ‘how are you?’ type of question at the beginning is used to open discussion about issues that clients have on their minds (Kuronen 1993: 34; NIHW 2014b). After a discussion of current concerns at the public health nurse’s desk, measurements and tests are taken and/or discussed. During pregnancy, recurrent examinations include blood pressure, protein and sugar in the urine, and the weight and heartbeat of the foetus (Klemetti & Hakulinen-Viitanen 2013: 113–133). For the baby or child, typical issues that are followed up include weight, height, head size, eyesight, hearing, neurological development and speech development (MSAH 2004: 313). At certain encounters the child is also vaccinated (ibid.: 313). During the examinations the public health nurse and clients may also initiate discussion about topics related to the ongoing tests and measurements or to other issues. At the end of the encounter there is typically still time for discussion, and the public health nurse may ask if the clients have something on their minds. In addition, the next appointment is often booked at the end of each encounter. The first encounter during the pregnancy is slightly different than the others, as the clients’ preliminary information is gone through and entered into the electronic client record (see Kuronen 1993: 32–33).

The public health nurse may bring up issues that are listed in the guidelines during the beginning stage of the encounter, but these topics may also be discussed during other stages. During pregnancy, topics to be discussed include the mother’s physical health and mood, the family’s way of life, parenthood, the parents’ relationship, childbirth and breastfeeding (Klemetti & Hakulinen-Viitanen 2013: 103–107). During child health clinic encounters, the topics include parents’ observations of the child’s development, their sources of happiness or concern, the daily routine, breastfeeding and solid food (MSAH 2004: 130–157).
The data used in this dissertation was collected as part of a research project focusing on the implementation of a new family-centred model of MCH clinics (see Ruusuvuori, Lindfors, Homanen, Haverinen, Lehtonen & Keskinen 2008). This model includes several new work practices and ways of organising the work (Kangaspunta & Värri 2007). First, the continuation of the professional-client relationship is supported organisationally, with the same public health nurse working with the family from the beginning of the pregnancy until the child is six years old (ibid.: 3). Second, public health nurses work with multi-professional teams including doctors, social workers, psychologists and family workers. Teams meet regularly, and the professionals may consult other team members over cases they are worried about. In addition, if all participants agree, the family may come to the team meeting to discuss their situation. (Ibid.: 3–5.) Third, talking about parents’ psychosocial concerns is encouraged, with a questionnaire given to all client families once during the pregnancy and twice after the baby is born. Topics covered in the questionnaire include social support, mood, alcohol use, conflict resolution between parents, stress, their financial situation, their ideas about the baby (during pregnancy), and the relationship between parents and baby. The questionnaires are filled in by both parents before the encounter, and are then discussed with the public health nurse during the encounter. (Ibid.: 7–8, 28–39.) Fourth, a home visit during pregnancy and peer groups are seen as important ways of supporting parents (ibid.: 8–9).

The data I use in this dissertation includes encounters both from clinics that are implementing the new model and from clinics that are not. As the new family-centred model does not change the core of the MCH work but offers new ways of organising it, and as the research questions of this dissertation are not relevant only for the new family-centred model, I analyse the data primarily as a representation not of the new family-centred model, but rather of work practices in MCH clinic encounters in general. As the aims of supporting parents in their psychosocial concerns and acknowledging the father as a part of the family are highlighted in the new model (Kangaspunta & Värri 2007: 2) perhaps even more explicitly than in the general guidelines, it may be that the practices supporting these aims are emphasised in the data. However, I do not aim at comparing different ways of organising MCH services or presenting quantitative generalisations. The specificity of family-centred model is explicitly observable when I analyse a few encounters in which the psychosocial questionnaire is used. The questionnaire’s effect on the encounter is also observable and taken into account in the analysis (see Chapter 4).
1.2 The gap between policy and practice in shared parenthood

As in other Nordic countries, in Finland the state aims to integrate paid work with family life through various leave arrangements, state-funded childcare services and financial grants offered to parents (Leira 2002; MSAH 2013: 6). In addition, the family policy is targeted at ‘strengthening fatherhood’ (MSAH 2013: 6), and the family leave system promotes gender equality (Haataja 2009: 5; Leira 2002: 85; MSAH 2013: 16). Fathers have had a right to paternity leave since the 1970s, and recent developments have both extended the leave period and made it more independent of other leave periods (MSAH 2013: 9, 18). However, although the majority of fathers take at least part of their paternity leave, the vast majority of the parental leave available to both parents is taken by mothers (Haataja 2009: 9, 16; Salmi, Lammi-Taskula & Närvi 2009: 32; Takala 2009: 44). According to a survey, most parents know about fathers’ right to take parental leave, and thus unawareness does not explain the bias towards mothers’ take-up of parental leave (Salmi et al. 2009: 53–55). Approximately half of the fathers in the survey reported that one of their reasons for not sharing parental leave was the difficulty of arranging a long absence from work (ibid.: 55). In addition, statistical analyses suggest that socio-economic factors such as education or income level are less significant for the likelihood of fathers taking parental leave than are the parents’ gender ideologies (Lammi-Taskula 2007: 97–98, 2008: 141–142; Salmi et al. 2009, 56–57). Parents’, especially fathers’, attitudes towards parental leave affect the likelihood of fathers sharing such leave, as do their perceptions that the father has a primary responsibility to provide for the family and that the mother has primacy in childcare (Lammi-Taskula 2007: 81–82, 2008: 142; Salmi et al. 2009: 57). In addition, Leira (2002: 87) has pointed out that the parental leave system, which lets parents decide who will take the leave and claim financial support in order to care for the child at home, has led to mothers staying at home for prolonged periods. As Leira (2002: 88) puts it, ‘gender-neutral parental choice has produced gender-differentiated consequences.’

In addition to these differences in the take-up of parental leave, gendered parental roles are also observable in studies on time use in unpaid housework. Women use more time for childcare and housework than men, whereas men do more maintenance work at home, although the gender differences in time use have decreased (Official Statistics of Finland 2011; Miettinen 2008: 51–52). Drawing on an analysis of interviews with Nordic heterosexual couples with children, Magnusson (2008) has described several discourses used by such couples to argue
against the relevance of gender equality in their everyday lives. For example, couples refer to practicality, individualism, genetic differences between men and women, and the avoidance of arguments (Magnusson 2008: 83–86, 91). It is also interesting that couples who do not see gender equality as relevant to themselves may nonetheless support gender equality in society in general (ibid.: 81).

Previous studies have also revealed discourses of gendered parental roles within various textual contexts, such as in parenting advice texts (Sunderland 2000), childcare magazines (Sunderland 2006), advertisements (Lazar 2000) and the writings of family professionals (Eräranta 2005; Vuori 2009). In addition, gendered parental roles are represented in institutional encounters between professionals and parents. For example, Alasuutari (2010: 133–144) has noted that in meetings between parents and childcare professionals to discuss the child’s education plan, when fathers are present they typically participate actively in the discussion and parents describe the childcare as shared, but when mothers alone are present, fathers’ parenthood may be quite invisible. The parents interviewed in Alasuutari’s study also often took the mother’s participation in the meeting for granted, but not the father’s participation (ibid.: 131–132). Similarly, in institutional encounters between parents and social workers, fatherhood is not presented as self-evident in the same way as motherhood, but rather is something that is hoped for and encouraged (Forsberg 1994: 113–120, 1995: 136–138). Social workers also discuss fatherhood more with mothers than they do with fathers themselves (Forsberg 1994: 116, 1995, 141).

In MCH clinics, taking fathers into account as clients is an explicit aim. The guidelines for child health clinics define one part of family-centeredness as follows: ‘mothers, fathers and children are the child health clinic’s clients, whose knowledge and skills as experts on their own family are the basis of the work’ (MSAH 2004: 22, my translation). Fathers are also acknowledged in the guidelines for maternity clinics in the statement that ‘the mother, the father and the whole family should experience expecting the child, undergoing childbirth and taking care of the baby as safe and enriching of family life’ (Viisainen 1999: 9, my translation). Recently updated guidelines for maternity clinics in turn connect family-centredness to an interest not only in the mother’s health and well-being, but also in that of the father or other partner and of the whole family (Klemetti & Hakulinen-Viitanen 2013: 20); these guidelines include a whole chapter discussing men as clients in maternity clinics (ibid.: 30). The guidelines also recommend informing parents of the benefits of sharing childcare (MSAH 2004: 84) and of fathers’ ability to be as good as mothers at taking care of small children (Klemetti & Hakulinen-Viitanen
2013: 30). The importance of the aim to include fathers in MCH care is also vividly demonstrated by the fact that the Ministry of Social Affairs and Health has published a separate guide on it (Säävälä, Keinänen & Vainio 2001).

However, previous studies suggest that although public health nurses welcome fathers’ attendance at MCH clinic encounters, they may also see building a relationship with the father as more difficult than with the mother (Kuronen 1993: 52–53, 1995: 127), or see themselves as lacking the ability to support fathers in their parenthood (MSAH 2008: 39–40). Qualitative studies reporting fathers’ experiences in MCH clinics both in Finland and elsewhere have also suggested that at least some fathers feel left out during the encounters (Deave, Johnson & Ingram 2008; Fägerskiöld 2006: 81; Kaila-Behm & Vehviläinen-Julkunen 2000: 202; Mesiäislehto-Soukka 2005: 124; Paavilainen 2003: 100–101; for a review see Steen, Downe, Bamford & Edozien 2012: 427). An ethnographic study (Kuronen 1993: 52–55, 95–99; Kuronen 1995: 127–130) and video-based phenomenological studies (Olsson, Sandman & Jansson 1996: 69–70; Olsson, Jansson & Norberg 1998: 210–211) support these descriptions of fathers’ secondary role in MCH clinics. Moreover, these qualitative reports of the differences between fathers’ and mothers’ roles are backed up by a quantitative study demonstrating that fathers are not as content with MCH services as mothers are (Viljamaa 2003: 84).

Reasons for feeling left out mentioned by interviewed fathers include difficulties in fitting their work schedule around the appointments, not being invited to the clinic, and not being talked to (Paavilainen 2003: 100–101). An ethnographic study of MCH clinics also points out that the father may get left out of discussions because questions about the child are primarily posed to the mother (Kuronen 1993: 55). In addition, the seating arrangement may force the father to sit further away from the public health nurse, and thus preventing him from being able to participate easily in the discussion (ibid.: 55).

To sum up, previous studies have revealed the discourse of gendered parenthood in different settings, and have suggested that this discourse may even be present in MCH clinic encounters, despite the family policy and guidelines for MCH care that support gender equality in childcare. However, previous studies have not demonstrated in detail what kind of interactional practices lie behind this production of parental roles that potentially highlight the mother’s primacy as both a client and a parent. These interactional practices are one focus in this dissertation.

When referring to the discourses related to the distribution of responsibilities between parents, previous studies have named for example, the discourses of ‘shared parenting’ and ‘exclusive mothering’ (Vuori 2009), ‘egalitarian gender
relations’ and ‘conservative gender relations’ (Lazar 2000) and ‘part-time father/mother as main parent’ (Sunderland 2000). These illustrate that the issue of symmetrical or asymmetrical parental roles can be approached with different names which also highlight different aspects of it. In this dissertation, on the one hand I use the term ‘shared parenthood’ which stems directly from the MCH clinic guidelines (the term used in Finnish is ‘jaettu vanhemmuus’, MSAH 2004: 84). As the research questions of this study are tightly based on the aims of MCH services, it is worthwhile to connect the terms used here to the ones used in MCH services when possible. On the other hand, I use the term ‘gendered parenthood’ with which I aim at highlighting the ways in which the asymmetry or differences between the parents’ responsibilities in childcare are linked to gender. Inevitably, using only two terms to characterise the symmetry or asymmetry between parents ignores the various nuances in the combinations of parental roles. Thus, these terms should be understood as tools that organise the detailed analysis of interaction rather than comprehensive descriptions of everyday life between parents.

1.3 Challenges in providing early support in problematic situations

A large amount of research has provided information on parents’ experiences, feelings of stress or anxiety, well-being, concerns and other issues related to their potential need for support (e.g. Boyce, Condon, Barton & Corkindale 2007; Deave, Johnson & Ingram 2008; Hildingsson & Thomas 2014; Solmeyer & Feinberg 2011; Widarsson, Engström, Rosenblad, Kerstis, Edlund & Lundberg 2013; see also literature reviews by Nyström & Öhrling 2004 and Razurel, Kaiser, Sellenet & Epiney 2013). The guidelines for MCH clinics highlight the aims of early intervention and problem prevention. In maternity clinics the aim is to detect problems or risks during pregnancy and families who need extra support as early as possible in order to be able to intervene and give support (Klemetti & Hakulinen-Viitanen 2013: 17). The child health clinics have similar aims, with the focus on problems and risks for the child’s health and development as well as for the family and the child’s environment (MSAH 2004: 20–21). Drawing on research, the guidelines list various situations in which families may need support (Klemetti & Hakulinen-Viitanen 2013: 33–34; MSAH 2004: 98–99).

A previous study has suggested that public health nurses are rather competent at detecting issues that might hinder the child’s development, but that bringing these up with the parents is not easy (Puura et al. 2001: 4860). In terms of the
interaction, difficulties related to talking about problems are not only associated with MCH clinic encounters, but are at least to some extent a more general phenomenon (see e.g. Jefferson 1980, 1988; Jefferson & Lee 1981).

In MCH care aspects related to the institutional context also potentially make talking about problems challenging. First, the logic of MCH care as a preventive service may affect how talking about problems is initiated during the encounter. Appointments with the public health nurse are typically booked in advance to coincide with particular milestones suggested in the MCH guidelines. Therefore it is not assumed that clients are coming to the encounter because they have a problem; instead it is the professional’s task to find out whether they have any problems and to intervene in them as early as possible. Drawing on an analysis of encounters between healthcare professionals and pregnant women, Nishizaka (2010a: 283–284) has pointed out that this kind of preventive check-up does not incorporate the same kind of structural point at which problems can be brought up as acute medical encounters do. The guide for MCH clinics suggests asking the parents a ‘how are you?’ type of open question at the beginning of the encounter (NIHW 2014b). However, because the reason for the appointment is not an acute problem as it is in general practice encounters (for the structure of acute medical encounters, see Robinson 2003; Robinson & Heritage 2005; Ruusuvuori 2000: 48–57), ‘how are you?’ questions offer an opening for talking about all kinds of things, not just about potential problems.

Second, the difficulty of talking about problems in MCH clinics can also be linked to the overall orientation towards normality in MCH clinics, demonstrated for example in studies by Bredmar and Linell (1999) and Kuronen (1993: 61–65). Although the professional’s task of monitoring clients’ health requires the former to gain information on health-related problems, professionals try to avoid worrying their clients (Bredmar & Linell 1999: 256–259; see also Kuronen 1993: 63).

Third, the difficulty of talking about problems in MCH care may be linked to the inherent challenges of the activity of giving advice as giving or asking for advice suggests that the parents lack knowledge and competence (Heritage & Sefi 1992: 367–368; Heritage & Lindström 1998: 410; see also Chapter 2.1). Because of the surveillance aspect of MCH care (Bredmar & Linell 1999: 256; Heritage & Sefi 1992: 365–368, 412–413; Heritage & Lindström 1998: 401–403), merely asking for advice, let alone talking about problems, may itself be seen as undermining parents’ competence.

The importance of interactional elements when talking about problems is also acknowledged in the MCH clinics’ guidelines, which make some general
suggestions about how to detect families’ support needs, for example by using questionnaires and a dialogical interaction style (Klemetti & Hakulinen-Viitanen 2013: 34–35; MSAH 2004: 95–97, 99–102). In addition, the National Research and Development Centre for Welfare and Health has published a guide to a specific method for bringing up concerns in interactions between family professionals and parents (Eriksson & Arnkil 2012; see also Eriksson & Pyhäjoki 2007 in the MCH clinic work handbook). However, the suggestions seem not to go into the details of the interaction, but rather describe the theoretical background of the importance of dialogue between professionals and clients (Eriksson & Arnkil 2012: 37) and the steps through which professionals can prepare to discuss their own concerns about the clients’ situation with those clients (ibid.: 12–18).

In this study I provide detailed descriptions of actual interactions between public health nurses and parents when discussing potential problems. One aspect of supporting parents when they have problems is discussing the potentially problematic situation in a way that gives parents an opportunity to talk about what the situation is like. In this study I focus on this aspect and present an interactional practice through which parents can be encouraged to elaborate on their problems.

1.4 The need for a detailed methodology in studying family support in interaction

To analyse in detail the interactional practices related to supporting parenthood requires a methodological approach that addresses the details of interaction. I will now briefly introduce two approaches that are often used in studying family support in MCH care: 1) focusing on the clients’ and professionals’ views and perceptions of MCH services, and 2) measuring the effects of a specific intervention in MCH care (see review by Tiitinen et al. 2014). I will point out that although these approaches offer valuable knowledge of MCH care, they do not get down to the details of interactional practices.

The first approach focuses on clients’ and professionals’ views and experiences of MCH care, and uses questionnaire or interview data to gain knowledge of them (Tiitinen et al. 2014). Recent examples of this approach are the studies by Rautio (2013), Tammentie, Paavilainen, Tarkka and Åstedt-Kurki (2009) and Tammentie, Paavilainen, Åstedt-Kurki and Tarkka (2013), in which analyses are based on interview data. Using a narrative approach, Rautio (2013) analyses parents’ experiences of support given through the new provision of home visits for parents.
who attend MCH clinics. Tammentie et al. utilise grounded theory to describe experiences of interaction in child health clinics on the part of both public health nurses (Tammentie et al. 2013) and families with mothers suffering from post-natal depression (Tammentie et al. 2009).

The second approach focuses on the effectiveness of specific interventions in MCH care. Studies by Jolly et al. (2012), Kemp et al. (2011) and Leung and Lam (2012) are recent examples of this approach. They report the results of randomised controlled trials to measure the effectiveness of interventions that aim to improve for example, child development (Kemp et al. 2011), support the continuation of breastfeeding (Jolly et al. 2012), and reduce stress and depressive symptoms among mothers of babies whose grandparents participate in childcare (Leung & Lam 2012).

Studies focusing on participants’ views and experiences or on the effectiveness of interventions offer valuable information on MCH care. For example, Rautio (2013: 930–931) and Tammentie et al. (2009: 720) report that parents experience having discussions with professionals and being acknowledged as individuals as important. Tammentie et al. (2009: 719) also suggest that parents often feel criticised by the public health nurse in child health clinics. These kinds of results help to assess what kind of services parents see as important. Controlled trial studies, for their part, offer knowledge of the effectiveness of interventions. Leung and Lam (2012), for example, demonstrate that group sessions for pregnant women are effective in reducing stress, while Jolly et al. (2012) suggest that the peer support service provided before and after childbirth has no effect on breastfeeding rates. These kinds of results help to assess which services parents should be offered.

However, methodological approaches that focus on views and experiences and on the effectiveness of interventions lack the ability to describe in detail the interactional practices and processes in MCH care (Tiitinen et al. 2014). As people are not able to remember or repeat all the details of the interaction, the interview data cannot offer a detailed description of the discussions (Heritage 1984: 236–238) during which parents may feel, for example, that they are not being listened to or are being criticised (cf. Tammentie et al. 2009: 719–720). Also, interviews have to be seen as the result of the interview situation as an interaction in which interviewees’ descriptions of the topics at issue are influenced by the ongoing actions to which they are responding (Ruusuvuori 2010; Ruusuvuori & Tiittula 2005). In addition, although evaluating an intervention tells us whether it has had an effect on specific outcome measures, randomised controlled trials do not usually
describe the details of the interaction between the professional and the client during the intervention which might have affected the results. For example, advice that has the same content can be given in different ways in interaction (see Heritage & Sefi 1992; Vehviläinen 2012). Heritage, Robinson, Elliott, Beckett and Wilkes (2007) have demonstrated that even very subtle details can make a difference in discussions between professionals and clients: the doctor’s question, ‘Is there something else you want to address in the visit today?’ encourages patients to talk about their secondary concerns significantly more often than the same question in which the word something is replaced with anything. This finding illuminates the importance of analysing interactional practices in detail. In this study I use the method of conversation analysis, which enables the investigation of the details of interactional practices related to family support.

1.5 Focus of the study

In this study, I address the two challenges presented above: that related to the policies and institutional aims of supporting parenthood, and the other related to the need for a methodology that is able to get to the detailed level of interaction. First I provide empirical and detailed descriptions of the interactional practices related to supporting parenthood in MCH clinic encounters, which in turn enable an analysis of whether and how those institutional aims are actualised in interaction (see Peräkylä, Ruusuvuori & Vehviläinen 2005). I address the second challenge by using the method of conversation analysis (CA), which enables a focus on the minute practices of interaction in and through which parenthood is supported.

In approaching the question of supporting parenthood by using CA, I draw on previous knowledge of the organisation of participation in interaction. I start from the notion of the participation framework, which refers to the idea that participants in interaction have various roles in relation to the ongoing utterance (Goffman 1981: 137). For example, unratified and ratified hearers as well as addressed and unaddressed recipients have different participation roles in interaction (Goffman 1981: 131–133; see also Levinson 1988). If the focus is widened beyond the categorisation of different participation roles (see C. Goodwin & M. H. Goodwin 2004: 222–225 for a critical analysis), participation can be seen as regulated and negotiated by all participants in interaction using not only verbal but also non-verbal practices such as gaze direction and body posture (C. Goodwin 1979, 1980, 1981, 2007; M. H. Goodwin 2007; Levinson 1988: 174–176; Rossano 2013: 311–
My starting point is that the ways in which the participants in the encounter orient to parents’ roles as participants in the ongoing interaction – for example, by organising verbally and non-verbally who is the addressed recipient and how turns are designed for a particular recipient – also produce presuppositions about their roles as clients and parents.

Building on these ideas of participation, I ask: 1) how fathers’ parenthood and their participation in interaction is supported compared to mothers’ through the regulation of parents’ participation roles in the encounter and the suggestion of particular responsibilities for each parent, and how these practices may be seen as producing gendered parental roles; 2) when parents have potential problems, how parenthood is supported through an orientation to talk about problems in a particular way. The next chapters on previous research (Chapter 2) and methods used in this study (Chapters 3.1) further introduce the ideas of participation and the structural organisation of interaction. The specific research questions are presented in Chapter 3.2.
2 Previous studies of healthcare encounters

Previous CA studies of MCH care have addressed many themes related to supporting parenthood: for example, how MCH professionals organise giving advice, building a relationship with the client and talking about problems. In this chapter I present the settings and research themes of previous CA studies of MCH care, and I summarise the relevant results in relation to supporting parenthood. I will suggest that only a few CA studies of MCH care have addressed the regulation and production of clients’ roles in interaction or the function of the gaze in that regulation, which form the central themes in this study. However, the themes of participation and the gaze have been addressed in studies concerning other healthcare settings. In the second section of this chapter I therefore present studies focusing on participation in different kinds of multi-party healthcare encounters, and in the third section I outline approaches used to study the gaze in various kinds of healthcare encounters.

2.1 Interactional practices in maternity and child healthcare

Previous CA studies have analysed interactions between professionals and clients in preventive MCH care and have dealt with numerous different themes, such as the giving of advice or instructions by professionals (Heritage & Sefi 1992; Heritage & Lindström 1998, 2012a; Kawashima 2010), talking about delicate, problematic or morally charged topics (Heritage & Lindström 1998, 2012b; Linell & Bredmar 1996; Nishizaka 2010a, 2011), information and decision-making (McKenzie 2009; Opel et al. 2013; Pilnick 2004, 2008; Pilnick & Zayts 2012), partnerships or relationships between professionals and clients (Heritage 2002; McKenzie 2010; Plumridge, Goodyear-Smith & Ross 2009; Raymond 2010), reassurance and emotional support for clients (Bredmar & Linell 1999; Heritage & Lindström 1998, 2012b), the assessment of clients’ support needs (Cowley, Mitcheson & Houston 2004; Mitcheson & Cowley 2003), power relationships between professionals and clients (Mitcheson & Cowley 2003; Plumridge, Goodyear-Smith & Ross 2008), the sequential organisation of specific parts of

The number of CA studies of MCH care seems to be modest\(^1\) when compared, for example, to the vast number of CA studies of doctor-patient encounters (for overviews see e.g. Gill & Roberts 2013; Heritage & Maynard 2006: 362–367). Several CA studies focus on interactions between professionals and clients in institutional settings related to reproduction and/or children’s and families’ health and well-being, such as childbirth (Näslund 2013), paediatric encounters (Aronsson & Rindstedt 2011; Clemente 2009; Stivers 2001, 2007), family therapy (Hutchby & O’Reilly 2010; O’Reilly & Parker 2013), helplines for women who have experienced traumatic childbirth (Kitzinger & Kitzinger 2007) or are planning a home birth (Shaw & Kitzinger 2007), and helplines for parents who need parenting support or information about their child’s development (Butler, Danby, Emmison & Thorpe 2009). In this section, I summarise studies that use CA to study settings that represent preventive MCH care services for expectant parents and parents of children under school age, and where the professional and the client meet face-to-face.

The institutional settings analysed in these previous CA studies of preventive MCH care vary, as services are organised in different ways in different countries. For example, the professionals included may be midwives (e.g. Bredmar & Linell 1999; Kawashima 2010), health visitors (e.g. Heritage & Sefi 1992; Mitcheson & Cowley 2003), nurses (e.g. Plumridge et al. 2008), obstetricians (Nishizaka 2013) or paediatric providers (Opel et al. 2012). Clients are either expectant mothers or parents as in Bredmar and Linell’s (1999) study, parents of children as in Plumridge et al.’s (2008, 2009) studies, or both as in McKenzie’s (2009, 2010) studies. Table 1 summarises the settings and the data as well as the focus of previous CA studies of preventive MCH care.

\(^1\) It should also be noted that the number of individual studies is higher than the number of different datasets. For example, Heritage and Sefi (1992) Heritage and Lindström (1998, 2012a, 2012b), Heritage (2002) and Raymond (2010) use the same dataset of health visitor encounters.
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### Focus on the sequential organisation of a specific part of the encounter

| Characterizing providers’ immunization communication practices during health supervision visits with vaccine-hesitant parents: A pilot study (*Opel, Robinson, Heritage, Korfias, Taylor & Mangione-Smith 2012*) | Video-recorded health supervision visits with paediatric providers, vaccine-hesitant parents and their babies in the USA | Communication practices during immunisation discussions |

Many of the studies summarised in Table 1 analyse MCH professionals’ interational work practices during encounters with clients. Heritage and Sefi (1992: 365–366) suggest a classification of the different roles of MCH professionals. Based on their analyses of health visitor-mother encounters, they suggest that health visitors can be seen either as experts who have knowledge of babies’ health and childcare and who give advice and evaluate mothers’ competence, or as ‘befrienders’ with whom mothers can share all their concerns, not only those related to the baby, and who affiliate with those concerns (Heritage & Sefi 1992: 365–366; Sefi 1988 cit. Heritage & Lindström 1998: 433). The previous CA studies of MCH care summarised in Table 1 emphasise different aspects related to both the expert and supportive roles of MCH professionals. Next, I discuss the previous studies with regard to what they reveal about these two roles of MCH professionals.
MCH professionals’ role as experts is considered, for example, in Plumridge et al.’s (2008) study of the interactions between nurses and parents during children’s immunisation. They suggest that parents usually orient to nurses as experts and treat the asymmetry of knowledge as acceptable in relation to medical issues, but the same does not apply to knowledge about their children (Plumridge et al. 2008: 16). In addition, although policy recommendations foreground the importance of clients’ participation in the management of personal issues such as assessing their own health needs, and thus also foreground clients’ expertise on these issues, working practices may highlight professionals’ control over the assessment of clients’ needs (Mitcheson & Cowley 2003; Cowley et al. 2004: 515–519).

The expert role of MCH professionals has been analysed perhaps most extensively with regard to the practices of requesting and giving advice and instructions. Heritage and Sefi (1992) and Heritage and Lindström (1998: 2012a) have highlighted the problems inherent in the actions of requesting and giving advice. If parents request advice, they present themselves as less knowledgeable or competent than health visitors; by the same token, giving unrequested advice invokes the epistemic asymmetry between the health visitor as a knowledgeable advice giver and the parent as an incompetent recipient of advice (Heritage & Sefi 1992: 367–368; Heritage & Lindström 1998: 410, 2012a: 170).

These problems play a role in the organisation of giving and responding to advice in MCH care encounters. For example, professionals have different procedures to make sure that the advice they give is relevant for the clients. Heritage and Sefi (1992: 377–380) present the sequence during which the health visitor poses further questions about the possible problem and in this way gradually, ‘step by step’, enters into advice-giving. Kawashima (2010: 210–215) presents two ways in which midwives ensure that the expectant woman is ready to receive instructions on self-care: asking whether she already knows the instructions, and connecting the instructions with a concern she has expressed.

In addition to professionals’ practices, the inherent problems of requesting and giving advice are revealed in the ways in which clients receive the advice. Clients may deal with the problematic invocation of the epistemic asymmetry between the giver and the recipient by describing their previous knowledge about the issue at hand, both when requesting advice (Heritage & Sefi 1992: 370–373) and when receiving it (Heritage & Sefi 1992: 402–409; Kawashima 2010: 210–212). Subsequently, if the client resists the given advice by not acknowledging it appropriately, the sequence of advice-giving may be difficult to terminate (Heritage & Lindström 2012a: 175–177, 189).
MCH professionals’ expert role also includes the task of giving information in such a neutral way that the client is able to make informed decisions concerning various medical procedures. McKenzie (2009) suggests that in this kind of informed-choice discussion, both the professional and the client are supposed to be experts. On the one hand, midwives give information and play an expert role in relation to the issues at stake. On the other hand, it is the woman who makes the decision, and thus she is treated as the expert about her own life, and the midwife is supposed to support her in whatever she decides. Although midwives cannot give the woman advice that contradicts her decision, they can treat the decision as not yet informed. (McKenzie 2009: 169–170.) In addition, Pilnick (2004, 2008) demonstrates some challenges in making informed choices about antenatal screening. Although participation in screening is presented as something that has to be decided by pregnant women, midwives often initiate the discussion about the screening after they have presented routine tests, and thus antenatal screening may be seen as part of the routine (Pilnick 2004: 455–456; 2008, 522–523). This sequential placing of the discussion about screening, alongside other interactional features, leads to a situation in which, according to Pilnick (2004, 2008), clients give their consent for screening or decide between a new and an old screening method, but do not actually make a choice about whether to participate in screening or not.

The supportive or ‘befriending’ (Heritage & Sefi 1992: 365) role of MCH professionals stands out in McKenzie’s (2010) and Plumridge et al.’s (2009) studies, for example, which emphasise the importance of ‘small talk’ between MCH professionals and clients. McKenzie (2010) suggests that through casual talk about the client’s everyday life, the midwife and the woman reveal what is new information and what was previously known, and in this way they build their relationship and situate themselves within it. Plumridge et al. (2009: 1190–1192) demonstrate that the nurse’s encouraging talk to the baby or infant during the immunisation event may reassure parents and children alike, and also inform them on how to act during the immunisation.

Bredmar and Linell (1999) suggest that midwives support expectant mothers by reassuring them that their pregnancy is proceeding normally. For example, midwives may ask the woman about some symptoms in order to be able to state that they are normal (Bredmar & Linell 1999: 246–247). In cases of deviating test results, midwives also work to mitigate the importance of the results in order to reassure and not upset the woman (ibid.: 250–253). Nishizaka (2010b: 311–314, 2013) also points out the multimodal organisation of reassurances about normality during prenatal ultrasound examinations. For example, although midwives and
obstetricians rarely gaze at the pregnant woman’s face when conducting the examination, they may do so when giving an estimation of the foetal weight that indicates the normal development of the foetus (Nishizaka 2013: 81–82).

Reassurance and support may also be provided through affiliation (Bredmar & Linell 1999: 256), of which Heritage and Lindström (1998, 2012b) offer an example. In their example, a mother describes her feelings of not bonding with her newborn baby in several successive encounters. Heritage and Lindström (1998: 418–434, 2012b: 271–272) demonstrate that although the health visitor offers sympathetic responses and optimistic reassurances about the normality of such feelings, the mother is reassured only after the health visitor abandons the frame of medical expertise and shares her own similar experiences, not only of her feelings towards her baby but also of the ‘moral stigma’ attached to those feelings.

Heritage (2002) and Raymond (2010) also point out the importance of question design for building the relationship between the health visitor and the client. Health visitors design their questions to be suitable to each client’s situation, thereby showing that they remember what the client has previously said (Heritage 2002: 326–329). Moreover, if there is no reason to assume otherwise, questions about childbirth, for example, are designed to presuppose no-problem responses (ibid.: 322–326). With differently designed questions the health visitor also distinguishes between the questions that come from the bureaucracy represented by the questionnaire, and those that come from her personal interest (Raymond 2010: 96–101).

Practices by professionals seem to be the focus of many of the CA studies of MCH care. However, Nishizaka’s (2010a, 2011) studies provide examples that emphasise the client’s interactional practices. As a starting point, Nishizaka (2010a: 283, 2011: 247) states the difference between primary care encounters and prenatal check-ups: the client does not come to the check-up because of any acute concern, and thus there is no established structural place in the organisation of the visit for presenting concerns. However, clients do initiate discussion of their concerns, for example in relation to incipient activities (Nishizaka 2010a) or as an expansion on the professional’s routine questions (Nishizaka 2011).

Although previous studies of MCH services have covered a great number of different aspects of MCH care, less attention has been given to the production of the clients’ roles both as participants in the interaction and as clients and parents, or to multimodal analysis of the practices. This study adds to previous knowledge by providing an analysis of these areas. It should also be noticed that the different ways of organising the services in different countries may have an impact on the
interactional practices. Thus, this study adds to the field by analysing MCH services in Finland in which MCH care has not been previously studied using CA. Further, many of the previous studies summarised in Table 1 use data that has been collected in 1980s or 1990s. Although interactional data and results on interactional practices do not become outdated quickly, various changes in the policies guiding the aims and tasks of MCH care have taken place in 20–30 years and thus, the interactional practices related to these aims might well have changed. For example, policies related to supporting fathers in MCH services have been introduced increasingly in Finland since the end of 1990s (MSAH 2008: 13–15). Thus, especially when analysing the production of parenthood in MCH clinics it is reasonable to use data collected after the introduction of the policies related to supporting fathers.

2.2 Participation in multi-party healthcare encounters

When technical opportunities for video-recording were not yet easily available, the recordings of interactions on the telephone offered an important opportunity to study data in which the analyst had access to all the same features of interaction as the participants themselves (Schegloff 2002: 288; Heritage 1989: 31–32). Thus, many of the early conversation analytic studies utilised recordings of interactions on the telephone as data and were thus based on dyadic interactions (Haakana, Laakso & Lindström 2009: 18–20; Heritage 1989: 31–32). However, Sacks, Schegloff and Jefferson noted in their groundbreaking article in 1974 that the organisation of turn-taking in multi-party interactions has some distinct features when compared to dyadic interactions (Sacks, Schegloff & Jefferson 1974: 712–714; see also Haakana et al. 2009: 20). Since Goodwin’s (1979, 1980, 1981) analyses on data from multi-party everyday interactions, various studies on everyday (Lerner 2003) and institutional settings for example, classrooms (Kääntä 2011; Mortensen 2008), workplace meetings (Ford 2010; Mondada 2007), political meetings (Mondada 2013) and group therapy (Halonen 1999) and meetings of recovering alcoholics (Arminen 1998) have provided knowledge on the organisation of turn-taking and participation in multi-party interaction.

Since this study focuses on the production of the roles of mothers and fathers as participants in the interaction and as parents, I use as data primarily encounters in which both the mother and the father are present. Participation and the roles of clients in multi-party interactions have been somewhat neglected themes in
previous CA studies of MCH encounters. Most of the studies of interaction in maternity and child healthcare encounters summarised in Table 1 analyse dyadic interaction, namely encounters between the MCH professional and the mother. Of course, after the baby is born, the encounters are at least triadic, as the baby is also present; but interactions in encounters with a baby are typically analysed as dyadic, i.e. between the adult participants, understandably taking into account the limitations on the baby’s ability to speak. However, some CA studies analyse MCH encounters involving multiple professionals or multiple adult clients. For example, in Nishizaka’s (2007) data the prenatal check-ups included not only a midwife and a client but also a student midwife. Furthermore, although Heritage and Sefi (1992: 360) and Raymond (2010: 88) for example first present their data as including health visitors’ visits to mothers, later it is mentioned that other adults may also have been present (Heritage & Sefi 1992: 365), and the extracts analysed include cases in which the father or grandmother is present (e.g. Heritage & Sefi 1992: 367, 373–375, 393–394; Raymond 2010: 92, 101–102). Thus first of all, the data from MCH encounters typically include only one adult client. Second, although some of the studies include data with multiple clients, the organisation and negotiation of the potentially varying roles of the multiple clients is not the main focus in any of these studies.

In the following, I will widen the focus from MCH clinic encounters and summarise qualitative2 studies concerning participation in interaction and the roles of clients in relation to each other in all kinds of healthcare encounters with multiple clients (or a client with a companion), including doctors’ or nurses’ encounters with children (Aronsson & Rindstedt 2011; Buchbinder 2009; Clemente 2009; Stivers 2001), family therapy (Hutchby & O’Reilly 2010; O’Reilly & Parker 2013; O’Reilly 2006; Parker & O’Reilly 2012; Suoninen & Wahlström 2009), couples therapy (Buttny 1990; Muntigl & Choi 2010), childbirth (Näslund 2013), AIDS counselling (Peräkylä & Silverman 1991) and genetic counselling (Sarangi 2010). Previous qualitative studies concerning questions of participation in interaction and the roles of clients in relation to each other in multi-party healthcare encounters offer information on the following (partly overlapping) themes: 1) professionals’ and clients’ interactional practices that enable or support the participation of a specific client; 2) professionals’ and clients’ interactional practices that prevent or hinder the participation of a specific client; 3)

2 The studies use methods such as conversation analysis, discursive psychology and discourse analysis, or a combination of these.
professionals’ and clients’ interactional practices through which the participants negotiate and produce the clients’ roles or positions in relation to each other or to the professional. Next, I summarise the results of previous studies in relation to these three themes.

First, healthcare professionals’ interactional practices that enable or support the participation of a specific client are presented for example by Stivers (2001), who analyses speaker selection in paediatric encounters. Stivers (2001: 259–260) shows that doctors can address a question soliciting problem presentation to the child patient by using either the child’s name as an address term or a second person pronoun. Addressing the problem solicitation to children, as well as engaging them in discussion before the problem solicitation, often leads to their presenting the problem (ibid.: 268–271). Likewise, Aronsson and Rindstedt (2011: 130–131) show that the doctor may address the child by name and also pose ‘ceremonial’ questions to the child, not to gather information but just to engage the child. Focusing on an encounter in a diabetes clinic that involves both a child patient and a parent, Buchbinder (2009: 179–183) shows that the nurse practitioner gives the child an opportunity to influence the organisation of the encounter and orients to the child’s autonomy in describing problems, even when the mother participates in the discussion. In addition, O’Reilly and Parker (2013: 501–503) suggest that family therapists can support children’s engagement by validating the challenges they face in the therapy, for example when they need to listen to discussions about their own behaviour.

Stivers’s (2001), Aronsson and Rindstedt’s (2011), Buchbinder’s (2009) and O’Reilly and Parker’s (2013) studies focus on settings with children (or adolescents) and adults and on how their participation in the interactions is coordinated. Heritage’s (2002, 2005) observations about health visitor encounters, on the other hand, concern a setting with two adult clients. Heritage (2005: 112–113) shows that health visitors open the discussion during the first visits differently when the mother is alone compared to cases in which the father (or other significant person) is present. When the mother is alone, the health visitor focuses on starting to build the relationship with her, and poses personal questions, for example about her condition or the birth. When the father is present, however, the health visitor starts

3 The article by Heritage published in 2005 is not listed in Table 1 summarising previous CA studies of MCH services, as it concerns not MCH services but the conversation analytic approach to institutional interaction. Its observations from health visitor data are presented as an example of how choices between different types of work practice can tell us something about institutional ideologies (Heritage 2005: 112).
with questions or compliments about the baby, and in this way the father is not excluded from the discussion. (Heritage 2005: 112–113.) Furthermore, when the father is present, the health visitor can use the standardised questionnaire both to engage him and to justify the questions that are only addressed to the mother, whereas when the mother is alone, the questionnaire is typically treated only as an interruption to the main tasks (Heritage 2002: 316–321).

Clients can also enable and support their own participation or that of another client. In healthcare encounters involving a child patient and a parent, parents can support children's participation by giving them space to talk, even if they have difficulties producing an answer to the healthcare professional’s question (Stivers 2001; Buchbinder 2009: 183). Stivers (2001: 271–277) demonstrates that although the parent quite often ends up answering the questions addressed to the child, these cases are the result of an interactional negotiation between the participants. Moreover, Clemente (2009) presents the child’s strategies in soliciting the parent’s help to answer while still remaining the principal speaker in the paediatric encounter. The child may ask the parent verbally or non-verbally to confirm an uncertain answer or part of the answer, or to participate in producing the answer, but by (dis)confirming or modifying the parent’s response, for example, the child can restrict the parent’s participation (Clemente 2009: 878–883).

Similarly, multiple adult clients can create space for each other’s participation. Sarangi (2010: 247) discusses how a client in genetic counselling asks for her partner’s view on a particular topic in order to create a space for their discussion to take place in the presence of the professionals. In Muntigl and Choi’s (2010: 336, 339–343) study of couples therapy, one client’s statement that they do not remember something that the therapist has asked about creates an opportunity for the other client to talk about the topic in question, since the couple’s shared history typically means that the second client also has first-hand experience of the matter at hand.

The second theme in the studies concerning participation and the roles of clients is professionals’ and clients’ interactional practices that prevent or binder the participation of a specific client. As was mentioned earlier, in Stivers’s (2001) study the problem solicitation that was addressed to children encouraged them to present the problem. On the other hand, doctors may also solicit the problem presentation from the parent, for example by referring to the child in the third person, and in such cases it is always the parent who presents the problem. If the question is obscure in its selection of the next speaker, it is also typically the parent who presents the problem. Thus addressing the question that solicits the problem
presentation to the parent, or to none of the participants unambiguously, may hinder the child’s participation in the paediatric encounter. (Stivers 2001: 258, 262–268.) Moreover, all participants in an encounter with a child patient and a parent may hinder the child’s participation or autonomy: the child may ask for the mother’s assistance, the mother may bring up her own concerns related to the child’s condition, and the nurse practitioner may suggest and discuss with the parent a solution that departs from the child’s viewpoint (Buchbinder 2009: 182–190).

O’Reilly (2006: 564) suggests that in family therapy, children may have difficulties getting space to talk because adults restrict their right to speak. Parents and therapists tend not to acknowledge children’s interruptions, and parents may even tell them to be quiet if they interrupt with something that is not related to the ongoing discussion (ibid.: 554–561). If parents in paediatric encounters typically seek to negotiate over whether they will answer questions addressed to children (Stivers 2001), in family therapy parents may respond to questions addressed to children without giving the child space to answer (Hutchby & O’Reilly 2010: 52–56). In this way parents get an opportunity to highlight their own reasonable parenting compared to the child’s misbehaviour (ibid.: 56–57). The influence of parents’ agendas leads us to an issue that may complicate multi-client healthcare encounters: professionals need to take into account both the children’s and the parents’ viewpoints. In family therapy, the therapist has to both engage children in discussion about their misbehaviour – for example, by asking for their version of events – and also to show that they believe the parents’ version of events (Parker & O’Reilly 2012: 468–471). In the diabetes clinic encounter with a child patient, the nurse practitioner needs not only to support the child’s autonomy, but also to take into account the potential for getting relevant information about the child’s condition from the parent (Buchbinder 2009: 183–187).

The third theme observable in qualitative studies of participation in interaction and clients’ roles in multi-party healthcare encounters is the interactional practices through which professionals and clients negotiate and produce the clients’ roles or positions in relation to each other or to the professional. For example, Peräkylä and Silverman (1991) analyse cases in which counsellors, patients and their companions talk about the other client’s experiences in AIDS counselling. When talking about one of the client’s experience, participants can demonstrate their orientation to the specific role of ‘the owner of the experience’, for example through gaze direction and body posture (Peräkylä & Silverman 1991: 453–460). Buttny (1990: 232–235) shows that in a couples therapy session, the typical
participation framework of one client’s talk about their problems to the therapist restricts the other client’s opportunity to respond to criticism expressed by their spouse. Also in relation to responses to potential criticism, Aronsson and Rindstedt (2011: 133–136) discuss how parents in paediatric settings can align themselves with doctors by clarifying or upgrading doctors’ recommendations addressed to the child, and thus treat the recommendations as being essentially addressed to them.

In addition to interactional roles, the clients may also produce their identities in and through the interaction during healthcare encounters, as demonstrated by Näslund (2013), Suoninen and Wahlström (2009) and Parker and O’Reilly (2012). Näslund (2013: 57) discusses how mothers, fathers and midwives at the moment of childbirth treat the father’s cutting the umbilical cord as a ritual that constructs fatherhood, whereas the same act by the midwife does not have a special meaning. Fatherhood is also in focus in Suoninen and Wahlström’s (2009) study, which analyses how in family therapy the therapist’s and clients’ actions place them in specific positions in relation to each other and build various potential identities for the clients. Parker and O’Reilly (2012: 462–467) also analyse family therapy encounters, and show how parents use various interactional practices to build their own identity as good parents when talking about their children who are also present. Sarangi (2010: 241, 252) points out that clients in genetic counselling encounters position themselves not only in relation to the participants who are present during the encounter, but also to family members who are absent.

These three themes concerning participation in interaction and clients’ roles are all analysed in this dissertation. I concentrate on the professionals’ interactional practices, but the clients’ actions are also taken into account. The multi-client encounters analysed in the studies presented above differ in quite significant ways from MCH clinic encounters at which both parents are present. Compared to paediatric encounters with very young patients in particular, the setting in the MCH clinic is different, as both clients – not including the baby in child health clinic encounters – are adults, and thus are equally competent participants in the interaction. In addition, unlike settings in which the patient – a child or an adult – and a companion are both present, in the MCH clinic both parents are regarded as clients. (In maternity clinic encounters the mother’s role is more central during the physical examination, as she is the one carrying the baby, and thus at least those parts of the encounters recall situations involving a patient and a companion.) Moreover, MCH clinic encounters differ from couples therapy encounters involving two adult clients in that MCH is preventive care, whereas therapy is not. Only Heritage (2002) analyses situations that are very similar to the MCH clinic encounters.
encounters studied in this dissertation. However, Heritage (2002) does not focus on cases with both parents present, but analyses health visitor-mother encounters in general and makes some observations about cases with both parents present. Thus a focus on analysing MCH clinic encounters with both parents present offers new insights into participation and clients’ roles in multi-client healthcare encounters.

2.3 Approaches to studying the gaze in healthcare encounters

Many of the CA studies of MCH care summarised in Table 1 use audio-recorded encounters as data. Furthermore, few of the studies using video-recorded encounters as data (Nishizaka 2007, 2010b, 2013) analyse the data from a multimodal perspective, treating the visual aspects of interaction as an important focus of the analysis. The focus on only verbal aspects means that some important multimodal features of interaction may be left unexamined. In this study, I pay special attention to public health nurses’ gaze direction during MCH clinic encounters. As previous research concerning the gaze in MCH encounters is limited, in this section I summarise previous research on professionals’ and clients’ gazes in all kinds of healthcare encounters.4 The conversation analytic background

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4 To get a comprehensive picture of previous research analysing the role of participants’ gaze direction during healthcare encounters between professionals and clients, I conducted literature searches in 12 databases in the fields of social sciences, health sciences and humanities through four publishers: 1) EBSCOHost: Academic Search Premier; CINAHL; Humanities International Complete; 2) Ovid: PsycARTICLES Full Text; Ovid MEDLINE(R); 3) ProQuest: Applied Social Sciences Index and Abstracts; Linguistics and Language Behavior Abstracts; ProQuest Dissertations and Theses A&I: the Humanities and Social Sciences Collection; PsycINFO; Social Services Abstracts; Sociological Abstracts; 4) Elsevier: Scopus. I used the search phrase (gaze OR ‘eye contact’) AND (‘healthcare’ OR ‘medical care’ OR doctor OR nurse OR physician) and limited the searches to peer-reviewed texts published between 2000 and 2013. In all the databases apart from PsycARTICLES and MEDLINE(R), the search phrases were limited to either the abstract or the title and keywords, according to the options in the databases. The searches resulted in 779 hits, of which I included 67 articles for a closer review. I excluded a) duplicates; b) items other than scientific research articles; c) articles in languages other than English; d) articles in which the word ‘gaze’ had some other, non-interactional meaning (e.g. ‘medical/clinical gaze’); e) studies focusing on the diagnosis or treatment of medical conditions which might include e.g. problems in communication or dysfunction in eye contact; f) studies focusing on the gaze in other than interactional situations or in interactions other than those e.g. between professionals or between a parent and a child; g) studies focusing on the teaching of communication skills for healthcare professionals or students, or evaluating students’ communication skills; and h) cases in which the search words were not mentioned in the title or abstract (this concerned the two databases in which this limitation had not been set during the search process).
for analysing gaze linked to the interactional phenomena analysed in this dissertation is presented in Chapter 3.1.2.

The importance of eye contact between the professional and the client in healthcare encounters has been addressed in studies based on interviews (e.g. Kiguli, Mafigiri, Nakigudde, val Dalen & van der Vleuten 2011). However, interview studies cannot analyse the gaze in detail as a part of the interaction. Recordings of interactions give more solid opportunities to analyse the interaction in detail (Heritage 1984: 234–238). Nevertheless, studies using recordings of interactions also take different approaches to interaction and gaze/eye contact. Most such studies use primarily quantitative methods, and these studies can be roughly divided into four categories with regard to their focus.

First, the quantitative studies using recordings as data and addressing the gaze in healthcare encounters may focus on the quality, features or content of interactions between the professional and the client during the encounter. For example, the frequency of gazing at the other participant can be one of the measured features of non-verbal behaviour in the interaction (Roberts & Bucksey 2007). Second, quantitative studies may focus on the influence of a new working method or tool on the interaction between the professional and the patient. In these studies, analysing the gaze can for example be a way to analyse the use of electronic medical records by measuring the time taken to gaze at the screen, as in Margalit, Roter, Dunevant, Larson and Reis’s (2006) study. The third theme covered in the quantitative studies is the influence of culture or the professional’s and client’s characteristics on the interaction; the percentage of the professionals’ gaze that is directed towards the client can be one of the features measured in the interaction, as in van den Brink-Muinen et al.’s (2003) study. Fourth, quantitative studies using recordings as data may analyse the influence of the gaze as one interactional element, or the influence of an interactional style that includes the element of the gaze, on a specific outcome, either within or outside the interaction itself, or may focus on some combination of these (e.g. Dijkstra, Albada, Klöckner Cronauer, Ausems & van Dulmen 2013).

Quantitative studies analysing recordings of professional-patient encounters provide valuable information, as they are able to utilise very large amounts of data by coding participants’ behaviour, and thus are able to draw conclusions about effects, associations and differences between different outcome measures and settings. However, when gazing is measured only at certain interval points and/or in terms of overall time per consultation, it is not possible to analyse the gaze in detail as a part of verbal and non-verbal actions and interactional practices (see the
critique of the measurement of laughter per time unit in Schegloff 1993: 104–105). The potential deficiencies of using only quantitative measurements of the gaze are illustrated in Gorawara-Bhat and Cook’s (2011) study of associations between the physician’s eye contact with the patient and patient-centeredness. The authors analysed the same video-recorded data using both quantitative measurements and qualitative observations of the gaze, and concluded that consultations measured as having a ‘low’ level of eye contact can be misleadingly rated as patient-centred if it is not taken into account that the physician’s verbal behaviour can be coded as indicating listening even when the physician is not gazing at the patient (ibid.: 445).

All in all, the use of quantitative methods to study interaction does not in itself inhibit the analysis of the gaze in association with interactional practices, but it is a measurement of the gaze in quantitative terms. It is possible to take a detailed variable of the gaze by taking into account its relation to a specific interaction practice in a quantitative study. A great demonstration of this is a recent study by Stivers (2012), in which one variable used to analyse when children answer to physicians’ questions is the physician’s gaze, defined as ‘during the asking of the question the physician looked at the child’s face’ (ibid.: 6).

In this study the gaze is analysed in relation to interactional practices, and the approach is qualitative. Previous qualitative studies that use recordings of healthcare encounters as data, and that analyse the gaze either as their primary focus or as one element of interaction among others, can be divided into three categories. First, qualitative studies have analysed the non-verbal management of the context (Bonnin 2013) or certain stages during consultations, such as openings (Robinson 1998), closings (Park 2013), and transitions from history-taking to physical examination (Robinson & Stivers 2001).

Second, qualitative studies may focus on the effects of gazing at medical records or using a computer (Alsos, Das & Svanæs 2012; Booth, LeCouteur & Chur-Hansen 2013; Rhodes, Small, Rowley, Langdon, Ariss & Wright 2008; Ruusuvuori 2001), including tele-consultations (Sävenstedt, Zingmark, Hydén & Brulin 2005). For example, Ruusuvuori (2001) demonstrates that the doctor’s gaze direction away from the patient at certain points during the problem presentation is related to the disfluency of the patients’ problem presentation.

The third theme addressed in qualitative studies using recordings as data and analysing the gaze as a part of interaction is participation in multi-party healthcare settings. In these studies it has been suggested that the professionals’ gaze at the patient/client is relevant, for example, in facilitating the building of a relationship with the child in a child healthcare clinic encounter (Hydén & Baggens 2004: 76–
77), in establishing cooperation with regard to storytelling in team meetings in acute psychiatric inpatient care (Vuokila-Oikkonen, Janhonen & Väisänen 2004), and in managing the interaction during a doctor’s consultation with an interpreter (Pasquandrea 2011). Moreover, Cahill and Papageorgiou (2007: 869–870) suggest that during paediatric consultations, parents are more likely to give the child patient space to answer if they see that the doctor is gazing at the child.

In this study, the public health nurse’s gaze direction is analysed in relation to participation in a multi-client encounter, that is, when both the mother and the father are present. The previous studies presented above that address the gaze in relation to the regulation of participation have not addressed an equivalent setting to that used in this study. Previous studies have analysed settings with two professionals (namely a doctor and an interpreter, Pasquandrea 2011), multiple professionals, a patient and a companion (Vuokila-Oikkonen et al. 2004), and a child and a parent (Cahill and Papageorgiou 2007; Hýden and Baggens 2004), whereas in this study the gaze is analysed in relation to the management of participation in a setting with two adult clients.
3 Methods, data and research questions

In this chapter I present the method, conversation analysis (CA), the specific research questions and the data used in this study. First, I give an overview of the general principles of CA and describe the particular approaches within CA that I use in the articles. While presenting the methods I also make some general points about their relevance to the articles, and in the second section the detailed research questions are outlined, using the concepts presented in relation to the methods. In the third section, I describe in more detail the data and the sequences in focus in each article, and the fourth section focuses on research ethics.

3.1 Conversation analysis as the method for this study

In this study I analyse the ways in which supporting parenthood is actualised in and through minute practices of interaction. The method of CA enables this kind of analysis. CA builds on the ethnomethodological approach to social action developed by Harold Garfinkel (1967/1984), which sees people as jointly recognising and producing the social world as understandable and meaningful by using moment-by-moment socially shared methods (Heritage 1995: 391–393; Heritage 1984; Maynard & Clayman 2003). What this means for conducting the analysis, and how CA conceptualises the organisation of interaction, is presented in this section.

3.1.1 Basic principles of conversation analytic research

To analyse interactional practices, conversation analytic research utilises naturally occurring interaction that is either audio- or video-recorded. The insistence on using this kind of data comes from the recognition of people’s inability to imagine, perform or remember interactional phenomena as they occur with all their detail in natural interaction. (Heritage 1984: 234–238; Heritage 1995: 395–396; Sacks 1984: 25–26.) Since one of the fundamentals of CA is that no detail of interaction can be
assumed to be irrelevant for the participants (Heritage 1984: 241–243), the data and analytic tools have to make the details available for the analysis. Using recordings as data gives an opportunity to watch or listen to the situations in focus over and over again, and in this way to pay attention to even the smallest details of interaction (Heritage 1984: 234–238; Sacks 1984: 26). The transcription conventions developed by Gail Jefferson (2004) and used in CA also help to take all of the details into account, as they include the marking of such features as pauses, overlapping talk and intonation (see also Schegloff 2007: 265–269).

The analytic process in CA is inductive, including the detailed analysis of a systematic collection of sequences concerning a certain phenomenon and a search for similarities and differences between cases. The result of the analysis is typically a detailed description of a distinctive interactional practice to which participants orient as relevant. Cases that deviate from the general pattern are also analysed in detail, and potentially the description of the practice is modified until the deviant cases can be explained in relation to the pattern. (Arminen 2005: 71–74; Heritage 2011: 213–222; Sidnell 2013: 86–92; Stivers & Sidnell 2013: 2.)

The core of CA is the analysis of everyday interaction (Heritage 1984: 238–240), although it has also been widely applied to institutional settings, as in this dissertation. However, when analysing an institutional setting such as an MCH clinic encounter, one cannot automatically assume that such a setting is different from everyday interaction. Instead the analysis needs to address the ways in which the interaction during the encounter potentially differs from everyday interaction, and how the participants orient to the institutional setting as relevant for their actions. (Arminen 2005: 16–20; Heritage 2005: 106–110.)

In CA research, interaction is seen as structurally organised (Heritage 1984: 241; Sacks 1984: 22–23). Of course people have different personalities and motives, which can have an effect on the way they communicate, but the kinds of structural organisation to which CA refers are not influenced by individual differences (Heritage 1984: 241), and at least some instances of this organisation also seem to be fairly universal within various cultures (see Stivers et al. 2009 for a comparative study of cultural variations in the organisation of turn-taking). The dimensions of this orderliness that are relevant to this dissertation deal with the organisation of turn-taking and sequences, which I briefly introduce next.

The term sequence organisation refers to the ways in which turns accomplish courses of action (Schegloff 2007: 2). Participants in interaction constantly monitor the kind of action that is being done (ibid.: 2–3). All the turns in interaction both orient to the context built by the previous turns and also reshape the context for
the following turns (Heritage 1984: 242; Pomerantz & Fehr 1997: 69; Stivers 2013: 191). The most basic unit around which many types of sequence are formed is an adjacency pair (Schegloff 2007: 9), defined as two successive turns by different participants in which the first pair part specifies a range of possible types of action done in the second pair part. Common adjacency pairs include, for example, question and answer, greeting and greeting, invitation/offfer and acceptance/refusal. (Schegloff & Sacks 1973: 295–296; see also Heritage 1984: 245–246; Schegloff 2007: 13–14; Stivers 2013: 192–193.) Naturally, a first pair part is not always followed by a relevant second pair part in conversations. However, what is significant is that participants orient to the normativity of the adjacency pair structure when deviations from that structure are treated as accountable. (Heritage 1984: 246–253.)

The analysis of sequence organisation and adjacency pairs forms the basis of all three articles in this dissertation. Collections of question-answer pairs or larger segments comprised around them are analysed in Articles 1 and 2. In addition, in Article 3 the focus is on formulation-decision pairs, in which formulations refer to turns that summarise or give an inference of what has been previously said by the other participant (Heritage & Watson 1979, 1980). With regard to question-answer pairs, the analysis also focuses on question design in Article 1. Question design includes dimensions that concern the ways in which questions set agendas, invoke presuppositions and preferences, and suggest epistemic stances (Heritage 2010: 44–51; Boyd & Heritage 2006: 154–162; Hayano 2013: 399–408). The participant answering the question may accept or resist the agenda, presupposition, preference or epistemic stance suggested by the question design (Boyd & Heritage 2006: 154–155; for the design of responses to questions see e.g. Hakulinen 2001; Raymond 2003; Sorjonen 2001: 33–92; Stivers & Hayashi 2010; Stivers & Heritage 2001; and a summary by Lee 2013). The ways in which questions by public health nurses invoke presuppositions of parenthood and responses by parents are the focus of analysis in Article 1.

Besides sequence organisation, a relevant organisation for this study concerns turn-taking, that is, the ways in which participants in interaction manage who speaks and when. Two elements are important for turn-taking organisation: one is related to how turns are constructed and when they are complete, and the other is linked to how speaker selection or turn-allocation is managed (Sacks et al. 1974: 702–703). First, each turn-at-talk is seen to be composed of one or more turn constructional units (TCU) (a word, a sentence and so on), which are the smallest units that can be understood as making a complete understandable whole. Each TCU is then
followed by a transition relevance place (TRP) in which the change of speakership may occur, and turns are often designed in such a way that the TRP is projectable beforehand. (Ibid.: 702–703, 720–723; Clayman 2013.) Second, with regard to turn-allocation, participants have various techniques for selecting either another participant or themselves to speak next (Sacks et al. 1974: 716–720). In multi-party settings, explicit turn-allocation techniques for the current speaker to select the next include posing the first pair part of an adjacency pair and addressing the next speaker with an address term or gaze. Tacit turn-allocation occurs for example when the speaker initiates a repair or poses a first pair part to which only one of the participants is eligible to respond. (Ibid.: 716–718; Hayashi 2013: 168–173; Lerner 2003.) In multi-party settings it is also possible to address multiple participants at the same time by addressing them as an association, as one party (Lerner 1993; Schegloff 1995: 32–35). In this dissertation, I analyse turn-allocation in sequences in which the public health nurse poses a first pair part, a question, and verbally addresses both parents by using a plural pronoun (Article 2). The focus is on the simultaneous application of another turn-allocation technique, namely the gaze, and in the ways in which practices by the public health nurse and the parents produce different participation roles for themselves and each other.

3.1.2 Approaches within conversation analysis used in this study

In this study I use the method of CA and follow all the basic principles described above. However, there are three ways of complementing or focusing the analysis that are utilised in the articles. First, I analyse the data from a multimodal perspective (Deppermann 2013; Stivers & Sidnell 2005), taking into account not only the verbal aspects of the interaction but also the public health nurse’s gaze direction (Articles 2 & 3). Second, quantitative analysis is used as a preliminary way of organising the basis for the qualitative analysis (Article 2). Third, when studying the production of parenthood (Article 1), I use approaches outlined within feminist CA. In the following, I briefly present the relevance of these approaches for the analyses.

First, in two of the articles the focus is not only on the participants’ verbal interaction, but also on the public health nurse’s gaze direction. Rossano (2013: 311–324) has categorised previous CA research on the gaze into studies that focus on the functions of gaze in 1) producing participation roles, 2) regulating turn-taking, turn-allocation and sequence organisation, and 3) forming social actions.
This study contributes to the first two categories by analysing the role of public health nurses’ gaze in turn-allocation and the participation roles of parents, as well as in engaging parents to elaborate on their problems.

Sacks et al. (1974: 717) mentioned in their groundbreaking paper on turn-taking organisation that the gaze is a turn-allocation device when linked with the first pair part of an adjacency pair. Likewise, Goffman (1981: 133) suggested that the speaker often points to the addressed recipient in a multi-party setting with ‘visual cues’. Lerner (2003: 179–182) has further analysed the gaze in turn-allocation, and points out that although it is an explicit turn-allocation device, it is also vulnerable, as it has to be seen by both the selected participant and the other participants. The gaze, among other forms of speaker selection, has also been analysed with CA for example in paediatric settings by Stivers (2001, 2012) and in classroom interaction by Kääntä (2011). The analysis in Article 2 helps to demonstrate the utilisation of the gaze as a turn-allocation technique in MCH encounters.

Further, the analysis presented in Article 3 utilises the previous CA observation that participants can display their engagement, the focus of their interest and attention, with their gaze direction (Goodwin 1981: 95–125; Heath 1984; see also Robinson 1998; Ruusuvuori 2001). In addition, Rossano (2012: 308–309, 2013: 319–322) has pointed out that gaze withdrawal is related to closing courses of action. This finding is used in Article 3 when presenting a practice used to topicalise parents’ problem descriptions.

The second way of complementing basic methods of CA is to utilise quantitative analysis. CA is a qualitative method, and it has been suggested that combining it with quantitative analysis involves some risk. Schegloff (1993: 103–110) points out for example, that one has to be careful in defining on the one hand, which cases are counted as representing the interactional phenomena in focus, and on the other hand, what is the environment in which the interactional phenomena in focus can occur. In Chapter 2.3, in line with Schegloff (1993), I briefly mentioned the deficiencies related to analysing gaze in health care encounters and defining the environment in relation to time rather than the ongoing actions.

Since Schegloff’s (1993) reflections, conversation analysts have remained cautious about the risks of quantification but also the great potential of it has been noticed; already in 1999 Heritage pictured the future in which quantitative analyses are increasingly linked to CA. Arminen (2005: 238), Heritage (1999: 71–72) and Peräkylä (2011: 377) have distinguished for example the following research areas in which quantification can be beneficial for CA studies: 1) the differences or changes
in interactional practices can be analysed against the differences in the settings, and 2) an interactional practice can be analysed as a variable that is connected to some other interactional variable (or outcome) in an institutional setting. Examples of the first branch include comparative studies on the historical changes in the ways journalists pose questions to presidents (Clayman & Heritage 2009) and on professionals’ responses to troubles-telling in doctors’ and homeopaths’ encounters (Ruusuvuori & Voutilainen 2009: 218; see also Ruusuvuori 2005, 2007). Many examples of the second branch come from health care settings and these studies analyse for instance, the interactional outcomes of doctors’ different ways of a) communicating the diagnosis (Peräkylä 2006), b) presenting the opening question at the beginning of the encounter (Robinson & Heritage 2006; Stivers 2001), and c) coordinating their gaze while patients are presenting their problems (Ruusuvuori 2001). In Peräkylä’s (2006), Ruusuvuori’s (2001) and Stivers’s (2001) studies the outcome can be observable in the on-going interaction, in the patients’ responses to the doctors’ actions. However, in Robinson and Heritage’s (2006) study, the outcome is defined in more general terms as they measure patients’ satisfaction with questionnaires. During the recent years CA has also been used to develop a categorisation of video-recorded data from paediatric settings that served as the basis for statistical analyses (Stivers 2012; Opel et al. 2013). In addition, in Heritage et al.’s (2007) study previous CA knowledge was used as the foundation for a quantitative intervention study concerning the solicitation of new concerns in doctor-patient encounters.

In this dissertation the core of the analyses remains qualitative and the quantification and cross-tabulation are used in order to get a comprehensive view of general patterns in the data, and systematic and detailed CA is used both before and after the quantitative analysis to investigate what happens in interaction and thus what lies behind the pattern and deviances from it (Article 2). Thus the participants’ orientations remain the focus of the analysis, and the cases to be counted are defined on the basis of qualitative analysis.

The third way of focusing CA methods in this study is to apply the ideas formulated within feminist CA (Kitzinger 2000, 2008). An important starting point for CA research is that all participants in interaction can be characterised in relation to an infinite number of categories related to, for example, gender, age, profession, sexuality, religion and so on; thus the analysis cannot assume that any particular characterisation is relevant for the participants simply because it is accurate (Schegloff 1991: 49–50, 1997: 165). Studies analysing gender differences in language use have indeed been criticised for taking gender categories for granted.
and using the assumptions of categories as the starting point for the analysis (Kitzinger 2000: 169–170; Speer & Stokoe 2011: 2–4; Stokoe 2000: 552–553, 556–558). However, gender as well as social problems related to gender and sexuality (such as heteronormativity, heterosexism, sexual harassment and gender inequality) can be studied in ways that still remain faithful to the basic principles and starting points of CA (see e.g. Garcia & Fisher 2011; Kitzinger 2000, 2005, 2006, 2008; Kitzinger & Frith 1999; Land & Kitzinger 2005; Ohara & Saft 2003; Tainio 2003; for critical arguments on the possibilities of combining CA and feminism, see also Whelan 2012; Wowk 2007).

In line with feminist CA (Kitzinger 2000, 2008), I use CA to study how parenthood is produced in and through interactions in MCH clinic encounters rather than, for example, how mothers and fathers talk in MCH clinic encounters. When analysing the production of parenthood, I analyse 1) the patterns of turn-allocation, and 2) the ways in which the presuppositions are invoked in question design, treating the participants’ actions and their orientation to sequence and turn-taking organisation as the fundamentals of the analysis. In the analysis of the presuppositions, I use CA in the same way as it is used to analyse the forms of question design relevant for invoking presuppositions about, for example, life style issues (Lindfors & Raevaara 2005: 142) or medical history (Boyd & Heritage 2006: 159–160). Although the gap between the policy and practice of shared parenthood outlined in Chapter 1.2 suggests that producing gendered presuppositions might be problematic, I do not claim that the participants necessarily orient to the production of gendered parenthood as problematic – or that they even orient to the production of gendered parenthood taking place. However, their orientation to the presuppositions of asymmetrical responsibilities for parents as natural and non-problematic does also provide an interesting point for analysis (Kitzinger 2000: 171–172).

The fact that all participants can be accurately characterised in relation to various categories also raises the question (Schegloff 1991: 49–50, 1997: 165) of how I should refer to participants in MCH encounters in research texts based on the data. I have decided to use the terms ‘public health nurse’, ‘mother’, ‘father’ and ‘parents’, as these are the categories that are relevant for the MCH encounters that I study. Another category term that would have been institutionally relevant is ‘client’. However, as there are two clients in the encounter, it seemed awkward to refer to them as ‘Client 1’ and ‘Client 2’, for example. In addition, at the institutional level MCH clinics often seem to use the terms ‘mothers’, ‘fathers’ and ‘parents’ along with ‘clients’, ‘women’ and ‘men’ in their recommendations
(Klemetti & Hakulinen-Viitanen 2013; MSAH 2004), as well as in the questionnaires aimed at parents (see Homanen 2013: 379–400 for the questionnaires). When choosing between the two gendered ways of characterising the clients as ‘mother/father’ and ‘women/men’, I preferred to use the categories related to parenthood rather than to gender, since after all parenthood is the reason why the clients are at the clinic. Moreover, references to the clients using the terms ‘mother’ and ‘father’ also occur somewhat often in my data, although there is no systematic analysis of the use of category terms in the encounters. Thus although the gender of the clients is already present in the way I refer to them in my research text, I do not assume that gender will be relevant for all sequences of interaction in MCH clinic encounters (as becomes evident in Article 3, which does not address the issue of gender in any way).

3.2 Research questions

The general research questions outlined in Chapter 1.5 were: 1) how fathers’ parenthood and their participation in interaction is supported compared to mothers’ through the regulation of parents’ participation roles in the encounter and the suggestion of particular responsibilities for each parent, and how these practices may be seen as producing gendered parental roles; 2) when parents have potential problems, how parenthood is supported through an orientation to talk about problems in a particular way. Drawing upon the concepts and ideas provided by my methodological framework presented above, I can now formulate the research questions in more specific terms. In this dissertation I ask:

1. What are the practices in and through which the participants engage parents in the interactions during encounters in MCH clinics?
   - How are mothers and fathers engaged in talking about issues concerning them both in maternity clinic encounters? (Article 2)
   - How are parents engaged in talking about their own and their children’s problems? (Article 3)

2. How and what kind of parenthood is produced in and through the interactions during encounters in MCH clinics?
   - How do the public health nurse’s practices of designing questions about parenthood invoke presuppositions of parenthood? (Article 1)
   - How do parents orient to presuppositions about parenthood? (Article 1)
- How do public health nurses’ practices of speaker selection between mothers and fathers implicate the primacy of a particular parent? (Article 2)

3. What is the function of the public health nurse’s gaze direction in the practices of engaging parents and producing parenthood? (Articles 2 & 3)

By analysing these questions, I am able to describe in detail the interactional practices in and through which supporting parenthood is actualised moment-by-moment in interaction, and whether and how these practices are also connected to the production of gendered parental roles.

3.3 The data and research process

In this dissertation I use video-recordings of encounters between public health nurses and clients as data. The data was collected in the course of the research project ‘Preventive healthcare in maternity and child health clinics: The changing professional-client relationship, teamwork and the family-centred model’, conducted at the University of Tampere (Ruusuvuori et al. 2008). The data was collected between 2006 and 2008. The researchers were not present in the consultation rooms during the encounters, but simply turned on the recording device. Most of the data was collected by Riikka Homanen, and the data collection process is described in her doctoral dissertation (Homanen 2013: 84–87; see also Ruusuvuori et al. 2008: 2–4).

The whole database collected during the research project includes 143 encounters. In each article I use a different sample (see below) of this dataset; in total I use 33 encounters as data. These 33 encounters were video-recorded in five different clinics with 12 different public health nurses. In addition to the public health nurse, the parties present are either both of the parents or the mother alone, and in the child health clinic encounters the baby is also present. Because of the remit of the research project, all of the video-recorded child health clinic encounters are with a child not more than one year old. In some encounters, there is also a nursing or medical student or an older sibling of the baby present. The duration of encounters varies between roughly 16 minutes and over one hour.

In each article I use a different sample of encounters, because of the different questions addressed in each article (see Chapter 3.2). In Article 1, I use all the child
health clinic encounters in which both parents are present (n=17). For Article 2, I gathered a sample of the maternity clinic encounters at which both parents are present (n=10). I included encounters with parents who were expecting their first child because I assumed that the issue of producing the father’s role as a client would be especially important at the transition to the parenthood in respect of future encounters at the clinic. To ensure that the encounters during which participants go through the new questionnaire on psychosocial issues (see Chapter 1.1) were not over-represented in the sample, I randomly chose only two of these eight recorded encounters. For Article 3, I collected a sample of 30 encounters that I was already familiar with or of which significant parts had already been transcribed, and/or during which I knew that the client described some problems thanks to the previous analyses and observations conducted within the research project. I excluded encounters in which the questionnaire on psychosocial issues was discussed, as the questionnaire provides a specific structure for talking about problems.

The three articles focus on different types of sequences or segments of interaction based on the research questions addressed in them (see Table 2 for a summary of the data and the focus of each article).

Table 2. Data used and segments focused on in the articles

<table>
<thead>
<tr>
<th>Article</th>
<th>Participants in the encounters</th>
<th>N of encounters</th>
<th>Focus segments</th>
<th>N of focus segments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Public health nurse, both parents and baby</td>
<td>17</td>
<td>Segments of talk about topics related to shared parenthood</td>
<td>43</td>
</tr>
<tr>
<td>2</td>
<td>Public health nurse and both expectant parents (during pregnancy)</td>
<td>10</td>
<td>Sequences in which public health nurses verbally address a question to both parents</td>
<td>89</td>
</tr>
<tr>
<td>3</td>
<td>Public health nurse, mother / both parents (and baby)</td>
<td>30</td>
<td>Sequences in which public health nurses formulate parents’ problem descriptions/topicalising formulations</td>
<td>32/15</td>
</tr>
</tbody>
</table>

5 One of these encounters is with a family in which the mother is pregnant. The beginning of the encounter concentrates on discussing the one-year-old baby’s development, checking his growth and vaccinating him; the rest of the encounter involves such things as discussing the mother’s condition and listening to the foetal heartbeat.
In Article 1, in order to analyse the production of parenthood in child health clinics, I focus on segments during which the participants explicitly talk about topics related to shared parenthood (n=43), for example, sharing childcare or housework, combining work and family life, and the father's participation in childbirth. Preliminary observations of the data suggested that mothers and fathers were asked differently designed questions. The decision to focus on the ways in which the public health nurse designed her questions about topics related to shared parenthood was further supported by previous CA knowledge about question design, which suggested that questions are a way to invoke presuppositions (Heritage 2010: 47–48; Boyd & Heritage 2006: 159–160; Hayano 2013: 401–402).

In Article 2, the aim is to analyse speaker selection, that is, which of the parents is addressed as the next speaker. I concentrate on the sequences in which the public health nurse poses a question that is verbally addressed to both parents using plural forms of verbs or the plural pronoun ‘te’ in some of its forms (n=89). As it is the public health nurse who uses the plural form, it is she who verbally shows that the question concerns both parents, and thus it is not merely my interpretation as the analyst. Using the plural form as an indicator of questions concerning both parents was relevant in maternity clinic encounters, but to conduct a similar analysis for child health clinic encounters would have been difficult: in child health clinic encounters the plural form can refer to the whole family, or just to the parents, or to one of the parents and the child.

The idea for Article 3 started to form when I observed some variations in questions concerning problems while I was analysing the data for Article 1 and paying attention to question design. To analyse these observations in more detail, I made a collection of sequences in which the participants talked about the parents' current problems. It seemed that it was most often the public health nurse who initiated the talk about problems with a question or problem-indicative

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6 The question of who initiates the talk about the problem is not unambiguous in every case. According to Nishizaka (2010a: 294), during prenatal check-ups the mother initiates problem presentation when she provides a no-problem answer to the midwife’s question but elaborates on another related symptom that the question does not address. In my categorisation this kind of case is counted as being initiated by the public health nurse’s question, as it is the question that opens the space for talk about problems in general or about the topic to which the problem is related. In addition, when parents start to talk about a problem without the public health nurse’s question, they are often actually reopening talk about a problem that has already been discussed – after the nurse’s initial enquiry – during the encounter. It should also be noted that although parents quite often ask for advice or information, this does not automatically indicate that they have a current problem (for example, requests for information about whether it is safe to do something during pregnancy, or about the public health nurse’s views on taking care of the baby in a certain way).
description; I therefore collected these sequences (n=96) in both maternity and child health clinics. I also included the sequences (n=31) in which the talk about the problems addressed in these 96 cases was reopened by the public health nurse or parents later during the encounter. First, I analysed in detail the sequences of talk about problems in child health clinic encounters. As soon as I realised that the sequence on which I was focusing contained similar phases to the step-by-step sequence of advice-giving described by Heritage and Sefi (1992: 377–389) in health visitor–mother encounters, I started to organise the sequences of talk about problems into a table, with each step recorded in different rows. This slightly atypical way of organising the collection (compared to the traditional CA style of working with transcripts) helped me to effectively recognise the different phases in the sequences, and to easily complete the collection with sequences from maternity clinic encounters.

The base collection of sequences for Article 3 thus includes sequences of talk about problems. While I was working on my initial observation about differentially designed questions, my interest was caught by a certain type of first pair part used by public nurses, namely formulations, since they were used somewhat rarely and seemed to be performing a rather different action than the yes/no questions that the data was full of. The collection of sequences in focus in Article 3 thus includes the nurse’s formulations of problem-indicative talk by parents (n=32) gathered from the sequences of talk about problems. The analysis presented in the article concentrates especially on the formulations that topicalise parents’ problem descriptions (n=15).

The analyses are based on the video-recordings and their transcripts. Some of the encounters I use as data were transcribed in full and some were partly transcribed, either by me, or by research assistants working on the project, or by students conducting their theses within the project. As a minimum, transcriptions were made of the sequences or segments focused on in the articles (listed in Table 1). All the transcriptions capture the talk verbatim and its sequential organisation, including for example the positions of pauses/silences and overlapping talk, in/out-breaths and laughter. The transcriptions of focus sequences also include markings of intonation and other fine-grained aspects of speech delivery (see Schegloff 2007: 265–269 for an overview of the transcription notations). I have also made notes about participants’ gaze directions7 when relevant.

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7 In some cases it was not possible to see the actual direction of the eyes. Following Goodwin’s (1981: 53) principles based on the knowledge that participants orient to head direction as relevant, I
3.4 Research ethics

The ethical board of the city offering the MCH services in question gave permission to collect the data (SOTE:3827/403/2006). All the participants gave their informed consent to be video-recorded after having received information on the research, both verbally and in writing. The participants were informed in general about the research project’s purpose of studying interaction and MCH practices. The participants were informed with regard to how the data is processed and stored and how the results are reported. In the information sheets it was also stated that participation in the research is voluntary and that the clients’ decisions about their participation does not influence the services they get. (See Homanen 2013: 405–409 for the original research information sheets and their English translations.)

As the clients may talk about very private and delicate issues during the encounters it is important to ensure their anonymity when publishing the research results. Thus, all the names of the participants mentioned in the discussions have been changed and the picture of an interaction situation that has been published in Article 2 is in the form of line drawing. As the analyses reported especially in Articles 2 and 3 focus on non-verbal aspects of interaction, providing video-clips of extracts online for all the readers would have been useful. However, this kind of provision of data was not possible in terms of permissions given by the participants. In the phase of collecting the data it became clear that although many of the parents were willing to allow a more broad usage of the data (for instance not-anonymised usage in teaching and training), the public health nurses were not. The whole dataset of 143 encounters include only one encounter (not included in the 33 encounters that I use) for which there is the permission of both the parents and the public health nurse for using the data in teaching and training. Careful anonymisation of both voice and video can provide an opportunity for a more broad presentation of the data but it should also be noted that the anonymisation may hinder the possibilities of distinguishing all the details of non-verbal interaction.

have used head direction as the signal of gaze direction in cases where the eyeballs are not visible. As the main focus in Article 2 was on the public health nurse’s gaze direction, I excluded sequences in which the nurse’s gaze direction was not reliably detectable. However, in Article 3 I included the few cases in which the public health nurse’s gaze direction was not detectable, as in this article the interest also lay in the design of the formulation, and these cases offered information on that topic.
4 Results of the articles

Each of the following three sections answers a particular research question (see Chapter 3.2). The question about the engagement of parents in interactions is analysed in Article 2, ‘Engaging parents through gaze: Speaker selection in three-party interactions in maternity clinics’, and in Article 3, ‘Using formulations and gaze to encourage parents to talk about their and their children’s health and well-being’. Article 1, ‘Producing gendered parenthood in child health clinics’, and Article 2 provide results that shed light on the production of parenthood. Finally, the question of the relevance of the gaze for engaging parents and producing parenthood is addressed in Articles 2 and 3.

4.1 Engaging parents in interactions

The question ‘What are the practices in and through which participants engage parents in the interactions during the encounters in MCH clinics?’ is addressed from two perspectives. First, it is analysed as a matter of turn-allocation – how one of the parents is selected to answer the public health nurse’s questions concerning both parents. Second, the process of engaging parents is analysed in the context of talk about problems by investigating a practice that encourages parents to elaborate on their problem descriptions.

Turn-allocation in the sequences in which nurses pose questions that are verbally addressed to both parents is analysed by focusing on who the public health nurse gazes at in TRPs and who answers the question first. The cross-tabulation shows that the public health nurse’s gaze direction in the TRPs of questions addressed verbally to both parents has a statistically significant connection to which parent answers the question first (Article 2). Thus if the public health nurse gazes at the mother, it is highly probable that the mother will answer first; the same applies to the father. The results of the qualitative case-by-case analysis also point out that the public health nurse’s gaze direction is not the only element in interaction that regulates speaker selection; the parents themselves, and the
ongoing interactional context, are also relevant. For engaging fathers in particular, the psychosocial questionnaire (see Chapter 1.1) seems to be a relevant tool.

Second, engaging parents in talk about problems is focused on in Article 3. This article describes an interactional practice by public health nurses that facilitates talk about problems by encouraging parents to elaborate on the problem that they have indicated they are experiencing. This practice has three relevant features. First, the public health nurse formulates the parent’s problem-indicative utterance and addresses the problem-relevant features (instead of other possible features) of the situation in the formulation. Second, she leaves space for the parents to continue (she does not rush into giving advice, for example), and third, she gazes at them at the end of her formulation and after the first possible point for closing the formulation-decision pair. The practice of topicalising by formulating and gaze encourages parents to elaborate on their problems. It works with different types of problem descriptions, that is, with both implicit and explicit problem descriptions. In addition, the practice of topicalising by formulating and gaze works in different sequential locations, that is, both after problem-indicative answers to the public health nurse’s initial enquiry, and after utterances that elaborate on the initial problem description after the public health nurse’s focusing questions or topicalising turns.

Formulating and gaze also seem to encourage parents to talk about problems according to a different logic than typical yes/no questions. Article 3 presents a comparison between two cases, one of which includes a formulation and the other includes multiple yes/no questions. Comparison between responses to formulations and yes/no questions is not unproblematic, as many things in the whole sequence of talk about problems, such as the design of the initial enquiry, may affect the discussion. However, these two cases have similar starting points: they are both taken from the first encounter during the pregnancy; they both begin with the public health nurse’s open question about the mother’s condition; and in both cases the mother provides a problem-indicative answer to the question. In the one case, the public health nurse topicalises the problem by formulating the mother’s problem-indicative turn, while in the other case the public health nurse poses several further questions which address some normal symptoms of pregnancy. The comparison reveals that the formulation gives the mother more space to elaborate on different aspects of the problem, whereas the yes/no questions suggest those aspects the mother can describe.
4.2 Producing parenthood

The question ‘How and what kind of parenthood is produced in and through the interactions during the encounters in MCH clinics?’ is addressed by 1) analysing the presuppositions about parenthood that public health nurses’ turns invoke and to which parents orient (Article 1), and 2) interpreting the analysis of the practices of turn-allocation mentioned above from the point of view of the production of parenthood (Article 2).

First, the analysis of segments in which the public health nurse and the parents are talking about topics related to shared parenthood demonstrates that public health nurses often invoke presuppositions of asymmetrical responsibilities for parents, in their questions for example. It seems that the questions are biased in the way that they suggest the mother as being primarily responsible for childcare. Thus although the father’s role in childcare is treated as expected to some extent, it is not oriented to as self-evident in the same way as the mother’s role. For example, public health nurses may topicalise fathers’ role in childcare, as in one case in which the mother describes how she and the father have taken turns at being ready to comfort the baby at night during recent weeks while they both have been on leave, and the public health nurse asks the father: ‘Do you also wake up because of sounds made by the baby?’

Second, the patterns of turn-allocation by public health nurses to mothers and fathers can be interpreted in light of the production of parenthood. The analysis of the sequences in which public health nurses pose questions that are verbally addressed to both parents demonstrates that nurses typically treat the mother as the principal respondent by gazing at her in TRPs. Accordingly, mothers answer the majority of the questions addressed to both parents. (Article 2.)

These two patterns – 1) treating the father’s role in childcare as not self-evident, and 2) treating the mother as the principal respondent to questions that both parents are eligible to answer – demonstrate that public health nurses produce gendered parenthood, and show how they do so.

On the other hand, Articles 1 and 2 both also highlight the parents’ own role in orienting to and invoking presuppositions of gendered parenthood. In some cases mothers upgrade the gendered presuppositions invoked in the public health nurse’s question by completing the father’s description of his role in a way that suggests that his role is secondary. In addition, parents may invoke gendered presuppositions when they describe sharing childcare or housework but at the same time mark it as somehow accountable. (Article 1.)
Likewise, Article 2 demonstrates that in most of the cases in which the mother answers the public health nurse’s question first, all the participants treat the mother as the principal respondent. The public health nurse does so by gazing at the mother or at the questionnaire filled in by her, and the mother also does so by answering, and the father by staying silent and sometimes by gazing at the mother. Other types of cases further highlight how parents regulate their participation roles – which can be seen as related to the production of their roles as parents –, such as those in which 1) the mother self-selects as the respondent when the nurse is not gazing at her, and 2) the father treats the mother as the principal respondent to the question by staying silent even though the nurse is gazing at him.

Based on the analyses in Articles 1 and 2 it seems that gendered parenthood is often produced by both public health nurses and parents in MCH clinic encounters. However, both analyses also present cases that deviate from the typical pattern. First, parents may undermine the gendered presuppositions invoked by the public health nurse. For example, in some cases when the public health nurse asks a question that topicalises the father’s role in childcare, he treats the question as presupposing something that is self-evident. Second, public health nurses occasionally pose questions about sharing childcare tasks without invoking the presupposition of gendered parenthood. (Article 1.) Third, the father can be treated as the principal respondent to the public health nurse’s question concerning both parents (Article 2). The deviant cases in which the father is treated as the principal respondent particularly highlight the significance of the psychosocial questionnaire (see Chapter 1.1) in engaging the father in the discussions, as was briefly mentioned in the previous section. Nine of the 11 cases in which the father self-selects or is selected as the first respondent are from the two encounters in which this questionnaire is discussed. This shows that the questionnaire that is filled in by both parents helps to create a context in which both parents are treated as equally important clients. The remaining two deviant cases presented in Article 2, on the other hand, demonstrate the impact of context on turn-allocation, as in those cases the immediately preceding discussions have already created the basis for the father to self-select or to be selected.

To sum up, Articles 1 and 2 provide a description of two interactional contexts – turn-allocation and the invocation of presuppositions through question design – in which gendered parenthood is both produced and deviated from.
4.3 The function of the public health nurse’s gaze direction

It was argued in the previous sections that the public health nurse’s gaze direction has an important function in relation to 1) turn-allocation and 2) the topicalisation of problem talk. The significance of the gaze as a turn-allocation device has been suggested in earlier studies as well (e.g. Sacks et al. 1974: 717; Lerner 2003: 178–182). The analysis in Article 2 shows how the gaze works in maternity clinic encounters and can be used as a way to engage parents in the discussions. In addition, the aforementioned patterns of gazing reveal the common orientation to mothers as the principal respondents to questions concerning both parents, and thus indicate that the gaze can serve as a way of producing clients’ roles not only as conversationalists but also as parents. The limits of the gaze direction as a turn-allocation device in the MCH clinic context are also presented: the ongoing and previous sequence of conversation, as well as the parents’ presuppositions about the institution’s agenda, have an influence on which parent answers a question addressed verbally to both parents.

Second, the function of gaze direction with regard to engaging parents in talk about their problems is demonstrated in Article 3. The public health nurse’s gaze direction towards parents is an important feature of the practice of topicalising parents’ problem descriptions. Although the focus in Article 3 is on the practice of topicalisation, an example of a sequence in which a formulation closes down the talk about the problem is also presented, and in that case the public health nurse’s gaze direction away from the parents is interpreted as signalling that her primary focus has moved away from talking about the problem. The public health nurse’s gaze direction is thus related to organising the sequence of talking about problems.

To sum up, Articles 2 and 3 demonstrate that the public health nurse’s gaze direction towards parents plays an important role both in engaging parents in interactions and in producing parenthood.
5 Discussion

In this study, the topic of supporting parenthood has been approached from two perspectives: 1) how fathers’ parenthood and their participation in interaction is supported as compared to mothers’, and 2) how parenthood is supported when parents have potential problems. In what follows I will discuss the results of this study in relation to these questions and in light of previous research, and I will suggest some practice implications for MCH work based on the results. Finally, I outline some ideas for future research on 1) interactional practices in MCH care, 2) MCH clinic encounters compared to other institutional settings, and 3) the production of parenthood in different contexts.

5.1 Supporting shared parenthood

As was illustrated in the introduction, there is a gap between the policy and the practice of shared parenthood, both in MCH clinics and more generally in Finnish society (Chapter 1.2). Thus in what follows I will first present the results of this study in relation to previous studies of the organisation of participation roles in multi-client healthcare encounters, and will discuss practice implications for MCH work. Then I will discuss the results concerning the production of gendered parental roles in interaction in relation to the discourses and cultural assumptions of parenthood.

5.1.1 Participation roles in multi-client maternity and child health clinic encounters

Two of the articles (Articles 1 & 2) analyse encounters with both parents. Previous interactional studies analysing multi-party encounters in healthcare have analysed interactions for example between professionals, children and parents (e.g. Aronsson & Rindstedt 2011; Buchbinder 2009; Clemente 2009; Hutchby & O’Reilly 2010; O’Reilly & Parker 2013; Stivers 2001), and between professionals,
adult patients/clients and their companions (e.g. Peräkylä & Silverman 1991; Sarangi 2010). Despite the differences in these settings, there are some similarities between the focus points and results of this study and previous qualitative studies of participation in multi-party healthcare encounters.

Previous studies analysing healthcare encounters between professionals, children and parents have presented the interactional practices by the professionals that enable or support the child’s participation (Aronsson & Rindstedt 2011: 130–131; Buchbinder 2009: 179–183; O’Reilly & Parker 2013: 501–503; Stivers 2001: 259–260, 268–271). The results of this study contribute to this body of knowledge by presenting a non-verbal interactional practice, namely turn-allocation by gazing, for engaging parents in interactions in MCH clinic encounters (Article 2). The function of the gaze as a turn-allocation device has already been suggested within CA (Sacks et al. 1974: 717; Lerner 2003: 178–182) and demonstrated to some extent in institutional multi-party settings such as in classrooms (Kääntä 2011), but systematic analyses of its function in healthcare settings are few. Stivers (2012: 7) demonstrates in a paediatric setting that if the doctor gazes at the child patient when posing a question, the likelihood that it will be the child who answers the question increases. The results of this dissertation are in line with those of Stivers’s (2012) study with regard to the gaze. By focusing on a healthcare setting with two adult clients, this study adds to existing knowledge. It was also demonstrated that both public health nurses and parents participate in negotiating participation roles (Article 2). This is in line with previous studies of multi-party healthcare encounters illustrating for example how parents give the child patient space to talk and coordinate their own turn-taking in relation to the child’s actions (Buchbinder 2009; Stivers 2001), and how clients’ turns can create space for each other’s participation in settings with two adults (Muntigl & Choi 2010: 336, 339–343; Sarangi 2010: 247).

In addition, the results of this study suggest that the questionnaire on psychosocial issues enhances the equal participations of both parents. Heritage (2002: 316–321) also points out the usefulness of a questionnaire in encounters between health visitors and parents, as it enables the health visitor not only to engage the father, but also to coordinate the discussion in such a way that the questionnaire provides the justification for the topics that relate to the mother only. In Heritage’s (2002) study, the health visitor filled in the questionnaire, which included preliminary information on the parents and the birth, whereas in our data the parents had filled in the questionnaire on psychosocial issues before the
encounter took place. The fact that the questionnaire is given to both parents may itself help to create a context in which both parents’ participation is presupposed.

The participation roles can also be seen as relevant for producing the clients’ roles as parents. In studies by Heritage (2002) and Raymond (2010), health visitors’ different ways of designing questions for parents were related to the building of a relationship with them. For example, by designing a question in a way that takes into account what the parents have already said, the health visitor can demonstrate that she remembers her previous conversation with them (Heritage 2002: 326–329). In this study, the public health nurses’ ways of 1) designing questions about topics related to shared parenthood and 2) addressing questions to parents concerning both of them were analysed. Rather than focusing on the relationship between the professional and the client, this analysis enabled an investigation of the ways in which practices of question design and speaker selection produce clients’ roles in relation to each other as clients and parents. It was shown that questions can be designed in such a way that they produce gendered roles for the parents (Article 1). In addition, treating the mother as the principal answerer to questions concerning both parents (Article 2) can be seen as a way of treating her knowledge of the couple’s shared issues as more relevant to the institution, and thus as a way of treating her as the principal representative of the family, that is, the principal client in the clinic.

The MCH reports suggest some ways to take fathers into account as clients. In general, the suggestions about interaction during the encounters are quite non-specific. For example, they include the suggestion that professionals should pose question to fathers (MSAH 2008: 52), seat parents next to each other, ask parents questions about each other, and talk actively with fathers and indicate that their active participation is a good thing (Säävälä et al. 2001: 37, 42). The CA approach to institutional encounters has the potential to clarify the institutions’ own theories concerning interaction (Peräkylä, Ruusuvuori & Vehviläinen 2005: 106–107). The results of this study also provide detailed descriptions of actual interaction in MCH encounters which give grounds for more detailed suggestions than those presented in the guidelines. First, the interactional practice of turn-allocation by gazing can be used to engage fathers in interaction. Addressing both parents verbally is demonstrably not enough to get the father to participate if the mother is the one who is gazed at. Second, the results indicate that the suggestion to ask fathers questions as a way of engaging them in the discussions needs to be clarified. Attention must be paid to the question design, because otherwise there is a risk that the aims of engaging fathers and supporting shared parenthood will conflict: a
question that topicalises the father’s participation in childcare can engage the father in the discussion but at the same time invoke a presupposition of gendered parenthood (see also Säävälä et al. 2001: 45).

5.1.2 Producing gendered parental roles in interaction

Above I have already discussed the practical implications for the support of fathers’ participation in MCH clinic encounters. The question of supporting shared parenthood can also be discussed at a more general level. The finding that there is an orientation to gendered parental roles in MCH clinics is not surprising in light of previous studies demonstrating discourses of the mother’s primacy in various types of texts (Eräranta 2005; Sunderland 2000, 2006; Vuori 2009) and in interview data (Magnusson 2008), and of studies reporting fathers’ experiences of being treated as secondary during MCH clinic encounters (Fägerskiöld 2006: 81; Kaila-Behm & Vehviläinen-Julkunen 2000: 202; Mesiäislehto-Soukka 2005: 124; Paavilainen 2003: 100–101). The take-up patterns of parental leave are also strikingly gendered (Haataja 2009: 9, 16; Salmi et al. 2009: 32). The contribution of this study is to present how a macro issue such as gendered parental roles is produced in the details of interaction (see Antaki 2011: 3–4; Speer & Stokoe 2011: 15; Kitzinger 2000, 2005, 2008) in the institutional context of MCH clinics. The results of this study add to the study by Garcia and Fisher (2011) in which they analyse how participants in a divorce mediation session produce unequal, gendered parental roles by constructing themselves in relation to different definitions of ‘being there for the children’.

The invocation of gendered presuppositions about parenthood in an institution such as MCH clinics can be seen on the one hand as stemming from more general cultural or institutional assumptions about parenthood. As was suggested in Article 1, parents may orient to gendered presuppositions about parenthood even when the public health nurse did not invoke those presuppositions in the preceding turn, and may emphasise the presuppositions invoked by the public health nurse. Thus in interaction parents may relate descriptions of their own actions to assumptions about what is expected of them as parents within the institution of MCH care.

On the other hand, and more importantly, the invocation of presuppositions of parenthood in institutional interaction can be seen as constituting cultural assumptions about parenthood (see Kitzinger 2006: 74–78). As parents’ ideologies of parental roles are associated with whether and how they share parental leave
with their spouses (Lammi-Taskula 2007: 81–82, 2008: 142; Salmi et al. 2009, 57), cultural assumptions of parenthood can potentially have an effect on what mothers and fathers see as available options for them in relation to taking responsibility in childcare and taking parental leave. The results of this study thus make visible the interactional practices which are related to how parental roles are defined in families, within the institution of MCH care, and also in society more generally.

The results of this study point out not only the practices related to the production of gendered parental roles, but also how those gendered parental roles can be negotiated and refused. Parents may undermine gendered presuppositions in their own descriptions of their everyday life (Article 1); public health nurses may pose questions that presuppose that both parents are involved in childcare (Article 1), and may use their gaze as well as the questionnaire to engage the father as a client (Article 2). Thus the analysis shows the potential for change – potential ways not only to actualise the aims of family-centeredness and support for shared parenthood (MSAH 2004: 22, 84; Klemetti & Hakulinen-Viitanen 2013: 20, 30; Säävälä et al. 2001) discussed in the previous section, but also to reformulate cultural norms concerning parental roles.

5.2 Facilitating talk about problems and giving support

Talking about problems is an important prerequisite for being able to support parents through their problems, as many of the problematic situations will not come to the public health nurse’s knowledge unless the parents talk about them. However, the difficulty of talking about problems (see Chapter 1.3) restricts the ways in which problems can be discussed in MCH clinic encounters. The practice of topicalising by formulating and gaze may be useful here, as it gives parents space to elaborate on their potential problems and at the same time lets them decide, perhaps more freely than with yes/no questions, the terms within which they will continue to talk about the problem.

In Article 3 it is shown that discussions of potential problems can be initiated at various points of the encounter. Parents’ problem-indicative turns can be very explicit, but are also quite often somewhat implicit, and talk about a potentially problematic situation is also a negotiation over whether it is a problem. This aspect of talk about problems recalls everyday interaction: the same difficulty suggested by implicit problem descriptions has also been observed in everyday interactions, since the direct presentation of problems is avoided and discussions are
characterised by the participants’ dual orientation towards talk about problems and ‘business as usual’ (Jefferson 1980, 1988).

On the other hand, when compared to other healthcare settings in which clients’ problems are discussed, such as acute medical encounters and therapy encounters, the role of the professional in the MCH clinic encounter is somewhat different. Jefferson and Lee (1981) have presented a distinction between two kinds of interactional orientation towards talk about problems, namely ‘troubles-telling’ and ‘service encounters’. In ‘troubles-telling’ the focus is on the teller’s experiences, whereas in ‘service encounters’ the focus is on the properties of the problem (ibid.: 411; see also Heritage & Lindström 2012b; Ruusuvuori 2005, 2007). Moreover, Vehviläinen (2014) has drawn a distinction between professionals’ different ways of orienting to clients’ problems during different types of encounters between professionals and clients. In both service encounters (for example, acute medical visits) and therapy encounters it is the patient/client whose problems are focused on; but the difference is that in service encounters the professionals orient to solving the problem on the basis of their own expert knowledge, whereas in therapy encounters professionals offer a setting in which clients’ problems are explored collaboratively (ibid.: 52). Vehviläinen (2014: 52, 111) also suggests that in counselling encounters professionals use both of these orientations (see also Vehviläinen 2003). MCH encounters might also be seen as falling somewhere between service encounters and therapy encounters: public health nurses have expert knowledge about pregnancy and child development, but according to the MCH guidelines they also need to help parents to find their own strengths (Klemetti & Hakulinen-Viitanen 2013: 17; MSAH 2004: 20).

The description of the practice of topicalising problem talk by formulating and gazing adds to previous observations about the importance of accessing the clients’ perspectives and knowledge. Heritage and Sefi (1992: 380) have pointed out the usefulness of ‘stepwise entry into advice giving’ in health visitor-mother encounters: the health visitor asks further questions about the problem in order to be better able to fit the advice to the particular situation (see also Vehviläinen 2012). In addition, Maynard (1991: 467–473) has demonstrated that using the ‘perspective display series’ – that is, asking for the clients’ perspective first – helps the professional to create ‘a hospitable environment’ for delivering a malign diagnosis in a way that takes the client’s perspective into account. Various types of question have also been suggested as helpful for accessing the clients’ perspective in order to explore it further (Vehviläinen 2014: 143–148). Vehviläinen (2014: 147–148) lists formulating as one of the ways in which the counsellor can invite
the counselee to elaborate on the issue being discussed. Using CA, formulations have also been extensively studied as part of psychotherapy (Antaki 2008; Antaki, Barnes & Leudar 2005; Weiste & Peräkylä 2013) and counselling encounters (Hutchby 2005) as well as in other healthcare settings (Beach & Dixson 2001; Hak & de Boer 1996). The contribution of this study is that it describes in detail the design of the formulations and the patterns of public health nurses’ gaze direction, both of which are relevant for the practice of encouraging parents to elaborate on their problems.

In addition to topicalising practices that encourage talk about problems, a trusting professional-client relationship is another prerequisite for talking about problems (Klemetti & Hakulinen-Viitanen 2013: 21; Kuronen 1993: 49–50; MSAH 2004: 95). I suggest a potential link between the production of parenthood (described in Articles 1 & 2) and a trusting client-professional relationship. The production of gendered presuppositions inhibits the treatment of fathers as equally important clients and parents who can share their problems with the public health nurse. Moreover, the production of gendered presuppositions inhibits the treatment of mothers not as the principal parent, but as having equal responsibility with the father for childcare. Thus if the gendered presuppositions conflict with the parents’ ideas of their roles in the family, those presuppositions may hinder the building of a trusting professional-client relationship. On the other hand, if the parents themselves support the traditional idea of gendered parental roles and the public health nurse asks questions presupposing that they share childcare responsibilities equally, it may well undermine the trusting relationship. Thus, to be able to promote a trusting client-professional relationship, the public health nurse may have to balance between supporting shared parenthood and respecting both parents’ individual perceptions on parental roles which can also differ between the mother and the father.

5.3 Generalisability of the results and ideas for future research

The data used in this study placed some limitations on the interpretation of the results, as happens in all research. I acknowledge that there are elements outside of the data I used that are linked to the phenomena analysed: for example, in their everyday lives each parent takes a different amount of responsibility for childcare. However, these contextual elements do not challenge the results, as the aim is to describe the interactional practices in and through which support for parenthood
and the production of parental roles are actualised in the minute practices of interaction in MCH clinic encounters.

The database used in this study is not very large, and it is not representative of all MCH clinic encounters in Finland, let alone all MCH professional-client encounters in other countries. Nonetheless, the interactional practices presented in this study – turn-allocation by gazing, the invocation of gendered presuppositions through question design, and the topicalisation of problem talk by formulating and gaze – are generalisable as possible practices in MCH clinic encounters (Peräkylä 2011: 375–376). Thus although the practice of topicalising by formulating and gaze may not be used by the majority of public health nurses, the detailed level of description of this practice makes it possible for any public health nurse to use it (see ibid.: 376). Similarly, I do not claim that all public health nurses treat mothers as principal parents, but paying attention to the practices through which gendered parental roles are produced provides an opportunity to see how presuppositions about parenthood are invoked in interaction in MCH care.

Viewing the results as possible practices (Peräkylä 2011: 375–376) also highlights the opportunity to implement them into practice: The results of this dissertation could be used in planning and organising training workshops for public health nurses (see Kitzinger 2011: 104–111 and Stokoe 2011: 125–137 for workshops based on conversation analytic research results). In addition, it could be beneficial to incorporate the results into the guidelines targeted at MCH professionals.

There are a number of topics for future research that arise directly from the analysis presented here and would help to gain a more comprehensive picture of the phenomena. First, while Articles 1 and 2 describe (among other things) parents’ orientations to each other’s actions and participation roles, future research could further analyse how parents orient, for example to each other’s epistemic rights (Heritage 2012; Raymond & Heritage 2006) to talk about everyday life with the child. Based on previous research on interaction, for example in assessment interviews with prospective adoptive parents (Noordegraaf, van Nijnatten & Elbers 2010) and couples therapy (Buttny 1990; Muntigl & Choi 2010), it seems that spouses mutually coordinate their answers in relation to the institutional situation. Thus analysing the ways in which parents jointly produce each other’s roles in interaction could offer more knowledge of the parents’ orientations to the institutional ideologies of parenthood.

Second, the analysis of formulations with regard to talk about problems could also be extended and deepened. Preliminary analyses suggest that formulations of parents’ problem descriptions can have various functions in sequences of talk
about problems. Functions other than topicalisation could be addressed in more detail in future studies. Another topic for future research might be the coordination of the gaze and topicalisation with formulations or other interactional practices in situations where the primary ongoing task is to do something other than interview the clients.

Third, there are various further points of interest in relation to talk about problems in MCH clinic encounters. While analysing the sequences of talk about problems, I noticed that a problem that had been talked about was quite often addressed again later during the same encounter by either the public health nurse or the parents. This phenomenon is something that needs further investigation. In addition, future research could also analyse in more detail actions other than formulations in sequences of talk about problems. The preliminary analyses, for example, hint that both the public health nurse and the parents can suggest a solution to the problem by normalising it, or by talking about what has been or should be done to solve the problem. Further analysis could describe how the participants move on from discussing and ‘diagnosing’ the problem to solving it. This analysis should definitely take into account the multimodal aspects of interaction, as the analysis of the topicalisation of problem talk (Article 3) demonstrates the importance of the public health nurse’s gaze direction for that practice.

In addition to topics linked to interactional practices within MCH care, this study has highlighted more general topics for future research. First, future research could systematically compare interactional practices in MCH care with other institutional settings. The interactional practices presented in this study are potentially also generalisable as possible practices (Peräkylä 2011: 375–376) in other preventive healthcare encounters, at least when those encounters share the relevant elements: the practice of turn-allocation by gazing is connected to having two (adult) clients in the encounter, and the practice of topicalising problem talk seems to be connected to the difficulty of talking about problems in MCH clinics. However, the extent to which these practices work similarly in other healthcare and counselling settings remains an object of future research. The differences and similarities in the ways in which the practices work in different contexts would make it easier to perceive the particular ways in which the institutional tasks are conducted in each setting (see Drew 2003; Ruusuvuori & Voutilainen 2009; Weiste & Peräkylä 2013).

Second, since this study has illustrated the ways in which gendered parenthood is produced in interaction in MCH clinic encounters, an analysis of the production
of parental roles in other settings would also be highly relevant for a better understanding of this phenomenon (see also Garcia & Fisher 2011). For example, future research could address how parental roles are produced in workplaces between bosses and employees when they are talking about parental leave, or in mundane interactions between mothers and fathers or friends when they are talking about parental responsibilities. This study has addressed the production of gendered parental roles in relation only to heterosexual couples. Future research could also address how and what kinds of presupposition are invoked in relation to the parenthood of gay and lesbian couples (see also Land & Kitzinger 2005) as well as single people.

Based on the analytic process it is also possible to draw two methodological implications for future studies. First, in this study, CA was combined with quantitative analysis. The potential risks related to defining the phenomena that is counted discussed by Schegloff (1993) were taken into account and all the cases were analysed one-by-one in detail. Continuing the previous line of studies which have linked quantification to CA when analysing institutional interaction (e.g. Peräkylä 2006; Ruusuvuori 2001; Stivers 2001), this study demonstrated the benefits of quantification in showing the outcomes of interational practices as well as making recurrent and deviant patterns observable. Second, using the approaches outlined within feminist CA (Kitzinger 2000, 2008), this study has highlighted the importance of studying the production of gendered parenthood in and though actual sequences of interaction. This kind of detailed analysis of interaction makes visible the kinds of social actions which maintain cultural and institutional norms, and which otherwise would remain out of reach.
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Websites


Acts and decrees


ORIGINAL ARTICLES