

**HOW CONCERNS ABOUT ERECTIONS ARE
DISCURSIVELY CONSTRUCTED AND TREATED ON A
SEXUAL HEALTH HELPLINE.**

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The effort devoted to this dissertation is dedicated to my mother, Geraldine, upon whose boundless support my ambitions are founded.

Special thanks to Dr Lourens Human for introducing me to the Postmodern “mind” and encouraging a lived psychology.

Abstract

This dissertation deals with how the topic of erectile dysfunction is treated and constructed on a sexual health helpline. The majority of research in sexual health is from a medicalised perspective and is concerned with factors such as prevalence and causality. This report takes up a Discursive Psychology position in order to analyse the conversational practices on the helpline in their “local interactional context” in order to gain an impression of what is “done” through language. This is achieved through a detailed analysis of the turn-by-turn sequential unfolding of talk on the helpline. Ultimately it is suggested that the institutional context of the helpline is introduced through the discursive performances of the participants in conversation. The research report explores the consequences of such institutionalised conversational practices. For instance, medicalised accounts of erectile dysfunction are privileged and caller’s personal concerns are negated.

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Chapter 1

INTRODUCTION

1.1 Problem

In my experience of psychological training in South Africa, very little attention is paid to “sexual health” in the development of theoretical knowledge, practical experience and professional expertise. It appears that the topic of sex is not easily breached in professional settings and yet “sex” is increasingly becoming involved in public discourse. This research is an attempt at gaining an impression of how sexual concerns are constructed through language within the context of a sexual health helpline, working towards the advancement of knowledge and expertise in the field of sexual health.

1.2 Question

How concerns about erections are discursively constructed and treated on a sexual health helpline?

1.3 Research Goals

1.3.1 General Goal

The goal of this research is to gain an impression of how concerns about erections are treated and constructed through interaction, on a sexual health helpline.

1.3.2 Specific Goals

The research involved drawing a limited sample of recorded calls from a sexual health helpline in order to gain an impression of what is being constructed through language in that specific context. My particular interest is in how concerns about erections are constructed discursively and treated rhetorically on the helpline.

In general, the facilitators are expected to, through the course of a helpline conversation: Collect as much statistical data as possible about the caller through filling out a caller information sheet (Appendix A); communicate certain information such as the available oral medications for erectile dysfunction; and by the end of the call significantly motivate the caller to seek further help from a health care professional and a referral should have been made to at least 3 relevant health care professionals.

The research aim was to look at: how callers introduce their sexual health concerns, how the facilitators manage these concerns, and, in the process, how both callers and facilitators position themselves in the construction of these concerns. Therefore, through addressing the callers' concerns, how do the facilitators manage the expected tasks of collection of biographical data, information providing, motivation and referral? Additionally, what then are the implications of such expectations (information collection, information providing and referral) for the construction of sexual health concerns?

Broadly speaking, it is hoped that an understanding of the discursive performances on the helpline will lead to a more informed approach to managing the helpline. From a discursive psychology perspective, the interest is in both "everyday" and "institutionalised" conversational practices, and how such practices might manifest on the helpline. Although we can view helpline activity as a more specialised context that is likely to involve a specific content, it is a discursive assumption that everyday conversational practices will inevitably be present on the helpline, albeit adapted for the purposes of the work done by the helpline. It is my aim to see how such practices present themselves in the context of this helpline and, therefore, what helpline-specific normative practices might have developed in order to get the work of the helpline done.

The discursive context in which concerns about erections are constructed and treated are explored through:

- 1) An exploration of literature and research that contribute to a professional understanding of erectile dysfunction.
- 2) The recording, analysis and transcription of helpline conversations.
- 3) Providing a report of the analysis by falling back on a corpus of discursive psychology literature and research in order to validate and expand upon the analysis.
- 4) The development of an understanding of interaction on the sexual health helpline and the implications thereof for the construction and treatment of concerns about erections. Based on these findings recommendations for the helpline work are made and ideas concerning a refreshing approach to communication skills in the field of sexual health are considered.

The research is a move away from measuring the prevalence of dysfunctions, exploring different treatment options and investigating causes. It is less concerned with an ability to generalise about its findings and more concerned with contributing to a refreshing understanding of how sexual health concerns can be understood in terms of language use within a specific context. It is a look at how concerns about erections might translate into actual talk and how this talk is managed in a helpline setting. The research is informed by social constructionist thinking and the field of discursive psychology. It serves as a break from positivistic and more traditional approaches to research. My aim is to help introduce and build upon new and progressive approaches to sexual health. Hopefully the research does not only help in developing an understanding of a specific helpline, but

is a step closer towards understanding ways in which sexual health concerns (and related themes) are potentially treated, negotiated and constructed through interaction.

Chapter 2

LITERATURE REVIEW

2.1 The Dominant Perspective

Most medical literature on difficulties with erections begins with proclamations like - “erectile dysfunction affects millions of men” (Carson, 2004). It could be assumed that the rhetoric of such statements is one that attempts to normalise erectile dysfunction – “don’t worry, it is common”. The majority of research and literature that I have encountered on Erectile Dysfunction appears to be of a medical nature and focuses on the prevalence of the dysfunction, its relation to other medically treatable illnesses, the physiology of erections and pharmacological treatment options.

Difficulty with achieving and maintaining a lasting erection has been classified as “erectile dysfunction” and has come to be known by the pharmaceutical industry, practitioners, and increasingly in the general public, as “ED”. The notion of “ED”, with its colloquial ring, is a welcome departure from the original classification of the experience as “impotence”. The term impotence was replaced in the 1990’s due to its connotation with an overall lack of “potency”. It is understandable that with the development of effective oral treatments for “ED” that have revolutionised the medical approach to erectile dysfunction, it has become the dominant focus of recent research in

the field of sexual health. Therefore, a relatively thorough medicalised understanding of the experience is available in the academic literature, which is briefly explored below.

2.1.1 Defining “ED”

There appear to be slight variations in the definition of what constitutes erectile dysfunction. The core of any definition is the inability to *achieve* an erection. However, problems with erections also relate to the inability to *maintain* an erection. Another consideration is the regularity at which the problem exists – its *persistence*. Some researchers define erectile dysfunction based not only on the ability or inability to achieve and maintain an erection but also on the extent to which this ability/inability accommodates *sexual intercourse or penetration* (De Klerk, De Villiers & Isaacs, 2003). According to an update by the European Association of Urology (Wespes, Amar, Hatzichristou, Montorsi, Pryor & Vardi, 2002, p.3), erectile dysfunction is defined as “the persistent (lasting for at least 6 months) inability to attain and maintain an erection sufficient to permit satisfactory sexual performance”. The Diagnostic and Statistical Manual of Mental Disorders (4th ed.) or DSM – IV, however, requires the exclusion of any other medical condition that might account for the condition. The DSM-IV (American Psychiatric Association, 1994, p.504), defines male erectile dysfunction as:

- A. Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection.
- B. The disturbance causes marked distress or interpersonal difficulty.

- C. The erectile dysfunction is not better accounted for by another Axis I disorder (other than Sexual Dysfunction) and is not due exclusively to the direct physiological effects of a substance (e.g. a drug of abuse, medication) or a general medical condition.

There is, therefore, a significant difference between the medical and psychological diagnosis of erectile dysfunction – criteria C rules out the diagnosis, if due to any axis one disorder or general medical condition. This difference is significant if one considers the strong association between erection problems and severe ailments such as diabetes and cardiovascular disease (explored below). Furthermore, the classification itself may have certain consequences. The way concerns about erections are classified is considered highly relevant to this research - How problems with achieving and maintaining erections are constructed and treated as a “disease process” is likely to have implications for how these concerns are managed in conversation. Therefore, when managing concerns related to sexual wellbeing, what are the implications of utilising a disease model for how such concerns are treated and constructed?

2.1.2 Prevalence of “ED”

There is considerable variation in findings on the prevalence of what is defined as erectile dysfunction. The prevalence in the general population studies range from 13% to 52%, and appear to be influenced by the age group studied, the method of research used and

what kinds of experiences are considered to warrant the classification of an “erectile dysfunction” (De Klerk *et al.*, 2003). Two research projects that appear to have had a considerable impact on thinking in the sexual health field are: The Massachusetts Male Aging Study (Feldman, Goldstein, Hatzichristou, Krane & McKinlay, 1994) and a study on the prevalence of erectile dysfunction in black and mixed race primary care populations of the Cape Flats and Helderberg Basin area of the Western Cape (De Klerk *et al.*, 2003). The Male Aging Study results were achieved through the study of a random sample of non-institutionalized men aged 40 to 70 years, from 1987 to 1989. Blood samples, psychological measures, socio-demographic variables, psychological indexes, and information on health status, medications, smoking and life style were collected by trained interviewers in the subject’s own homes. De Klerk *et al.* (2003) conducted their research in a similar fashion through a cross sectional survey by interviewer administered questionnaires in two primary care medical centres with men 25-75 years of age, who were either black or of mixed race.

These studies divided the prevalence of erectile dysfunction according to minimal moderate and complete dysfunction (Feldman *et al.*, 1994) or minimal, moderate and severe dysfunction (De Klerk *et al.*, 2003). Feldman *et al.* (1994) found the combined prevalence of minimal, moderate and complete dysfunction to be 52%. However, of men in Feldman *et al.*’s (1994) sample only 1.3% experienced minimal impotence, 25.2% were classed under moderate impotence, and 17.2 % of the sample, were considered to suffer from complete impotence. De Klerk *et al.*’s (2003) sample indicated a similar

breakdown of “minimal”, “moderate” and “complete” erectile dysfunction, and found that the combined prevalence of minimal, moderate and severe dysfunction was 77.1%.

Proponents of the medical model of disease have been criticised for framing prevalence estimates of conditions in order to maximise the conception of the problem and therefore render treatment consumable (Moynihan, Heath & Henry, 2002). Although the combined statistics are relatively high, a relatively small percentage of the sample population experienced “minimal impotence”. The research question then comes to mind: What happens to this “minimal” erectile dysfunction group through conversations on the helpline? Is this distinction made? If so, how is it constructed discursively? One understanding of the symptoms of “ED”, utilised in encouraging treatment, is that difficulties with achieving and maintaining erections are a potential indication of other health problems.

2.1.3 Erections as the window to Men’s Health

Many factors have been cited in the aetiology of the dysfunction. Ailments associated with the presentation of erectile dysfunction include: vascular dysfunction, smoking and smoking related illness, alcohol consumption (in younger males), hyper cholesterol, hypertension, diabetes mellitus, hormonal complications, psychogenic factors, depression and mental disease, and the side effects of therapeutic drugs (Carsons, 2004; De Klerk *et*

al., 2003; Feldman *et al.*, 1994). In fact, one of the flagships to the aggressive marketing and advocacy of consulting a medical practitioner for the treatment of ED is the understanding that the dysfunction serves as a window to the preventative diagnosis of other, “more serious”, “illnesses” such as cardiovascular disease and diabetes. Ironically, the actual treatments of other ailments also play an important role in the aetiology and preservation of symptoms of erectile dysfunction. Such treatments include anti-hypertensives, antidepressants (serotonin re-uptake inhibitors), surgery or radiation for malignancies in the prostate, rectum or bladder, and medications that reduce testosterone levels (De Klerk *et al.*, 2003). Levine (2003) adds to this list the presence of thiazide diuretics and beta-blockers. He also cites stress from impending marital and vocational failure as key variables in the aetiology of erectile dysfunction. Another, less mentioned, but severe cause of erectile dysfunction is spinal cord injury. In general, however, problems with achieving and maintaining erections are associated with the natural ageing process (Carsons, 2004; De Klerk *et al.*, 2003; Feldman *et al.*, 1994). According to Levine (2003), the prevalence of erectile dysfunction is particularly high for men over 60.

From De Klerk *et al.*’s (2003) South African sample, it was found that, in line with other studies, diabetes mellitus, hypertension and heart disease were strongly associated with erectile dysfunction and were probably related to the vascular pathology associated with these diseases. These diseases are considered to be very common amongst the South African population and might strongly influence the comparatively high prevalence rates of erection problems found in the study.

Therefore, in terms of the above mentioned studies, concerns about erections are very easily translated into the symptomology of other disease processes. Again, a research question that comes to mind is: How do concerns about disease processes such as cardiovascular disease, participate in conversations about erections and in what ways do they contribute to the construction of concerns about erections?

2.1.4 The Physiology of Erections

The facilitation of an erection requires an increase in flow of blood to the penis, the relaxation of smooth muscle, and the restriction of the outflow of blood from the penis. The European Association of Urology considers an erection to be, “a neurovascular phenomenon under hormonal control, and includes arterial dilatation, trabeculat smooth muscle relaxation and activation of corporeal veno-occlusive mechanisms” (Wespes *et al.*, 2002, p.3). Put more simply, by Steers (2002), from a pharmacological perspective erections are the result of increased blood flow to the penis, relaxation of cavernous smooth muscle, and restriction of venous outflow from the corpus cavernosum. This event relies on input from the parasympathetic nervous system, specifically within the sacral (s2-s4) spinal cord region. This parasympathetic input relies on visual, auditory, olfactory, imaginative, and tactile stimuli. Pelvic nerves run from the cavernous nerves and supply autonomic messages in the form of three different neurotransmitters that result in the relaxation of cavernous smooth muscle. ED is often the result of lack of

cavernous smooth muscle relaxation and oral treatments facilitate such an event through activities in the central nervous system. In effect, it is the successful treatment of ED that has lead to a more thorough understanding of its mechanics.

2.1.5 Treating “ED”

There has been a growing focus from the pharmaceutical industry on sexual health concerns. In fact, it is arguably such interest that has lead to the branding of Erectile Dysfunction to the marketable phrase of “ED”. I believe that the pharmaceutical interest in erection problems has had a dramatic effect on the public approach to sex, as well as individual’s experience of their sexual health problems - If one has difficulty in achieving an erection and, therefore, in engaging in a fulfilling sexual relationship, this can be explained in terms of physiological mechanisms and is relatively easily treated with oral medication. Therefore, the potential implication is that the meaning given to the experience is that there is nothing wrong with my “manhood”, nor with my relationship with my partner, but there is a problem with my mechanics that can easily be fixed by a visit to my physician and a tablet.

Arguably, therefore, the developments of oral treatments for the failure to achieve or sustain an erection have brought about new public sexual awareness. For instance, a renewed interest and openness to sexual health concerns was introduced by the public

launch of Pfizer laboratories proud new drug Viagra ®. I understand the impact of this drug as twofold: 1) It allowed men who had been struggling to function sexually to regain functioning, and 2) in doing so created room for the public and private acknowledgement of the existence of sexual health problems. In South Africa, in 2003, Pfizer launched an “ED” public awareness campaign, including print, radio and televised advertisements, which served as a wonderful contribution to “normalizing” sexual health problems and introducing dialogue about sexual concerns directly into people’s living rooms.

Although I wholeheartedly welcome such an awareness, my concern is that this surge in awareness is, at present, monopolized by marketing and medical interests that harbour discourses that might be contraindicated to sexual health. Since Pfizer launched Viagra®, pharmaceutical companies such as Bayer™ (with Levitra™) and Eli Lilly (with Ceilis™) have entered the ED market with highly competitive oral treatments. As a result of the close competition between these drugs, awareness campaigns have been on the increase with tag lines such as “feelalive” (Viagra®), “24-hours-of-freedom” (Ceilis™) and “seize the moment” (Levitra™).

What if such awareness campaigns, although encouraging healthy sexuality, may risk producing (or reproducing) discourses that could be jeopardising to aspects of sexual health? For example, the sentiments shared by Dr Rosie King at the First African Sexual Health and Rights Conference, held in March 2004, who emphasised that we should be

cautious with the discourses that are drawn upon in order to market treatment of sexual health problems: For instance, it is possible that through the marketing of treatments for erectile dysfunction one can indirectly be supporting the “myths” about men that require that they are to be “super-potent”. Keeping alive such myths may lead us further away, rather than closer to, sexually healthy ideals in society. There has also been criticism that the “sensationalism” around the advocacy of oral treatments risks exacerbating disappointment for men for whom the treatment does not work (Tobler, 2004).

Nevertheless, the three oral treatments that are now available for treating difficulties with achieving and maintaining an erection have proven to be far less invasive and, for most groups of patients, are far more effective than previous treatments. Each drug has a slightly unique pharmacological makeup but induces very similar results, varying mainly in terms of drug interaction, time required to take effect, length of time likely to be effective (often referred to in terms of half-life) and nature of (very mild) side effects.

2.2 Beyond Physiology - How erections are understood beyond their physiological construction.

Some researchers propose that, in many cases, erectile dysfunction is associated with modifiable or reversible factors, such as lifestyle, or drug related factors that can be modified in conjunction with or prior to treatment (Wespes *et al*, 2002). They also claim

that psychological factors, although perhaps not as concretely understood as the physiological factors, appear to play an important role in the development and maintenance of the problem. The purpose of this research is to shift focus from pursuing causality and the binary positioning of mind (or psychogenic) and body (or organic), to focusing on how erectile dysfunction operates as a construct through language.

2.2.1 The Psychogenic Erection

According to Levine (2003), although there is a shared understanding that a minority of ED cases are purely psychogenic and that some are purely organic, the most common type seen in clinics is of a “mixed” nature: “Mixed” being a combination of biological, psychological, interpersonal, and cultural elements. Levine (2003) also makes the observation that the purely psychogenic cases tend to occur more often with younger men, the “mixed” during mid-life, and the purely organic more often in aged men. However, it could be argued that attempting to differentiate psychogenic from organic causes of ED is inappropriate as elements of both are likely to co-exist.

When it comes to psychogenic factors involved in the development of erectile dysfunction, performance anxiety is believed to be a central element (Levine, 2003). Any male who might have struggled to achieve an erection on one or two occasions may develop an anxiety that further inhibits his “*res-erection*” (so to speak). He is then haunted by the anxiety of not being able to achieve an erection in his next encounter and

risks becoming preoccupied with his performance or non-performance. Anxiety appears to predominate “whenever he gets into any kind of difficulty during sex, whether it’s because he has an arterial diminishment in the flow to his cavernous artery or because he may feel guilty about something” (Levine, 2003, p.242). Therefore, whether the aetiology is primarily organic or not, the experience is likely to involve some aspects of psychological experience, such as performance anxiety. In relation to this, Levine (2003) identifies five “psychogenic related” factors that might impair performance: 1) Anger and alienation from sexual partner, 2) separation or divorce, 3) guilt, 4) illness in self or partner, and 5) job failure or grave disappointment with self. Although performance anxiety appears to have an overarching influence, Levine (2003) also identifies *sexual desire* as a significant factor in sexual performance and describes it as the interaction between three disparate components of drive, motivation and wish.

This understanding differs somewhat from the more common view of sexual response shared in the field of sexual health that was based on the original work of Masters and Johnson’s (1966), that breaks down sexual activity into more physiologically based components – desire, arousal, orgasm and restoration. Masters and Johnson’s (1966) work built upon that of Kinsey’s, and based on their extensive study of 382 females and 312 males, they delineated four basic phases of a normal sexual response cycle: 1) the excitement phase; 2) the plateau phase; 3) the orgasm phase; and 4) the resolution phase. Masters and Johnson’s (1966) research was aimed at answering the question of “what do men and women do in response to effective sexual stimulation?”. Males were found to

follow only one typical sexual response cycle that appeared to vary only in duration. Women, however, were found to demonstrate three typical sexual response cycles that differed in both intensity and duration. Ultimately, however, this research looks at the similarities, rather than the differences in subject's sexual response cycles. Based on these findings, the idea of a physiologically "normal" human sexual response cycle was established and since then most traditional approaches to sexual counselling/therapy have focused on facilitating a return to this "normal" pattern - primarily through cognitive behavioural techniques. Levine's (2003) work differs in that he focuses on desire and conceptualises "drive" as the biological component, "motivation" as the psychological component and "wish" as the cultural component. Therefore, the conceptualisation of a sexually healthy response is shifted from a primarily physiological understanding.

Nevertheless, popular approaches to sexual problems appear to be based on Masters and Johnson's principles and are well utilized in practice - including the PLISSIT model and the sensate focus technique. Sensate focus gives specific guidelines as to how the couple should engage intimately. The goal is to promote physical closeness and positive touching in a way that alleviates performance anxiety through avoiding focus on penetration (Albaugh & Kellog-Spadt, 2002). According to the PLISSIT model (Wallace, 2003), the advised steps to conversations about sexuality include:

- **P** – Obtaining **P**ermission from the client to initiate sexual discussion.
- **LI** – Providing the **L**imited **I**nformation needed to function sexually.

- **SS** – Giving Specific Suggestions for the individual to proceed with sexual relations.
- **IT** – Providing Intensive Therapy surrounding the issues of sexuality for the client.

From a discursive position, guidelines such as obtaining permission would be of value, but of primary interest would be the different discursive resources utilised in gaining permission and the implications of such choices for the constructive nature of the conversation. How might conversations differ that focus on psychogenic versus organic understandings of “ED” and how might participants in conversations manage psychogenic and organic understandings of “ED” through talk in different ways?

2.3 The Construction of “ED”

2.3.1 Origins of “Normal” Functioning

It might be of value to briefly explore how notions of “normal” sexuality came about in order to understand the cultural pressure on men to be sexually potent. The medicalisation of sex and the very conception of what is “sexually healthy” appears to be rooted much further back in history than the work of Masters and Johnson (1966) and the advent of oral treatments for erection problems. Nye (1989) looks at the ways in which

medical theory helped create and maintain the sexual norms of 19th century French bourgeois culture. Nye's review excavates the notions of "honour" and "impotence" from discourse on sex, gender and sexuality in 19th century French medical literature. According to Nye (1989), such notions were not unique to France and flourished throughout Western Europe.

In the "Old Regime" sex was reduced to reproduction and the ultimate purpose of marriage was to procreate. Virility, therefore, was the capacity to "engender" and more specifically - to engender sons. The 19th century middle class French society gradually moved away from the notion of sex for fertilisation purposes and opened up to the idea of sex for pleasure. However, the stigma on "male reproductive incapacity" remained. According to Foucault (in Nye, 1989), the "sexual technologies" of the time did not necessarily intend to repress non-marital, non-genital, non-heterosexual sexuality, but rather they placed emphasis on "normal" marital sexuality and made the husband responsible for its success because his lineage depended on the success of this relationship. In essence, male honour became extended to both the ability to engender and to please ones partner sexually. These notions were supported by ideas in medicine that had become well established by the 19th century. Medical scientists developed the notion of biological norms and the measurement of vital processes (such as body heat, respiration, circulation and heart rate). These measurements were then plotted on a spectrum: the middle range of the spectrum was considered "normal" and extreme ranges, that were rarer, were considered excesses or deficits. Therefore, in the field of sexuality,

the norm would be “procreative love”, the excess “satyriasis” in men and “nymphomania” in woman, and the deficit would be “impotence”. A discourse also developed that sustained excess would lead to permanent deficit, which gave scientific validity to notions of inhibition. Nye (1989) highlights how the language of “honour” and “shame” began to filter through into these notions of normal and deficient.

In the 19th century, the relationship between males and females was constructed as being one half of a complete being, whose sacred mission was the reproduction of the species (Nye, 1989). The female, however, was designed to receive and the male to give. The male is to “pour out its force” with “abundance and generosity”, and the female is to receive, welcome and absorb “through her timidity”. Such notions appeared to be built upon biological notions of thermodynamics. A man’s masculinity (deep voice, courage etc.) was a manifestation of his vital force that was embedded in the energy of his semen. Female qualities were the result of a lack of this “vivifying fluid”. The transference of semen from male to female during intercourse was considered man’s loss and women’s gain. A man’s fate, therefore, was to be gradually demasculinised. Nye (1989), through his discourse analysis, highlights how medical authors of the time increasingly saw modern life as posing a threat to male sexual potency.

Ultimately, however, impotence became associated with shame, disgust and feminisation. Although by the 19th century impotence was no longer grounds for divorce, the literature of the time still highlighted the dark humiliation associated with the condition: “An

ardent, vital, expectant young woman who marries a man bringing only satiety, disgust and impotence to the conjugal bed will be led by her needs to forget in adultery the impotent who let her pleasures, her youth, her ardor, and her beauty wither in silence” (Virey in Nye, 1989, p.58).

Therefore, a construction of what was sexually “normal” developed and from this, strategies for optimizing the normal and avoiding the “abnormal” (or “shameful” consequences of abnormality) were introduced. The normal functioning man’s honour became linked to his ability to ensure the continuation of his lineage and satisfaction of his partner, without spending too much of his vigour. Deviance from the norm in terms of excess or deficit would mean dishonour and dishonour was linked to the binary conceptions of gender. Therefore, the dishonoured male was an effeminised male. Impotence was linked to cowardice and effeminism and through impotence more than just a physical functioning was lost, one’s honour and position as a man was also forsaken. There is no doubt that today’s male who experiences ED is likely to experience a degree of shame, my interest however is in how professional discourses might orientate to male experiences of sexuality.

2.3.2 (Res)ecting masculinity through language

Representations of masculinity through science are still evident in modern scientific discourse, as is illustrated by Moore's (2002) analysis of how representations of sperm are socially constructed within contemporary science. This feminist critique illustrates how scientific discourses are related to gender practices and representations. Through this critique of scientific commentary in the field of fertility, Moore (2002) illustrates how the representations of sperm are situated within the existing struggles of masculinity. In other words, the research highlights how depictions of sperm and semen can be considered as "situated" activities. Therefore, how we understand sperm is related to who is defining it, under what social circumstances and for what purposes. Moore (2002) considers the social context to be one of hegemonic masculinity¹ and that descriptions of sperm implicitly serve to naturalise, defend and uphold a hegemonic reality. Therefore, scientific rhetoric concerning fertility treatment and sperm health is read as an attempt to resurrect hegemonic masculinity in heteronormative ways. The analysis illustrates how metaphors from social arenas such as car racing or football matches are drawn upon in order to describe the "behaviour" of sperm. Her interpretation is that, when masculinity is threatened, socially through changes in societal structure and the development of fertility treatment (i.e. the possibility of dad-less families), and

¹ The term "hegemonic masculinity" was introduced by Connell to mean "the configuration of gender practice which embodies the currently accepted answer to the problem of the legitimation of patriarchy, which guarantees (or is taken to guarantee) the dominant position of men and subordination of women" (in Moore, 2002, p4). See also Potts (2001).

physiologically through increasingly lower measures of men's sperm counts, then science attempts to resurrect masculinity through the language it uses. Ultimately, the research asks the question, "How is it that when real men are attacked, sperm are enabled to be triumphant?". The answer to this question appears to relate to the use of discourse or language and how sperm are constructed through language. This approach is relevant in considering my own research question - My interest is therefore in - when the ability to achieve and maintain an erection is threatened, be it by aging, disease, anxiety or whatever identified physiological, psychological, interpersonal cause - how is this threat managed through the use of language and what is being constructed about men, sex, masculinity, health care, causality and a variety of related themes, through this observed use of language.

2.3.3 Cautioning the Dominant Voice

Despite interesting research like that of Moore's (2002), it still appears that the majority of research in the field of sex and relationships, related to treatment and commentary on sexual health, is from a predominantly medical paradigm. To illustrate, Winton (2001a; 2001b) examined the presentation of male and female sexual dysfunctions in the Journal of Sex and Marital Therapy, the Journal of Sex Education and Therapy, the Journal of Sex Research, and the Archives of Sexual Behaviour. The results indicated two major trends: Firstly, that the focus has shifted to male sexual dysfunctions, with specific attention being given to erectile dysfunction. Secondly, that the medical model has

emerged as the dominant paradigm for the treatment of male sexual dysfunctions. Furthermore, Winton (2001b) calls for a need for research on how sex therapists are actually approaching sexual dysfunctions (namely erectile dysfunction) in practice.

Levine (2003, p.241) warns that although, since the release of Viagra (now over five years ago), the attention to a “once-neglected and stigmatized condition is welcome, it has [however] come with an unfortunate tendency to oversimplify ED as solely organic and easily treated”. Nevertheless, even when psychological aspects of erectile dysfunction are included, a dichotomous relationship tends to be implied - Aetiology is seen as organic versus psychological/psychogenic factors. Although, Levine warns of the implications of treating the physiological while neglecting the psychological, there is little research on the myriad of possible implications of treatment of “ED” in and of itself, and what “successful” treatment might imply. In particular, there is almost no research that focuses specifically on how we treat erections discursively – the nature of talk and texts in relation to concerns about erections.

However, Potts (2004) has looked at how couples talk about treated erections and as a cautionary voice, has introduced the notion of “Viagra Cyborgs”. The research is based on interviews of several couples with regards to their experience of using Viagra. Interviews were conducted throughout New Zealand with men and women who volunteered to take part in a qualitative study of the social impact of sexual pharmaceuticals. Participants came from a variety of socioeconomic backgrounds, men

were aged 33-72 (average age of 60) and women were aged 33-68 (average age of 53). Although most of the men had been prescribed Viagra for the treatment of erectile difficulties, some had also used it for recreational purposes. Interviews focused on participant's "perspectives and experiences" of erectile difficulties and the use of Viagra within relationships.

Potts (2004) draws on the metaphor of the cyborg, a hybrid "of organic bodies and machines; entities that confuse the boundaries between human and non-human, natural and artificial, reality and fiction." (p.1). The "Viagra Cyborg" or the "Viagraborg" is the amalgamation of the organic and the synthetic, a blurring of the distinction between natural and synthetic. Citing the work of Barbara Marshal and Meika Loe, Potts (2004) notes how rhetoric around Viagra makes use of machine metaphors - the penis is viewed to operate by simple mechanical principles and Viagra is proposed as a mechanical solution to a mechanical problem.

Ultimately, the use of pharmacology to enhance performance can be seen as forming part of a cyborg culture of which we are increasingly becoming a part of. Potts' work is stimulated by an interest in the potential implications of the blurring between the natural and unnatural, or authentic and synthetic. Her work takes a look at "the ways in which the experiences and narratives of those using Viagra and engaging in Viagra-assisted sex are reinforcing or disrupting the discursive construction of nature and culture, originality and authenticity; and what kinds of stories are being told about masculinity." (Potts,

2004, p.3). The questions she is asking that are most relevant to my own exploration being: “Are the body modifications associated with Viagra use always accepted? Or are they resisted and challenged, even by those who desire and endorse the drug?” (Potts, 2004, p.4). My interest is in how such endorsements or resistances are discursively presented and managed – how they manifest through actual talk. It appears that the present marketing of oral treatments for erectile dysfunction draw upon restorative and naturalizing metaphors in endorsing and promoting treatment.

Potts (2004) reports that many couples constructed Viagra as restoring the penis to its original youthful functions. For example, some respondents saw Viagra as “one hundred percent natural” and a “turning back the clock” or “a temporary correction of a chemical imbalance” brought about by the “common” event (erectile dysfunction) due to aging. However, in other respondent’s reports, Viagra appeared to allow for or exacerbate a distinction between the physical and emotional, “You can be completely unemotionally involved, and yet have a rock hard erection, it’s incredible” (Potts, 2004, p.6). Although this respondent found this experience “incredible” he also concedes that, although the treatment helps, sex with his wife becomes “a bit like a battery hen”, highlighting a mechanical and unemotional potential to the experience of using sexopharmaceuticals. Such accounts should not however discount the potential efficacy of the drug altogether. As Potts (2004) indicates, even the presence of the drug up in the cupboard, creates great erectile security in some respondents. For some, Viagra is not only a return of physiological functioning but a restoration of masculinity - “It gives you your manhood

back again” (Potts, 2004, p.8). On the other hand, there is the risk that such treatments and the discourse that surrounds them, feed into myths of super-potency in men. “Aided” sex becomes better than “natural” sex and the very discourses that contribute to difficulties with erections (that men are and should be super-ever-potent and the related anxieties) are upheld rather than resisted. Ultimately, I think the work done by Potts introduces an important question – What are the implications of restored, improved or “better manhood through chemistry”? By looking at how people language their experience of “treated erections”, her research indicates that some of the implications might be cause for concern. This again emphasises how research should look beyond the simple restoration of mechanical functioning of the penis, to how do individuals orient to such restorations (or the possibility thereof).

2.3.4 The Voice of Therapy

Rosing (2004) points out how sexuality will always have a social dimension and there is no sexual dysfunction that can be considered in isolation from a partnership or social environment. It is concluded, therefore, that the main aim of sexual rehabilitation is to improve the quality of the overall sexual relationship and not just create the circumstances necessary for penetration or to simply treat the malfunctioning organ.

Therapeutic approaches to sexual health concerns have included psychoanalytic concepts and the use of theories of psychosexual development in order to understand sexual

problems. Behavioural concepts were also introduced, such as systemic desensitization techniques and cognitive psychology, which explored the role of dysfunctional thinking in individual's sexual problems (see Schnarch, 2002). Cognitive-behavioural treatment developed from these approaches (although not unchallenged by psychodynamics) and were promoted by pioneers such as Masters and Johnson (in Schnarch, 2002). These approaches have, however, been criticised for focusing purely on the sexual dysfunction and not the context in which it occurs (Schnarch, 2002). There are, therefore, many differing and competing positions from which sexual health concerns are potentially treated.

It is perhaps important here to highlight the differentiation that Schnarch (2002) makes (from a systemic position) between sex therapy and couple therapy. Sex therapy is focused specifically on changing sexual behaviour whereas couple therapy, when addressing specific sexual issues, tends to operate under the assumption that with the improvement of the couples relationship comes the improvement of the sexual satisfaction. Schnarch (2002) looks at how most therapeutic approaches to sexual concerns "are based on the common sense notion that sex is a natural function that can be restored through disinhibition and/or reeducation" (p.239). He heeds that this approach may, in itself, cause new problems as it pressurises patients to perform in certain ways (move through set stages of Masters and Johnson's sexual response cycle) while paradoxically requiring that the patient not focus on sexual performance. Such approaches focus on a return to that which is "natural" rather than a focus on that which

might be idiosyncratically experienced as intimate and erotic for the couple. Schnarch (2002) criticizes the notion of “natural sexual functioning” for leading to the conclusion that the absence of presumably automatic functioning is pathological. Such an approach implies that a failure to recover is a failure to be normal and locates the “pathology” in the individual ignoring other dynamics such as the “system that the couple creates” (Schnarch, 2002, p.239). In terms of this, treatments based on approaches such as the four phase model of Masters and Johnson and the “tri-phasic” model of Kaplan can be seen as limited. It is argued that our unique abilities as human beings (our complex meaning making ability and profound ability for intimacy) should be integrated into approaches to sexual functioning and experience. Schnarch (2002) also highlights “differentiation” - our ability to retain a clearly defined sense of self, while remaining in a close relationship with significant others - as essential to maintaining a satisfying sexual relationship.

My interest is in how the implications of such treatment might unfold through the constructive nature of language. Research and literature on erectile dysfunction tends to make mention of psychological factors, the importance of including the partner in treatment, and the creation of an appropriate atmosphere and suitable line of questioning in the diagnosis and treatment of erectile dysfunction. However, research or literature offering an explicit understanding of, and strategies for, psychological interventions appear to be scarce.

2.4 Commentary on Helplines

Although telephone counselling is a very well utilised form of helping, little is known about its effectiveness compared with more traditional methods of helping (Kenny & McEachern, 2004). In South Africa, especially with the increasing threat of the AIDS epidemic, several sexual health related helplines have developed since the 1980's in order to provide counselling and information, including:

- LoveLife's "the tha junction" (pronounced te-ta-junction)
- National Aids Helpline (0800 012 322)
- Childline (08000 55555)
- Sex worker education and advocacy task force (Sweat)
- People Opposing Women Abuse (POWA)
- OUT in support of same sex relationships

In their review of research on the effectiveness of telephone counselling and the quality of the counselling relationship, Kenny & McEarchen (2004) highlight the unique nature of telephone counselling. One primary advantage of helpline services is that they reach a broad base of people from a variety of socio economic backgrounds. In addition, although there is an absence of non-verbal cues, which might place some limitations on the therapeutic encounter, greater emphasis is placed on the clients' and counsellor's voice, flow, rhythm, tone and speed of speech.

In the sample researched it was found that clients rated telephone counsellors no different from face to face counsellors and found them to be both “emotionally invested” and “influential” (Kenny & McEarchen, 2004). However, such research involved a service for which the average number of telephone sessions per client was 12 and the average length of each session was 30min. On the helpline of interest to this research, the helpline calls last as little as 2 minutes and are usually once off. Nevertheless, especially in the field of sexual health, a confidential helpline allows callers to engage with difficult and embarrassing questions about personal sexual behaviour and issues of sexuality with greater ease. Sexual health helplines also inform callers on a variety sexual health related issues and provide an opportunity for detailed dialogue and referral (Stratten, 1999). A further benefit of a helpline is that it can provide an opportunity, through the relatively easy and effective provision of information, for the challenging of dominant myths, misconceptions and discourses that might hinder the development of healthy sexuality.

Nevertheless, the line between information providing and telephone counselling appears to be a relatively blurry one. According to Stratten (1999), in the HIV/AIDS sector, the trend has been to start off by offering both information and counselling and then to adapt the purpose of the helpline according to the needs of the target market. The target market of sexual health helplines vary greatly from type of treatment sought to type of audience targeted (youth, teenagers, mothers, partners, victims etc.). In terms of the helpline being researched, my interest remains in what are the implications of the existing orientation

towards callers (whether it be more counselling or more information providing) for how their concerns are constructed.

2.5 What has been heard – A brief summary

From the literature review, it appears that there is a definite biological basis to erectile functioning that has been well explored and that is an important consideration in treatment. Since 1999, there have been very significant developments in the medical treatment of erectile functioning through oral medications. Such developments have given substance to an increase in the medicalisation of sexual health concerns. Although there are undoubtedly positives to a medicalised approach to sexual health concerns, some commentary within the field of sexual health has been made that argues for a look beyond the mechanics of sexual functioning to ways in which sexual functioning is embedded in a variety of contexts such as intimate relationships, meaning making processes, emotions, politics, social construction and language. Although mechanical solutions are available and have been proven to be very effective for erectile dysfunction, there is a need to explore how such solutions participate in a broader context. My primary concern is the discursive context in which concerns about erections are constructed and treated.

Chapter 3

RESEARCH METHODOLOGY

3.1 Context

The research was conducted over two full days at the call centre of a local non- profit, non-governmental organisation (NGO) - The South African Sexual Health Association (SASHA). Although the helpline fields calls about any sexual health concern, over the two days that the calls were recorded, all but one of the calls in the sample involved queries or concerns about erection problems.

3.2 Participants

The research involved the recording of conversations on calls to the SASHA helpline. There were a total of twenty recorded calls from twenty different callers of various ages and cultural backgrounds. Only two of the callers were female, the rest were male. The calls were facilitated by the participation of three helpline facilitator's who were, at minimum, at an honours level (4th year) in psychology training - two of whom were female and one male.

3.3 Research Position

Discursive Psychology (from here on referred to as DP) is the application of certain discourse analytic principles to psychological topics (Edwards & Potter, 2001). My understanding of discursive analysis is that it serves as a detailed and meticulous form of discourse analysis. The term discourse has a variety of theoretical and philosophical applications. For the purposes of this research, from a DP position, “discourse” represents the language used to achieve certain “acts” - language used in constructing our lived realities.

Potter (2003a, p.4) introduces DP as “one strand of discourse analysis that has its origins in social psychology and sociology, but is now common place in communication and other social science disciplines”. According to Potter (2003a), discursive analysis aims to demonstrate the ways in which discourse is central to action – what we do with others we do through discourse. From a discursive perspective, talk and texts are used to perform certain actions (Potter, 2003b), in both deliberate and non-deliberate ways. Therefore, the ways in which we perform through talk and text, and the variety of implications for such performances, are the interest of DP. Such a shift in interest has lead to rigorous analysis in the form of tape recorded and transcribed records of interaction in naturally occurring contexts such as everyday telephone conversations between family members,

mealtime conversations, talk in work and institutional settings, and talk in relationship counselling (Potter, 2003b).

From the position of DP, the construction of mental states, thoughts, perceptions, motivations, dispositions, prejudices, and so on, are the business of talk and texts (Edwards & Potter, 2001). Our reality is constructed by the use of language through the performance of everyday tasks/business (Edwards & Potter, 2001). DP, therefore, favours the analysis of records from natural interactions or textual materials that are produced as part of “life’s activities”, as opposed to making use of experimentation, surveys or interviews as the basis of findings (Edwards & Potter, 2001). Discourse is considered central to everyday natural settings and such settings are understood through the analysis of the discourse produced within that setting. Even when activities in these settings are “non-verbal”, these activities are understood by how they are constructed through discourse. From a DP position, therefore, language is not limited to the representation of mental states and cognitive processes. Rather, language is the means by which mental states and cognitive processes are constructed.

3.3.1 Discursive Psychology and its “taken-for-grantedness”

As a methodology, discursive analysis is viewed not only as a novel approach to researching communication, but as a shift in how psychology itself is understood. As a

result, the methodology and the epistemology are inseparable. Understanding the value of discursive methodology requires an understanding of how it theoretically constructs social practices. As a theory and methodology, the development of DP demonstrates how:

Social inquiry is in ongoing (re)construction in activities such as research, writing, teaching and consulting, and conference presentations. All social practices reproduce certain taken-for-granted about what exists; this is the question of ontology. So, for example, practitioners of the human sciences construct people (with personal characteristics such as motives, and cognitive maps), organisations (with structures, and a mission) and environments (complex, turbulent...).

Hopkin, 1999, p.2

The theoretical “taken-for-granted” in DP, essential to its analysis, serve to strongly challenge previous taken for granted in the field of social enquiry. Central to its analysis is the understanding that: discourse is 1) *Action orientated*, 2) *situated*, and 3) both *constructed and constructive* (Potter, 2003a; Potter, 2003b; Edwards & Potter, 2001)

3.3.2 Action Orientation

“It is about unpacking and rendering visible the *business* of talk”

(Potter, 2003a, p.6)

Discourse is capable of performing an array of actions or practices such as agreements, blaming, invitations and displays of neutrality (Edwards & Potter, 2001). The notion of “action-orientation” emphasizes how discourse is always orientated to some sort of doing

(deliberate or not), even when it comes to seemingly factual and descriptive discourse (Potter, 2003b). Talk is, therefore, not limited to mere “speech acts” where a specific set of words correspond to a specific act, rather, the relationship between discourse and its doing is far less linear. Specific verbs are not limited to the performance of specific/obvious acts. Therefore, from a DP position, utterances are capable of an array of discursive achievements and what is being “done” by talk can often be very indirect and un-intentioned. Hence, a discursive analysts’ concern is with what is being done by talk and not what the structure of the language is (i.e. linguistics) or what cognitive structures the language is evidence of (i.e. cognitive psychology).

Potter (2003a) highlights 3 important questions in relation to viewing talk as action:

- 1) What is the discourse doing?
- 2) How is the discourse constructed in order to achieve this action?
- 3) What “discursive resources” are available to perform this action?

Not all discursive actions are deliberate or intentioned and therefore discourse analysis avoids taking an evaluative or critical stance towards the participants.

3.3.3 Situatedness

“Analysis will consider the way that talk and texts are embedded in sequences of interaction, are orientated to institutional settings and identities, and are put together rhetorically” (Potter, 2003a, p.8)

Discourse is situated in 3 ways (Potter, 2003b), it is a) situated sequentially, b) situated institutionally and c) situated rhetorically. That is:

- a) The context of what is said is related to what came before it (although not determined by it) and by what will potentially come next.
- b) Tasks and identities related to the institutional context, such as the identity of helpline facilitator and the task of information providing, are relevant to (but do not determine) what takes place.
- c) Descriptions are chosen from a multitude of possibilities and are constructed in ways that resist being received as attempting to achieve certain acts. As a result, accounts and descriptions tend to have either an offensive or defensive rhetoric.

Discursive actions or practices do, therefore, not simply “hang in space” but are occasioned – “greetings follow greetings; acceptances follow invitations; minimizations follow complaints.” (Potter, 2003a, p.7). Although situated, interaction is not necessarily governed by the obvious or official setting in which it takes place and context does not rigidly determine discursive actions. Rather, it is what participants’ make of the setting and hence “do” with that setting that is important. As Potter (2003a, p.7) illustrates,

“Two people interacting in a surgery room, say, may do so as doctor patient, or as friends, or as lovers, or as religious white guy and irresponsible adolescent.”

3.3.4 Constructed and Constructive

“In discourse analysis [discursive analysis], the way versions are constructed and stabilized as independent of the speaker is treated as an analyzable feature of the production of discourse” (Potter, 2003a, p8).

Discourse is put together (constructed) through the use of various resources such as words, certain categories, commonplace ideas and broad explanatory systems. It is also constructive, however, in the way that it builds and stabilizes versions of the world/events/actions/people's phenomenology in talk through discursive actions. For example, a person might construct their “lateness” through versions of the highway traffic or descriptions of their own faulty cognitive processing – “You have no idea how hectic the traffic was” / “I don't know where my mind is today”. Therefore, discourse is constructed in order to achieve certain actions. Lateness, for example, may be constructed in ways that negate blame or shift responsibility.

3.3.5 A shift in perspective: Non-cognitivism and a focus on the specifics of social interaction

From a discursive position, talk is not viewed as generated from or as a result of mental states (Edwards in Lamerich, 2003). Therefore, it is not the work of DP to make inferences about the mental states of participants. Cognition and cognitive states are viewed in terms of how they are treated through discourse. Therefore, talk and action are not explained in terms of people's cognitions. Nevertheless, "It is important to point out how the non-cognitivist focus in DP does not imply that people do not think or feel or that nothing goes on in their heads." (Potter in Lamerich, 2003, p.45). Rather, what it means is that both the *analytic* and *explanatory* focus is moved from considering *cognitive processes* and entities to *discursive practices* and the *resources* they draw on. In addition, not only does DP serve as a move from more traditional views of psychology but its focus also serves as a shift within the field of postmodernity (Potter in Lamerich, 2003, p.45):

Finally, it is import to note that Discursive psychology's account of the constructive nature of discourse differs slightly from that of social constructionism and work based on that of Foucault, in that it focuses on how versions of the world are constructed through specific social interactions rather than theorizing about broader themes that have been internalized by people and society through social relations. The focus here is on people's localized discursive practices rather than studying broader, theoretically based, social relationships, topics, themes and constructions.

Through this shift in perspective, DP has ventured into interesting territories, analysing discursive practices in a variety of local settings from the construction of eating at mealtime conversations (Wiggins, Potter & Wildsmith, 2003) to an analysis of the construction of pain through language in elderly hospice patients (Duggleby, 2002). Although DP is a relatively novel and challenging form of research, considerable analytical work has already been done within the health care setting, including: a look at doctor patient interaction and patients' options for participating in their own diagnosis (Drew, Chatwin & Collins, 2001); the potential of conversational analysis for psychotherapy (Madill, Widdicombe & Barkham, 2001); negotiating for facilitating change in patient lifestyles (Karhila, Kettunen, Poskiparta & Limatainen, 2003); a look at the benefits of a discursive approach in health psychology (Wilkinson, 2000); and an analysis of how "concern" is constructed and utilised on a child protection helpline (Potter & Hepburn, 2002).

3.4 Method

3.4.1 Coble-stones along the Road Less Travelled

I have put considerable effort into negotiating for discursive analysis as the appropriate research methodology for this setting (Sexual health and helpline facilitation). To

effectively manage helpline facilitation in the context of sexual health and pharmaceutical interest, a thorough understanding of what is being “done” on the helpline and the implications of such “doing” is needed. However, there were many raised eyebrows at the supposed lack of adequate methodical thinking behind the research. Concerns about representative sampling, standardised procedures and replication, were immediately raised. Ultimately, as already argued, the research is a shift from traditional research ideology. As Potter (1998, page unknown) points out, “If there is one thing that qualitative methods are commonly thought to lack it is precisely an adequate methodical way of arriving at findings.” Potter (2003b) highlights this with reference to the difficulty in writing (or talking) about qualitative methods, such as discursive analysis, because the terminology available for describing research (such as reliability, validity, sampling, factors, variance and hypothesis testing) has been developed primarily to demonstrate quantitative methods. Potter (2003b) points out how such terminology has become so taken for granted that it has become synonymous with what we conceive of as “research”. My own support of the discursive approach arises from an alliance with some of the current thinking that traditional psychological methods such as questionnaires, experiments and statistically based research do not always successfully advance our understanding of human behaviour. This does not, however, mean that empirical research is not considered important to science but that such research techniques are not necessarily “bottom-line” guarantees of progress in science (Potter, 1998).

Another milestone to the implementation of a discursive methodology was the prevalent discourse that sex is a delicate topic that people have great difficulty talking about and, therefore, recording such conversations would make it only more difficult to approach the topic. Nevertheless, as Hepburn & Potter (2003, p.182) clarify:

One of the reasons often given for studying interviews rather than naturalistic materials [such as recordings of naturally occurring conversations] is that interviews allow the researcher access to stuff that is too sensitive to obtain permission to study, or that occurs too rarely to collect realistically. Our experience, however, is that in practice permission can be gained if the right kind of approach is made.

My own argument is that it would be a great irony if we were, as a profession, to encourage individuals to be open, honest and shameless about their sexual concerns and simultaneously feed into the discourse that “sex is not to be said”. It is such a discourse that has been known to perpetuate sexual health problems and challenging this discourse brings us further along the road of giving people permission to engage with their sexual health problems.

3.4.2 Steps along the Road

The SASHA's, sexual health helpline was researched by means of a digital dictaphone (Newgen©) that was plugged into the facilitator's phone port. Calls were recorded and

downloaded onto dictaphone specific software in order to be played back, analysed and transcribed.

3.4.2.1 Recordings

A sample of twenty helpline conversations were recorded. In terms of DP methodology, it is necessary to collect a sample large enough that allows for the identification of a particular discursive pattern in relation to the construction of concerns about erections, including identifiable deviant cases that serve as alternatives to the identified pattern. A total of twenty calls appeared to be sufficient for the scope of this report. Although callers might call in for a variety of sexual health concerns, at present the majority of calls to the helpline relate to concerns about erections and it is these calls that are of greatest interest for the scope of this research. For validity purposes (in DP terms) the sample of callers should allow for a variety of facilitators, to avoid biasing the research with a specific facilitator's communication style, and for the presence of possible deviant cases to the identified discursive pattern (see Hepburn & Potter, 2003). Although the participation of more facilitators would have been ideal, the three facilitators that did participate tended to be those working most frequently on the helpline at the time (three to four days out of every week), therefore the participation of the three facilitators could be considered to be fairly well representative of the present practices on the helpline. In

addition, due to the institutional nature of the calls, illustrated in chapter 4, there is arguably relatively little room for facilitator's personal style.

3.4.2.2 Transcription

Significant interactions have been transcribed according to an adaptation of Gail Jefferson's model (see Madill *et al.*, 2001), illustrated in Appendix B. The Jefferson model of transcription has become a relatively standardised method in DP. Although this method may seem quite tedious, it aims to capture (as best possible) the very fabric of interaction in order to record what "actually" went on. This practice was slightly limited due to the dictaphone specific software that would not allow for recoded data to be converted to relevant software designed to aid meticulous analysis (such as Transana developed by David Woods, available at www.dur.ac.uk). Therefore, it was difficult to fulfil some DP requirements such as the measurement of pauses in utterances per tenth of a second. Nevertheless, although all twenty sample conversations were taken into account in the analysis, only five conversations have been transcribed (conversation five is not fully transcribed due to its excessive length), and are available in Appendix C for the readers own interest (please note that in transcriptions "F" represents facilitators' utterances and "C" callers' utterances). The five transcribed conversations were selected on the basis that they were representative of basic discursive trends in the sample, following careful scrutiny of all twenty calls recorded.

3.4.2.3 Analysis

Analysis involves the use of ten extracts from the five transcribed sample conversations. Recordings of helpline calls were analysed according to the theoretical principles briefly explored above. Analysis involves a move in research epistemology from how does X influence Y, to how is X done in support of certain practices (Hepburn & Potter's, 2003). Therefore, rather than asking "what are the causes of erectile dysfunction", I ask "how is the construction of causes of erectile dysfunction done". This is achieved by focusing on the three core features of DP – action orientation, situation, and construction. Using Hepburn & Potter's (2003) guidelines, these features are illustrated through the way that individual calls unfold, drawing upon trends in the overall corpus to validate claims. Relevant question include - How do callers introduce their concerns and in what ways are these concerns dealt with discursively? What is of great significance is how participants orientate themselves towards the constructed concerns and towards one another's turns in conversation. The analysis of the transcriptions is supported by previous research in the field of DP.

3.5 Quality

Those familiar with more traditional and quantitative approaches to research might misinterpret qualitative research, such as DP, as an 'anything goes' approach. In

response to difficulty with finding a norm for how good qualitative research might look, leading academics in the field, Antaki, Billig, Edwards & Potter (2002), propose what they consider to be six potential analytical shortcomings that allow for “non-analysis” in DP:

1) Under analysis through summary

Simply transcribing the data in detail does not imply that it has been analysed, something must be done with the data. Although transcription prepares the data for analysis, it does not imply analysis itself. Furthermore, simply summarising the themes that participants have addressed in their interaction is not an analysis of the data. Summarising the data does not allow room for the intricacy of the data to reveal itself and makes it difficult to illustrate what discourses the participants are utilising, how they are actually utilising it and what is being done through the interaction.

2) Under analysis through taking sides

It is also possible for the analyst to utilise the data as a platform for communicating a moral, political or personal stance. There are varying opinions on whether discourse analysts should in fact take up any position towards their own data (opposing or aligning with speakers). There is, however, consensus that such work, on its own, does not constitute analysis.

3) Under analysis through over quotation or isolated quotation

Although under analysis through summary fails to do justice to the intricacies of the data, under analysis through over quotation fails to get past the text. Over reliance on quotations risks providing an analysis that is divorced from the relevant context of the entire corpus of data. Ultimately, analysts cannot leave it up to the quotations to do the work of the analysis. Analysts also risk getting stuck on the content of isolated quotes rather than what is being achieved through discourse. In this way, isolated quotes may be employed to demonstrate the analysts own position rather than demonstrating discursive features of the data. Quotations, on their own, do not constitute analysis.

4) The circular discovery of discourse

Analysts should avoid using a form of discourse as an explanatory resource without finding substantiation for it in the data. In other words, through exploring the data, an analyst might claim that participants are using a certain identifiable discourse, repertoire or ideology without sufficiently explicating its use in the specific context. Furthermore, the existence of the ideology itself is then utilised as an explanation for its use. This can be said to be a circular argument. Although identifying the existence of particular discourses is an important part of analysis, the proponents of DP argue that good analysis requires an exploration of how the discourse is being used within that particular interactional context and to what ends.

5) Under analysis through false survey

Analysts also risk a tendency to extrapolate from the data to the world at large. For instance, because a certain discourse is utilised by a participant, analysts might imply (explicitly or unintentionally through their writing) that all people of the same demographics as the participant might do the same. Few qualitative researchers intend providing surveys through analysis, however, without careful consideration of how analysis of the data is being communicated, ‘survey’ may be implied. The argument is that if the intention is a survey, then research techniques designed for the purpose of surveys should be utilised.

6) Under analysis through spotting

The growing corpus of discursive research has allowed for the identification of relatively consistent use of specific conversational properties. Analysts should acquaint themselves with these identifiable features. However, simply identifying these features in the data is not considered to be analysis. Proper analysis would illustrate how such properties of talk are relevant to the analysed interactional context.

Therefore, if the above constitutes non-analysis, how might valid analysis look? Madill *et al.* (2001) cite the four properties of analysis identified by Potter that constitute valid and reliable research. These are: 1) readers’ evaluation, 2) participants understanding, 3) deviant cases and 4) coherence:

- 1) Extracts and the process of analysis of these extracts should be laid out for readers' own scrutiny.
- 2) The researcher meets the research requirements of DP if the ways in which the participants themselves (and not only the researcher) make sense of the topic at hand is explicated.
- 3) The analysis of deviant cases allows for the demonstration of how the interaction might look if the participants do not orientate to the conversation in the manner that is explicated by the analysis.
- 4) The analysis should be coherent. In other words, it should "inform practice" – building upon previous DP work and providing room for further developments.

From an exploration of what the proponents of DP consider to be non-analysis and an exploration of how valid analysis might look, I have concluded for myself that one should not simply allow the data to speak for itself. At the same time, one should avoid speaking on the data's behalf. Ideally one should enter into a conversation with the data that systematically allows one to reveal the discursive features of the analysed interaction and the constructive implications thereof, whilst keeping relevant theory in mind. This report is an attempt to achieve just that.

3.6 Relevance

The research aims to contribute to the growing corpus of work from which a refreshing approach to psychology is developing – that of DP and the awareness of what language “does”. More specifically I have attempted to develop a closer understanding of what is being “done” in a sexual health context, more specifically on the sexual health helpline. Such an understanding will allow for better management of the helpline by illustrating various implications for ways of dealing with and discursively managing callers’ concerns. It is hoped that the research will be a step closer towards research and training in communication skills for health care providers in general. Furthermore, as is apparent from the literature survey, there is little work that deals with unpacking discourse related to the treatment of sexual health concerns.

3.7 Ethics

As mentioned, the research is inherently linked to my involvement with SASHA, the NGO that houses the helpline. The research was influenced by a need to manage the helpline more effectively and it has been suggested that recordings of helpline conversations become standard practice for training and development purposes. Written consent has been obtained from the organisation for the research to be conducted.

Through my supervision of the helpline facilitators they have been made familiar with the research ideas. Although the prospect of recording the calls was met with some anxiety, the facilitators have shown an appreciation for the value of the research in the development of their own facilitation skills. Written permission was gained from all facilitators involved.

Two methods of obtaining consent from callers for the recording of helpline calls were considered. A standard, pre-recorded statement could have been placed on the helpline prior to officially answering the call, giving the callers the choice of whether the calls could be recorded or not, or the callers could be introduced to the research at the very beginning of the call. After lengthy debate, as a board, SASHA decided that I, the researcher, on answering the call, would request consent following which the call would be transferred to a facilitator. The advantage of this is that I would be able to address any questions or concerns about the research that might come from the caller. A similar method was used by Hepburn & Potter (2003) for the same reasons, with great success. A basic script was developed in order to guide the initial requesting for consent from callers.

Chapter 4

RESULTS

4.1 Introduction

DP uses tools drawn from the interdisciplinary arena of discourse and conversation analysis (CA) (Wilkinson, 2000). It is, however, rarely found in the field of health psychology and especially rare in sexual health. DP is a significant shift from previous research in this area and as illustrated in chapter 3, talk is not understood as evidence of cognitions, beliefs or attitudes; rather talk is understood as a form of action designed for its local interactive context. As Wilkinson (2000, p.443) illustrates “The argument here is that talk (in interviews and focus groups, as much as in doctors’ surgeries or counselling sessions) is designed by speakers for its specific context, and is doing something relevant to, and occasioned by, that context.”. Therefore, the context in which talk occurs is of particular importance in DP. Analysis of the Sexual Health Helpline (SHH) calls will reveal the institutional nature of the calls and the implications of such a context for the construction of ED.

According to the tradition of CA, various forms of institutional talk are considered to be adaptations of the basic features of ‘ordinary talk’. From such a position the institutional context of a conversation is evident in the sequence of talk that unfolds within that context and how it might differ from ‘ordinary talk’ (Madill *et al.*, 2001). Therefore,

information regarding the context, beyond the actual words of the participants, is rendered irrelevant. This has, however, been subject to some critique and it is argued that the context of utterances does in fact feature as a resource for analysis in CA, although not necessarily explicitly acknowledged in the actual analysis (Hester & Francis in Mäkitalo & Säljö, 2002). What is clear, however, is that within the growing field of DP there are slightly various accounts of how context might manifest through talk. Although context is considered an important feature in studying interaction, it does not mean that in a medical context that doctor-patient interaction will be completely limited to their identities of doctor and patient. Ultimately, I will work towards the common DP understanding of context, allowing the data to lead the analysis to potentially relevant aspects of the context, rather than allowing aspects of the context to lead the analysis. In other words: How do participants make aspects of context relevant through their locally occasioned talk? As asked by Mäkitalo and Säljö (2002) - How do institutional contexts enter into concrete communicative practices?

4.2 The Institutional Script

An initial overview of the calls indicates that all calls in the sample tend to go through similar thematic sequences. In other words, as the work of the call gets done there are certain themes that are made allowable by the participants in the conversation. Almost every call involved introductory themes (A), product related themes (B), themes that are hearable as relating to aetiology of ED (C), themes that move towards referral making

(D), and finally moves towards closing the conversation – through goodbyes (E). These themes do not always follow a specific sequence and are at times revisited in order to get the task of the call done. The table below gives a more specific illustration of the themes:

Table 1

	Themes	Elaboration
A	Introductory	Certain introductory themes where drawn upon to initiate the call.
	Reduced Openings	Calls typically involved very brief Hello's of one or two lines.
	Identification Orientations	On occasion caller's probe for, or facilitators make relevant, any identification i.e. "who am I speaking to".
	Reason for Call (RFC)	One of the central features of the calls, the reason for call was made relevant very early in the conversation and served as a precursing move for the rest of the call.
B	Product	Products information related to treatment of ED
	Naming	Name of the product is given, often in direct response to the RFC.
	Informing	Certain information about the products was made relevant.
C	Aetiology	Certain themes were introduced that could be heard as relating to the aetiology of ED. These themes are also relevant to the caller information sheet that is filled out by the facilitator (Appendix A)
	Demographics	Callers were asked for their age on most occasions and on some occasions volunteered their age.
	Temporal	The length of time that the problem had been experienced was made relevant.
	Medication	Other medication or previous attempts at treatment of ED were introduced.
	Comorbidity	Other medical conditions where probed for or volunteered.
	Personal/Psychological	Very seldom were psychological aspects addressed, often mentioned towards the conclusion of the call and when introduced by caller, often not orientated to.
D	Referral	Calls involved attempts at making a referral to a doctor
	Script	The necessity for getting a script was introduced.
	Doctor	The need of a doctor in getting a script was made known. On some occasions the need for a doctor's professional opinion was introduced.
E	Goodbyes	Certain markers were used to close off the conversation.

The table illustrates how the calls on the SHH can be heard to follow a relatively fixed institutional script: the calls tend to go through specific themes that have some institutional relevance. However, the methodology of DP necessitates much closer analysis in order to illustrate the relationship between context and talk.

In order to explore this, I will draw upon extracts that highlight the differences and similarities of five helpline conversations. Readers are encouraged to familiarise themselves with these conversations as they appear in Appendix C, before we explore in more detail the unfolding communicative sequences through which the themes mentioned in table 1 are developed.

4.3 Invoking Context through introducing “Reason For Call”

A growing body of discursive research indicates both differences and similarities between everyday conversational practices and more institutionalised talk (*see* Potter & Hepburn, 2002). Research has shown that, in contrast to casual telephone conversations, conversations in a helpline setting tend to show a reduction of typical features, such as the “howareyou” in the opening sequence of conversations. Whereas everyday conversations may take up to 10 turns to get to the first topic of conversation (Schegloff in Potter & Hepburn, 2002), calls to helplines tend to get to the first topic of conversation much earlier in the sequence of talk. Therefore, from the very onset of the conversation, caller and facilitator tend to invoke contexts through the ways in which they position themselves discursively towards one another: Their abbreviated “hello’s” can be heard as a means of invoking context – defining the call as official business. Following the abbreviated “hello’s” is the introduction of the first topic of conversation. It appears that the manner in which the first topic of conversation is enacted plays a significant role in

how the participants negotiate their unfolding position towards each other in the rest of the conversation. Throughout the sample on the SHH, the first topic of conversation was the “Reason for Call” (RFC).

On the SHH, RFC’s were introduced through 1) *inferences* from the facilitator, 2) *probed* for by the facilitator, or 3) *volunteered* by the caller. However, RFC displays seldom end with a single turn and develop into a sequence of turns through which facilitator and caller *collaboratively unpack*² topics relevant to the initial RFC display, through a series of turns characteristically involving *acknowledgments* and *probes* designed to elaborate on the initial RFC display.

In line with Potter’s (2004) findings, the RFC design is significant as it tends to serve as *prefacing move* for the rest of the call, setting the topic for conversation and limiting the conversation in certain ways. The RFC can potentially be designed to make certain topics easier or more difficult to approach. Therefore, of interest here is the design of RFC’s as prefacing moves and the implications of the various RFC designs for the collaborative unpacking of the rest of the call. This kind of orientation to the data is in the spirit of DP’s concern with “sequential analysis” - a concern with exploring how

² “Collaborative Unpacking” is a term used by Potter (2004) to demonstrate how conversationalists co-participate in the unfolding of the calls. Many similar terms have become common place to DP in the development of a language that helps illustrate the action orientation of discourse. Such terms can be understood as discursive acts and I have placed them in italics.

utterances are designed to fit with previous utterances and how a single utterance will have implications for the utterances that follow it (Wooffitt, 2001).

4.3.1 Inferences

Extract 1 helps to illustrate how, through the design of the RFC sequence, institutional context can be invoked:

Extract 1

(Conversation 1)

- 3 F: You're talking.your phoning in connection with the ad on television
4 C: That's right ma'm
5 F: Alright (.) you need to information on um the product.
6 and the products name is called cialis
7 C: °cialin↑°
8 F: CIALIS (.) C I A =

Extract 1 begins directly following a reduced opening, with the facilitator moving to the caller's RFC in line 3 through a *probe* that *infers* why the caller is phoning - "You're talking.your phoning in connection with the ad on television". The facilitator is taking the initiative to speak "for" the caller. Such a positioning appears to be typical of talk in institutional settings, where the "professional" tends to have control over the introduction of topics and, therefore, the agenda of the conversation (Drew & Heritage, 1995). The inference that is displayed is that the caller is "phoning" in relation to the "ad".

Therefore, the facilitator chooses the topic of the “ad” as relevant to the RFC (line 3). The caller responds in the next turn with the agreement “that’s right ma’m”, with no further elaboration (line 4).

In order to explore the significance of the question answer series illustrated in extract 1, we must briefly revisit some DP theory. From a DP perspective, as mentioned in chapter 3, context does not only relate to physical or institutional context in which conversation occurs. The conversation itself becomes the context in which utterances are understood. Therefore, the relevance of the caller’s utterance in line 4 can be heard in the context of the utterance that came before it and the utterance that is expected to follow it. To illustrate: a normative property of talk is that utterances are usually coupled into “*adjacency pairs*”. An utterance by one speaker is usually “conditionally relevant” to the previous utterance of the other speaker (Wooffitt, 2001). Questions are followed by expected or unexpected answers, invites are followed by acceptances or rejections, and assessments are followed by agreements or disagreements. Each *adjacency pair* usually involves a potential *preferred* or *dispreferred* response. For example, the preferred response to a question is normally an expected and agreeable answer, rather than an unexpected and disagreeing answer. Pomerantz (in Maynard, 1991) has shown how when one participant produces an assessment, the other parties response is designed in different ways, depending on whether it is hearable as an agreement or disagreement in response to the preceding utterance. It was found that agreements are done immediately following the preceding utterance, are stated “forthrightly” and take up the entire turn.

Disagreements, on the other hand, tend to be delayed through pauses and prefaces, are mitigated, and usually only form part of a full turn. Therefore, disagreements are less likely to be overtly displayed. As Maynard (1991) indicates, institutional interaction (more specifically doctor-patient interaction), is typically agreeable despite potential differences in understanding that the participants demonstrate through their interaction.

Therefore, what are the implications of understanding line 3 and 4 as an adjacency pair? As a discursive act, the facilitator's utterance in line 3 indirectly places certain parameters on the caller's response. Line 3 can be heard as an *assertion* (that makes use of an *inference* to do its work) and according to Perinbanayagam (1991), assertions are statements that tend to be voiced in a manner that implies that they stem from a position of authority or knowledge. The facilitator, therefore, takes the position of authority by taking the liberty to infer the RFC and through such an assertion, chooses the topic of conversation. The preferred response to this assertion would most likely be an agreement. In addition, the assertion relates to the experience of the advert and therefore the agreement would normatively address the same topic. Hence the facilitator's inference serves to create parameters for the conversation – introducing the topic, taking the position of authoritative voice and potentially limiting the response from the caller to cooperative language.

Considering the above discussion, the question can be asked: What is the availability of alternative responses to the facilitator's assertion? If the caller wanted to produce an

alternative RFC, how would this be done? This would most likely have to be worked into his agreement or offered through a (dispreferred) disagreement. Interestingly, the caller's response does not elaborate on the RFC but merely orientates to the authoritative voice of the facilitator through an agreement accompanied by a respectful "ma'm".

Following the caller's agreement, the facilitator makes a further *inference* through an *assertion* (Line 5) that skips a potential turn by the caller (between lines 5&6), negating a potential opportunity for the caller to elaborate, agree or disagree - in response to the assertion. The inference in line 5 builds on the caller's RFC as a need for more information about the product and then moves directly into a naming of the product (line 6), eliminating the possibility for the caller's contribution to the RFC. Therefore, it can be argued that any potential RFC that might have been volunteered or elaborated upon by the caller is negated through the assertions that the facilitator produces by use of inference. As the RFC sequence proceeds beyond line 4, not only is the RFC inferred by the facilitator but further agreement from the caller is also assumed. Nevertheless, the caller cooperates with these inferred assertions by orientating to the name of product (line 7) and the conversation moves on to the next sequence of conversation - the "spelling out" of the name of the product.

Therefore, extract 1 illustrates how facilitator may take up the institutional identity of authoritative voice in the conversation, choosing the topics of the conversation through the use of inferences. If one takes the entire sample of calls into consideration, it appears

that the facilitator's inferences are based on a reliable assumption as, in general, callers do tend to orient to RFC as related to "the advert on TV" and finding out more about the tablet. Ultimately, although the facilitator's utterances get the work of the call done, they serve to potentially limit caller contributions to the conversation.

4.3.2 Probes

Although extract 1 is indicative of how an institutional stage is set or how facilitators might potentially set themselves up as the authoritative voice, there is evidence of variations in orientations between caller and facilitator that are slightly more common in the sample. The more subtle approach of the facilitator in extract 2 is arguably more common in the sample. In extract 1 the facilitator *infers* the RFC whereas in extract 2 (below), the facilitator makes use of a *probe* in initiating the RFC sequence:

Extract 2

(Conversation 5)

- 3 F: y:es (.) how can I help ↓you
- 4 C: hh um hh ya man uhhm (.)
- 5 I see you guys advertised a ah ah tablet on tv
- 6 F: y:es
- 7 C: hh. umm what tablet is that
- 8 F: alright the drugs name is ↑cialis

In the above extract, following the reduced opening, the facilitator probes for the RFC through the request for how the caller can be helped (line 3). This is followed by what is normally understood in DP as *troubled talk* (in line 4), hearable as the caller finding some

difficulty to volunteer the RFC, and then by a *report* that falls inline with the facilitator's inferences in extract 1, referring to the advertisement of a tablet on TV. Interestingly, in the next turn, the facilitator could choose to prioritise the goal/topic of the conversation (as in extract 1), but instead offers the *acknowledgment token* "y:es", that serves as a *continuer* (invite for the caller to continue), creating the space for the facilitator to elaborate on the RFC (line 6). After some troubled talk, the caller then moves to a request for knowledge about the tablet (line 7), which the facilitator cooperates with through a naming of the tablet (line 8).

It is interesting how in extracts 1 and 2 the facilitators approach the caller in varying ways and yet come to the same goal of naming the tablet. This perhaps reveals that, at this point of the conversation, facilitator and caller share the same goal, albeit that there are various ways of getting to this goal. Additionally, the underlying RFC is likely to be the experience of ED and the treatment thereof, and yet this is presented through reports of the experience of an advert and finding out more about the tablet. In extract 1 the facilitator can be heard to impose the goal on the caller, whereas in extract 2 the facilitator allows the caller greater contributions to defining the RFC.

4.3.3 Volunteers

Extract 1 and 2 are examples of how facilitators tend to initiate RFC, however, there are also examples of RFC being volunteered by callers. Wilkinson (2000) points out that

“going first” in a conversational context can be “interactionally tricky” as it opens oneself up for consequences such as disagreement. Waiting for other participants to go first allows one to position oneself against those utterances in less risky ways.

Extract 3

(Conversation 3)

- 3 F: Gooday ma'm (.) how are you
- 4 C: I'm fine thank you↑ (.) um who am I speaking to
- 5 F: you are speaking to ((facilitators name))
- 6 C: ((facilitators name))
- 7 F: ye::s
- 8 C: ((facilitators name)) (.) umm im phoning man because
- 9 my my:: (.)
- 10 I've got permission from my husband to phone
- 11 F: Ye::s:=
- 12 C: = um because we've got a problem
- 13 (.) um erection problem m'n
- 14 my husband is fifty
- 15 (..)
- 16 F: >Fifty years old<
- 17 C: <Fifty years old yes>
- 18 F: ahnd ho:w long:: has he been suffering from this problem

This conversation starts less characteristically with “howareyou”. In addition, the caller probes for an identification orientation. The repeat of this identification, the facilitator's name, is orientated to by the facilitator as a marker for the initiation of the first topic of conversation by the continuer “ye::s” (line 6). The caller's RFC account is interesting in several ways. Although it is encouraged by the continuer in line 6, it is not directly probed for by the facilitator. It, therefore, qualifies as a volunteer of RFC. Through a narrative that builds towards an RFC, the caller demonstrates several changes in footing. She starts with a report that she is phoning because “my”, presumably moving towards an

account of her husband's experience and then repositions to a report that she has permission from her husband to phone (line 10). This serves as a good illustration of how from a DP perspective, utterances function rhetorically. In other words, they are designed in ways that speak to how they might be heard by other participants. Therefore the caller's repositioning can be heard to function rhetorically to validate the RFC that can potentially be heard as impermissible. Following an additional continuer from the facilitator (line 11), that serves to permit the telling of the RFC, the caller gives a slightly adjusted account of the RFC, with a "we've" rather than a "my" having a problem (line 12). The adjustment to a "we" can perhaps be heard to serve as a justification of her calling. Constructing the problem as shared further negates the impermissibility of her calling. "We" can also be heard as a personalised account of the RFC that contrasts to many other calls that involve impersonal accounts of the RFC (explored below). The caller then moves straight to the naming of the problem as an erection problem (line 13). Hence the caller in this conversation, although having initial difficulty with producing the RFC indicated by troubled talk or hesitance (that is potentially "cleaned up" by facilitator continuers), is much bolder in her approach to the RFC and does much of the work that is usually left up to the facilitator's probes. Additionally, in line 14 the caller moves to the next sequence in the conversation by volunteering her husband's age. This allows the facilitator to continue with his work in the call and acknowledging the caller's utterance through a repeat (line 16), moves to the next institutionally relevant question – "how long". However, through this move to institutionally relevant tasks, the "we" has been

replaced by the “he”, moving past the potential of the conversation to address the caller’s personal experience.

In the above extract, personal experience is introduced in order to validate the RFC – a wife calling about a husband’s problem. As the RFC sequence unfolds, the focus is moved away from caller’s experience to the husband and his age. There are, perhaps, alternative questions that could follow from the sequence and could have picked up on the “we”. Hypothetically, the facilitator could have asked a question like: “how long has the erection problem been a problem for the two of you”. The choice not to ask such questions might relate to apparent difficulty with personalised talk in this context. See for example extract 4.

4.3.4 Probing for Personal Accounts

Many of the callers do not volunteer the topic of ED as personal experience as forthrightly as the caller in extract 3. Rather their utterances appear designed to resist the topic of ED as personal experience. It is therefore left up to the work of the facilitators to build up an account of ED as personal experience. This is done by orientating to the RFC through a series of *acknowledgement* and *probes* that work towards a more specific and personalised account of the RFC. The following analysis deals firstly with the facilitator’s work towards implicating the caller in a personal account of RFC and then looks at how facilitator’s utterances are designed to resist personal accounts.

Extract 4

(Conversation 2)

- 3 F: Can I help↑ you sir
 4 C: Yes (.) >I just wanted to find out< where can
 5 >I.somebody< find the tablet
 6 F: =You want to find out where to find the tablet
 7 what tablet are you talking to.about sir
 8 C: the one which I see the advert on the TV
 9 F: al>right< (.) the erection problem (.)
 10 y.you t.talking about that tablet
 11 C: (.)o:k:↓
 12 F: (.) have you got an erection problems
 13 C: °yes ma'm°
 14 F: Altight (.) how old are you

In extract 4, the RFC in line 3 is worked (through a sequence of questions and answers that serve to elaborate upon the RFC) towards acknowledgement by the caller of “erection problems” as personal experience by the *minimal response* “°yes ma'm°” (line 13). Line 3 *probes* for the RFC from caller. The caller then responds with a *report* of “just” wanting to find out where “somebody” can find “the tablet” (lines 4 and 5). This *report* is clearly hearable as a *request* for information about the tablet. The facilitator orientates to this *report* through a *repeat* of the caller’s *report* in line 6 that serves as an *acknowledgment token*. It is common within the sample for the facilitator to acknowledge what is been said by the caller through a *repeat*. These repeats can be heard as attempts to construct agreeable and collaborative conversation. As in discursive research on the construction of M.E. (Horton-Salway, 2001), *repeats* can be used to aid the construction of factuality (that what is being said is reliable and factual) and build

consensus into the conversation. Consensus building features such as *agreements* or *repeats* can perhaps be said to be common to conversations between client and practitioner, or patient and professional, as these conversations are normatively cooperative. In the context of the SHH they appear to at least serve as an acknowledgement of the caller's *report/request* that then allow for a move towards further *clarification*. Later in the discussion I will explore how acknowledgments, through their use in moving to the next topic of conversation, can be utilised in negating caller concerns.

Immediately following the co-operative *repeat* in line 6 is a *probe* for a more specific *report/request* – “what tablet are you talking to about sir” (line 7). Such a probe could be considered superfluous in the context of the sample of calls on the SHH: The call falls within the context of several similar calls that are in response to an advert that targets men suffering from erectile dysfunction, makes a tablet known and encourages viewers to find out more about the treatment. Therefore the facilitator is, most likely, perfectly aware of what tablet the caller is referring to. This approach, where the facilitator probes in apparent ignorance as to what tablet the caller is referring to, contrasts greatly from the orientation of the facilitator in extract 1 where the facilitator infers what the caller is calling about. Therefore, in contrast to the inferences made in extract 1, the probes in extract 4 can be heard as deliberately working towards caller elaboration.

In the next turn (line 8) the caller responds through the *report* that the tablet is the “one” which was seen on the “TV”. Characteristic of many of the SHH calls, the caller is preferring the RFC as relating to the experience of an advert rather than the experience of a problem/ED. The sequence of *acknowledgement* and *probes* is drawn upon by the facilitator - “al>right<” acknowledges the caller’s *report* and allows for the move to the *clarification probe* of the tablet as related to the experience of “erections problems” (lines 9 & 10). The caller gives a vague “o:k:↓” that is oriented to as a *minimal response* by a further *probe for clarification* that moves towards erectile dysfunction as personal experience to the caller: “have you got an erection problems”.

Therefore, the RFC sequence moves from a vague probe (in line 1), to a more specific and personal probe (in line 12). Although extract 4 contrasts greatly from extract 1 in that the facilitator provides opportunities for the caller to volunteer requests, these requests are probed for with turns that are hearable as designed to move the conversation in the direction of ED. Extract 4 serves as evidence that although caller is granted greater opportunity to contribute to the RFC, the facilitator is able to subtly prioritise certain agenda’s through the design of questions. The sequence that develops through the RFC can be likened to what Maynard (1991) identified as a perspective display series (PDS) in conversations between doctors and patients. In the PDS sequence that Maynard (1991) identified, using practices found in “ordinary talk”, clinicians would deliver diagnostic news (and hence their own perspective) in ways that allow the diagnosis to be heard as the sequel to the recipients (patients) own views or knowledge. Likewise, with the SHH,

ED as personal to caller experience is treated as an embedded feature of the caller's own perspective. The experience of ED is treated as an embedded feature of the caller's report of the experience of the advert.

4.3.5 Resisting Personal Accounts

Thus far, most of the analysis has focused on the design of the facilitator's turns. A comparison of the design of caller utterances in extracts 3 and 4 illustrates how callers might also participate in the unfolding of the RFC sequence in specific ways. Caller utterances appear to be designed to resist personalised talk. More specifically, callers tend to resist the facilitator's orientation towards erectile dysfunction as personal experience of caller. If so, how is this resistance designed?

Caller's requests and reports do not only serve as a *prefacing move* to the rest of the conversation by introducing a topic for discussion, but also serve as an opportunity to position the caller rhetorically towards the facilitator in ways that resist probes for personal elaboration. In DP this can be understood as *footing* - the relationship between speaker and what is said (Goffman in Wilkinson, 2000). Participants choose their footing based on how they expect to be heard by other participants, what has come before their utterance and what is expected to follow their utterance.

Wilkinson (2000) found that women in a focus group on breast cancer would choose their *footing* in ways that would defend against accountability for their views. For example, opinion about the causes of breast cancer would be attributed to “stories going about” rather than personal opinion. With such a footing the participant avoids contributions being heard as, for instance, personal foolishness. *Footing* on the SHH tends to function in similar ways. Callers offer accounts of RFC in ways that potentially serve to avoid being heard in certain ways – RFC is attributed to the experience of an advert on televisions, rather than other possibilities such as the experience of personal difficulty with erections. This serves as an illustration of how participants might choose from an array of potential utterances and how the choice of utterance is related to its potential to rhetorically undermine alternatives (Edwards & Potter, 1995).

In contrast to the caller in extract 3, who constructs the RFC as relating to a “we” having a problem, the caller in extract 4 presents the RFC as “just” wanting to find out “where” “somebody” can find “the tablet”. This *footing* operates rhetorically towards certain ends: “just” - may imply that there are no other discussable RFC’s; “where” - potentially limits the conversation to issues relevant to locating the tablet; the impersonalised “somebody” - resists personal questions related to the RFC³; and the description of product as “the tablet” – the vagueness of this reference implies knowledge from the hearer about what tablet is being talked about, resisting further probes about the tablet.

³ The manner in which “I” is repaired to “somebody” also serves as discursive evidence of the value in designing the utterance in this manner.

Such designs of a RFC can make direct questions about personal problems or experiences difficult to work into the sequence of conversation.

In extract 4, through the caller's choice of words in this utterance it is, as a request, hearable as an impersonal construction – not belonging to the caller himself. Rather than it being about his problem, his erection, “I” or “me”, denoted by the repair following the word “I”, the caller is able to construct his request in more global terms. This can be heard as use of “*impersonality*” and is very typical of designs of caller reports or requests on the SHH. According to Potter (1996), impersonality is useful as a means of avoiding certain sensitive topics or issues. Interestingly, research on interaction between physiotherapist and athletes indicates that impersonality is utilised in interaction to create distance between athlete and pain or a painful body (Muller, 2004). The focus of such research was on interaction in relation to the construction of pain and suggests that impersonality is utilised for its distancing or dissociative effect between self and experience. In other words, the use of impersonal language, served to construct pain or painful body parts as separate from self and therefore served as a potentially effective pain management strategy. Similarly, on the SHH, the callers tend to employ impersonality in their RFC constructions. Such constructions appear to place limits on the conversation, potentially avoiding sensitive topics or separating the caller from topics that are potentially difficult to talk about. Although there is evidence of both caller and facilitator making use of impersonalised talk (for instance by referring to “*the problem*”),

the use of impersonality could make it difficult for the facilitator to work towards the topic of erectile dysfunction as relevant to the caller himself.

Therefore, the caller's use of an impersonal footing requires that the theme of ED as personal to the caller be gradually worked into the RFC sequence rather than directly addressed at the opening of the call. Facilitator's utterances are hearable as being subtly designed in their work towards the "personal". For instance, the *acknowledgement token* through a *repeat* (in line 7 of extract 4), could be heard to lack the same impersonality of the caller's utterance, through the omission of the word "someone". The facilitator's *probes for clarification* are met by further limited responses and the call for acknowledgement of erection problems is met by the limited and ambiguous response of what can be heard as, through its intonation, a very uncertain "ok" (line 11). The limited response is orientated to by the facilitator with a direct *probe for acknowledgement* of erectile dysfunction involved in the callers own experience, particularly by the use of the words "you got" implying personal possession - "have you got an erection problems" (line 12). The caller's proceeding response, although an acknowledgment of the metaphor of erectile dysfunction for his experience, can be heard as resisting personalisation through the increasing briefness of his turns as well as his less prominent responses, marked by " ° " (line 13). In other words, the caller does not appear to actively participate in the design of RFC as related to personal experience of ED.

Therefore, in extract 4, although the RFC is originally presented in an impersonal and vague manner, through the facilitator's *acknowledgments* and *probes*, the RFC sequence becomes more specific and personalised, working towards the metaphor of "erectile dysfunction" as belonging to the caller. In line with Maynard's (1991) analysis of how *probes* from clinicians function in clinician-patient interaction, *probes* from facilitators tend to be related to a particular position. Some callers might volunteer RFC as related to personal experience of ED, as in extract 3. However, in the absence of such reports facilitators are able to work towards a co-construction of RFC as relevant to the experience of erectile dysfunction as apposed to the initial construction of RFC as relevant to the experience of an advert on television, that is often preferred by the caller. An overview of the sample indicates that even in calls where the topic of erectile dysfunction is not explicitly introduced, probes seem to move towards acknowledgement of "the problem". Again, much like Maynard's (1991) findings in doctor-patient interaction, the facilitator's orientation is treated as an embedded feature of the caller's position.

4.3.6 A Deviant Case

Closing the discussion of RFC designs, I would like to make use of one final extract where participants do not necessarily play the same collaborative game. Conversational analysis, upon which DP founds many of its claims, is rooted on the notion that social interaction is an independent locus of order (Ruusuvuori, 2002). Interaction in a

distinctive setting relies on specific normatively organised rules. The metaphor of the game is drawn upon by theorists in order to understand this. “As in a game of chess, rules governing the actions are seen as constitutive: if the rules were not followed, the game would not be chess but something else.” (Ruusuvuori, 2002, p 29). A break of the rules of the game leads to attempts by co-participants to sanction such activities or to reframe breaks in rules as a separate activity such as “joking”.

There are numerous analysable features to be found in the following extract, however, it serves to briefly illustrate how the collaborative unpacking of the RFC might breakdown when the normative rules for interaction in this context (illustrated thus far) are not observed by participants. Through less cautious work towards the experience of ED as personal to the caller and by a more overt resistance of construction of ED as personal experience, there is a breakdown in the rules of the game.

Extract 5a

(Conversation 4)

- 8 C: I was watching tv the other day
9 and then there was an advert from you:: (.)
10 which a say that ah ah one must choose the right moment
11 if it concerns ah ah it concerns sexualdis (.) function
12 something like that
13 F: ye::s um it its for people who've a:::h
14 impotence or erectile dysfunction (..)
15 and um (..) there a::: four of the available treatments for
16 the impotence or erectile dysfunction
17 and um::: (..)
18 can you tell me about a:: your problem a little bit
19 C: I DON'T HAVE ANY PROBLEM (.)

20 um I WAS WATCHING TV
 21 F: =ye::s
 22 C: AND THEN THERE WAS AN ADVERT THERE
 23 WHICH a (.) ah ahh hhh (...) was INTERESTING::
 24 >if I may so say< (.) that one must one must buy a tablet
 25 from you gu::ys
 26 hhh. and then a yu.when one ah chooses the right moment
 27 one can have a good sexual intercourse
 28 >blah blah blah<
 29 so ah I don't have a problem at the moment
 30 I was just ah you know intereste::d

The RFC is introduced following uncharacteristically extended openings, more likely in casual conversational practices that could be heard as an attempt by the caller to create some familiarity and challenge the institutional norms of the call (lines 1-7). This is followed by a volunteering of the RFC in the form of a narrative rather than a request or report (lines 8-12). The RFC narrative can be seen to function rhetorically in several ways: Much like in other calls, the RFC narrative begins with an account of watching TV the other day, locating the experience of an advert on television as central to RFC rather than other possibilities, such as the experience of a problem. There is a certain “by chance-ness” hearable in this narrative report in that the advert was experienced while watching TV “the other day”. Through the design of such utterances, callers’ can be heard to be managing their own “interestedness”. In other words, “People treat each other, and often treat groups, as entities with desires, motivations, institutional allegiances and biases, and they display these concerns in their reports and attributional inferences.” (Edwards & Potter 1992, p.158). Callers are therefore at risk of being heard as interested in an elaboration on the product due to personal difficulty. They can

therefore be said to be caught in a “dilemma of stake or interest”. In other words, participants tend to produce accounts in ways that attend to their own interests, whilst defending against accounts being heard as “interested”. This dilemma may be approached in a variety of ways. The callers’ tend to deal with it through the design of their reports.

For instance, the use of an impersonalised “one” as apposed to “I”, further resists personal experience as involved in RFC. The narrative, therefore, functions rhetorically, much like the request in Extract 4, to resist an orientation to the RFC that is personally relevant. Following some troubled talk the caller vaguely makes reference to sexual dysfunction. This vagueness is then continued by the statement “something like that” (line 12), and by punctuating a later utterance with “blah blah blah” (line 28). These utterances lack any specific form of request but can be said to function to compel the facilitator to follow with an elaboration. For instance, in research on interaction in psychotherapy, it was found that both therapist and client’s vague accounts would pressure the recipient for an elaboration (Madill *et al.*, 2001). It is suggested in the research that client’s vague accounts orientate to the asymmetry of the conversation and are designed to compel the therapist to clarify with an “expert” contribution.

Rather than responding with the strategy of combining *acknowledgments* and *clarification probes* as in extract 4, the facilitator follows with an acknowledgement “yes” and then moves directly to a description of available treatments (line 13-16).

Although in everyday conversational practice, a direct elaboration on the participant's narrative might be appropriate, in many of the calls in the sample such an elaboration tends to appear much later in the RFC sequence, often only following the acknowledgment by the caller of erectile dysfunction as involved in the RFC.

Therefore, not only can the facilitator's elaboration be heard as a premature introduction of erectile dysfunction as involved in the RFC, through the categorisation of the advert as for "people who've a::h impotence or erectile dysfunction" (lines 13-14), but it also serves to implicate the caller in the experience of erectile dysfunction. In other words, any further interest in the product would potentially implicate the caller in the experience of impotence or erectile dysfunction. The facilitator can also be heard to be having some difficulty with his elaboration, indicated by troubled talk and significantly long pauses. In DP, pauses that approach a second or longer are considered analysable. Unfortunately, for the present dissertation, technical constraints have made such thorough analysis difficult. There is nevertheless significant evidence of difficulty with producing a response that could be heard as difficulty with responding to the vagueness of the caller's narrative. Such trouble could, however, have been resolved if the caller had orientated to the long pauses as an invite to contribute to the conversation. Nevertheless, in the absence of the caller taking a next turn in the conversation, the facilitator makes a shift to a probe within the same turn, in lines 16-17, to tell "a little bit" about "your" problem – probing for a more specific and personalised account. This can be heard as an attempt to clear up the difficulty with elaborating upon the caller's vagueness and works towards a

more specific RFC from the caller. However, this probe also serves to further implicate the caller in the experience of ED through the inference of the personal experience of a “problem” (signalled by the use of the word “your”). Despite the facilitators attempt to undermine the threat of a personalised probe through the use of a *minimisation*- “a little bit” - the caller is uncooperative.

Therefore, whereas the caller has constructed the RFC as related to the experience of an advertisement (lines 8-12), the facilitator’s utterances serve to implicate the caller in the experience of ED (lines 13-18), making the personal experience of a “problem” necessary for the normative progression of the conversation. However, the caller does not follow with the normative agreeableness typical of institutional conversations. Rather he provides an uncharacteristically, non-collaborative, loud *rebuttal* that returns to a narrative of the experience of the advert and works towards a construction of the RFC as “just” “interested” (lines 19-28) as apposed to an alignment with having a problem. According to Perinbanayagam (1991, p.126), a “rebuttal” is a response to a charge, rebuke, complaint, insult, and similar acts “that challenge or seriously undermine certain aspects of the self”. Therefore, the facilitator’s request for information about the “problem” could be seen to be orientated to by caller as a challenge or insult and is countered by a denial (in a discursive rather than Freudian sense) through a *rebuttal* characterised by its tonal qualities. Perinbanayagam (1991) notes how such utterances tend to work towards restoring equilibrium to the relationship between participants. Therefore, the caller is not only challenging being implicated into the experience of ED

but challenges the asymmetry of the call that is induced by the presumptive position taken up by the facilitator.

4.3.7 Restoring Collaboration

In comparison to Extract 5a, the acknowledgements and probes in extract 4 can be heard as a much more cautious means of approaching the RFC in ways that work towards the acknowledgement of ED as personal experience, and caller is much more cooperative in being implicated in the experience of ED as personal. The deviant case therefore demonstrates how less cautious moves from the facilitator and a less cooperative footing from the caller might lead to a breakdown in the collaborative unpacking of the RFC.

The breakdown is resolved by a renegotiation between facilitator and caller as to the nature of the RFC, and in so doing – the rules of interaction.

Extract 5b

(Conversation 4)

- 44 C: in other words <the call ive just ma:de > ive wasted my time and money
45 F: noo not really because you wanted some information
46 C: yes
47 F: yes so you didn't waste your money and ah time
48 C: there's nothing you can tell me in other words (.)
49 concerning the tablets I have just enquired abou::t
50 aw:: something like that

51 F: OK (.) the the tablet its called cial↑is

Following an additional attempt by facilitator to make the acknowledgement of the experience of ED or impotence as personal necessary for the progression of the call, the caller sanctions this through the suggestion that the call is a waste of time and money. The sequence then works towards a more collaborative understanding of the RFC. The facilitator reformulates RFC as wanting some information (line 45) and the caller challenges the facilitator for information concerning the tablet he has just enquired about, again punctuating his utterance with vagueness “aw:: something like that”, compelling the facilitator to elaborate. The facilitator follows with a distinguishable “OK”, hearable as a renewed understanding of the caller’s RFC, and moves on to an elaboration of the product, omitting talk of personal concerns or ED.

4.3.8 Discussion

Drew and Heritage (1992) heed against offering “synoptic” definition of institutional talk. However, they do propose that some activities are resemblant of an institutional orientation to conversations and site various studies that have compared communication in “lay” and “technical” settings. In very formal settings, such as a courtroom, there are very definite norms governing activities like turn taking procedures. However, in less formal institutional settings such as a doctor’s consultation or on the SHH, the boundaries between these forms of institutional talk and everyday conversational practices “appear

permeable and uncertain” (Drew & Heritage, 1992, p.28). Therefore, it is difficult to give a generic account of how the institutional context of the SHH manifests through participant contributions, because the interactive patterns tend to be “non-recursive” and varied based on individual orientations. Ultimately, DP’s approach tends to highlight the varied complexity of the data rather than reduce it to overarching claims.

Nevertheless, it is apparent from the extracts explored above that approaching the first topic of conversation on the SHH is delicate business. Many callers prioritise the RFC as relating to the experience of an advert on TV and their utterances are designed to subtly resist personalised talk about ED or a “problem”. There is also a definite tendency, due to the relatively fixed orientation of callers to find out about the tablet, for the calls to be treated in a fairly routine manner by facilitators, risking the tendency to reduce all calls to one. Hence, the facilitator in extract 1 is able to “accurately” infer both the RFC and agreement thereof from the caller in getting the work of the call done.

It could be argued that in most of the calls, the introduction of ED as personal experience to the caller is made necessary to the progression of the call. This tends to be done, more commonly, through volition from the caller (for which there is evidence of difficulty in doing so) or through facilitators drawing upon the collaborative norm of institutional conversations, using the question answer sequence to gradually implicate the caller in an account of ED as personal experience. As is evident in the deviant case, a caller’s boldness in breaking with the normative agreeableness of the conversation and

facilitator's lack of subtlety in building up to the topic of ED as personal, can contribute to a break down in the "collaborative unpacking" of the RFC.

Mäkitalo & Säljö (2002) warn against a tendency to use context as an explanation in analysis of data without empirically grounding its relevance in the data. However, answering the question proposed earlier: Is there evidence thus far of how the institutional context enters into the concrete communicative practice? There is evidence in the manner that both caller and facilitator approach the RFC. Table 2 demonstrates how characteristics of the SHH fall in line with features that, according to Drew and Heritage (1992), can be identified as resembling the asymmetry of talk in institutional contexts.

Table 2

Theory	Practice
Institutional interaction typically involves an orientation by at least one of the parties to a relatively restricted goal.	There is a clear preference from both caller and facilitator for orientating to the goal of naming and elaborating upon the tablet. However, this goal is utilised by facilitator's in order to fashion a renewed orientation of ED as personal from the caller.
There are often particular constraints on what one or both of the participants will treat as allowable contributions in getting the work of the call done.	Although callers resist personalised talk, facilitator attempts to work towards the topic of ED as personal are seldom overtly opposed.
Institutional talk is also associated with "inferential frameworks" and procedures relative to the particular context.	It is inferred from the caller that facilitator poses knowledge about various aspects of the possible RFC. Likewise, facilitator's are able make certain inferences about caller – such as intention of the call or the experience of a problem.

If RFC sequences can serve as *precursing moves* for the rest of the conversation, how might the RFC sequences explored above impact the rest of the conversation? The RFC sequences appear to be an opportunity for facilitator and caller to position themselves not only towards one another but to the goal of the conversation. As illustrated by extract 1, through the adjacency pairing of inferences and agreements by facilitator and caller (respectively), the facilitator takes the position of authority and the caller the position of recipient in the conversation. Although in extracts 2 and 4, the facilitator is not so bold and direct in their approaches to the caller, they nevertheless subtly work towards specific goals in the conversation through the use of specifically designed *probes*. In extract 3, the caller dominates the contributions to the RFC through her volitions, but soon relinquishes such control as the facilitator moves into the etiological phase of the conversation. Extract 5a is a rarer case of how caller might challenge the institutional norm of the conversation. The caller in Extract 5a's retort is hearable as an attempt at challenging the asymmetry that is potentially brought about by the work done in the RFC sequence and the trouble with the call is cleared up when the facilitator shifts from an orientation to ED as personal to a collaborative agreement of the RFC as just interest in information (demonstrated in extract 5b).

Therefore, other than in the deviant case (extract 5), the facilitators appear to, in both overt and more subtle ways, have control over the topics of conversation. This has been recognised as an important dimension in the development of asymmetry that is

characteristic of institutional interaction – an interactional pattern that develops is typically of a question-answer nature that seldom allows for the “lay” person to take initiative.

However, through further analysis I will demonstrate the complexity with DP research: Although Table 2 demonstrates how caller and facilitator orientate towards the topic of ED in the RFC sequence, and this orientation might serve as a *precursing move* for the rest of the conversation by setting up facilitator as the one to steer the conversation, shifts in footing are nevertheless possible within different stages of the same conversation. As Drew and Heritage (1992) indicate, understandings of the goals and constraints of the conversation can shift within a single conversation, often depending on the phases through which the interaction moves. Analysis of the SHH data indicates that participants are able to take up multiple positions towards the topic of ED. This can be likened to Wilkinson’s (2001) research on a breast cancer focus group, in which the same participant might take up multiple views on the causes of breast cancer depending on the rhetorical demands within differing phases of a single conversation. Therefore, although caller’s might find personalised talk challenging within the RFC sequence, they might however make moves towards introducing personal experience or concerns at a later stage in the call.

Further analysis will look at how the asymmetry between participants that is set up through the RFC sequence is either honoured or undermined in later stages of the

conversation. I will also explore how such asymmetries or symmetries are discursively accomplished.

4.4 The Interactive Achievement of Asymmetry

Studies of doctor-patient relationships (Maynard, 1991) have indicated a unanimous asymmetry in knowledge and authority in the conversations, where doctors propagate the medical model of disease and in so doing undermine patient's own experience and understanding. It is, therefore, interesting how facilitators tend to work towards a similar asymmetry in conversations on the helpline.

To give an indication of how participants positioning might play out in the rest of the conversation, further analysis illustrates how asymmetry is either honoured or undermined by participants' contributions, and the implications of such contributions for the construction of concerns about ED. Maynard's (1991) research on clinician patient interaction emphasises how asymmetry appears to be characteristic of such interaction but that it is not necessarily entirely attributable to the concrete institutional context in which it occurs. The research argues for how power and authority is initiated through the way in which the interaction is organised. In other words, rather than the asymmetry being "imposed" by the context of helpline, it is "interactively achieved". Therefore, from Maynard's position, doctor is not authority only because he is doctor. He takes up authority through interaction.

Extracts from conversations 1 and 5 will be drawn upon in order to illustrate how more asymmetrical and symmetrical conversations might be interactively/collaboratively achieved. Additional extracts will indicate the consequences of asymmetry for the regard afforded to callers' personal concerns.

4.4.1 Enacting Asymmetry

Extract 6

(Conversation 1)

- 23 F: Y:eS:, how old are you sir↑
24 C: 62
25 F: 62 have you had the problem for a long time↑
26 C: ah few months but its got worse lately
27 F: its got <worse↓> () are you on any other medica>tion↑<
28 C: ah yes (.) I am using medication like um

Line 23 follows a brief spelling exchange between caller and facilitator. Here the facilitator uses the acknowledgment token “Y:eS:” to move on to the next topic of conversation – *age*. This initiates a new sequence in the call that I have identified as a grouping of themes hearable as relating to aetiology. Often these themes occur in three part lists. According to DP (*see* Potter, 1996), drawing on the work of CA, three part lists are used to build up believability or credibility to what is being said. It is, therefore, hearable as a means of developing an official-ness to the question answer sequence.

The acknowledgement in line 23 is accompanied by a probe for *age*. Following the callers response, the facilitator then continues by acknowledging the callers utterance through a repeat and then moves onto the next theme - *duration*. Not only does this turn allow for the introduction of the next topic, but it (as with some RFC sequences) makes use of inference to do its work. Line 25 is embedded with the inference that the caller has a problem, the notion of the experience of a “problem” (or ED) remaining implicit in the conversation up until this point. The caller responds cooperatively with a report “a few months”, which is however accompanied by a personal account “but its got worse lately” (line 26). Here the caller can be heard to be introducing a personal experience of “the problem”. There is therefore a slight shift in footing from resisting personal accounts to alluding to personal experience. However, although the facilitator acknowledges this account through a repeat in line 26, this acknowledgment appears to function as a device for moving on to the third aetiological topic – medication. The response lacks consideration of the caller’s personal experience and allows little opportunity for it to be elaborated upon. As Drew and Heritage (1992) indicate, when designing a turn, a selection is made from a variety of possibilities. The choice is available to the facilitator to address the “getting worseness” of the caller’s “problem”. Orientating to this “getting worse” could also be very instrumental in effectively moving towards the aetiology of the problem. Nevertheless, the facilitator relies on the routine questioning to continue with the call.

Although the facilitator is acknowledging the caller's responses through the use of *acknowledgment tokens* (through repeats of the caller's utterances), these acknowledgments are hearable as a means of moving onto the next institutionally relevant themes and negate rather than address caller's reports. In fact, listening to the auditory version of the calls makes one aware of an unusually pressured speech and that turns often follow almost straight into each other (indicated in the transcriptions by “=”). In light of this, it is likely that *acknowledgment tokens* are drawn upon to initiate facilitator turns and allow for move to institutionally relevant topics, therefore getting the work of the call done.

As a consequence the asymmetry of the conversation is honoured by the above sequence – facilitator remains “questioner”, the caller “answerer” and the facilitator prioritises the topics for conversation. This topic tends to remain medicalised and impersonal.

4.4.2 Enacting Symmetry

In contrast to extract 6, extract 7 is indicative of a much more flexible and caller sensitive orientation:

Extract 7

(Conversation 5)

- 18 F: hhh. was there anything: specific you wanted to ↑a::sk
19 or should I just tell you about the the tablets

- 20 C: well I think tell me about it and then then ill tell you
21 F: alright hhh. um they've been designed fo:r
22 for men with >erectile dysfunction<
23 C: ye:s
24 F: basically:: (.) men that cannot get an erection at all: (.)
25 or can get an erection but its not hard enough to for penetration (.)
26 C: ye:s
27 F: is that (.) kindof what you experience
28 C: hhh. um ya like hh I get an erection but as I say it doesn't last hey
29 [hhh.
30 F: ok]
31 C: and I don't know if it is perhaps that medication I take
32 or something you know (.)
33 because I'm a diabetic

As with extract 6, extract 7 directly follows a brief spelling exchange of the name of the product. However, rather than prioritising the next topic of conversation, the facilitator offers the caller a choice. The choice comes with a probe for a personally relevant question from the caller, “was there anything: specific you wanted to ↑a::sk” (line 18), but is also accompanied by the more institutionally relevant option of “should I just tell you about the the tablets” (line19).

Taking for granted that there is difficulty with personalised talk about ED – indicated through the difficulty with volunteering personal concerns, the preference for impersonalised talk and significant evidence of extended troubled talk throughout the sample - line 19 might not only serve to keep the institutional task of promoting a product relevant, but potentially serves to offer a less threatening, impersonalised alternative.

In line 20, the caller opts for hearing the telling about the tablet but keeps the option of a personal account available with the utterance “and then then ill tell you”. These two turns in the conversation differ greatly from those in Extract 5a and 6, as the *telling* is negotiated between facilitator and caller rather than prioritised by facilitator. The facilitator is, therefore, allowing room for the caller to introduce personally relevant topics into the conversation. Although the caller does not capitalise on this opportunity, the shift in facilitator positioning undermines the conversations asymmetry.

This suppleness in facilitator utterances is followed through with slightly more flexible definitions of the tablet and the experience of ED than in previous examples. The tablets are described as having been “designed for” men with erectile dysfunction (line 21). The word “designed” is hearable as offering leverage to the use of the tablet, as although it is designed for ED, its usage is opened up for interpretation. Following the continuer “yes” by the caller in line 23, the facilitator elaborates further with a definition of the experience of erectile dysfunction - “men that cannot get an erection at all: (.) or can get an erection but its not hard enough to for penetration (.)” (lines 24-25). This utterance is far less rigid than that displayed by facilitators in other conversations, such as extract 5a, and through its more encompassing design, is potentially more inclusive of caller personal experience. In other words, it speaks to the question asked in chapter 2 – How does a distinction between various experiences of ED manifest discursively on the helpline? This question is in response to research cited on the prevalence of ED (De Klerk *et al.*, 2003; Feldman *et al.*, 1994) that distinguished between men experiencing

minimal, moderate and severe difficulties with erections. Ultimately, utterances like those in lines 24 and 25 cater for more varied experiences of ED.

Following an additional continuer from the caller (line 26), rather than elaborating further, the facilitator moves to a clarification probe of whether this is “kindof what you experience” (line 27). In contrast to the inference of problem in Extract 6 (line 25), the facilitator allows for a personal account of the problem through a direct probe for personal experience. In addition, through the use of word “kindof”, the facilitator further encourages an account that is potentially deviant from her own. Through the use of words such as “kindof” or through the giving of two options (such as in lines 18-19) for the caller to respond to, the facilitator can be heard to be “*hedging*” her utterances. In other words, the facilitator does not take up a fixed position towards the topics being addressed.

Following some troubled talk the caller manages to give a personal account of his experience of the problem (line 29). The facilitator acknowledges this (line 30) and the caller then gives an account of not knowing whether it is his medication (line 31), vaguely alluding to additional possibilities with “or something you know” (line 32), ending the turn with the report that he is diabetic (line 33). The caller is clearly looking for an explanatory elaboration from the facilitator, positioning himself as “not knower” and giving the facilitator the opportunity to take the position of knower, alluding to a medicalised account for his experience in the process. With research on the construction

of M.E., an “illness” that has been subject to particular controversy, Horton-Salway (2001) makes reference to Herlich’s conceptualisation of “illness as liberator from the burdens of the world” (p. 168). In the context of Horton-Salway’s research, participants tended to talk in ways that defended against being heard as looking for such secondary gain due to illness. However, in the context of the sexual health helpline the discourse of “illness as liberator” may be drawn upon to avoid difficulty with personalised talk about ED.

Ultimately, therefore, extracts 6 and 7 contrast significantly in the design of facilitator turns. Through these turns, caller’s personal accounts are either negated (extract 6) or invited (extract 7). It appears that the mechanism for negating caller’s personal concerns is a reliance on institutionally relevant tasks. This is often achieved through the use of acknowledgments of caller utterances that are closely followed by probes that move to the next topic of conversation. Negation of caller concerns honours the asymmetry of the conversations, whereas inviting of the caller contributions, through greater flexibility in the facilitator’s position that invites caller contributions, tends to undermine the asymmetry. Nevertheless, within the institutional context, it is unlikely that the asymmetry is ever wholeheartedly done away with. As Linell and Luckmann (in Drew & Heritage, 1992, p.48) observe: “If there were no asymmetries at all between people, i.e. if communicatively relevant inequalities of knowledge were non-existing, there would be little or no need for most kinds of communication!” Therefore, as long as something must be “fetched”, so to speak, by the caller from facilitator, there will be a degree of

asymmetry. However, the degrees of such asymmetry appear to impact on the extent to which caller concerns are addressed.

4.4.3 Falling back on Institutional Tasks

My report works towards an account of how, through the institutional tasks, recording of caller information, making a tablet known and rendering it consumable through the construction of ED as personal, and through taking the position of questioner, information provider and authoritative voice – asymmetry is enacted and callers' personal concerns are negated. Further extracts from conversations 1 and 5 will briefly be considered in order to demonstrate how this negation of callers' concerns involves a falling back on institutionally relevant tasks.

Extract 8

(Conversation 1)

- 28 C: ah yes (.) I am using medication like um
29 (inaudible) (.) im taking (inaudable)
30 F: YES↑
31 C: and I ve got a lung.a lung problem (.) I've actually got infasim
32 F: alright (.) um (.) y.you must remember that you have to
33 go to the doctor
34 um in order to get CIALIS because you have to get a script
35 C: so I must get a.um so I must just go to the doctor
36 and.a.um and let him just.a get me a script for that
37 F: absolutely because you need to go.you cant bye it over the <counter>

38 C: Ill do that ma'm

39 F: Alright↑

Line 28 follows from extract 6. Following the question are you on any other medication, the caller manages to name a medication that he is on, and the facilitator's continuer in line 30 allows him to move to an account of a lung problem - emphysema. The facilitator responds with the acknowledgment "alright" (line 32) and following a moment of troubled talk, moves on to the next topic of conversation *referral making* (lines 32 & 33). The facilitator's are trained in psychology, to at least a 4th year level. It is, however, unlikely that they will have much knowledge about medical conditions such as emphysema, their comorbidity, pharmacological treatment or contraindications. The possible dilemma here, however, is that starting with the RFC sequence, through discursive actions, the facilitator has been set up as "knowledgeable"⁴ and therefore ignorance to the relevance of emphysema might be difficult to display. The facilitator's acknowledgement, "alright", can therefore be heard as a means of moving past the callers concern, to the next topic of conversation.

⁴ It is important to note here that, according to some DP work, the facilitator's position of "knower" is not only influenced by the interaction, but based also on inferences that callers might make due to the context of a helpline and the category of "helper" or "facilitator". It appears that within any given society separate categories of membership are created and inferences are made based on an individual's membership to such categories. Such thinking has lead to a form of analysis known as Membership Category Analysis (MCA). According to Sacks (in Mäkitalo & Säljö, 2002), such categories are therefore inference rich and one can "feel that you know" a great deal about a participant based on the membership category. Such categories are then drawn upon as resources in conversation. Certain rights and obligations serve as "constitutive elements" to such categories (become involved in such categories). Therefore, facilitators and callers are privileged to certain rights or obligations in terms of their participation in the conversation. For instance-facilitator prioritises topics.

The designs of utterances in lines 32-34 are interesting in two ways: Firstly, the facilitator moves past the caller's concern through the use of an acknowledgement and manages to maintain the position of authoritative voice by making use of an *instruction* - through a reminder to go to the doctor (lines 32-33); secondly, the facilitator uses this as an opportunity to get the *work* of the call done by encouraging a visit to the doctor in order to get a script (line 34). The facilitator instructs the caller to go to the doctor through a reminder, hearable as implying that this is common knowledge. Interestingly, the reasoning for going to the doctor is not constructed as a medical one but for the purposes of getting a script. Such constructions, of doctors as script givers, are common in the sample of calls. The caller then collaborates with this through repeating the facilitator's instructions that can be seen as a means of constructing collaboration, and in so doing taking the position of the *instructed*. The instruction to go to the doctor is emphasised by the *extreme case formulation*, "absolutely", followed by a further account of why a visit to the doctor is necessary - because you can't just get it over the counter. The caller makes a further display of cooperation "alright ill do that ma'am" and the conversation is closed by the marker "alright", followed by brief goodbyes.

Therefore, in potential defence of the position of authority, the facilitator does not address the caller's concern about his illness (emphysema). Rather, the facilitator draws on the institutional task of referral making, to move past the caller concern and build an account of doctor as necessary for the script. Specific discursive acts such as instructions and extreme case formulations support this work. For instance, according to Perinbanayagam

(1991, p.117) “The instructor as a discursive actor typically has both rhetorical and political power as well as the knowledge the other wants or needs.” Therefore, given the threat to the facilitator’s authority through a question that lies outside of the institutional work, devices such as *instructions* allow the facilitator to restore her authority and knowledgeableness in the conversation.

4.4.4 Interpretive Repertoires and the Construction of ED

If one revisits Appendix A, it is evident that the three part list of themes, drawn upon by the facilitator in extract 6, are necessitated by the caller information sheet. What is interesting is that there are many topics on this sheet but that facilitators tend to favour a select few (such as those mentioned above in the three part list). It is possible that the themes selected, are drawn upon in order to build up a medicalised account of ED and in so doing, the personal experiences of the caller are negated. If one revisits the literature review (CH2), there is a dominant perspective of the contributing factors to ED (Carsons, 2004; De Klerk *et al.*, 2003; Feldman *et al.*, 1994; Levine, 2003). For instance: that ED is symptomatic of other, more severe, illnesses; that treatments of these illnesses might contribute to ED; and that the disease is associated in the natural aging process. It is interesting that the facilitators (and at times the callers) tend to draw upon this medicalised discourse in their construction of the experience of ED. I would therefore like to continue with an exploration of how caller or facilitator might choose a particular ideological footing and the impact that these might have on their interaction. Although

the conversation between caller and facilitator in conversation 5 is not as asymmetrical as that in conversation 1, and the caller's contributions are significantly more personal and elaborate. The facilitator in conversation 5 still tends to rely heavily on institutional tasks and in so doing negates the caller's personal concerns. This serves as further evidence of how participants in a conversation might change their footing depending on what the specific interactional context demands in that moment in time. This is illustrated below through a discussion of how *interpretive repertoires* are utilised.

Extract 9

(Conversation 5)

- 51 F: okay hhh. alright um sir can I [ask how old
 52 C: sorry im a bit embarrassed] hehehum
 53 F: =↑oh(h)o::
 54 C: =ya but you know look
 55 F: =ya its something most people don't talk about
 56 so you know [its understandable
 57 C: ya but you know look] I also I don't want to (..)
 58 like um hhh (.)
 59 mess my marriage up either you know
 60 F: mm hhh. alright um and that that is a big factor
 61 how long have you been married
 62 C: hhum 20 years
 63 F: alr↑ight hhh. (.) and the problems with the erections (.)
 64 how long has that been
 65 C: um about the last (.) two years hey
 66 (..)
 67 F: and have you been to a doctor before about this before at all
 68 C: no I haven't hey
 69 F: kay (.) hhh. um (...) do you know
 70 >or I am sure that you do know that< (.)

In extract 9, as the facilitator makes a move to the institutional task of querying the caller's age, the caller interrupts with a report of finding the conversation embarrassing.

This is followed by what is hearable as awkward laughter from the facilitator (line 53) and as the caller moves into the next turn, the facilitator then offers a minimisation of his embarrassment through the account that “it” is something that most people don’t talk about (line 55). The caller then interrupts again with the concern that he does not want to mess his marriage up (lines 57-59). It could be asked, how does this utterance work rhetorically? Is there some behaviour he is alluding to that might put his marriage in jeopardy? For example, later in the conversation he does refer to making use of “smut” services as a potential solution to his problems with erections. Perhaps lines 57-59 are an attempt to work towards this topic. Alternatively, is it the problems with his erections that might “mess up” the marriage? Nevertheless, the utterance implies, through the use of “I” that there is some personal agency involved in the experience of the problem; that what the caller might or might not do will affect the problem, and that the problem is interpersonally involved (through reference to the marriage).

Thus far there is evidence of different “interpretive repertoires” being drawn upon in relation to the experience of ED. Interpretive repertoires relate to how historically we have developed certain ways of constructing reality and talking about ourselves. Edley (2001) defines interpretive repertoires as “relatively coherent ways of talking about objects and events in the world” (p.198). In extract 7 the caller draws upon the “dominant” interpretive repertoire for ED as medicalised and disease based. Later within the same conversation, in extract 9, the caller is drawing upon an alternative interpretive

repertoire of ED involved in personal and interpersonal matters. However, the facilitator does not make such interpretive repertoires allowable.

The facilitator's response is hearable as finding difficulty with responding to the caller's concerns about messing up his marriage, indicated through troubled talk in line 60, followed by an acknowledgment token that is amplified by the further acknowledgment that "that is a big factor". In line 61 the facilitator falls back on features typical to most of the SHH conversations - probing for a temporal account (in this case, the length of the marriage). Following the caller's cooperative response in line 62, the facilitator then moves to the routine probe for how long the problems with erections have been (lines 63). The facilitator could be heard to be entering an etiological search for the cause of the ED. This search is continued by the question of whether the caller has seen a doctor "at all" about this. Lack of seeing the doctor, emphasised by the *extreme case formulation* "at all", is hearable as a causal element of the caller's experience of ED. In addition, the facilitator's turns can be viewed as designed to work towards a more medicalised interpretive repertoire for his experience of ED.

Therefore, the sequence in the extract 9 moves from a personal concern (that may be alluding to *relationship jeopardising behaviours* that the caller might be attempting to introduce into the conversation) to a referral to a doctor. Typical within the sample of calls to the helpline, personal concerns are worked towards medical solutions and often such medical solutions are simplified to getting a script. This is done through the

combined use of routine *acknowledgment tokens* and *probes* that orient to the institutional work of the call as apposed to individual caller concerns. Through acknowledgments and probes, facilitators move to the next topic, gradually moving towards institutionally relevant activities such as product naming and referral making. There is evidence of difficulty with interpretive repertoires that draw on personal agency and medically based interpretive repertoires are drawn upon in support of institutional activities.

4.4.5 Resisting Medicalised Interpretive Repertoires

If extract 9 is an illustration of how the facilitator reworks callers' personal concerns towards medicalised accounts. Extract 10 illustrates how, even when medicalised interpretive repertoires fail, facilitators still draw upon institutional tasks in getting the call done and caller concerns remain negated.

Extract 10

(Conversation 5)

- 83 C: um hhh] you know maybe its just me or
 84 F: hhh. um look it isn't (.)
 85 and often like [I said the diabetes will have an effect
 86 C: .hhh]
 87 and so will allot of the other medications
 88 C: but I've just been diagnosed as diabetic now about a month ago
 89 F: oh really (.) ok hhh.
 90 C: °yhes°
 91 F: alright (.) um (.) hhhh. look the.the tablets tha::t
 92 >that you saw adverti::sed<
 93 C: °ye:s°

In line 83, the caller makes a move back to a personal account of the problem as “just me”. This is overtly refuted by the facilitator by “look it isn’t” (line 84) and the facilitator revisits the disease orientated account of problem emphasising the effects of diabetes, in line 85. This alternative account is designed in a way that highlights that this has already been made known to the caller with the reminder - “like I said”. With the reference to “other medications” in the next line additional medical accounts for the experience are given (line 87). The caller’s retort (line 88) is hearable as a resistance to a disease account for his problem. In this instance, the caller does not take up the opportunity to draw upon “illness as liberator”, rather he offers a temporal account that he has *just* been diagnosed a month ago that serves to undermine the plausibility of interpretive repertoire that the facilitator is drawing upon. The facilitator responds with what can be heard as surprise (“oh really”) and following much trouble talk, moves to a reference to “the tablet”. Therefore, when the facilitator fails to collaboratively build up a disease account of the caller’s experience, despite caller attempts to introduce an alternative account, the facilitator resorts to moving back to institutionally common tasks such as providing information about the tablet.

Therefore, in order to get the work of the call done, medical and disease orientated accounts are often built into the sequence. It is plausible that this work is done in order to validate referrals to doctors and rendering the advertised product consumable. Interestingly, even when attempts to build medical accounts for caller’s experiences fail,

institutional tasks such as referral making or information giving are nevertheless still relied upon.

4.4.6 Discussion

A comparison of conversations 1 and 5 illustrates the impact of the asymmetrical nature of the conversations on the incorporation of caller concerns. More flexible and less asymmetrical sequences, such as extract 7, involve facilitator relinquishing some control over the agenda of the conversation and inviting caller contributions. However, through their contributions to the conversation, both facilitator and caller appear to be able to make shifts in footing towards each other and the topic of ED. The same caller that moves towards a medicalised account of his experience in extract 7, argues for an alternative account in extract 10. Likewise, the facilitator who invites caller contributions in extract 7, negates such contributions in extract 10. Such shifts in footing should be considered in the interactional context of the conversation. From a DP position (Mäkitalo & Säljö, 2002), words used by participants in talk are not understood only by their isolated meaning but through the “situatedness” of their use. The caller might be resisting the facilitators work towards a medicalised account of his experience out of reluctance to see a doctor, which is more overtly expressed later in the conversation. Therefore, the interpretive repertoire of ED as “just me” is potentially drawn upon to resist the facilitators work towards a doctor’s referral. In the process, caller and facilitator enter into potential ideological dilemmas. Such dilemmas are an illustration of

the many contradictory or “dilemmatic” ideologies that might exist. However, from a DP position, this dilemmatic nature of ideologies is essential to their existence (*see* Mäkitalo & Säljö, 2002). Discursively speaking, contradicting interpretive repertoires such as “absence makes the heart grow fonder” versus “out of sight, out of mind” do not mean that one is undermined by the existence of the other, rather they are flexible resources that are drawn upon in discourse in order to achieve certain discursive work. Facilitator’s preferences for medicalised interpretive repertoires of the experience of ED support the institutional tasks of referral making and script encouraging. Likewise, callers’ might employ or resist medicalised accounts of their experience depending on what they are attempting to achieve within that moment in conversation. The caller in conversation 5 might introduce the notion of diabetes as relevant to his experience in order to initiate a conversation about ED in impersonal and less threatening ways. However, the same caller might resist medicalised accounts of his experience during later stages of the conversation through attempts to compel the facilitator to address interpersonal aspects of his experience, or simply to avoid encouragement to see his doctor (which he finds embarrassing).

Interestingly, even when medicalised interpretive repertoires fail as resources in aiding the work of the call, facilitators still fall back on institutional tasks of routine probes and encouraging visits to the doctor – preserving their position of authority, choosing the direction of the conversation, and honouring the asymmetry of the interaction – getting the work of the call done regardless of caller preferences.

Chapter 5

CONCLUSIONS AND RECOMENDATIONS

5.1 Conclusions

The difficulty with completing this report is that I found myself accustomed to collecting various pieces of research writing together and then attempting to re-piece them together into a picture that could be imposed on the data. In this way one is able to answer the research question before it is actually asked and based on the way you piece the facts together, you get to tell your own preferred story about the data. Such tendencies are difficult with DP as it necessitates working meticulously close to the data, relying on the data to make aspects of theory relevant. This report reveals how the data spoke most obviously to me. There are however many potential readings of the data and in reading through the data it is likely that readers might find differing aspects of the data relevant. In the end, what I hope to have achieved is a conversation between my reading of the data, the theme of erectile dysfunction, and previous work in DP. What follows is the outcome of this discussion.

5.1.1 The discursive position and its limitations

The understanding of DP should not be reduced to a thorough means of qualitative research, rather it can be understood as a refreshing approach to the very

conceptualisation of what constitutes the fabric of social practices. This research report has attempted to demonstrate how such a shift in social enquiry can account for what gets done on a sexual health helpline. More specifically: how conversationalists manage the historically tricky topic of sexual difficulty (in this case erectile dysfunction) within the “local interactional context” of a helpline.

Based on the growing corpus of DP research, interaction is understood as 1) action orientated, 2) situated, and 3) constructed or constructive (Potter, 2003a; Potter, 2003b; Edwards & Potter, 2001). Therefore:

- 1) Callers might achieve certain actions, such as accounting for the reason for the call, in ways that defend against personal accountability. Respectively, facilitators might develop a sequence of utterances that treat experience of ED as an embedded feature of the caller’s account of reason for calling.
- 2) Each utterance that is produced does not only have the potential to orientate to the institutional context of the helpline and the membership entitlements of each participant in relation to that context, but utterances can be considered within the more immediate context of the utterance that came before them and potential utterances that might follow them. Therefore, a caller’s utterance is understood as a *minimal response* in that it is followed by facilitators’ *probes* for further elaboration. Furthermore the facilitator’s *probes* are likely to be normatively followed by caller *elaborations*.

- 3) Ultimately, through the sequence of talk, something is produced. On the helpline a medicalised account of ED is often produced that renders a visit to the doctor appropriate and consumption of a pharmaceutical product relevant.

It has, however, been argued that if DP is the microscope through which we examine discourse, then we must at some point look up from this microscope in order to understand what happens beyond its detailed focus. In other words, the research is limited to the “local interactional context” and fails to examine extra-discursive experiences. As Wilkinson indicates (2000, p.452) “However, because it focuses on the specificity of talk in its local and particular context, discursive analysis does not easily permit either an overview of the full data set, or a detailed focus on the lives of individuals outside the research context.” Therefore, although the research might provide rich and detailed conclusions about what is being produced through interaction, it is difficult to give a broad overview of the work done by the helpline and does not make available to us an understanding of the implications of such productions beyond the local interactional context. Similarly, Frosh (in Sclater, 2003) poses the question ‘What is outside discourse?’, demonstrating a concern with regards to the potential of postmodern thought to produce an “alienating fiction” that allows for the “collapse of self-boundaries” through the limited idea that the self is no more than an effect of language/discourse.

DP does however leave us with a thorough understanding of various possibilities for how interaction is done on the SHH, which is briefly concluded below.

5.1.2 Institutional talk and the construction of ED

Following a detailed analysis of the sequential unfolding of the helpline calls, it appears that conversations do orientate to specific institutionally relevant tasks. This tendency seems to be common in institutional settings: “Whether in a medical consultation, or emergency call to police, in a job interview or a cross-examination in court, both lay and professional participants generally show an orientation to institutional tasks or functions in the design of their conduct, most obviously in the kinds of goals they pursue.” (Drew & Heritage, 1992, p23). The goals that are most obviously pursued by at least one or both participants in the majority of the conversations are: 1) the “naming” of the tablet, 2) reference to “the problem”, 3) building a medicalised account of the problem 4) and the “getting” of a script (often through referral making by the facilitator). It appears that it is the facilitator that makes such goals allowable and that these goals are at times pursued at the expense of callers’ personal concerns.

Therefore, from a DP position, the interest is in how the above mentioned gets done? Both callers and facilitators utilise discursive acts (such as reports, narratives, inferences, acknowledgments, vagueness, probes, rebuttals, agreements and instructions), and resources (such as impersonality, authority and interpretive repertoires) in order to get the

work of the call done. For instance, acknowledgments and probes by facilitator successfully procure a volition from callers of “ED as personal experience”. However, the facilitator cannot take all the credit for the unfolding sequence in the conversation and apart from the deviant case, the caller’s are characteristically cooperative in the collaborative unpacking of this agenda.

Arguably, the institutional orientation of the calls results in a routine script that calls typically follow and through which particular topics are addressed. The topics within this script tend to follow various sequences that involve characteristic discursive features. The research addresses the design of these sequences. Therefore, in answering the question of how the institution enters into the concrete communicative practices and the implications thereof for the construction of ED, I will give a brief overview of the analysed sequences.

5.1.2.1 Invoking Institution

The calls on the helpline indicate a reduction of features typical of casual conversations. Communication is therefore fairly limited to the “business” of the helpline. Through addressing the first topic of conversation – RFC – the parameters of the conversation are indirectly negotiated. Ultimately, through the unfolding of the RFC sequence, the facilitator tends to be set up as authoritative voice in the conversation. This may occur in varied ways: In overt ways, in which the facilitator imposes the goal of the conversation

on the caller (through inferences, that are followed by agreements), or in more subtle ways (through the use of acknowledgments and probes, that are followed by elaborations). Even when the caller volunteers the RFC, hence involving him/herself in prioritising the direction of the conversation, this tends to be utilised as a platform for the facilitator to orientate to the institutional agenda. The deviant case in the analysis indicates how these “rules of interaction” can, however, be renegotiated (initiated by the caller’s rebuttal). Nevertheless, it is uncharacteristic in the sample for the “rules of interaction” and, therefore, the asymmetrical nature of the conversations to be challenged by the caller. Rather, the degree of symmetry in the interaction tends to depend on the facilitator’s positioning – through manner in which caller utterances are moved past, reformulated or addressed.

Although certain contexts appear to necessitate degrees of asymmetry in order for the purpose of the interaction to be fulfilled, I have briefly explored how the asymmetry on the helpline potentially functions to negate callers’ personal concerns.

5.1.2.2 The Interactional Achievement of Asymmetry and the Negation of Caller Concerns

There appears to be a similarity in doctor-patient (Maynard, 1991) and caller-facilitator interaction in the asymmetry of knowledge and authority that is enacted. In both settings, this asymmetry tends to create the opportunity for the prioritisation of a biomedical model of disease that simultaneously undermines caller/patient concerns. The research

on the helpline indicates that such asymmetry is not just due to the institutional context in which it occurs but is invoked through the structure of the interaction - a reliance on routine tasks and discursive devices (such as the combination of acknowledgements and probes) that work towards a medicalised account of ED, and in so doing negate the caller's moves towards introducing personal experiences and concerns. A comparison of conversations 1 and 5 illustrates how asymmetry (or symmetry) is interactively achieved. This is illustrated through an exploration of some sequences of interaction that follow the RFC displays.

In getting the “business” of the call done, the facilitators tend to rely on routine tasks, such as probes for age, medication, and duration of the experience of the problem. Such reliance leaves little “room” for concerns from callers that lie outside of the work of these routine tasks. However, extracts from conversation 5 serve to indicate that it is possible for facilitators to provide “room” for greater caller contributions. For example, through overtly negotiating the agenda of the conversation, providing flexible definitions of experience of ED or inviting caller contributions. As a consequence, however, such an orientation tends to generate many more topics for interaction. As a result conversation 1 lasts 1 minute and 22 seconds, whereas conversation 5 lasts 18 minutes. Interestingly, even though conversation 5 honours greater symmetry in the conversation, allowing the caller greater personally relevant contributions to the interaction, ultimately the same work is done by the conversation – a medicalised account of the caller's experience is upheld that compels him to concede to seeing his doctor in order to assess his suitability

for a script. Therefore, the underlying rule to the interaction seems to remain – “Ask me anything and I will tell you only one thing”. As Maynard (1991, p.457) suggests, “It is as if there is no room and no time in the medical interview for accomplishing other features, particularly those that are characteristic of ordinary talk as an interactional domain organised independently of institutions and discursive formations that could subsume it.” Therefore, callers’ moves towards personal accounts and concerns risk changing the nature of the conversation in ways that do not uphold the institutional goals.

DP also illustrates that different stages within any given interaction might involve various rhetorical demands on the participants, resulting in shifts in footing. Conversationists may draw upon various *interpretive repertoires* as they take up a certain position towards each other and the topics in interaction. Ultimately, through their choice of footing, facilitators could be heard to have consistently taken on the “voice of medicine”. Maynard (1991) cites research that claims that biomedical talk is characteristically impersonal, objective, and scientific. Such talk is considered potentially problematic for patients, who reportedly resolve their difficulty through choosing to comply with “physician speech acts”. The conversations on the helpline are characteristically agreeable and the majority of callers concede to a “need” to see a doctor to get a script, despite their attempts in some conversations to provide room for alternative interpretations for their experience. However, analysis of the conversations also illustrates how both caller and facilitator might employ the “voice of medicine” at varying stages of their interaction. This voice appears to be drawn upon in order to

achieve certain ends. Both parties potentially draw upon an impersonalised and objective “voice of medicine” in dealing with the difficulty of talking about sex in more personalised ways. In addition, it is clear that facilitators tend to draw upon the “voice of medicine” in order to get the “business” of rendering a product consumable done. The analysis also demonstrates that when the “voice of the lifeworld” is introduced by the caller, it is not supported by the conversation. After all, a medical solution necessitates a medical problem.

5.1.2.3 The discursive treatment and construction of concerns about erections

At the risk of oversimplifying the calls on the helpline, the following serves as a brief overview that speaks to the research question. Contrary to my expectations, callers did not necessarily overtly produce “concerns” about the experience of erection problems. Rather, callers preferred reporting the experience of an advertisement on television. Although many of the calls can be said to be a response to the experience of the advertisement, such reports can be heard as impersonal devices that defend against calls being heard as related to the personal experience of a problem. From here, the experience of erection problems is often treated as an embedded feature of the call and the acknowledgment of “ED as personal experience”, that tends to be produced through delicate probing from facilitators as the sequence of interaction unfolds, allows for further work towards a medicalised account of the experience of ED. It is the routine sequence of questions that the facilitator introduces that prioritise a medical account of the caller’s

experience. Such a medicalised account validates a referral to a doctor for the purpose of getting a script. Conversations that treat ED in this manner leave little room for alternative constructions of ED (such as constructions that involve interpersonal concerns like the status of intimate relationships). Hence, concerns about erections are treated in ways that fall in line with what is hearable as the institutional task of rendering a product consumable.

5.2 Recommendations

The conversation initiated by this research report has the potential to speak to various settings: 1) the management of the helpline, 2) an understanding of “what it is” that we do in counselling settings, and 3) my own lived experience.

5.2.1 Helpline Recommendations

The research was motivated, in part, by questions concerning how the helpline should be run. The primary question was whether the helpline should simply serve as a basic information-providing and referral-making line, or lean more towards a telephonic counselling service. My argument was that this could not be determined unless we understood what is actually being “done” on the helpline at present. Through considering moment by interactional moment on the helpline, it is evident that even activities such as information-providing and referral-making are discursive acts in which actions are

achieved. Therefore, discursively speaking, the task of information providing does not necessarily avoid “doing” something to the caller’s experience. Nevertheless, introducing a counselling orientation to the helpline is likely to significantly lengthen calls, require shifts in the institutional goals of the call, and open up the calls to further complexity for which the facilitators are not necessarily sufficiently trained. Theoretically, the goal of the helpline, as the flagship to a non-profit organisation, is to provide credible and independent information to members of the public on any sexual health matter. Forming part of this goal is the requirement to make referrals to relevant health care professionals (including non-medical practitioners). In reality, the helpline is dependent on pharmaceutical sponsorship and many of the calls are in direct response to specific product advertisements. This seems to contribute to the present discursive practices on the helpline that orientate to what is hearable as the very limited goal of making a product known and consumable through a preference for medicalised accounts of experience and making referrals to doctors (the script givers). In addition, such an approach to the calls risks constructing problems with erections and purely organic and easily treated.

If a counselling approach to calls might not be feasible on the helpline, a broader orientation to the experience of ED and its treatment (that includes the relevance of concerns such as interpersonal relationships) should be built into the institutional routine of the calls. Arguably, the fact that there are interpersonal and psychological aspects to the experience of ED (Levine, 2003), and that many members of the organisation who

appear on the referral list are psychologists - rendering “psychology” consumable through the work done on the helpline should become an important consideration.

Furthermore, present practices on the helpline could open the institution up to accusations of what has been termed “disease mongering”. According to Moynihan *et al.* (2002, p.886), some forms of medicalisation could be described as disease mongering – “extending the boundaries of treatable illness to expand markets for new products”. Such practices involve turning ordinary ailments into medical problems, constructing mild symptoms as serious, treating personal problems as medical, seeing risks as diseases, or using/misusing isolated prevalence estimates/statistics to promote products. In other words, it is possible for discursive practices on the helpline to develop in ways that support “disease mongering” and, therefore, undermine the institutions credibility and independence.

Lastly, as mentioned, the limitations of the study include that it does not give us access to extra-discursive experiences. Therefore, it is difficult to illustrate whether greater consideration of caller concerns might lead to improved outcomes in the callers’ experiences. Therefore, following a less asymmetrical conversation, will callers be more likely to visit their a physician for a check-up, return to the bedroom with a renewed and improved understanding of their problem, or be more likely to initiate dialogue with their intimate partner about the problem? Although this question is difficult to answer, “it is

widely recognised that patient participation in discussions about treatment are important in the success of medical outcomes” (Drew *et al.*, 2001, p.58).

There are certain limitations to the present analysis. It is of limited scope and has only considered twenty calls to the helpline over a two day period. The organisation would benefit from further consideration of what is being done on the helpline, especially when it comes to other sexual health concerns. Furthermore, the present study could be built upon by looking at how sexual health concerns are constructed and treated in other, related setting. Related settings would include: 1) the media, and what is being “said” about sexual health concerns, especially in the adverts to which the callers’ are responding; 2) the helpline training, and how ED is constructed through supervision and training practices; and 3) how sexual health concerns are treated and constructed by those to whom the callers are referred. It is the later setting that brings me to the question of what it is that we are doing when we do have the opportunity to provide counselling for sexual health concerns.

5.2.2 What is it that we “do”? Discursive Psychology and Counselling

DP finds application in any setting in which interaction takes place. One area of focus is to understand what it is that we do in psychotherapy (Madill *et al.*, 2001). Certainly, at the heart of successful counselling lies successful interaction (Drew *et al.*, 2001). It is difficult, however, to decide what constitutes successful interaction in terms of

counselling practices. According to Foucault (in Strong & Fuller, 2002), health professionals require docility from clients in order to give “good service”. In terms of this, psychotherapy has been criticised for taking clients’ experiences and reformulating them according to the therapists own theoretical position (Madill *et al.*, 2001). Therefore, rather than therapy being an open negotiation between both parties of what the “problem” entails, therapeutic protocol tends to privilege therapists’ formulations of peoples’ experiences. Shifts towards postmodern approaches to therapy have lead to therapeutic approaches such as Narrative Therapy (see White & Epston, 1990) that oppose docility in clients and uphold the notion of therapy as a collaborative process. Considering the findings on the helpline, it would be valuable for further research to consider what is “done” with the sensitive topic of sexual experience in counselling settings.

Furthermore, although DP has found application in researching therapeutic settings, DP is yet to find application as a practiced form of psychology. In other words, is there the possibility for therapists to begin to consider themselves to be practicing discursively? For instance, I am beginning to find DP deeply relevant to how I go about my personal and professional life. Is there a possibility for a lived discursive psychology?

5.3 A Lived and Practiced Discursive Psychology

The great thing about good qualitative research is that it can shift the ground of conversation. It allows something to emerge.

John McLeod in Strong & Fuller, 2002, p.1

Through attempting to practice discursive analysis a new reality has emerged for me: More attention is paid to *how* clients talk about themselves rather than *what* they talk about. I am more aware of the consequences of my own *footing* in the conversation and how my own positions (real or imagined, personal or professional) might influence the client's contributions to our conversations. Therefore, there is a renewed interest in what clients bring to the conversation and what I try to "do" with what they bring to counselling.

For example, I consulted a client who was considering terminating her pregnancy. She gave a lengthy and believable account of why she should terminate the pregnancy that appeared to render the termination as an inevitable necessity. One could understand her utterances as a reflection of attitudes/cognitions/emotions that were a result of her desperately trying to make a personal and logical choice to terminate, that was in her own interest, but that others in her life were opposing. The therapeutic response to this understanding could have been to empower her to stand up for an ability to make choices in her life that were in her own interest and that others were preventing. However,

following a lengthy exploration of her experience of pregnancy, related personally themes such as freedom, commitment, responsibility, obligations and expectations - from a DP perspective - her hard work in the session to build a very convincing account of the termination of the pregnancy as “inevitable and positive” could be heard as an interpretive repertoire that she was developing in order to avoid being pigeon-holed by those around her into the dominant idea of how pregnant women and mothers “should be”. Therefore, her account of termination as “logical”, “inevitable” and “necessary” was hearable as a means of permitting the practice of termination that would allow her to escape negatively experienced constructions of her as pregnant woman or mother. However, through allowing her to give voice to her own (alternative and preferred) account for how pregnant women and mothers “can be”, gave her access to previously inaccessible positive feelings about being pregnant. Therefore, following a consideration of *how* she was talking rather than *what* she was saying created the space for us to try and unpack both positive and negative personally relevant accounts of pregnancy and termination. Therefore, a decision to terminate would not be restricted to a narrowly defined rhetorical position towards others’ expectations of her but based on a potential variety of personally relevant accounts of her anticipated experiences of both abortion and motherhood. In other words, in the end the choice could be said to truly be more “her own”. Additionally, throughout the therapy DP served as a cautionary voice that warned me against the possibility of treating my own perspective on abortion as an embedded feature of her own account.

On a more personal level, I have become increasingly aware of how a discursive reality operates in my everyday life. For example, when my partner displays “I love you”, not only is this a display of emotion but a discursive act that functions within an adjacency pair, calling for the normative response of “I love you too”, and how the absence of this normative response can be heard in various ways - for instance, as news of trouble in the relationship. Therefore, our “love” and the condition thereof, is negotiated through interactional moments. Likewise, even in relatively mundane settings, I am more acutely aware of how a discursive reality operates: When I park my car at the local shopping centre, within this specific interactional context, that when the gentlemen who ushers me into my parking initiates a “hello” - he is providing an offer/plea to look after my car and the acknowledgment of his “hello” is readable as an acceptance of his offer, and the sequence of interaction serves as a contract that I will pay him for “guarding” my car when I return.

Finally, I consider DP and the refreshing awareness that accompanies it, a skill as apposed to a methodology that one is able to execute simply by knowing and applying the principles that underlie the theory. It is a skill that is improved over time and that is maximised by familiarity with the discursive properties of language and the data being worked with.

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Appendix A

HELPLINE CALLER INFO SHEET

SASHA

Date: _____ Time: _____ Facilitator: _____

Which Advert/Publication/Show: _____ Tried Previous Treatment: ☐

Medical check-up up within the last two years: Yes ☐ No ☐

Source:	Relationship Status:	Race:
Radio	1 Single	1 Black
Newspaper	2 Partnered	2 White
Magazine	3 Married	3 Coloured
TV	4 Divorced	4 Indian
MCI	5 Widowed	5 NS
Friends	6 Not specified	6
Other/ Not Specified	7	7

Age:	Region:	Sex:
<19	1 Eastern Cape	1 Male
20-29	2 Northern Cape	2 Female
30-39	3 Western Cape	3 Transgender
40-49	4 Gauteng	4
50-59	5 Free State	5
60-69	6 Northern Province	6
70->	7 North West Province	7
NS	8 KZN	8 Heterosexual
	9 Mpumalanga	9 Homosexual
	10 Foreign	10 Bisexual
	NS	11 Not Specified

Presenting Female Prob.	Presenting Male Prob.	Reported Medic. Prob.
Loss of Libido	1 Erectile Dysfunction - duration	1 Diabetes
Lack of Orgasm	2 Premature Ejaculation - duration	2 Hypertention
Vaginismus	3 Performance Anxiety	3 Heart Condition
Menstrual	4 STI's/HIV	4 Prostate
Fertility	5 Pain During / After Sex	5 Gynaecological
Contraceptives	6 Fertility / Vasectomy	6 Birth Complication
Abortion	7 Loss of Libido	7 Endometriosis
Pain During / After Sex	8 Penis Size	8 Fertility
Abuse / Rape	9 Fetishism	9 Other
HIV / STI's	10 Sexual Orientational Distress	10
Lubrication	11 Preoccupation with Sex	10 Reported Psych. Prob.
Sexual Orient. Distress	12 Sex workers	11
General / Other	13 Masturbation	12 Relationship Stress
Partner Query	14 General / Other	13 Occupational Stress
	15 Partner Query	14 Anxiety/ Mood Medication
		15

Referred to:	Other:	Information Sent
Psychologist	1	
Urologist	2	
Gynaecologist	3	
GP	4	
Own GP/Urologist	5	
MCI	6 Referred to:	Postal Address:
Other Organisation	7	
Sent Information	8	
Dea Calls / Wrong Number	9	
Office related call	10	
Other	11	

Appendix B

Adaptation of transcription symbols for CA/DA

[]	Square brackets mark the start and end of overlapping speech. Position them in alignment where the overlap occurs, as shown below.
↑ ↓	Vertical arrows precede marked pitch movement, over and above normal rhythms of speech. They are for marked, hearably significant shifts — and even then, the other symbols (full stops, commas, question marks) mop up most of that. Like with all these symbols, the aim is to capture interactionally significant features, hearable as such to an ordinary listener—especially deviations from a common sense notion of ‘neutral’ which admittedly has not been well defined.
Under <u>lining</u>	signals vocal emphasis; the extent of underlining within individual words locates emphasis, but also indicates how heavy it is.
CAPITALS	mark speech that is obviously louder than surrounding speech (often occurs when speakers are hearably competing for the floor, raised volume rather than doing contrastive emphasis).
°↑ <u>I</u> know it,°	‘degree’ signs enclose obviously quieter speech (i.e., hearably produced-as quieter, not just someone distant).
(.)	A micropause that is hearable but too short to measure.
(..) / (...)	Usually numbers in round brackets measure pauses in seconds and 10 th seconds, however, due to technical limitations, these pauses are demonstrated through as “(..)” slightly longer pauses that approach a second and as “(...)” pauses that appear to extend beyond a second.
((text))	Additional comments from the transcriber, e.g. context or intonation.
Yeh.	Periods (full stops) mark falling, stopping intonation (‘final contour’), irrespective of grammar, and not necessarily followed by a pause.

she wa::nted	Colons show degrees of elongation of the prior sound; the more colons, the more elongation. I use one per syllable-length.
hhh	Aspiration (out-breaths); proportionally as for colons.
.hhh	Inspiration (in-breaths); proportionally as for colons.
>he said<	‘greater than’ and ‘lesser than’ signs enclose speeded-up talk and are used in the opposite direction for slower talk.
solid.= =We had	‘Equals’ signs mark the immediate ‘latching’ of successive talk, whether of one or more speakers, with no interval.
heh heh	Voiced laughter.
sto(h)p i(h)t	Laughter within speech is signalled by h’s in round brackets.

Appendix C

Conversation 1

(Clip: 01.01)

- 9 F: Good day sir
- 10 C: Hello:::
- 11 F: You're talking.your phoning in connection with the ad on television
- 12 C: That's right ma'm
- 13 F: Alright (.) you need to information on um
- 14 the product.and the products name is called cialis
- 15 C: °cialin↑°
- 16 F: CIALIS (.) C I A =
- 17 C: =just hang on<=
- 18 F: =ok C I A
- 19 C: C I A
- 20 F: L.(.)L I S
- 21 C: L I S
- 22 F: yea.a is jy afrikaa:ns↑
- 23 (1.0)
- 24 F: is jy afrikaa:ns↑ (..)
- 25 C: ah't.doesn't matter
- 26 let me just spell it for me again
- 27 F: C I A
- 28 C: C I A
- 29 F: L I S
- 30 C: L I S
- 31 F: Y:eS:, how old are you sir↑
- 32 C: 62
- 33 F: 62 have you had the problem for a long time↑

- 34 C: ah few months but its got worse lately
- 35 F: its got <worse↓> (..) are you on any other medica>tion↑<
- 36 C: ah yes (.) I am using medication like um
- 37 (inaudible) (.) im taking (inaudable)
- 38 F: YES↑
- 39 C: and I ve got a lung.a lung problem (.) I've actually got infasim
- 40 F: alright (.) um (.) y.you must remember that you have to
- 41 go to the doctor
- 42 um in order to get CIALIS because you have to get a script
- 43 C: so I must get a.um so I must just go to the doctor
- 44 and.a.um and let him just.a get me a script for that
- 45 F: absolutely because you need to go.you cant bye it over the <counter>
- 46 C: Ill do that ma'm
- 47 F: Alright↑
- 48 C: okey (.) [thanks allot now
- 49 F: pleasu:::re]
- 50 bye:↑ bye:↑
- 51 C: bye↑ now:

Length 1 minute 35 seconds

Conversation 2

(Clip: 01.07)

- 1 F: Hello
- 2 C: Hello
- 3 F: Can I help↑ you sir
- 4 C: Yes (.) >I just wanted to find out< where can
- 5 >I.somebody< find the tablet
- 6 F: =You want to find out where to find the tablet
- 7 what tablet are you talking to.about sir
- 8 C: the one which I see the advert on the TV
- 9 F: al>right< (.) the erection problem (.)
- 10 y.you t.talking about that tablet
- 11 C: (.)o:k:↓
- 12 F: (.) have you got an erection problems
- 13 C: °yes ma'm°
- 14 F: Altight (..) how old are you
- 15 C: Fifty two
- 16 F: Fiftty two
- 17 C: [yes]
- 18 F: and when you say you have got an erection problem
- 19 what do you mean <sir>
- 20 C: I.Ive got no longer the pow::er
- 21 F: You don't [have] it and your stru[gging]
- 22 C: [°yes, yes°] [°yes m'm°]
- 23 F: and does it happen every time
- 24 C: [°yes m'm°]
- 25 F: or only some times
- 26 C: Naa (.) a.a.always
- 27 F: All the time
- 28 Anhowol and you said you w.re fifty two
- 29 Alright and y.ve (.) so you saw the advertisement
- 30 and now you want to know what tablet you can take
- 31 C: °yes m'm°
- 32 F: alright (.) the advertisement you saw on the television
- 33 umm is a tablet that you must get from a doctor

34 so you have to make an appointment with a doctor
35 <um> (.)the tablet's name is cialis
36 c i a l i s
37 Cialis that's the tablet's name
38 (.) um can you tell me (.) i.if y.you are on any other medication
39 C: °No m'm°
40 F: so your on no medication
41 C: °no°
42 F: Alright (.) so you have to get a perscriptiion
43 And then you take that to the chemist
44 =Do you have a doctor that you are comfortable with
45 C: nah.I.ill make a plan
46 F: Alright
47 C: t.to contact one
48 F: alright and you have to go go see the doctor
49 and then you.your prescription
50 if he agrees that it is the right thing to do right now
51 Um do you have any problems with your relationship
52 C: >No no↓ no↓<
53 No relationship problems
54 F: So it is ↑just this↓
55 AL↑right <sir↓>
56 C: Bye↑ bye↓
57 F: bye↓

Length 1 minute 50 seconds

Conversation 3

(Clip: 02.02)

- 1 F: Sasha Hello
- 2 C: Goodday::
- 3 F: Gooday ma'm (.) how are you
- 4 C: I'm fine thank you↑ (.) um who am I speaking to
- 5 F: you are speaking to ((facilitators name))
- 6 C: ((facilitators name))
- 7 F: ye:::s
- 8 C: ((facilitators name)) (.) umm im phoning man because
- 9 my my:: (.)
- 10 I've got permission from my husband to phone
- 11 F: Ye::s:=
- 12 C: = um because we've got a problem
- 13 (.) um erection problem m'n
- 14 my husband is fifty
- 15 (..)
- 16 F: >Fifty years old<
- 17 C: <Fifty years old yes>
- 18 F: ahnd ho:w long:: has he been suffering from this problem
- 19 C: um just a little bit over a year now
- 20 But at first we didn't worry about the problem
- 21 because it wasn't that major
- 22 F: ye:::s:
- 23 But um lately its becoming worse
- 24 F: hh. Um is your husband on any medication for any disease
- 25 C: only since a.um now for the last two moths
- 26 he has been on aa medication for high blood pressure m'n
- 27 F: high blood pressure
- 28 C: ya but this is only for the last two months now
- 29 F: ye:::s:
- 30 C: because he started at a: the first of june with a: the medication
- 31 F: okey
- 32 C: ya it's a two months now hey
- 33 F: and a:: did he try any oral treatment for e: the E D
- 34 erecti:le >dysfunction<
- 35 C: >nnno<
- 36 F: nnot at all
- 37 C: no not at all
- 38 a: when I saw your add:
- 39 F: ye:s
- 40 C: on the t:v: um: (.) I spoke to my husband and so. (.)

41 so he said I must phone and find out if there is a tablet vir hom
42 bec(h)uase we do(h)n't want to go to the doctor immediately
43 F: o:k:: (.) hhh. there are four um different eh:: types of tablets
44 that you can try (.) the first one being a: uprima: (...)
45 C: ya: (..)
46 F: can I spell it for you↑
47 C: >yes yes↑<
48 F: U P R I
49 C: U P R I
50 F: M A:
51 C: o:k: uprima (..)
52 F: [ye::s:
53 C: thts like] a hormone something
54 F: no its its it::s comes in the form of a tablet
55 C: a: but isn' it a:: because my hormone tablets
56 almost sound the same as this he(h)h
57 F: ow:: no:: its not a hormone tablet
58 C: oh ok
59 F: yes (.) and a this one it will lasst for two to three hours
60 in his system and it comes with two strengthes
61 C: two::
62 F: two strengthes
63 that is two milligrams and three milligrams
64 C: =oh: ok
65 F: ye:s
66 C: ok
67 F: [and
68 C: um]can I get this over the counter
69 F: you need the docta:'s prescription
70 C: do I need doctors perscription↓
71 F: =ye::s↓
72 C: ok well that's no [problem
73 F: and] ah:
74 C: we can go to doctor [and then.
75 F: for pr]escription [ye::s
76 C: yes] and tell me ah
77 It wont effect ah the medication that he's on:
78 F: um ah what you supposed to do (.)
79 when he goes to the docta (.)
80 he should take the medication w.[ah:
81 C: wi:th]
82 F: ya (.) so that he can sit which of these available treatment
83 ee: he can prescri:be

- 84 C: [°ok: °
85 F: um] let me give you the second one hhh
86 C: =°ok: °
87 F: its called the levitra↑
88 C: ok (.) can you spell that for me.↑
.....spelling exchange.....
89 C: ok:↑
90 F: it's also a ta:blet.
91 C: =ya
92 F: he needs docta's prescription
93 C: =ok
94 F: and he needs to take it at least twenty fi::ve minutes
95 before sexual:l activity.↑
96 C: =hm
97 F: and it will last for (.) at least four (..) to five hours
98 C: ah:: (.) that's too long a [h(h)a. h(h)aa↑↑
99 F: yee(h)he(h)he] (.) ya.
100 C: no no i'm.i'm i'mm ho(h)nest he:re
101 F: ya. ya. (.) you know wawawhat is happening ne
102 if. if. i:f it last for four to five hours
103 it doesn't mean that ah he will remain erect for five hours
104 C: o:k::
105 F: =ya ah he. he needs [ah
106 C: he will] go soft after
107 F: YA (.) for it to work he needs ee: (.) partners sexual stimulation
108 C: ya:↑
109 F: for him to achieve erection
110 C: o::k::
111 F: [so so he
112 C: but he]wont have the erection for that long (.)
113 F: no he wontehumm have that erection for five solid hours
114 C: [° oh ok:: °
115 F: he will]only achieve erection once you stimulate hi::m
116 C: °ye:s °
117 F: = hhh. and the third one it is called cialis
118 C: ya::
.....spelling exchange.....
119 F: umm its also a tablet
120 C: ya:
121 F: that he should take at least sixteen minutes before sexual activity↑
122 C: =okey:
123 F: =and ah it will last for thirty six hours:
124 C: ah ah ah ah [ah

- 125 F: three] six hours
 126 C: ah::
 127 F: =its strength its twenty milligrams
 128 C: o::k
 129 F: ye:s (.) hhh
 130 C: =but all of this I cant just get over the counter he::y↓
 131 F: no you y.you [you will need the:
 132 C: I have to get the] prescription
 133 F: =ye::s (.)
 134 C: alri:ght
 135 F: and the last↑ one (.)
 136 C: ya::
 137 F: its called the viagra
 138 C: oh no hhhh ya viagra everybody [kn(h)ows about viagra
 139 F: he(h) he(h)he]
 140 Ya
 141 C: even the child:ren
 142 F: YA: (..) so [this one
 143 C: hmmm]
 144 F: if you choose to use
 145 C: = is that one safe
 146 F: (...) th.they are all safe (.) d.d.d.depending on you::r
 147 your medical condition
 148 C: =° ok °
 149 F: =that's why you need your docta's prescripti::on:
 150 C: ok for every::thing ya::
 151 F: =ye::ss (.) this one he should take she.he should take it
 152 at least thirty to one howa before sexual activity.↑
 153 C: °o::k °
 154 F: and it will la::st for four to five hours
 155 C: ° alright alright °
 156 F: =and it comes on three stre:ngthess.
 157 (..) hh. (.) the first one is twenty five milligrams
 158 C: ° aha:: °
 159 F: ah fifty milligrams
 160 C: ° ermhmm°
 161 F: and a hundred milligrams
 162 C: ° ok: (.) fine°
 163 F: =hhh. and eh which province are you calling from m'm↑
 164 C: which province↑
 165 F: ye:ss
 166 C: >from cape town<
 167 F: <cape town> (...) o::key: hhh. (.) do you have any oth.

- 168 C: =western province hey↑
169 F: ye::s hhh (.) do you have any other questions regarding this
170 C: um no no no no its just that ahh that was a bit (..)
171 bothering to us about the ah:: (.) the.erection [problem
172 F: the erec] o:::ke:y
173 C: because umm (.) um (.) we do the check ups aah <for for for:>
174 Hhhhh. (...) whats it called for ahh
175 F: =>hypertension:<
176 C: no. no. no. no. no:: (.)
177 >like like< I do my breast my (.) breast check ups hey↑
178 F: ye:s
179 C: monthly↑
180 F: ye:s
181 C: um (.) i. i've shown my husband how to do his (.) checkups
182 fo:r aah any lumps or in his testicles or whatever
183 F: o::key:
184 C: so everymonth we are still doing that. hhhh. aah (.)
185 to be sure that there's nothing (..) um (.) se:riously (..)
186 F: oh
187 C: =the problem
188 F: ye::s
189 C: its just that theres no (.) there wasn't no function
((footsteps heard in the back))
190 there wasn't any function (.) for (.) about a year naw
191 F: ye:s hhh. because↑ the: hypertention is one of the
192 causes of ah erectile [dysfunction
193 C: umm] yes after um
194 I've I've I've looked up some information on hypertension
((baby heard in the background))
195 F: ye::ss
196 C: ive seen that it is one of the major problems for for
197 erectile problems ya
((baby heard in the background))
198 F: ye:ss hhh. [now] (.) can I refer you to one of our doctors
199 C: [ah]
200 F: Or you do have your own docta
201 C: we do have our own doctor
202 F: okey:::
203 C: that we go to ya:::
204 F: okey.
205 C: um been a family doctor for for most of our time now
206 F: alright
207 C: >for a long time< (.) so (.) we do ha::ve ah (...) there is (..) um

208 (...) you know communication with doctor and everything
209 F: ye::s
210 C: I just wanted some (.) informationnn (.) for myself also
211 so that I can go back to himm
212 F: okhey
213 C: both me(h) and my husb(h)and
214 F: A::lright
215 C: =>alright then<
216 F: =ah. (.) thanks for your call m'm
217 C: =thank you very much heh↑
218 F: by::e
219 C: >bye bye<

Length 2 minutes 52 seconds

Conversation 4

(Clip:02.05)

- 1 F: Sasha Hello (...)
 2 Hello (..)
 3 ↑Hel↓lo
 4 C: Hello::
 5 F: HI sir how are you
 6 C: I'm ok and how are you
 7 F: I'm fine::
 8 C: I was watching tv the other day
 9 and then there was an advert from you:: (.)
 10 which a say that ah ah one must choose the right moment
 11 if it concerns ah ah it concerns sexualdis (.) function
 12 something like that
 13 F: ye::s um it its for people who've a::h
 14 impotence or erectile dysfunction (..)
 15 and um (..) a::: four of the available treatments for
 16 the impotence or erectile dysfunction
 17 and um::: (..)
 18 can you tell me about a:: your problem a little bit
 19 C: I DON'T HAVE ANY PROBLEM (.)
 20 um I WAS WATCHING TV
 21 F: =ye::s
 22 C: AND THEN THERE WAS AN ADVERT THERE
 23 WHICH a (.) ah ah h h h (...) was INTERESTING::
 24 >if I may so say< (.) that one must one must buy a tablet
 25 from you gu::ys
 26 h h h. and then a yu.when one ah chooses the right moment
 27 one can have a good sexual intercourse
 28 >blah blah blah<
 29 so ah I don't have a problem at the moment
 30 I was just ah you know intereste::d
 31 F: Oh ok you don't have any [erectile dysfunction
 32 C: noo] no
 33 I don't have that (.) but ah eh eh eh
 34 according to the advert it was saying one must buy a tablet over there
 35 F: =h h h. h h h y.
 36 C: =a medication of some kind
 37 F: h h h. ye::s umm like I said it's only for people with erectile dysfunction
 38 (.) and ah those:: ah like ah sometimes they call it ah impotence
 39 (..)
 40 C: IMPOTENCE

41 F: ye::s
 42 C: in other words the.eh the call I have just made (.) ive just wasted my time
 43 F: >come again<
 44 C: in other words <the call ive just ma:de > ive wasted my time and money
 45 F: noo not really because you wanted some information
 46 C: yes
 47 F: yes so you didn't waste your money and ah time
 48 C: there's nothing you can tell me in other words (.)
 49 concerning the tablets I have just enquired abou::t
 50 aw:: something like that
 51 F: OK (.) the the tablet its called cial↑is
 52 C: how much does it cost
 53 (...)
 54 F: plus minus onetwenty (.)
 55 and you get it through docta's prescription (..)
 56 um (.)
 57 you take one tablet a day when needed (..)
 58 and eh the tablet will last you for about thirty six hours in your system
 59 C: how much ah can you spell eh eh the name of that tablet for me
 60 F: hh. C I A
 61 C: <C I A>
 62 F: L I S
 63 C: <L I S>
 64 F: ye↓::s
 65 C: C I A L I S
 66 F: ye↓:s
 67 C: I can only get it with a doctors prescription
 68 I cant just go to the counter and buy it
 69 F: no: (.)
 70 C: okay
 71 F: you get it through docta's perscritpion
 72 C: okay (.)
 73 F: ye↓:s (.)
 74 C: okay >thank. thank you very much<
 75 F: alright thank sir
 76 C: =>ok b↓ye<
 77 F: by:e

Length 18 minutes

Conversation 5

(Clip:02.08)

- 1 F: ((facilitators name)) hel↑lo::
- 2 C: howzit ((facilitators name))
- 3 F: y:es (.) how can I help ↓you
- 4 C: hh um hh ya man uhhm (.)
- 5 I see you guys advertised a ah ah tablet on tv
- 6 F: y:es
- 7 C: hh. umm what tablet is that
- 8 F: alright the drugs name is ↑cialis
- 9 C: hmmhm
- 10 F: hhh. umm (..)
- 11 C: ↑cia↓lis
- 12 F: ya: (.) it.
- 13 C: =how do you spell that
- 14 F: C I A: (.)
- 15 C: ya
- 16 F: L I S
- 17 C: ye:s
- 18 F: hhh. was there anything: specific you wanted to ↑a::sk
- 19 or should I just tell you about the the tablets
- 20 C: well I think tell me about it and then then ill tell you
- 21 F: alright hhh. um they've been designed fo:r
- 22 for men with >erectile dysfunction<
- 23 C: ye:s
- 24 F: basically:: (.) men that cannot get an erection at all: (.)
- 25 or can get an erection but its not hard enough to for penetration (.)
- 26 C: ye:s
- 27 F: is that (.) kindof what you experience
- 28 C: hhh. um ya like hh I get an erection but as I say it doesn't last hey
- 29 [hhh.
- 30 F: ok]
- 31 C: and I don't know if it is perhaps that medication I take
- 32 or something you know (.)
- 33 because I'm a diabetic
- 34 F: =alright
- 35 C: =and I also take heart medication
- 36 >so I take< (.) umso
- 37 let me tell you about some of the medications that I take
- 38 [I take
- 39 F: hhh.hhh]
- 40 C: livetrend

41 F: mm
42 C: ah ah carveloc
43 F: okay
44 C: then I take zocorm hhh
45 F: alright
46 C: and cozer (.)
47 F: okay
48 C: and walfrin
49 F: alright hhh
50 C: and then I take a tablet for my diabetes called um drasanin
51 F: okay hhh. alright um sir can I [ask how old
52 C: sorry im a bit embarrassed] hehehum
53 F: =↑↑oh(h)o::
54 C: =ya but you know look
55 F: =ya its something most people don't talk about
56 so you know [its understandable
57 C: ya but you know look] I also I don't want to (..)
58 like um hhh (.)
59 mess my marriage up either you know
60 F: mm hhh. alright um and that that is a big factor
61 how long have you been married
62 C: hhum 20 years
63 F: alr↑ight hhh. (.) and the problems with the erections (.)
64 how long has that been
65 C: um about the last (.) two years hey
66 (..)
67 F: and have you been to a doctor before about this before at all
68 C: no I haven't hey
69 F: kay (.) hhh. um (...) do you know
70 >or I am sure that you do know that< (.)
71 men who are diabetic very often have problems (.)
72 or have erectile dysfunction hhh. um
73 C: no you know look I'm you know the things is man
74 also like h(h)h this is now (clear throat)
75 also like funny I am talking to you but
76 our home doctor is also (.) hhhh.hhhh she's also a lady
77 and but she's also like a family friend [aswell
78 F: °alright°
79 C: and h(.)h you know I didn't want to go talk to her
80 but I also don't want to go talk to another doctor either so
81 hh. when I saw this umm I thought let me hh. (..)
82 F: find out [here
83 C: um hhh] you know maybe its just me or

- 84 F: hhh. um look it isn't (.)
85 and often like [I said the diabetes will have an effect
86 C: .hhh]
87 and so will allot of the other medications
88 C: but I've just been diagnosed as diabetic now about a month ago
89 F: oh really (.) ok hhh.
90 C: °yhes°
91 F: alright (.) um (.) hhhh. look the.the tablets tha::t
92 >that you saw adverti::sed<
93 C: °ye:s°
94 F: (.) hh. in most si: tuations they would definitely be effective hhh.
95 C: °ye:s°
96 F: but in your casse (..) there is a very strong likely hood that (.)
97 of the medications your on (.) hh.hh
98 one or more of them is a nitrate (..) um (.) its [kindof a class of drug
99 C: you mean a]
100 what type of a well name some of the nitrates mo:re (.)
101 commonly prescribed (.) and then maybe I can tell you if I itiswannathem
102 F: um unfortunately I don't know that but I know that they are often
103 prescribed fo:r for people with heart conditions
104 C: oka:y hhh
105 F: kay hhh. um: so (.) y'
106 if you are going into any medication for the erectile dysfunction
107 [hhh.
108 C: °yes°]
109 F: =you are going to need a prescription from a docta
110 C: °ye:s°
111 F: hh. um so can'I.first step would be
112 if if you aren't comfortable speaking to:: your ↑own doc↓ta hh.
113 [then:
114 C: ag I']spose I will eventually
115 you know I'll get up enough courage and go [but
116 F: and] do it one day
117 C: yaa hhh you know I'll go.look I'll have to go and do it because hhh.
118 F: =°kay°
119 C: =a person gets a bit (.) umm how can I say (...)
120 not frustrated maybe but
121 F: =mm
122 C: =youknow you sort of like (.) hh.hh um you avoid talking about it
123 >youknow what I am saying<
124 F: =ya:
125 C: hh. and hh youknow hh.hhh um hh (.) um ahdo ahdo you know
126 as I said idont want to hh mess up my home life hh.

127 youknow ive got a (.)

128 F: = ° mm °

129 C: = good homelife hh (..) and I've got nice kidsandstuff (.)

130 I don't want to mess it up for something stupid you know

131 F: ya hhh.

The conversation continues for about 12 more minutes along similar lines, ending in the concession to consult his family doctor “at some time”.

Length 18 minutes