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Calling Time:
A Discursive Analysis of Telephone Calls to an Alcohol Helpline

By
Mandi Hodges

A Doctoral Thesis
Submitted in partial fulfilment of the requirements for the award of Doctor of Philosophy of Loughborough University

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Abstract

This thesis takes Discursive Psychology as its main theoretical influence. Drawing on the resources of Discursive Psychology and utilising analytic tools provided by Conversation Analysis, these principles are applied to the study of addiction, and specifically alcohol problems.

The data explored are telephone calls to an alcohol helpline. Four analytic chapters are presented. The first focuses on the concept of loss of control over drinking, identifying features of how this concept is constructed in talk and suggests possible functions of control talk for both callers and Advice Workers. The second analytic chapter examines how Advice Workers respond to callers' professed impaired control over their drinking and I demonstrate that embedded in discursive sequences of problem formulation and advice giving are issues of agency, accountability and responsibility. The thesis moves on to explore the role of knowledge in calls to an alcohol helpline and the analysis reveals that both the expert status of the Advice Worker and the speciality of the topic are co-constructed between the speakers on the helpline. The final analytic chapter features just one telephone call and demonstrates the application of such an analysis for alcohol service providers.

The thesis ends with a discussion of the main overall findings and the implications of the research for clinical practice. I close by arguing that initial agency contact is a very important site of study and recommend that this should be explored utilising naturally-occurring talk.

KEYWORDS: Discursive psychology; alcohol; addiction; telephone helpline; initial agency contact; naturally-occurring talk; alcohol treatment services
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And in the sense of saving the best until last, thank you to my two daughters, Siobhan and Michaela; you are my idols and I worship the water you walk on.
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Chapter 1
Introduction

This thesis takes Discursive Psychology as its main theoretical influence. Drawing on the resources of Discursive Psychology (DP) and utilising rigorous analytic tools provided by Conversation Analysis (CA), these principles are applied to the study of addiction, and specifically alcohol problems. In this chapter I will explain my interest in both the study of addiction and discursive psychology and I will explain how I came to marry together these two disparate areas. I will end this chapter by giving a brief overview of what readers can expect to find as they work through this thesis.

The motivation

In my experience the concept of 'addiction to alcohol' is one of the most fascinating, convoluted and contested concepts that I have encountered. Consider the adolescent who drinks cheap wine or white cider, who has recently left school with no qualifications, nothing to occupy their mind or time and little motivation to do anything other than find the money for a bottle of Lambrini; the single parent who puts the children to bed and passes each evening with a bottle of wine; the man who, following the desertion of his wife, seeks daily solace and the company of others in the local pub with a few too many beers; the elderly person who passes the time between rare visits from grandchildren with the odd sherry or two, or three, or.... Which of these people has a drink problem? Do they all, or do none? How do we define these and other similar people? What is the distinction between a 'big, heavy drinker', someone with a bit of a problem, or an 'alcoholic'?

Such musings led me to believe that there are no answers to such questions. After further consideration, coupled with reading related literature and research I came to believe that addiction to anything is constructed within a network of descriptions provided by people of their own and others' behaviour. This inspired two questions which provided the motivation behind the research, culminating in this thesis; firstly, how do people design their descriptions in such a way that constructs a concept of addiction? Secondly,
why would people organise their talk in such a way; what function does it serve? The questions I ask expose the theoretical and epistemological position that I adopt throughout my research.

The theory
The analysis in this thesis focuses closely on the detail of the talk on an alcohol helpline. As this research is informed by Discursive Psychology, language is not conceptualised in a positivist way of referring to a world outside of itself. Language constructs the speaker's reality, hence, unlike more traditional approaches to the study of addiction, I do not focus on the speakers' accounts as a reflection of their experiences or some pre-existing reality in which they can be said to live. Instead I was concerned with how this reality is constructed, and what this achieves for speakers on an alcohol helpline.

Conversation Analysis provides analytic tools with which to unlock the intricacies of talk-in-interaction, which enabled me to discover what actions are embedded in discursive sequences of problem formulation, giving or receiving advice, and other activities performed on the alcohol helpline.

The research presented in this thesis explores uncharted waters in the sea of addiction research. This has been made possible not only by the position adopted and the approach I took to the study, but also because of the data I explored.

The data
The data scrutinized in this research are telephone calls to an alcohol helpline. These data were specifically chosen for the research I wanted to conduct for reasons which are fundamental to the research project.

Telephone helpline interaction represents naturally-occurring talk; that is, an interactional exchange that would have taken place even if no such research project were conceived of. As I discuss in chapter three of this thesis, previous qualitative data explored in addiction research has almost exclusively been generated through research interviews. Whilst such an approach has
produced interesting, valuable and well-conducted research, I express a number of concerns and discuss what I consider to be limitations of relying on interview techniques to explore how people formulate descriptions which construct everyday concepts. My interest is in how people design their talk when going about the business of their daily lives, and naturally occurring talk captures such activities. There may be few people who discuss or consider drink problems on a daily basis; some who do feature in this thesis. The organisation from which the helpline calls examined in this thesis were recorded deals solely with alcohol problems rather than extending services to people who engage in other types of substance use or other problematic or 'addictive' behaviours. Therefore an Advice Worker's time is centred on problem drinking. For callers, deciding to ring a helpline for advice is generally not a decision taken lightly. As alluded to earlier, deciding whether someone's behaviour constitutes a drink problem is rarely a clear-cut matter and in the analysis provided in the following chapter we see evidence of this as callers initially express caution in labelling their drinking problematic. Making the decision to contact alcohol service has often taken an appreciable length of time and considerable thought and contemplation before a person acts.

Telephone conversations are classic data for research employing a Conversation Analytic methodology, stemming from the early development of Conversation Analysis when Harvey Sacks, the pioneer of CA studied calls to emergency services (Silverman, 1998). When deciding on data to collect I chose this because when listening to the recordings I would be in the same position as the two speakers; I could not see the other speaker. This put me in a stronger position to notice interactional quirks and to explore their consequences or implications. For example, how do callers display an interpretation of Advice Workers' unexplained silences; how do Advice Workers deal with a caller's unenthusiastic response to suggestions? Both situations may actually be accounted for by, for example, distractions of one sort or another, but none of the listeners can be sure of that and the two interlocutors need to manage such interactional uncertainties.

Another strength of the data is that it is taken from a point very early in a person's contact with alcohol services; often the first contact callers have had, with most claiming never to have spoken to any sort of professional about their
drinking before. This again represents a completely new area of research in the field of addiction. The vast majority of research in this area utilises people who are receiving or have received some form of treatment or intervention. The data therefore offer an, as yet, unique research opportunity and affords novel insights, as are discussed at appropriate points throughout the thesis.

Having started from this exciting position, let me now provide a brief overview of how this came together and an outline of the following chapters.

The overview
I begin the thesis by reviewing literature in areas which I feel this research can contribute something interesting and informative. Initially I begin by providing a historical account of addiction. As I have previously noted, this is an intriguing and absorbing concept, and as such, its construction provides a fascinating history. I end the chapter by making apparent my own position on a theoretical understanding of alcohol problems.

I move on to review qualitative research conducted in this area. I show that such research not only represents a positive move away from decontextualised statistical analyses, but has also produced some exciting and useful findings. However I express a number of concerns with the theoretical and epistemological position adopted in previous research and present an argument for conducting research in the manner adopted in this thesis. The following chapter (chapter 4) makes explicit the theoretical and epistemological position adopted in this thesis and I provide details of the methodological approach and the data explored in this research. From there the thesis moves on to present the analysis which covers the next four chapters.

When beginning to analyse the data I noted the prevalence of talk about issues of 'control' over drinking. As a control construct has long been a central feature of theories of addiction and alcoholism it seemed highly appropriate that this should become the focus of the first analytic chapter. Whilst the concept of 'impaired control' has been studied fairly extensively, two things appeared to me to be missing from the literature; firstly, a detailed examination of how people construct and manage issues of control; what constitutes issues
of control and how 'impaired control' gets done. Secondly, how and when issues of control appear in people's talk outside of research interview settings, when they drink alcohol excessively and are asking for help to stop or cut down on their alcohol intake. The analysis set out to address such questions.

The analysis presented in the 'control' chapter (Chapter 5) demonstrated that this construct is highly resistant to challenge. As such, I became intrigued as to how Advice Workers deal with callers' 'impaired control' constructs. In the analysis that followed (Chapter 6) I discovered that embedded in the ensuing discursive sequences of problem formulation and advice giving were issues of agency and responsibility. The chapter includes a consideration of the implications for callers of such implicit topics in the talk.

A recurrent theme throughout the first two analytic chapters were issues of expertise and knowledge, however, these were sidelined in favour of the previous analyses so became the focus of the third analytic chapter (Chapter 7). The analysis uncovers the co-constructed nature of the Advice Workers as knowledgeable experts. The chapter closes with a discussion of the implications of callers' expert knowledge of the details of their life and the function of such knowledge as a challenge to or resistance of the advice offered by Advice Workers.

The data collected and knowledge gained from the analysis of the calls provided excellent resources for training new Advice Workers. Materials prepared for use in training sessions provided the basis for the fourth analytic chapter (Chapter 8). Here I discuss practical applications of the research project and demonstrate how useful a close detailed analysis of Advice Workers' practices can be for the organisation. When approaching analysis with practical applicability in mind I felt it was not my job to try to identify issues such as the sort of advice the organisation should be offering or what information can aid callers to go on to receive further help. My analysis highlights that what is important are issues of how something is packaged as advice, reassurance, support and various other discursive activities which Advice Workers on the helpline routinely engage in.

The final chapter (chapter 9) comes full circle and replies to the questions I raised in the introductory chapters. I consider the analyses presented and
relate it to the literature I reviewed in the early chapters. In the process of assessing the thesis as a whole, implications became apparent which were not anticipated at the outset. In the discussion chapter I outline and cautiously suggest that callers may be 'trained' in or encouraged to use a particular way of talking by the Advice Workers, and I provide evidence to support such a proposition. I also discuss implications of the research project for other debates and concerns within treatments for alcohol problems. The chapter ends by highlighting the implications of this research for clinical practice, and in light of the analyses have presented, I suggest new areas of research. Overall the thesis demonstrates that what happens during initial agency contact, that is, the first time a potential client contacts alcohol services, may have far reaching implications and I recommend that this is an important site for further study.
Chapter 2

A History of Addiction

The 'disease model', also known as the 'medical model', is the predominant, most powerful and influential account of addiction. It is a model that assumes that a continuation and increase in an addict's substance use will occur, and that an individual's volition in this behaviour is minimal; addiction is taken to be a progressive condition characterised by an inability to resist or control substance use. Ideas from this account permeate everyday discourse, media discourse (Herbert & Akbar, 2002; Loudon, 2002), medical discourse (APA, 2000; WHO, 1990), government policies (Home Office, 2002), indeed almost anywhere that addresses issues of excessive behaviour one can trace elements of the disease model of addiction. It is generally accepted, widely believed and commonly used. This is somewhat astounding, since it has never been underpinned by anything 'scientific' or 'objective'; a charge which will be addressed in the subsequent pages. The following literature review attempts to pick a route through the vast amount published on this topic and endeavours to show the motivations and assumptions behind the amassed 'knowledge' through to current day thinking. The history of addiction that I present will focus mainly on alcohol for two reasons; firstly because the data and analysis that this thesis is based on specifically concerns alcohol and secondly because the early history of addiction predominantly focused on alcohol, and this, until recently, has had the biggest influence on other areas of addiction. Whilst I intend to present the information in an open, straightforward way and outline arguments from all sides, this will inevitably be influenced by my reading of it. Not only will this review set the stage for the later analysis presented in this thesis, I hope readers will agree that this is a fascinating journey through an important aspect of a social history.

Alcoholism, and indeed addiction more generally, has been well researched within psychology, with a focus on its cause, course and consequences. Alcoholism as the construct is understood today is relatively new, but alcohol use and drunkenness have a long history. We will survey this history in this chapter, through a discussion first of some of the earliest records of problem drinking, then through a discussion of Alcoholics
Anonymous (AA). We will move on to review problems and weaknesses inherent in a disease model account, ending with a consideration of up-to-date accounts of excessive or problematic drinking.

**A pre-history**

In 18th century Britain, consumption of alcohol, even in large quantities was acceptable. However, drunkenness that led to social disorder was seen as a social problem and deemed intolerable. Habitual inebriety was associated with crime, vice and public disorder, consequently, drunkards were controlled by punishment (Babor, 1997). In the mid 19th century, as medicine and psychiatry developed as 'modern' professions, the view was adopted that in many cases, habitual drunkenness was not simply a vice to be dealt with by criminal punishment, but more probably a disease that should be treated with less punitive interventions (Johnstone, 1996). This disease affected moral functioning, and particularly willpower, such that some people got drunk because they wanted to, and therefore were culpable for their behaviour, but sufferers of this disease felt compelled to drink and, although were less blameworthy, were moralistcally held as 'weak-willed' (Valverde, 1997). Unfortunately, defining alcoholism as a disease of the will produced problems for the medical profession, who were hard pressed to provide a treatment that would re-build 'the will'. At the heart of this disease was the substance itself; alcohol was believed to have the power to enslave. This view of alcohol was forcefully and effectively advanced by the Temperance Movement which was gaining power and momentum, and was a driving force behind the introduction of the prohibition of alcohol in the USA in January, 1920 (Fingarette, 1988; Hartmann & Millea, 1996). Whilst these views were paralleled in the United Kingdom, no similar prohibition was enforced in the UK.

**Alcoholics Anonymous**

Alcoholics Anonymous (AA) started in Akron, Ohio, USA in 1935, when two 'alcoholics', popularly known as Bill W and Dr Bob, met and agreed to support each other's attempt to abstain from alcohol. The first Alcoholics Anonymous meeting in the UK was in Gloucestershire in 1948.
The philosophy was predicated on a hybrid pseudomedical, psychological and religious foundation. AA maintained that 'alcoholics' are a specific group of people who are unlike others and have a particular vulnerability to alcohol. They advocate that, while most people can drink alcohol without problems, with regard to alcoholics, there is a biological element "which differentiates these people, and sets them apart as a distinct entity" (Alcoholics Anonymous, 1976: xxviii. See also, AA, 1939, 1955). Furthermore, literature produced by Alcoholics Anonymous (1976: xxiv) stated "We were sure that our bodies were sickened as well. In our belief, any picture painted of the alcoholic which leaves out this physical factor is incomplete". This sickness was akin to an allergy, where the reaction to alcohol was an irresistible craving and loss of control over drinking. According to AA's teaching, alcoholism is a "malady" (AA, 1976: 23) or disease which is progressive, irreversible and incurable (McMurran, 1994). The message has three significant points, firstly that the root of the disease is situated within the individual, not within the substance of alcohol, secondly the drinker is compelled to drink due to craving and loss of control over drinking, despite an expressed desire not to do so or any negative consequences, thirdly the condition is incurable and irreversible, hence it can only be arrested by total abstinence from alcohol and the 'recovering alcoholic' can never return to 'normal' social drinking.

The repeal of American prohibition in February 1933 saw a direct and steady increase in alcohol-related problems, and drunkards were again seen as a troublesome nuisance. Prior to prohibition, alcohol itself had been seen as the source of the problem, causing the witnessed problematic drinking in certain people. Since the failure of prohibition, this was obviously going to be a difficult position to return to and unlikely to receive widespread public support. In 1937, money was granted to the Research Council on Problems of Alcohol to conduct medical research into alcoholism. The prestige of scientific research would be needed to convince people that vulnerability to the dangers of alcohol were experienced by the few rather than by the many, that habitual drunkards required treatment rather than punishment and to remove the social stigma. Hence, it has

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1 On this point, AA ideology has remained stable to the present day with one AA member telling me that "being an alcoholic is like being pregnant; either you are or you aren't" (Joan, AA member. See Dytham-Hodges & Wiggins, 2001)
since been argued (see Reinarman, 2005) that the main objective of the research was to keep inebriates out of jail and get them into treatment, rather than to make academic or scientific advances in knowledge.

The research into alcoholism was conducted by Jellinek (1952). After collecting extensive data, Jellinek outlined the phases of a typical alcoholic’s drinking career which, due to an increased involvement with alcohol, saw a drinker pass through a stage of progression, characterised by behaviours such as ‘occasional relief drinking’. Subsequently, a crucial phase involving ‘moral deterioration’, ‘impaired thinking’ and an ‘obsession with alcohol’ was followed by a chronic phase where ‘all alibis were exhausted’ and ‘complete defeat was admitted’. At this point, ‘obsessive drinking continues in vicious circles’. For some, an ‘honest desire for help’ begins a rehabilitation phase, whereby the alcoholic ‘stops taking alcohol’, ‘meets normal, happy former addicts’ and ‘right-thinking begins’. With continued ‘group therapy and mutual help’, the recovering alcoholic passes through the recovery stage where an ‘enlightened and interesting way of life opens up with a road ahead to higher levels than ever before’. This ‘scientific’ description of alcoholism and the pattern of decline and recovery flawlessly matched the Alcoholics Anonymous account. AA used this prestigious evidence to strengthen their argument, resulting in a gain of power sufficient for them to exert considerable influence both in the American Medical Association and in USA government agencies (Hartmann & Millea, 1996; Jellinek, 1960, Reinarman, 2005).

However, while elements of Jellinek’s work may have withstood the test of time, it did not survive academic scrutiny and many people became sceptical, questioning its objective, scientific basis. It is pointed out that all of Jellinek’s findings were based on data obtained solely from AA members. The questionnaires he used were designed by AA and were distributed to members through the AA newsletter ‘The Grapevine’. Furthermore, Jellinek’s influential research was based on an accumulated data set of just 98 men. Of the total 158 completed questionnaires returned to the researcher, 60 were removed for various reasons, including any that were completed by women because their responses appeared considerably

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2 This became popularly known as the Jellinek Curve.
3 In as much as, this is still the account of alcoholism taught by Alcoholics Anonymous.
different from the men's (Fingarette, 1988; Hartmann & Millea, 1996; Heather & Robertson, 1985). Arguably a scientific façade was being used to legitimate the AA position on alcoholism, or, as Heather and Robertson (1985: 71) write "it was merely an attempt to dress up the AA model in academically respectable clothes". Nonetheless, this was seen as a worthy venture by many, as disease model proponents "argue that the labeling of alcoholism as a disease frees alcohol abusers from feeling guilty or ashamed of their drinking and thereby makes it easier for them to seek treatment." (Fingarette, 1988:4)

Jellinek's model was refined and further developed over a number of years and culminated in his highly influential book, *The Disease Concept of Alcoholism* (Jellinek, 1960). Alcoholics present differently, so, although there was only one disease model, logically then, only one disease, there seemed to be many types of alcoholics or drinkers with different characteristics, drinking patterns and behaviours. Jellinek's idea was to create a typology in order to better understand the aetiology or mechanisms leading to the disease, to improve treatment and to enhance the theoretical understanding of alcoholism and its consequences (Babor, 1996).

Pre-Jellinek any attempts at typologies were based on clinical observation and anecdotal evidence, hence, they were unsystematic, lacked empirical or scientific foundations and were often confusing. Also, they gave no indication of aetiology. However, they set the stage for the development of more sophisticated typologies. Babor (1996) argues that Jellinek's typology was important and influential

"because it was imbedded in a credible and comprehensive theory of alcoholism that represented the cumulative contributions of scores of clinicians and scholars[, d]rawing from the clinical literature published in France, England, Germany and the United States, and from the growing body of experimental research conducted in the 1940s and 1950s" (Babor, 1996:10)

Jellinek (1960) identified five types of excessive drinkers, only two of which were considered 'diseased' in any physical sense. Jellinek reported biological changes causing the experience of craving and loss of control over drinking, and asserted that, due to these biological changes, intolerable
withdrawal symptoms were experienced by the alcoholic if alcohol were not ingested. The aetiology of the condition in the three remaining types of drinkers was more psychological; in these groups, excessive alcohol either caused psychological problems which lead to further drinking, or excessive drinking was a symptom of psychological problems. In effect, Jellinek drew a distinction between alcohol addicts who were afflicted by the disease, and 'habitual symptomatic excessive drinkers' whose drinking may be causing harm to themselves or others, but are not afflicted by the disease. These are important distinctions; however, the crucial point is that they still imply that the drinker is not simply choosing to drink excessively.

Let us summarise the disease model of addiction we have addressed so far. Alcoholism is:

- Characterised by loss of control.
- Incurable and irreversible
- Progressive
- A condition afflicting only a sub-group of individuals who are very different from other people

We have also seen that there appears to be little empirical research evidence to support it. Worryingly for disease model proponents, there is a wealth of evidence which can be marshalled against it.

**Challenges to the disease model**

**Loss of control**

Let us turn our attention first of all to the concept of 'loss of control' over drinking; the cornerstone of the disease model. Here it is assumed that drinking is perpetuated by a person's acquired lack of ability to control their alcohol intake once alcohol has been ingested. Early research that attempted to test the construct found little support for it and it has proved difficult to tie down experimentally. Following laboratory-based experiments Merry (1966) reported a lack of evidence of loss of control, while both Cohen, Liebson, Fillace and Speers (1971) and Sobell, Sobell and Christelman (1972) demonstrated that alcoholics could control their drinking when offered an incentive to do so, even after a 'priming dose' of alcohol was given. Interestingly, Marlatt, Deming and Reid (1973) found sufficient evidence to argue that it is the belief that one is drinking alcohol
which prompts increased drinking, but not actually drinking the alcohol itself. This brief overview is indicative of the trouble, no doubt with operationalising and certainly with proving such a phenomenon as 'loss of control'. This is an issue that we will return to many times throughout this thesis.

**Incurable and irreversible**

According to the disease model, alcohol addiction is incurable and irreversible, hence the only relief for the alcoholic is a lifelong abstention from drinking alcohol. However, whilst there had been repeated 'unofficial' reports that some diagnosed alcoholics had returned to normal, social drinking, there had been few systematic studies. The first study to cause real controversy was DL Davies (1952) who reported normal drinking in former alcoholics, based on the criteria that participants had to achieve at least five years of problem free drinking. Davies' work became the object of scrutiny and some criticism, but despite this it inspired a flurry of replications, each producing similar findings (Cameron, 1995; See also, Davies, 1992; Denney, 1976).

The Rand Corporation were a private organisation in the USA specialising in social science research. They were commissioned to collect and analyse data on the outcome of treatment provided by Alcoholism Treatment Centres between 1970 and 1974, publishing their findings in the Rand Report of 1976 (Armor, Polich & Stambul, 1978). 758 randomly selected males who had attended an Alcoholism Treatment Centre were subject to a four year follow up. After the 4 years, 46% were in control of their drinking: 28% through abstinence and 18% through controlled drinking (Polich, Armor & Braiker, 1980).

An initial look at these figures indicates that most of the participants had lapsed, that is, returned to problematic drinking, so initially appearing to provide some support for the disease model. However, it was reported that a return to moderate drinking is no more likely to result in relapse than abstinence. An important point to note is that, although 18% may seem quite a low proportion of men who managed to control their drinking, this should not have been possible at all according to a disease account. This report prompted a heated debate. AA argued that anyone who can return to
'normal' unproblematic drinking was never a real (diseased) alcoholic in the first place, despite these men being previously 'diagnosed' alcoholics.

The National Council on Alcoholism in the USA criticised the report in the media, stating that the conclusion that former alcoholics could resume normal drinking was "unethical, unprincipled and ... playing Russian roulette with the lives of human beings" (Heather & Robertson, 1985:85). Heather and Robertson (1985) argue that there may always have been people who have returned to normal drinking but because they are going against medical advice they have either not admitted drinking at all or have simply not kept in contact with the treatment provider. Logically, if someone is drinking unproblematically, there would be no need for them to continue treatment, and therefore have not. However, to this day, the concept of controlled drinking in former problem drinkers has remained a highly contentious issue (Saladin & Santa Ana, 2004).

This indicates some of the problems that have bedevilled this type of research, where the labelling of 'normal' versus 'diseased' hangs over the research and produces findings that replicate these assumptions about the individual as the identifiable source of their own pathology.

**Progressive**

The notion that alcoholism is a progressive condition is a related issue. Household survey research, that is community and national surveys, showed that people could move in and out of phases of problem drinking; that is to say, drink like an alcoholic for a period followed by periods of average or 'normal' levels of alcohol intake (Cahalan, 1970; Clark & Cahalan, 1976) without any form of treatment or intervention (Roizen, Cahalan & Shanks, 1978). This research undoubtedly contests the idea of an inevitably progressive condition.

**A distinct group of people**

This explanation proposes that alcoholics are biologically dissimilar to other people, resulting in a specific vulnerability to alcohol. To test this, Edwards (1970) reviewed alcohol consumption patterns within populations. The predominant assumption was that consumption was bi-modal, suggesting that most people were drinking at a 'sensible' level and clustered around a
lower mean, and that 'alcoholics' clustered around a much higher mean. This, then, would have supported the view that 'alcoholics' are very different from others who are 'normal' drinkers. Edwards discovered that consumption was actually unimodal, so population drinking was on a continuum rather than two separate groups. Therefore, problem drinkers would have to be defined as drinking above some agreed cut-off point. Clearly this is at odds with the idea that alcoholics are a separate group suffering from or experiencing a distinct condition. Following this revelation, alcoholics could no longer be compared with expectant mothers!

Edwards (1970; 1977) also noted that problem drinking may be viewed differently in different settings, for example, different social settings, social classes, genders, ages and the like. Consequently, it was reasoned that problem drinking did not necessarily reside within the person but in the individual's interaction with their environment.

Finally, a moral argument was levelled against the prevailing view of addiction. Fingarette (1988) argued that one of the biggest disservices that the disease concept performs is to focus only on 'alcoholics' rather than encouraging heavy drinkers to see that their drinking is causing problems and harm. Indeed,

"the very prevalence of the disease concept has had a range of adverse effects on all aspects of society's efforts to understand or help heavy drinkers. First, the disease concept focuses disproportionate resources on the small minority of heavy drinkers who are diagnosed as having the so-called disease, all the while providing heavy drinkers who do not fit the pattern of symptoms with a rationalization for denying that they have serious drinking problems." (Fingarette, 1988: 92)

In view of the reasoning presented above, it would seem sensible to assume that the disease model would be reeling from such an onslaught. Yet I proposed earlier that the model still has an influence today, and therefore appears to have survived. Let me explain how this could be so.
Alcohol Dependence Syndrome

In the early-1970s The World Health Organisation commissioned a revision of the International Classification of Diseases*. A great deal of work was being conducted in many areas of health and illness and the WHO brought together researchers to look again at the concept of addiction, under the direction of a British man, Griffith Edwards and an American, Milton Gross. Together they developed the Alcohol Dependence Syndrome, and Edwards remains the most significant person associated with the Syndrome and its later developments and influences. Taking into account additional social and environmental factors, Edwards and Gross (1976) included evidence from a wider view rather than relying solely on experimental research conducted with ‘alcoholics’. Essentially, Edwards (1977:138) concluded that “the syndrome is best conceived as a psycho-physiological disorder”; dependence is neither purely physical nor psychological but a complex interaction of both. He added that the presentation of the syndrome will always be influenced by a person’s own personality, environment and culture.

According to Edwards and Gross (1976), alcohol dependence comprised seven criteria. Notably, the defining elements of the Syndrome do not require a definition or identification of cause. These phenomena do not all have to be present at the same time or with the same intensity.

Box 1

<table>
<thead>
<tr>
<th>Alcohol Dependence Syndrome</th>
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<tbody>
<tr>
<td>The Syndrome has seven essential elements;</td>
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<tr>
<td>1) narrowing of the drinking repertoire – that is, the pattern of drinking behaviour becomes increasingly stereotyped. The drinker may develop a routine and start to drink in fewer places spending most of their drinking time in the same places.</td>
</tr>
<tr>
<td>2) salience of drink-seeking behaviour – that is the drinking behaviour becomes more important than other activities.</td>
</tr>
<tr>
<td>3) increased tolerance to alcohol – more alcohol is required to have the same effect that less alcohol used to. The drinker can consume more alcohol before appearing (or being) drunk.</td>
</tr>
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* This is discussed further and in greater depth on page 19
4) repeated withdrawal symptoms - both physical symptoms (eg, shaking) or psychological symptoms (eg, anxiety) experienced when not drinking.
5) relief or avoidance of withdrawal symptoms by further drinking – this can also include starting to drink earlier in the day to prevent the onset of withdrawal symptoms.
6) subjective awareness of compulsion to drink – often called craving, an awareness of an irrepressible ‘need’ to drink.
7) reinstatement of the syndrome after abstinence – so after a period of not drinking, the person returns to the behaviour with the same fervour. Tolerance and withdrawal symptoms rapidly reappear.

(Adapted from Edwards & Gross, 1976)

As characterised by the Syndrome, alcohol dependence is theoretically distinct from level of use, that is, it is not important how much a person actually drinks in terms of quantity. Also, dependence is distinct from problems caused by use, so a person could be dependent even if there is no evidence of it causing problems for the drinker in their relationships, in employment, legal problems and so on. These are important advances in thinking, as often, especially in lay terms a ‘drink problem’ is measured by the amount of alcohol consumed and what problems the drinker experiences. Conversely, Edwards and Gross (1976) suggest that a person could be alcohol dependent without appearing to ‘suffer’ from it.

A forte of the Alcohol Dependence Syndrome is that in its development an attempt was made to integrate different elements of problem drinking, such as physical, social and existential factors. As it did not rely on a particular aetiology, it promised to provide a useful clinical tool for people of different perspectives.

However, there are alternative assessments of the Syndrome - it has its critics. Heather & Robertson (1981:15) note that Edwards & Gross “admit that their delineation of the Alcohol Dependence Syndrome is based more on clinical impression than on substantial scientific evidence”. This incited McMurran (1994:19) to contend that “in the absence of supporting empirical evidence ... The syndrome is something of an article of faith”
As the items vary so widely and attempt to cover every aspect of problem drinking its utility is weakened. Diagnosis relies heavily on subjective self-reports and observable behaviour, both of which are highly problematic. By not indicating a cause, how useful is this? If withdrawal symptoms are observed, as suggested by point 4 (see Box 1), is this because the drug is removed thereby suggesting a physical dependence requiring a physical treatment, or because the activity is prevented, suggesting a psychological dependence requiring a different treatment approach.

If the items included in the checklist do not all have to be present, how many and which combinations are sufficient for a diagnosis of alcohol dependence? Without explicit guidelines on this the Syndrome's utility is enfeebled and it becomes merely a description rather than a tool. Edwards and colleagues have not addressed such problems clearly or satisfactorily.

Shaw (1979) argued that there was a political motivation behind the development of the Alcohol Dependence Syndrome, where the objective was to find a substitute concept for alcoholism which overcame criticisms of the disease model, yet retained all its essential assumptions and implications.

So, let us sum up what we have discovered so far. Whilst the concept of addiction has reportedly been based on valid and trustworthy evidence, this can be seen as a scientific façade; reliable empirical evidence appears to be somewhat thin on the ground. From the early days of Alcoholics Anonymous, many of the underlying assumptions and implications of the AA ideology have not been abandoned and remain intact. The key issues are that the 'alcoholic' suffers from a condition for which they are not culpable and over which they have little or no control. Irresistible craving and loss of, or impaired control over drinking are believed to be at the heart of this condition. This representation of alcoholism is supported by the comparable models provided by Edwards and Gross (1976) and Jellinek (1952; 1960). As the Alcohol Dependence Syndrome received a mixed reception within academic circles, let us move on to discover where the notion did have some bearing.
The enduring influence of the disease model

As claimed in the introduction to this chapter, despite all of the limitations and criticisms of the disease model, this theory still has an influence today. This is evident in two widely used and highly regarded psychiatric classification publications: the International Classification of Diseases (World Health Organisation) and the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association). Both are revised periodically, with the ICD currently in its 10th edition (WHO, 1990) and DSM its 4th edition (APA, 2000).

The ICD classifies not only mental disorders but also physical conditions. In 1891 the International Statistics Institute at its meeting in Vienna, commissioned a committee to compile a classification of causes of death. The first edition of the International List of Causes of Death was produced in 1893, was revised in 1900 and has regularly since been re-revised at intervals of approximately 10 years. Alcohol and drug related problems were classified as 'chronic poisoning and intoxication'. The World Health Organisation took over responsibility at the 6th edition (ICD-6, WHO, 1948), when it became known as the International Classification of Diseases, and included a new separate section on mental disorders so throughout ICD-6 and ICD-7 (WHO, 1955) alcohol and drug 'addiction' were placed under the heading of 'Disorders of character, behaviour and intelligence'. ICD-8 (WHO, 1965) witnessed a move to the category 'Neuroses, personality disorders and other non-psychotic mental disorders'. Although remaining in the same category in ICD-9 (WHO, 1975), there became three separate disorders listed; the Alcohol Dependence Syndrome, drug dependence and nondependent drug use. It is perhaps worth remembering here that it was the WHO who commissioned the work that Edwards and Gross (1976) conducted when developing the Alcohol Dependence Syndrome, which was arguably politically motivated and in essential ways was highly analogous of Jellinek's (1952; 1960) work, which in turn was overwhelmingly influenced by Alcoholics Anonymous, who advocated a disease model and worked towards getting a better deal for alcoholics.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) first appeared in 1952 (APA, 1952). Alcoholism and drug dependence appeared
in the category of 'Sociopathic personality disturbance'. This category also included antisocial behaviour and sexual deviance. Such activities were viewed as socially deviant or troublesome, hence arguably the classification of alcohol and drug dependence harboured moral implications. In DSM-III (1980), a separate category was provided for substance use disorders, with two types of disorder identified: substance abuse and substance dependence. Substance abuse was characterised by continued inappropriate substance use despite social, interpersonal, work or legal problems. Dependence was characterised by the presence of tolerance, withdrawal and issues of control over substance use. Again, there is clear evidence here of the influence of Jellinek (1960) as these are the same two distinctions between types of drinkers that he identified, with some experiencing biological changes and a physical dependence, whilst for others, excessive alcohol either caused psychological problems which lead to further drinking, or excessive drinking was a symptom of psychological problems.

The inveterate but enigmatic ‘loss of control’

This section will begin by scrutinising the DSM classification as a way of getting us into a more in depth consideration of the defining characteristics of alcohol dependence. This will help us to see weaknesses inherent in the notion more clearly. First let us take a closer look at the different classifications of substance dependence and substance abuse (DSM, APA, 2000). The category of dependence contains the same or similar items as the category of abuse with the addition of two points:

- The substance is often taken in larger amounts or over a longer period than intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.

(DSM criteria for substance dependence, points 3&4. DSM-IV-TR, APA, 2000)

As these do not appear in the diagnosis of substance abuse, they represent criteria that differentiate between abuse and dependence. This observation is of fundamental importance, as these points can be translated into 'loss of control' or 'impaired control', with issues of control over drinking having
played a central role throughout the history of addiction. Indeed, with reference to the Alcohol Dependence Syndrome, Heather & Robertson (1981) inform readers that Edwards, Gross, Keller, Moser and Room (1977) "write that the syndrome 'might be defined simply as a disability marked by impaired capacity to control intake' and that the leading symptom of the syndrome is 'impaired control over the drug ethyl alcohol'.” (Heather & Robertson, 1981:19)

The enigmatic 'loss of control': “a confused notion” (Fingarette, 1988:48), a discursive justification (Davies, 1997) or the “sine qua non” of addiction (Goodwin, 1994:77). Whatever it is, the concept cannot be ignored, however problematic it proves to be.

The problems began with where to find it, as discussed earlier; but the notion is further challenged by the problem of how to define it. Jellinek (1960) suggested that loss of control was simply the case of an alcoholic "continu[ing] to ingest more and more – often with quite some difficulty and disgust – contrary to their volition” (1960:41). Arguably this could be seen as quite an extreme interpretation. Dickerson and Baron (2000) propose that loss of control involves consistently going beyond one's own pre-set limits, thereby supposing that a drinker always has pre-set limits. Goodwin (1994) states that many specialists in the USA believe that loss of control is an indispensable condition or prerequisite of alcoholism. He argues that not all alcoholics 'lose control' or get drunk every time they drink, adding that the "distinctive feature of alcoholism" (p77) is that a person cannot be sure of being able to stop or control drinking once they have had a drink. Cahalan and Room (1974) regard loss of control as a purely subjective experience of alcoholism. Finally, in their summing up of the disease model of alcoholism, Heather and Robertson (1985:79) explain that “in later, more sophisticated” disease models it is admitted that control is not necessarily always 'lost' but simply impaired. However, disease models still see diminished control as invariably present in an account of alcoholism. They point out that from the disease position the alcoholic's drinking behaviour is "wholly or partly involuntary and not completely within the realm of personal choice" (Heather and Robertson, 1985:79).
Despite the confusion and lack of empirical evidence, the concept will not go away, and is still clearly important and prevalent both in professional discourse and in everyday common-sense understandings of addiction. Walters and Gilbert (2000) demonstrate that 'loss of control' is still identified as a defining feature of addiction by both clients and 'experts'. Within this study the clients were inmates in an American medium security federal prison who were enrolled on drug abuse education classes and the experts were individuals who have attained 'Fellow' status in the Division on Addictions (Division 50) of the American Psychological Association.

As is common with many concepts surrounding the construct of addiction, including 'addiction' itself, the status of control over drinking has become a highly contentious issue with questions being asked as to whether alcoholics really are helpless and unable to control (Davies, 1992; 1997a). Whether drinking 'cannot' be controlled or people 'do not' control is very difficult to ascertain, leading researchers to somewhat abandon this enterprise and instead examine the construct, exploring what it means to a person. Marsh and Saunders (2000) argue that the mechanisms underlying impaired control over drinking are poorly understood and they aimed to investigate such mechanisms. They noted that impaired control was experienced by non-dependent as well as dependent drinkers although treatment drinkers had statistically significantly higher levels of impaired control than social drinkers. Following interviews, the authors proposed that problem drinkers stated that control and impaired control both have advantages and disadvantages, and whilst not controlling drinking led to negative consequences, impaired control is functional and rewarding because it allowed people to either fully enjoy 'the moment' or to forget other stresses and problems. Additionally, Marsh and Saunders report evidence from their interviews that many drinkers did not intend to control or limit their drinking as lack of control offered an explanation. They conclude that "impaired control reflects decision-making processes, and loss of control explanations are attributions to justify and explain drinking to excess" (Marsh and Saunders, 2000: 263).

We can therefore begin to see loss of, or impaired control over drinking less as an objective fact and more as a subjective experience with functional
utility. I will return to this point later in the chapter, but first let us reflect on the journey we have taken so far and where we have arrived.

**Implications of the challenges to the disease model of addiction**

Let me now summarise the implications of the arguments I have presented so far:

1. A hard and fast line cannot be drawn between alcoholics and non-alcoholics.

2. There is no cut-off point for addiction: people can have problems at any level of engagement with the activity of drinking alcohol. There are no alcohol-related problems that can be used as criteria as all sorts of problems are experienced to a greater or lesser degree and are not all correlated with the amount of drinking.

3. Addiction is not irreversible.

4. Loss of control is unhelpful because it has not been established that 'non-alcoholic' drinking is fully in voluntary control but 'alcoholic' drinking is not. However, it may be argued that "versions of impaired control and craving have some validity in the description of the behaviour and experience of some problem drinkers" (Heather & Robertson, 1985:117)

5. There is no evidence that problem drinking will inevitably get progressively worse.

6. There is no single explanation as problem drinking appears to include biological factors, psychological factors and cultural and social context.

Let us continue our journey and go on to sift through explanations of deleterious substance use which rely less on a disease or illness model of addiction.
Post disease-model theories of addiction

Aspects of the disease concept were taken as 'fact' and 'reality', and the model provided a framework within which addiction problems were defined and resolved. Once this had been undermined, researchers were freer to explore and theorise other explanations and treatments. In the following pages I will briefly outline some of the more important or well developed theories. These will be in less depth than the discussion of the disease model, as, to date, they have had far less impact and influence over research, treatment options, and the everyday perceptions or constructions of problem drinking. We will begin with two theories which conceptualise substance use as a social activity with personal benefits before moving on to a final explanation proffered which focuses on biological aspects of substance use and abuse.

Excessive appetites

One of the more highly regarded of such theories is that proposed by Orford (1985; 2001). Orford explains there is a range of activities which can become excessive and he complains that too narrow a focus on certain behaviours, such as drinking alcohol and illicit drug use, has led to an unclear, unbalanced picture, therefore his theory extends to activities such as gambling, eating and sex, which he describes as appetitive behaviours.

He suggests that there are a number of influences on a person which can have some bearing on a person's engagement with an activity or appetitive behaviour and the development of an excessive appetite. These include character and personality, but stronger determinants are social and cultural factors, including the availability and opportunity for engagement in activity, and normative influence of friends and so on. These determinants can restrain and offer disincentive as well as encourage and offer incentive.

Each appetitive behaviour can serve "numerous personal functions for different individuals, and even within the same person" (Orford 1985:319). Let us just make these three important points more explicit. Firstly, an activity, such as drinking alcohol, gambling, taking illicit drugs and the like, serves a function for the individual involved. Secondly, the function...
performed can be different for each person. The third essential point is that the activity can serve different functions within the same person. The different personal uses that these behaviours serve can vary a great deal, especially influenced by factors such as age, gender, social class and so on. Orford reasons that it is little surprise that theories that focus on one factor do not have much success, for example, a theory that proposes that alcohol addiction is due to an attempt at stress or tension reduction may be the case for some people some of the time, but not everyone and not all of the time.

Orford maintains that there is a need to take a more longitudinal approach to understanding the behaviour. Changes in behaviour are normal. As previously mentioned, the same appetitive behaviour can serve different functions for a person at different times. "This relatively new emphasis upon appetitive behaviour as a dynamic, changing process through time provides further grounds for mistrusting simple predispositional theories of excessive behaviour" (Orford, 1985:320).

Orford accounts for the progressive element often witnessed as a process of increasing attachment. Over time the activity or behaviour starts to serve a wider range of functions, and it starts to serve functions that are increasingly more personal and non-social. Individuals within a culture are typically bound by social ‘rules’ and ‘norms’ which moderate behaviour, including norms about when, where, with whom and how much it is appropriate to drink, or engage in other ‘appetitive’ behaviours. These conventions which previously moderated a person’s engagement with the activity start to erode, so that an individual may start drinking at different, additional times or in places or settings where they would not previously have drunk.

Orford emphasises the importance of the balance struck between positive and negative outcomes expected from a behaviour. When a person starts incurring costs to their behaviour, such as problems of various guises, this can often result in the reduction or cessation of the behaviour, even if only temporarily. However, Orford argues that this could also increase the behaviour as it increases the benefit of it; for example, if family, friends or colleagues complain about or are critical of the behaviour, or if the activity
is causing problems, increased alcohol (in the case of problem drinking) could be a way of avoiding acknowledging the problems or taking responsibility.

Theoretically then, in the face of mounting financial or legal problems, loss of family, loss of support, loss of employment and the like, alcohol becomes more of a way of coping. Ultimately, costs can make the personal function of use or engagement in the activity more important and 'necessary'.

Let us take a moment to consider this proposal. A theory of excessive appetites represents a significant step forward from disease model accounts and, with its integral focus on individual variability, is a positive move away from the one-size-fits-all approach which characterises previous explanations. By proposing alcohol consumption as a social activity, certainly in the earlier stages of problematic use, this reflects normative notions of acceptable substance use. By highlighting the individual personal benefits of use, the drinker is positioned as an active agent in the behaviour rather than a passive victim. However, does this suggest that people are choosing to drink more and more excessively? As such, does this have moral implications which can run into the thorny issues of personal accountability and culpability? Does this then indicate that a theory of excessive appetites, rather than representing a move forward away from a disease model, hints of a move backwards towards a moral model which the disease account was designed to eliminate? Rather than grappling further with this concern let us move on to view a potential explanation of substance abuse which may help us to address the above issues.

**Behavioural economics**

An exciting and interesting group of theories have recently been developed. Behavioural choice theories are a hybrid of behaviourism and economics (Vuchinich & Heather, 2003). The 'behavioural' aspect comes from the original behavioural theory of choice known as the 'matching law' (Hernstein, 1970). Hernstein argued for a relationship between how often a reinforcer is received and how often a behaviour is performed. This theory is based on all behaviours so proposes to account for not only addictive behaviours but all activities a person engages in. In relation to addictive
behaviours, the reinforcer received from engaging in drinking alcohol, taking illicit drugs and the like are offset against the reinforcer received from other activities, for example, pleasure from relationships, work satisfaction, and so on. The behaviour 'matched' the reinforcement, such that the more positive reinforcement received, the more the behaviour is performed. The 'economic' connection proposes that, rather than seeing a behaviour and a consequence as a reflex, these are viewed as being associated with a cost/benefit ratio over time. So, the more 'valuable' something is, the more resources such as time, behaviour and money, an individual will put in to it. In many ways this element compliments Orfords' (1985) advocacy of a theory of 'excessive appetites'. The merger of the behavioural 'matching law' theory and cost/benefit ratio of economics, produced the basis for behavioural economic theories. Whilst there are a number of specific theories proposed under this banner, what they collectively suggest is that essentially problem drinkers use the same decision-making processes as everyone else. To a large extent then, although this theory emphasises the individual choice aspect of a person's behaviour, it offers a normative account for the choices that are made, in as much as this is a choice that anybody could make with any behaviour.

So, have theorists completely abandoned all traces of 'disease' or biological factors? Not entirely; as we shall now see.

The biology of 'wanting' and 'liking'
Robinson and Berridge (2003) propose that excessive drug use results in drug-induced changes in the brain with associated changes in psychological functioning. Neural sensitisation for a particular drug makes the dopamine-related brain system over-react to the drug and to cues for the drug (Robinson & Berridge, 1993). They argue that changes in the brain's dopamine system can cause a 'wanting' or an irrational desire for something without this necessarily being linked with a 'liking' for the substance (Berridge and Robinson, 1995). Furthermore, sensitisation of this neural system causes "compulsive motivation" (Robinson and Berridge, 2003:25) to take the drug and frontal cortical systems which normally regulate decisions-making and inhibitory control over behaviour are rendered dysfunctional due to drug-induced changes, which lead to impaired judgement and impulsivity. Hence, compulsive use and apparent loss of
control witnessed in addicts’ behaviour are a result of drug-induced changes to the brain.

May (2001) disputes biological accounts of addiction, arguing that seeing that, after death, there are obvious signs of bodily organs being different in addicts than from non-addicts tells us what they have been doing, that is, using substances, but tells us nothing about the intentions, motivations and agency behind the behaviour.

What all of these accounts have in common is that there is characteristically a move towards explaining substance abuse in terms of some on-going, advancing process; be that an increased need or necessity for engagement in the behaviour or a process of neurological sensitisation. Similarly, they all have face-validity; they appear to make normative sense. However, after so many years and so much work, and as so many theories have been explored and proposed, why have we not found the answer to what causes addiction, or correspondingly and more importantly, how it can be corrected or prevented? As we have seen, addiction is a highly contested concept; so much so that some researchers even argue that it does not exist at all.

"Addiction is nonexistent, a fabled concept"

Social constructionists concern themselves with the different arguments in the past about every aspect of the addiction construct and also highlight the political, social and moral motivation behind the ‘addiction’ movement and the current utility of such a construct. Instead they argue that people choose their behaviour, including excessive behaviours. As May (2001) explains;

"there is a (minority) view that seems to be moving towards regarding addiction as a discursive device, through which individuals are able to explain their loss of volition and independence, but which has no pathological existence that is independent of these explanations (see for example, Davies, 1992; 1997). In other words, addiction is an expression of attributions that legitimise particular kinds of behaviours (Eiser et al 1985). The effect of such a view is to reinstate personal volition and agency: addicts are not helpless in the face of
particular behavioural possibilities, but are able to modify and control their behaviour according to circumstances." (May, 2001:394)

There are two important and related points to be made explicit from this perspective. Firstly, the addiction construct has no real origin beyond individuals' descriptions of their behaviour. The second contention is that the concept of addiction is highly functional which accounts for its ubiquity.

It is argued that the addiction construct has no real foundation because not everyone becomes addicted even if they use substances that are thought to be highly 'addictive'. Research has been presented which claims to demonstrate that the use of powerful, dangerous and ostensibly 'highly addictive' drugs like cocaine and heroin is relative, subject to change, and often controllable or able to be brought under control, fuelling the assertion "that addiction is nonexistent, a fabled concept with no real referents" (Peele, 2000:604). Harrison and Mungford (1994) presented evidence of controlled cocaine use; Stimson and Oppenheimer (1982) witnessed people moving in and out of problematic heroin use without treatment agency intervention; whilst Shewan et al (1998) reported on controlled heroin users who had regularly been using heroin recreationally over an extended period of time but show no signs of dependence or addiction (see also, Shewan & Dalgarno, 2005 and Stallwitz & Shewan, 2004). Reminiscent of the work of DL Davies and the Rand Report on alcohol use, the findings of regular, non-problematic drug use have not been welcomed by all (Davies, 1998).

Despite having the appearance of a coherent theory, the construct of addiction changes according to the behaviour being described and the context of use. Hammersley & Reid (2002) suggest that in relation to illicit drugs, the addiction construct "provides a clear answer" (Hammersley & Reid, 2002:12) The 'clear answer' to drug problems is consensually taken to be to stop the supply of illicit drugs because the person is taken over by, and becomes addicted to the drug, therefore their individual volition in this behaviour is minimal; hence, in addition to stopping the supply, abstinence should be the obvious treatment goal, and people should be urged never to use such substances in the first place. However this does not appear to apply to alcohol because, at the time of writing, there are no proposals to introduce the prohibition of alcohol, and the legal status of certain
psychoactive substances has undergone review and revision changing the accessibility and acceptability of the drug. (Cohen, 1990). So, the implication here is that the ‘addiction’ concept is different for different substances.

Heim, Davies, Cheyne, and Smallwood (2001) argued that the ‘meaning of addiction’ is functional and context dependent and attempted to demonstrate that theories in common use depend on the theory user and context in which it is used. They reported that participants, who were not drug users, used elements of the ‘addiction’ construct in variable, often contradictory ways when explaining different social contexts. This suggests that the construct is malleable and is used differently according to the function it is serving relative to what the speaker is explaining or accounting for. Heim et al conclude that “Addiction, it appears, can be understood as a functional representation of social knowledge of drugs and morals, rather than a summary of (scientific) facts about the addicted state.” (Heim et al, 2001: 61-62)

One of the most vocal proponents of the anti-addiction movement is John Booth Davies. His views have been presented in an array of publications (Davies, 1990; 1992; 1997a; 1997b; 1998; 2001; 2004), with two fundamental principles; firstly, that ‘addicts’ choose their behaviour rather than being at the mercy of some controlling force, and secondly, talking in terms of ‘addiction’ is functional for the individual and for society more generally.

Hence, the argument here can often see the individual as choosing certain behaviours over others, rather than being controlled by ‘addiction’.

**Alcohol use and expectations**

Let us address the first of these points; that people use drugs, alcohol and engage in such behaviours because they want to and because it serves some purpose. While it is acknowledged that the behaviour may be causing problems or distress for the individual and/or others around them, for the substance user, the benefits outweigh the problems. In many ways, this line of reasoning harmonizes with Orford’s (1985, 2001) theory of excessive
appetites, however, whilst Orford attributes the cause of the behaviour to a response to psychosocial factors, personal circumstances and characteristics, Davies (1997a) asserts that 'addicts' use drugs, alcohol and the like because they choose to and because they see more reason to carry on than to stop. This bald assertion is evidenced by research exploring the positive expectancies of alcohol use. Lowe (1990) reported findings of drinker's expectations that alcohol will change the imbiber's mood, either through raising spirits, making 'merry' and giving 'Dutch courage', or by removing negative moods such as relieving stress and tension, removing anxiety and enabling the drinker to forget worries. Social gains were also reported in the form of being part of a group and through peer acceptance and approval (Lowe, 1990). The important role of expectation is further illuminated when comparing different levels of alcohol consumption. Light drinkers expect to experience less pleasure from drinking than do other (heavier) drinkers (Rohsenow, 1983). In a complementary way, heavy drinkers expect more positive outcomes than do light drinkers and whilst heavy drinkers also expect negative outcomes, the expected reinforcement from drinking outweighs and offsets the negative aspects (Critchlow, 1986). Furthermore, heavy drinkers who experience more effects, both good and bad, than light drinkers perceive the 'good' effects of drinking as more pleasurable, and the 'bad' effects as not so bad as do light drinkers (Lowe, 1990). With reference specifically to problem drinking, the positive expectancies of 'alcoholics' have been shown to differ from medical patients, students and non-problem drinkers (Jones, Corbin & Fromme, 2001). Rohsenow (1983) demonstrated that people have different expectancies in different places, hence, substance users have an awareness of situation specificity of drug effects and, therefore, do not expect the same outcome in all situations. Christiansen, Goldman and Inn (1982) explored the development of expectancies in 12-19 year olds, reporting that expectancies develop in the absence of personal drinking experience. Whilst this would suggest that social learning factors are responsible it would be premature to conclude that such phenomena are wholly learned as later "pharmacological experience with alcohol may confirm existing expectancies" (Christiansen et al, 1982:64)

Collectively, the above research highlights a clear relationship between increased drinking and high expectations of positive outcomes of drinking.
The function of addiction discourse

Davies' second point was that talking in terms of 'addiction' is functional for the individual and for society more generally. The only knowledge that academia, treatment agencies, the media and all other interested parties have of the experience of 'addiction' is via self-reports of 'addicts', elicited either through questionnaires or by interview techniques. Let me ask you to consider the following quotation.

"An alcoholic is a person who defines him- or herself as an alcoholic. To this definition I add two features. First, the alcoholic has lost control over drinking. Once an alcoholic starts drinking he or she is unable to stop and will continue until intoxicated. Second, the alcoholic is unable to abstain from drinking. These two criteria were present in the life stories of every alcoholic I observed in this investigation." (Denzin, 1987:11. my italics)

The point I wish to make here is that whilst these things may be observable, one cannot ascertain the motivation behind behaviour; has the alcoholic lost control, are they unable to stop or abstain? It is possible to ask a person why they engage in an activity, so as in the case of research interviews, such issues can be described by an informant. However, this does not assure that the information is an accurate account of past behaviour, feelings, motivations and so on. This may be the case, but one cannot assume that to be so. The rationale adopted by Davies and others is that the descriptions of ex-drug users' lives when told by themselves "are constructed for socially and personally functional reasons and cannot be regarded as factual accounts" (Hammersley & Reid, 2002:10). The reasons that people use this way of talking are twofold; firstly, all language is functional, hence 'addiction' talk is used to perform certain tasks, and secondly, social and cultural norms and expectations make such talk necessary for the substance user. The utility of this way of talking is to explain and account for a person's 'addictive' behaviour. Davies (1992; 1997a) argues that in the social and cultural climate that these informants live in, due to the legal control and moral implications attached to these

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5 This argument will be further developed and extended beyond 'addiction talk' in the following chapters.
behaviours, it becomes necessary for people to excuse engaging in behaviour that others regard or treat as unacceptable.

In common with the more readily recognised addictions, such as alcoholism and drug addiction, newer 'addictions', such as shopping addiction, internet addiction or addiction to exercise, have come on to the scene because to say that a person is compelled to perform the behaviour and cannot stop it, allows them to continue to engage in the behaviour and it absolves the 'addict' of moral responsibility for their action and for its cessation. Hammersley and Reid (2002) argue that it could be conceived that some people take drugs in order to abandon their self-control. Whilst they concede that "this is possibly taboo" (Hammersley and Reid, 2002:20), Orford (2001) concurs that such behaviour is not so much losing self-control as temporarily renouncing it. The utility is clear; if it is believed that behaviour is not under the individual's control once intoxicated, a person can say or do whatever at the time they desire and then 'blame it on the booze' (Critchlow, 1983).

Seemingly, addiction talk is so highly functional that it seeps into every aspect of talk about an activity that is engaged in more than a society deems appropriate. Yet, if addiction does not exist beyond the language that people use to describe their behaviour, why is the construct still so pervasive?

**Why has the myth of addiction persisted?**

Not only is addiction a useful explanation for behaviours that deviate from the norm and a useful way of separating out those who perform undesirable behaviour from those who do not, its utility extends beyond that. Cohen (2000) argues that individualised cultures prize having self-control, and that not being in control of ones self is a serious problem. A cultural function of the addiction construct is that it is an illustration of how not to behave. Like a demon, a drug is supposed to be able to possess a person and make them do things that the person themselves would not do. The construct of addiction encourages the belief that people who behave in such a way are in the grip of something terrible as under normal circumstances they clearly would not choose to behave in a way that is 'bad'. Religious and
moral groups can emphasise the importance and moral superiority of moderation, and the danger and depravity of excess. The concept provides the media with 'a good story' (Hammersley & Reid, 2002); especially in the case of 'celebrities', the media can demonise substance users, or make media consumers pity them. Accordingly, demonising 'bad' behaviour helps to keep a culture's moral order in place.

A final, possibly cynical, account of the pervasiveness of the concept of addiction is drawn to our attention by Blomqvist and Cameron (2002), Harris (2005) and Martin (1999). Seemingly there is a great deal of money to be made from treating people with a difficult problem to sort out, from privately owned treatment centres through to large multinational drug companies. The more complex the problem, as addiction is formulated to be, the more expensive the treatment.

However, as a closing thought, despite all of this Peele (2000) argues that addiction is a useful concept. He asks, without it, how else do we explain the extreme self-destructive behaviour observed in many individuals and how do we respond to the critical realities of such deleterious substance abuse? Indeed, "To confront a radical critic who claims addiction does not exist with such a self-destructive individual is to reveal the critic as an academic completely unprepared to deal with addicts" (Peele, 2000:604)

This chapter has discussed theories which attempt to explain why people engage in activities which, to many, appear excessive, deleterious and immoral. This thesis takes seriously the views put forward by Davies (1992, 1997a) and other constructionist theorists. However, if talk of alcohol use is functional, how can we discern what that function may be? The following pages attempt to set out a method that may enable us to do that.
Chapter 3
Qualitative Research In Addiction

The previous chapter surveyed a range of historical and theoretical issues pertaining to alcohol addiction. In this chapter we will be focusing in on a specific style of research – qualitative research into addiction.

In psychological research the mainstay of qualitative data is the interview, after all, if you want to know about people's lives and their reality who would know better than the individual? Hence, ask them about it. In this chapter I take issue with such a position and many of the types of analyses conducted with such data. The following pages are an attempt to explain and justify the approach I take to data collection, presentation and analysis. I will begin by briefly outlining some of the research previously conducted in the field of 'alcoholism' and addiction, with a particular focus on qualitative studies. I will present an argument for using naturally-occurring data, transcribed using a full Jeffersonian method and analysed using a discourse analysis informed by discursive psychology1 (Edwards & Potter, 1992, 2001)

A useful starting point here is to briefly explore some of the mainstream quantitative research, and to start to explicate some of the problems with this. In much of the research conducted in the field of addiction important aspects are treated as being an objective matter which can be studied as such. The most obvious evidence of this may be found in the extensive research conducted using animals to assess the effects of alcohol and other psychoactive substances, which has long been established (Conger, 1951; see also, Ewing, 1982; Higgins, 1976) and is still being undertaken (e.g., Crawshaw, Wallace, O'Connor, Yoda & Crabbe, 2006; Engleman, Ingraham, McBride, Lumeng & Murphy, 2006; Jung et al, 2006). As in many other areas of psychology, statistical analyses dominate, with randomised controlled trials being seen as a potent way of assessing treatment outcomes (Project MATCH, 1997, 1998; UKATT, 2001, 2005). Statistical analyses are also used to assess people's attitudes to drinking and drug use (Brotchie, Meyer, Copello, Kidney &

1 Some of the concepts and arguments presented here will be discussed in more detail in the following chapter
Waller, 2004; Harris et al, 2003), motives for drinking (Ooteman, Koeter, Verheul, Schippers & Van den Brink, 2006), commitment to treatment (Amrhein, Miller, Yahne, Palmer & Fulcher, 2003) or to explore people's attributions (Eiser & Gossop, 1979; Eiser & van der Pligt, 1986; Eiser, van der Pligt, Raw & Sutton, 1985; Seneviratne & Saunders, 2000), primarily by means of questionnaires or interviews after which responses are categorised and quantified in preparation for statistical analysis. Seneviratne & Saunders (2000) note limitations of such work by suggesting that many of the findings may actually be an outcome of cognitive actions such as attribution processes, so therefore may not be 'accurate' in some way, of what the participants 'really' think. Evidently they appear to concur with the misguided notion that 'attributions are just attributions, but the truth is simply the truth' (Davies, 1992). I will unpack this criticism in more detail later in the thesis.

Let us consider for a moment the concept of responsibility in relation to substance abuse, as this is a construct that I will return to later in the next chapter, and in more detail in the analysis in chapter 6. Responsibility is a difficult and dangerous entity in addiction work. As seen in the previous chapter, a disease model of addiction does much to remove personal responsibility from an individual, and even people who do not subscribe to such a model also feel that to apportion personal responsibility to the individual for their behaviour and situation smacks of 'victim blaming' (Peele 2000; Boyarsky et al, 2002). However, if contemporary views of addiction are that no such affliction exists, with some (e.g., Davies, 1992, 1997a) arguing that people use alcohol and drugs because they want to and can see no good reason to stop, what is one to make of the issue of personal responsibility both for the problematic behaviour and for its cessation?

Research has explored where issues of responsibility, including synonyms of blame and obligation, should be appropriately placed, for example, within the individual through their own choice (Rogers, 1988) or due to their biological make-up (Robinson & Berridge, 2003); within a wider social setting (Boyarsky et al, 2002); in employers (Gusmano, Schlesinger & Thomas, 2002); or in the judicial system (Davies, 2003). Rather than report the findings of such work I wish to focus on research which deals with individual responsibility, and in
particular, how the notion of responsibility has been conceptualised, and by what methods people have gone about studying it.

Firstly, the authors of such papers provide no 'definition' of 'responsibility'. Whilst I would not wish to suggest that they should, my point is to highlight that this assumes everyone knows and agrees on what we are talking about, thus it is constructed as an unproblematic entity. Furthermore, 'responsibility' is a scale on questionnaires, and as such different questions can tap into this disembodied and context-free concept. The fact that 'responsibility' can be addressed by questionnaire items suggests that it is quantifiable and measurable. Reassuringly for some, this tricky concept appears to be a common-sense notion from which difficult questions can be removed. However, when disconnected from the questionnaire and instead returned to people's lives and observed as an issue for the speakers, is this construct quite so straightforward? We will return to this question later, but first let us move on from statistical analyses, noting that responsibility is just one of the tricky concepts that appears as quantifiable in this style of research, and instead start to explore research which employs qualitative methodologies.

Tell me all about it

Interesting new research in addiction argues that health promotion and clinical treatments need to take more account of what people say about their drinking and drug use. For these people, 'addiction' and drink problems are not contentious concepts but are 'a way of life' (Larkin & Griffiths, 2002). In line with the shift from theorising 'addiction' as an illness, there has also been a partial shift in research focus. Much research is now being conducted which attempts to understand the world inhabited by the problem drinker or drug user. Larkin and Griffiths (2002) recommend that research must address the issue of subjective experience in addiction, and they make a case for the important contribution to the psychological understanding of addiction that subjective accounts can make. They take the position that addiction is a social, cultural and political construct, but conceptualising it as a construct does not then make it unreal. For a person with a drink problem it is very real. Therefore researchers need to address the person's experience, and only the label that researchers wish to put on it (for example, 'addiction', 'dependence',
'abuse' etc) is the discursive construction. They aim to understand the 'lived experience'; a representation of what things are like for the individual.

Two pieces of research that can be said to exemplify such a challenge are Allen, Copello & Orford (2005) and Orford, Dalton, Hartney, Ferris-Brown, Kerr & Maslin (2002). Allen et al (2005) conducted interviews with participants about their experience of undergoing alcohol detoxification and focused their analytic attention on expressions of fear. They reported that participants expressed fear in relation to the setting in which detoxification took place, the physical experience of withdrawal from alcohol, the medication given to manage withdrawal and their expectation of a future without alcohol. The authors made practical recommendations based on the findings and also argued that closer attention needs to be paid to the personal meanings individuals make of receiving treatment for alcohol problems.

Following computer administered questionnaires and individual interviews, Orford and colleagues (2002) reported that with heavy drinkers the reported benefits of their drinking outweighed the drawbacks; that social benefits and drawbacks were talked about more than anything else; drinking was strongly associated with coping and relaxation; and in the health domain, short-term drawbacks were more salient than long-term illness effects. The authors conclude that "these findings suggest a model of the perceived benefits and drawbacks of heavy drinking which challenges both conventional health promotion efforts and motivational balance models of alcohol consumption" (Orford et al, 2002:347). Such work can be said to have taken a considerable step forward from decontextualised, disembodied statistical analyses, but are not without their limitations. I will attempt to develop in more depth some of the troubles that accompany this style of work as we move through the chapter.

The discourse of addiction

Before moving on to evaluate qualitative research in addiction, I would like to draw readers' attention to an interesting and burgeoning body of qualitative work. The work I wish to outline is a form of critical discourse analysis which identifies a particular 'discourse' in informants' talk. My reasons for including it is because, as previously noted, there has been a witnessed increase in this
approach to analysis, it represents a move away from accessing and assessing cognitive notions, it attempts to account for people's continued 'addictive' behaviour, and it questions and challenges health promotion efforts (Gillies, 1999).

According to Burr (1995: 48), a discourse is "...a set of meanings, metaphors, representations, images, stories, statements and so on that in some way together produce a particular version of events or construct an object in a particular way". The argument is that discourses both allow and limit possibilities of understanding an object or event of interest, and they imply certain ways of 'seeing the world'. Moreover, they also allow and limit possibilities for people too; they make available or unavailable certain ways of 'being in the world' by providing 'subject positions'. Citing Davies & Harré (1990), Burr (1995: 141) argues that "Subject positions provide the possibilities for, and limitations on, what we may or may not do and claim for ourselves within a particular discourse." A more imaginative account is provided by Hardcastle (2003) who muses that people build identities for themselves in much the same way they build houses, but, once built, they are forced to live in it and become its prisoner.

In specific relation to the topic of this thesis, the argument here is that there are certain ways available for people to talk about drug or alcohol use that is seen as problematic or unacceptable. A 'discourse of addiction' produces a version of substance use which relies heavily on notions of physical and psychological dependence, lack of control, and overwhelming compulsion to continue in the behaviour, and is considered a powerful, dominant discourse due to its extensive use. As seen in the previous chapter, this does much to remove personal responsibility from an individual for their behaviour leading researchers to argue that such ways of representing one's substance use are commonly used "not because they are inherently 'true', but because they make functional sense to large numbers of people who use drugs and are in broadly the same situation" (Davies, 1997a: 90). In keeping with this line of theorising, Gillies and Willig (1997) conducted interviews with women who smoked and reported that all of the women framed their smoking within a discourse of addiction, which the authors argue is used to explain and justify the women's smoking. However, Gillies and Willig (1997) go on to add that an addiction
discourse is "deterministic and disempowering" (p.297). Gillies (1999) explains that discourses and discursive constructions shape how individuals behave and experience the world, and as a particular discourse constrains people and restricts what they can do, the argument is that an 'addicted' way of talking disempowers people so that they find it more difficult to stop their problematic behaviour (Eiser and colleagues, 1979, 1985, 1986; Peele, 1997). Furthermore, Rodner (2005: 344) maintains that the "dominant discourse of drugs probably has an effect on how the informants feel about themselves and their position in society".

These studies represent an analysis that Antaki, Billig, Edwards, and Potter (2002:1) describe as "under-analysis through circular discovery". Extracts of the data are quoted as evidence of the discourse which is argued to be apparent in the data. The extracts are then explained in terms of the discourse, such that, speakers are using particular discursive constructions because they are framing their behaviour within a discourse of addiction. Furthermore, such discourses are viewed as being fully formed and out-there in the world ready for people to use, but once such use begins, they are trapped within it. Gillies and Willig (1997) noted that in their interviews with women smokers, "a number of contradictory constructions were subsequently employed" (p291) that is, on occasions the informants worked up constructions of control and self-regulation. The authors comment that the interview respondents had alternative ways of talking available to them other than just an 'addiction discourse'. However, the authors did not, or, due to their approach to analysis, could not account for when the women changed their way of talking or what may have occasioned such a change. Hence it would seem that such analyses represent a summary of the data rather than a detailed analysis of what the interactive functions of particular constructions might be. This requires some sensitivity to the context in which utterances are appearing, for example in a social science interview, and the identities that are made salient by the interviewer, for example, 'female smoker'. We will explore the critique of interview in more depth later on.

**Issues of qualitative research in addiction**

The qualitative research outlined above has produced some interesting findings. However, I would like to argue that the more traditional qualitative
analyses could be said to be very limited, significantly because it takes what people are saying as being a more or less accurate reflection of experiences, inner beliefs and the like. Whilst critical discourse analysis does not fall into this trap, we can still see that such analysis is somewhat flawed. An additional issue that I would like to raise is that they are all based on interview data and the authors do not address the limitations or significance of the interview situation. If we concur with these authors then we have a view of the individual who can tell us about their cognitive activity, they can give us a passive and objective description of their reality and experiences, and they are not bound into any social context; not within their life nor, importantly, within the research interview setting. I wish to discuss such work focusing on three major areas which I shall detail below: firstly on selection of participants; secondly on methodological grounds and thirdly, epistemologically.

**Sampling issues**

Until the mid-1990s, with very few exceptions, previous work on problematic 'addictive' behaviour has been conducted with participants recruited from some sort of treatment agency, with much of the data collection taking place within such settings. There are two problems I wish to raise with this. Firstly, this encouraged a view that 'problem drinkers' are a special breed of people and that in order to gain an understanding of excessive or problematic drinking one must ask the people who, by merit of their label, are the ones who are able to speak about the subject This suggests a clear distinction between problem drinkers and non-problem drinkers and does not encourage the view that this status is something which is contested, negotiated and constructed. Throughout this thesis I propose that such a status or identity is adopted, resisted, and managed according to the current situation and to take the view that it is a given property of the person is problematic.

More recently work has begun to be conducted with a population of non-treatment seeking hazardous or harmful drinkers, most notably, the Birmingham Untreated Heavy Drinkers Project headed by Jim Orford (Ferris-Brown et al, 1999; Kerr et al, 2000; Maslin et al, 1998; Orford et al, 1998; Orford et al 2002). The categorisation of 'heavy drinkers' circumvents the issue of whether or not drinking is problematic, although this issue is alluded to as 'untreated' means that these participants are not currently seeking help
or advice about their drinking. Participants are included or excluded according to researcher generated categories, specifically the level and regularity of drinking and whether or not treatment is being sought, therefore assumptions are built in to the selection process and further assumptions are made as to what can be learnt from such participants. Clearly then this is not an unproblematic process and attention needs to be drawn to these assumptions as they then influence what can be found and what implications these findings may be deemed to have.

The second issue concerning the use of treatment service users as participants is that individuals have been through numerous processes, and often services, before someone reaches any sort of treatment provider. How people decide whether their drinking is problematic, if so, whether it is sufficiently problematic to seek help, and the like, cannot be explored at the time of happening because that was clearly some time previously if research is conducted with service users already receiving treatment. Davies and colleagues (1997a, 1997b, 1998) conducted interviews with drug users with varying degrees of engagement in drug use activity, within a treatment agency setting. Following analysis they identified five ways of participants talking about their drug use, one of which was described as an 'addicted' type of discourse. Davies (1997a) noted that people who employed an 'addicted' way of talking went on to full agency contact. The important point I wish to draw attention to is that the way people talk about their substance (ab)use may be highly influenced by the words, phrases and constructs they have heard during the journey to treatment, how they may have been trained in an 'addicted' type discourse?, and what they have learned about what sort of talk receives what sort of response. One of the great strengths of this thesis is that it explores data which often appears to come at the very beginning of the process as many people state that they have not spoken to any form of interventionist or treatment provider about their drinking before this interaction, so 'problem' identification and use of phrases and constructs is as it happened at the time rather than a reconstructed recollection.

2 See analysis later in this chapter

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Methodological issues

Potter and Hepburn (2005) note that, despite different researchers in psychology studying different topics using different methods of analysis, interviewing is not only the most common method of data collection for all researchers, but is almost taken for granted that people conducting qualitative research will conduct interviews to generate data. They also note that very little justification is provided for using interviewing and very little discussion of whether interviewing is the most appropriate method of collecting data on the particular topic. As Hollway (2005:312) bemoans, "there is a dominant tendency to treat the interview method as unproblematically transparent (you ask, they answer and then you know)." From a rather different perspective to Hollway's, Potter and Hepburn (2005) explicate a number of concerns about interview research which are discussed below. This will be a useful discussion to return to later on and it begins to flesh out some of the reasons why this thesis is focused on 'naturalistic' rather than interview data.

Deletion of the interviewer.

In many research reports the interview extracts are presented as stand-alone quotes from the interviewee. This is often then presented as a salient concern of the speaker. However, as the interviewer's question has not been presented, this does not encourage the reader to see the quote as a specific answer to a specific question. As Potter and Hepburn (2005) recommend, it would be preferable to include at minimum, the interviewer's questions. Regrettably, even in research reports where the interviewer's question is presented in the extract, the specific wording of the question can still be omitted from the analysis. In order to explain my criticism I will reproduce an extract and analysis reported by Allen, Copello and Orford (2005) as outlined earlier. Their study examined interview data from people who had undergone inpatient alcohol detoxification the previous week and focused on people's fears surrounding the experience. The authors write:

"fears about the physical effects of withdrawal were influenced by cultural assumptions about the nature of drug withdrawal. Such assumptions were transmitted verbally via street lore, or more indirectly, via media portrayals of substance withdrawal:

Respondent: I was really worried about how I'd be – I thought I'd be vomiting in buckets and that, no control over my bowels."
Interviewer: Your ideas about being sick and incontinent, where did they come from?
Respondent: Well it came from talking to people who had been in here, winding me up, and watching stuff like *Trainspotting.*”
(Allen et al, 2005:507)

No additional analysis of this extract is provided, hence the analysis misses the fact that the interviewer’s question nicely elicits external attributions for the description the respondent has just produced. The interviewee’s reply needs to be seen as a specific type of response to a specific question, and in the example here the interviewee provides the locations from which her/his “ideas” came, as requested by the interviewer. I will return to address the respondents answer to the question in more detail later in this chapter, but for now I wish simply to make the point that an analysis is weakened by deleting the interviewer from both the extracts of data presented and from the analysis of such data.

Hollway (2005) further problematizes the issue of the presentation of extracts by arguing that relatively short extracts from a larger interview can be seen as equally as unsatisfactory. This is because an utterance relates not just to the preceding talk, but possibly to things within the whole interview, or indeed beyond the interview setting, which are overlooked by presenting a short excerpt.

The conventions of representation of interaction.

Potter and Hepburn (2005) argue that the way that interviews are transcribed and presented misses out potentially important interactional details. As Sacks (1992) argued, nothing should be taken as insignificant a priori. Hence, Potter and Hepburn (2005) recommend that extracts should be transcribed and annotated to a level that indicated the intricate detail and subtle elements of speech delivery, as this was available to both interlocutors at the time and needs to be available to the researcher and reader in order to understand the interaction. Commentators on this position argue that the level of transcription required depends on what analysis the researcher wishes to conduct and is unnecessary for many types of analysis (Smith, 2005). Nevertheless, whichever form of analysis is to be conducted, or whichever research questions the investigator is interested in, it is still imperative that
the researcher and reader understand not simply what the interlocutors are saying, but how it is said, given that this can drastically change the meaning of an utterance. Consequently for all qualitative work where the aim is to represent the voices of others, surely a detailed transcript is an obligation that one has to one’s participants, to represent their voices fully.

The specificity of observations.
Findings from interviews are often presented as a general summary of an extract. Often it is not possible to recognize the specific parts of the interaction which relate to the reported findings, therefore it is important to present data in such a way that precise actions within the talk can be identified to support the analysis (Antaki et al, 2002). Hollway (2005) complains that the close attention to detail promoted by the Jefferson transcription method and the line numbers and short lines of talk as suggested by Potter and Hepburn (2005) is more likely to mean that the least important, small, inconsequential bits of the data are given greater importance, which then leads the researcher to not attend to the bigger issues going on in the data. However, to counter this, it is arguably the case that, rather than distracting from some wider concern, the specifics of elements of talk can provide evidence of it, as I hope to demonstrate towards the end of this chapter.

The unavailability of the interview set-up.
The categories under which people are recruited have a large impact on what they are supposed to be knowledgeable about or indeed ‘experts’ in. For example, if someone is recruited as a heavy drinker, it can be expected that they will talk from this position. However, it has been demonstrated that this is not necessarily the case as evidence can be seen of people working up an entitlement to know about things (Potter, 1996) as the analysis in later chapters will show, and speakers can and do talk from various positions and identities at different times (Antaki, Condor & Levine, 1996; Antaki & Widdicombe, 1998). Also we can ask, what do participants understand about what is expected of them? Have they been asked to tell their story of their experiences, or something else? Do they know what the data will be used for; do they think they may inform future types of treatments, or the organisation of a particular agency? All of this background knowledge is important to understanding what a person is saying and the way they present themselves
during the interview; however, such information is rarely presented in research reports or attended to in the analysis.

The above four points can be summarised as both a failure to understand what people say as performative, as 'doing things' for them in that context, and, more basically, a failure to consider the interview as interaction. Let us return to the short excerpt I reproduced on page 43 from Allen et al's (2005) study of people's fears of alcohol detoxification. In response to a question asking where the interviewee's ideas came from, the interviewee cited talking to other people and from the movie *Trainspotting*. The authors argued that this was evidence that people's fears were influenced by cultural assumptions transmitted via street lore and media portrayals. What this analysis overlooks is the important 'footing' (Potter, 1996) work being performed here by the respondent. By presenting this as another's description, this allows the speaker to align with or distance themselves from this version at a later stage. This reading of the response is further indicated by the speaker her-/herself who states that the "people" were "winding me up" (Allen et al, 2005:507), thereby indexing a motivation for the people to whom this description is attributed.

When viewed as interaction, further problems can be explicated with previous analyses of interview data. The position of the interviewer as social science researcher, a person who is attempting to gather data for analysis, can influence questions asked, phrasing and so on. To elaborate, one outcome of the analysis in this thesis is that we can start to specify the different (and sometimes competing) agendas of the caller and the Advice Worker, for example, the Advice Worker's aim is to identify the severity of the problem and offer help and advice, and the caller aims to produce a problem appropriate to such a helpline, before really knowing what that helpline is. It can be seen fairly clearly that right from the outset these kinds of simple agendas influence and shape the helpline interaction. In interview data, such agendas are about collecting and providing information for social science research purposes, hence the agendas similarly influence the talk. It can be proposed then that there is the potential for a social science agenda to have some bearing on the interaction in an explicit or implicit way, despite not being the intention of the interviewer. Agendas, assumptions, categories and so on are bound up with, and embedded in the questions that interviewers ask.
An even more worrying practice has now become more common. Orford et al (2006) audio recorded interviews with participants during and following treatment for alcohol problems. From these recordings and notes taken during the interviews a 400-800 word report was produced for each interview. The reports then became the data for analysis and people's experiences of change during and following treatment were reported based on these data using a grounded theory approach. This then adds another layer of agendas, assumptions and categories; firstly bound up with the interviewer's questions during the initial data collection process and secondly at the report writing stage when the researchers summarise the interview. (For further examples of this practice, see Ferris-Brown et al, 1999; Kerr et al, 2000; Maslin et al, 1998, Orford et al, 1998; Orford et al 2002).

Let us pause for a moment to consider one of the problems with viewing talk as an objective passing of information. People in addiction research are recruited on the basis of being members of a particular category, so an interviewee in a study about experiences of 'alcoholism' would be a problem drinker or 'alcoholic'. However, there are also an endless number of other categories or identities that may apply to that person, for example they may be a woman, a mother, a middle-aged adult, an ordinary person, a person to whom something extra-ordinary happened, a feminist, someone who had a successful career and lost it, an unmotivated and unambitious person who is 'happy with their lot'...the list could go on ad infinitum. Any or all of these identities or categories could apply to the same person at different points in a conversation depending on the interactional business at any point. This is also the case for the interviewer who also has an endless number of associated categories, any or all of which could be made relevant at any given time, of which some candidate examples may be researcher, social scientist, interested listener, fellow 'recovering alcoholic', political socialist, man, student, an only-child...again, the list goes on. Consequently both interlocutors speak from different identities or 'positions' at different times depending on the business of the talk at the time. Clearly then, to claim that any utterance is a straightforwardly representative and salient concern for a category of people such as ex-drug addicts is problematic. When looked at with these concerns in mind, it is clear that it is not possible to see any stretch of talk simply being an unproblematic description of a problem drinker talking about their experiences.
Above I have provided a lengthy and detailed examination of problems inherent in relying on interview data and conventional methods of analysis as a way of exploring and understanding a concept of addiction. However, some of the issues I have raised lead us to the heart of qualitative research and the essential quest of such an enterprise. Let us follow this trail and move on to consider the epistemological position of the researchers and ask what this type of research can allow us to know and how we can know it.

**Epistemological issues**

Whilst it could be argued that qualitative researchers are doing something very different from quantitative researchers, they both stand on very similar epistemological terrain. Mainstream qualitative researchers work with theoretically formulated categories, such as, addict, problem drinker and drug (ab)user, which stand to represent people. Furthermore, embodied activity is substituted with statistically or linguistically represented acts (Button, 1991). From this position veridical or unmotivated knowledge of events and cognitive attributes are unproblematically given possessions of the person that can be unproblematically accessed, so the world is accessible, measurable and understandable, both for the individual and for the researcher. Whilst many qualitative researchers in addiction contend that they do not see 'addiction', or elements of it, as an unproblematic 'real' entity, to some extent they proceed as if it is, for instance, by asking people how they understand or experience it. McIntosh and McKeganey (2000) conducted interviews with "recovering addicts" (p1503) who "were encouraged to describe in their own terms, how they had come off drugs" (p1504). The authors state that the language used to discuss the cessation of drug use contains contested notions which are subject to conflicting interpretations, and they acknowledge that the existence of addiction outside of the language individuals use to describe their behaviour has been questioned. They continue that the study that they present does not attempt to engage in such debates. The analysis reports narratives, or life stories, which are labelled by the authors as "narratives of recovery" (p1501); but recovery from what? This gets directly to the heart of the debate that McIntosh and McKeeganey seek to avoid because if the authors do not consider 'addiction' to be an unproblematic concept, and indeed, an illness, what are
their interviewees said to be "recovering" (p1503) from? (see also, Marsh & Saunders (2000) on 'loss of control').

Conventional psychology can cope with most qualitative research because it does not challenge the real foundations of psychology, to the degree that some researchers argue that quantitative and qualitative methods can be used side-by-side (for example, Bryman, 1992; 2004, Tashakkori & Teddlie, 2003). Reassuringly for traditional psychology, the way these 'new' approaches go about doing their research allows the family resemblance to become apparent. However, as Button (1991:6) argues "The point is that, by and large, when the human sciences examine such issues as method, theory, epistemology and the like, they do so without recourse to the situations and phenomena such matters are to apprehend." So, when researchers study something they set up a situation to collect data on it rather than collecting evidence from where things occur. We have seen an example of this with Allen, Copello and Orford's (2005) study of people's expressions of fear related to alcohol detoxification, relayed in a research interview setting.

In common with conversation analytic and other discursive work, within this thesis interactional events are used to back up the arguments about how events happen, as they are happening. In essence, "What they are is to be found not in the human sciences, but in their achievement" (Button, 1991:7) - that is, interaction is seen as the site of where things become 'thing-like'. As evidence of this, Tuffin and Howard (2001) explain that, in interviews, police officers talk about 'emotions', whilst 'emotions' were treated as 'unspeakable' at the time of the event. On this point the authors write of police officers, "in a series of interviews, officers have to discursively construct what come, after the fact, to count as having been emotions 'all along'.” (Tuffin and Howard, 2001:196) Hence, how far does an interview represent what a person's life is actually about if at the time of happening things were not seen as 'an emotion' but are described as such later as an ex-post-facto categorization? As Silverman (2001) concurs, there are problems with this positivist approach of taking talk as a source of fact and a pathway to people's experiences or an unproblematic representation of the past.
Rodner (2005) explains that Davies (1997a) argues "that words are always uttered by people with certain intentions and motivations" (Rodner, 2005: 344). Rodner claims that her participants took part in her study on unproblematic drug use in Stockholm because they "wanted to tell others about their perspective on drug related issues" (Rodner, 2005: 344, emphasis in original), therefore she maintains that her method of recruitment is good in light of Davies' argument. This represents a lack of understanding of what Davies is arguing. He is saying that at the time of telling, people are motivated by certain intentions which come from the social and political climate in which the speaker lives. This is an interesting idea and can usefully be employed. For example, citing methodological and conceptual grounds, Dunlap, Benoit, Sifaneck and Johnson (2006) questioned the growing number of studies reporting a rise in cannabis dependence, and argued that such studies may not accurately reflect users' experiences. They conducted interviews with blunt3 smokers, who through this practice are automatically exposed to nicotine. The authors reported that participants associated dependence with nicotine, but not cannabis. The usefulness of the different status of the two drugs is immediately apparent here as a potential motivation for the participants' descriptions and reported versions. Within the Western culture from which these participants were drawn (the USA), cannabis dependence has negative implications associated with it that nicotine dependence does not. By claiming dependency on a legal substance which is commonly constructed as 'highly addictive' one can account for ones smoking behaviour; additional substances, including ones that are illegal or problematic in other ways, can then be constructed as part of the activity but not part of a dependency or other problem.

However, if this talk is analysed only in terms of the way it is influenced by social, cultural or political constraints, or by restrictive ways of talking available to speakers, researchers are themselves limiting what can be found. Such a position represents a rather simplistic view as by seeing intention and motivation as being internal phenomena, and, by looking only at the wider picture researchers miss the local interactional business being attended to and how these things tell us more about what is going on in the conversation and

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3 Blunts are tobacco cigar shells filled with cannabis
also demonstrate how these ‘discourses’ are formulated at an interactional level and made to appear like a coherent discourse.

**An example of data and analysis**

Considering all of the above arguments, a compelling case can be made for using naturalistic data and the type of transcription and method of analysis adopted in this thesis. Below I provide an extract from a telephone call to an alcohol helpline which is an example of the type of data used in this thesis. In including this analysis, my intention is to illustrate the points and arguments I have presented above.

The caller has just reported to the Advice Worker that she drinks half to a full bottle of wine most nights and does not suggest that this is problematic, with which the Advice Worker concurs. However, the caller states that when she goes out with other people in a social setting she drinks until she's 'ill', and later in the call explains that at such times she 'puts herself in vulnerable positions' and 'makes a fool of herself'. So, the caller has suggested that for her the problem is not her ordinary level of drinking, but her drinking on social occasions, and the subsequent talk begins to explicate the problem.

**Extract 3.1 Don’t/Can’t control**

1. Advice Wkr: Right okay and how often would that happen.
2. Caller: Well it’s not very often 'cause I don’t go out very often.
3. Advice Wkr: =Right okay=
4. Caller: =You know it might be once a: 'bout once a month or something
5. Advice Wkr: [Oka::y ]
6. Caller: [But ( )] er on those occasion erm I don’t control?
7. (0.9)
8. Caller: I’m unable to con[trol? ]
10. Caller: Yes
11. Advice Wkr: [Okay]
In extract 3.1, the caller adopts a style of talk which ends a statement with a questioning intonation. However, whilst it cannot be suggested that the caller is requesting some sort of ‘answer’ to this ‘question’, it could be argued that this style of talk indicates that this is an invitation for the second person to speak, even if this is only with some sort of response token (McCarthy, 2003). So, whilst an ‘answer’ is not necessarily directly set up, some sort of rejoinder is (see Chapter 4; adjacency pairs; Sacks, 1992). Hence, the caller’s statement at lines 9-10 intonationally indicates that the Advice Worker should speak. This could easily be missed without a clear transcript and an understanding of how interaction works. As we saw previously, Hollway (2005) argued that this type of transcript and analysis draws the researcher to focus on small details which she argues are the least important, inconsequential bits of the data and as a result are given greater importance than they merit. If this were the case, the pause at line 11 would not seem relevant or noteworthy, whereas, on the contrary, this pause, both where it is placed and how long it is, is of central importance and can tell us much about not only the local interactional business, but also about ‘bigger issues’. The pause indicates to both speakers that this is an appropriate place for the Advice Worker to respond. The fact that he does not suggests that the Advice Worker has nothing to say at this point. Having received no reaction from the Advice Worker, when arguably the caller was looking for one, she continues to talk, but this time changes I don’t control to I’m unable to control. With reference to cognitive notions, given the change in the caller’s appraisal of her control over her drinking from something that she does not control to something that she cannot control, it is difficult to see how it could be argued that this ‘unmotivated account’ was stored in some cognitive structure before she spoke to the Advice Worker, or that either version is necessarily a veridical account of the caller’s experience. It would seem more sensible to suggest that this concept was co-constructed by the two interlocutors, built in situ and that its construction as something that reflects the caller’s abilities and experience can be seen as a direct function of the Advice Worker’s uptake, or lack thereof. In such an extract we can see the flexible, negotiated nature of accounts.
Let us focus on the overlapping speech in lines 12 and 13:

12 Caller    I'm unable to control?
13 Advice Wkr [You're] unable to
14          control.

By presenting the extract with line numbers and short stretches of speech on each line, it is possible to pinpoint and identify particular activities in the talk. We saw earlier that the Advice Worker did not respond to I don't control and now we can see that in line 13 he starts to talk before the caller has finished speaking, indicating that he has heard enough to project what is coming and produce a response (Liddicoat, 2004). Looking at where that overlap occurs we could speculate that the word 'unable' is the key that allows the Advice Worker to rejoin the conversation, and is the version of the caller's account that he picks up. This is potentially a very big picture that attention to the small detail has enabled us to detect because, from this short extract we can speculate that issues of control are brought up by the caller in response to a request to identify the problem, and an inability to control drinking is arguably a requirement of the Advice Worker before he can begin to give advice. This then challenges the idea of a dominant discourse by which people are trapped, leading us to wonder why an 'addicted' way of talking appears to be so readily rehearsed. Additionally, it lays open to question the utility of recruiting participants from treatment centres as here we witness the potential 'training' of a caller in the type of talk that the service provider can respond to, evidenced by the lack of uptake of I don't control and the ready uptake of an inability to control formulation. These ideas are currently a tentative suggestion and would require further study in order to be able to say anything more substantial; however, my point is that, without a clear transcript, an understanding of how interaction works and a move away from the view that people will just 'tell it like it is', all of this would have gone unnoticed.

My aim in this thesis was not to find out what people understand about drink problems, not to find out how they experience or make sense of their lives; my aim was to explore how ideas associated with 'problem drinking' are constructed in discourse without recourse to cognitive structures or an objective reality. My interest was to see if I could find out what functions such
constructs served for people, and my intention was to look at where these things are happening in everyday life. In this chapter I have made a case for the type of data I have used in my research and the method of transcription and analysis I have applied. However, some of the concepts have been touched upon only briefly. In the following chapter I make more explicit the epistemological position I adopt and I provide details of the methodology and methodological tools employed in this thesis.
Chapter 4

Methodology

In the previous two chapters I have made statements about the approach taken towards language adopted in this thesis. I have stated that I do not take the view that language reflects inner beliefs and attitudes, that it is problematic to consider talk as an accurate reflection of people's experiences, and that talk is functional. In the pages that follow I will further explicate such ideas. The arguments and ideas presented above have been extensively developed, explained and demonstrated under the banner of discursive psychology (Edwards & Potter, 1992). My discussion will therefore include a review and explication of key features of this approach.

Discursive Psychology

The discursive psychology (DP) approach was developed by Derek Edwards and Jonathan Potter in 1992 and has since been updated and developed by them (e.g. Edwards, 1994, 1997, 2002; Edwards & Potter, 1992, 1993, 2001, 2005; Potter 1996, 1998a, 1998b, 2003; Potter & Edwards, 2001a, 2001b, 2003). One of the main aims and achievements of DP has been to challenge the individualist and cognitive assumptions of mainstream psychology. The basic premise of DP is that psychological concepts should be treated as discursively constructed objects, rather than as mentalistic or cognitivist notions existing outside of discourse.

In a large proportion of social research there is inevitably some move to take on trust things that we all simply know to be the case. One thing that much discursive research has in common is an unwillingness to take talk or texts at face value. Typically, discursive analysts do not take language to be referential, that is, it is not seen as directly referring to an existing entity separate from the speaker, whether that is an external reality or an internal entity. I will take both of these themes in turn.

Firstly, an external reality. Language is not seen in a positivist way of referring to a world outside of language. Language constructs the speaker's reality, hence, unlike more traditional approaches to psychological research the
discursive analyst does not focus on the account of participants as a reflection of their experiences or some pre-existing reality in which the speaker can be said to live. Instead the analyst is concerned with how this reality is constructed, and what this achieves for the speaker; so an external reality is an interactional accomplishment.

This in turn allows us to respecify internal entities, for example, psychological concepts; such that, mental 'objects' such as attitudes, beliefs, opinions and memories are not seen as objects inside a person's head which are discoverable with psychologists' research techniques. Rather, they are seen as resources for conducting social business. Hence, talk is functional; it does something.

In contrast with more traditional psychology, discursive psychology is anti-essentialist and rejects a mainstream psychological view of cognition. Let me explain these further.

Psychological concepts are treated in DP not as something we 'have' or we 'are', but as things we 'do'. Psychology becomes more interactionally focused, dynamic and culturally specific as a result. Cognitions such as memories, attributions and so on are being used to do things in talk, hence the job for the analyst is to look for the action orientation; how these 'cognitive' inner processes are being used to account, justify, blame and compliment. Cognitive acts such as remembering do not happen in isolation, they happen in a particular context, with particular people, when talking about particular things. They are not a neutral passing of information which is stored in cognitive structures; they are embedded in discursive sequences of action.

Discursive psychology is non-cognitive, rejecting an attempt to explain talk in terms of mental states which theoretically may have preceded, shaped or resulted from the utterance (Edwards, 1997). Research informed by DP analyses the talk in relation to what it can be seen to be doing in the interaction rather than relating it to some hypothesised cognitive apparatus, structure or activity. Research informed by DP explores how cognitive states are made relevant and appealed to in talk - so, memories, attitudes, beliefs, expectations, intentions and the like become empirically studiable as the business of interaction, these are the things that talk actively constructs. The
aim of this type of work is to observe how mental states are constructed, mobilised and used in talk; so an empirical study rather than theoretical conjecture.

I will bring the analytic resources outlined above to the data in future chapters. First I will survey a number of other resources that will be useful to future analyses. Within the DP framework, by putting talk-in-interaction at the centre and making it the topic of study, we can begin to view talk in a different way from traditional psychological views of talk.

**Talk in interaction**

Speakers have a stake in the way things are constructed; their role in things, they way they are seen by others, the implications of certain versions of things. Talk can be organised such that the speaker does not appear to have a vested interest in the version being presented. Potter (1996) has written that one way that this is achieved is to construct a version of events which seems factual, obvious and separate from the speaker. Therefore, the image portrayed is that this is not just the individual's version, which serves a particular function, this is 'just the way it is'. Discursive psychology has shown that, on the one hand, being able to claim something or someone is objective, real or true is interactionally powerful (Potter, 1996). On the other hand, being able to disclaim or refer to one's own or others' biases is equally powerful (Edwards, 1997).

**Talk as situated and sequential.**

To say that talk is sequential does not mean that it is serial in a regimented way, and that everything that is said is only relevant to the prior utterance. Rather it suggests that there are sequential activities - that things that are said relate to something within the talk, and a stretch or sequence of talk can be analysed for the activity it is performing in the broader interaction. People who are competent speakers do not just randomly make statements or bring up topics; things are said at a specific place in a conversation - memories described, attitudes expressed, compliments paid, attributions made, and so on. This is to do with the sequential organisation (Hutchby & Wooffitt, 1998; Sacks, 1992); where something comes in a conversation, what precedes it and what follows it. Talk is occasioned, that is, it is relevant on and for the
occasion of its production, which is set up, or provided for by what preceded it. Therefore it can be analysed for what it is doing on that occasion.

This also relates to the notion that talk is context bound – the accomplishment of discursive action is tied to the environment, both the institutional, physical, social environment and the local interactional environment in which they are produced; so talk is constructed by and constructive of the situation, context or reality.

**Intentionality.**

Rather than guessing at what a person 'meant' by a particular utterance, or what motivated someone to say something, the DP move is to look at what the speakers make of it. It is up to the speakers to decide what each other 'means' and display some sort of orientation to what was meant, that is, what is at issue. This removes the job of identifying intentions away from the analyst, and instead, focuses on what the participants are doing (Edwards, 2006). However, that does not allow the analyst to say 'speaker B thinks that speaker A meant x', a speaker treats an utterance as having a particular motivation or meaning, but that does not necessarily mean that the analyst can claim any sort of corresponding 'cognitive understanding'.

Within a DP understanding of human action, the issue of why people drink alcohol problematically or why some interventions appear to work better for some people than others, is different because of the different focus on talk as action. In the history of addiction that I presented in chapter 2 I demonstrated that within the culture from which these participants were drawn, problematic drinking is a morally sanctionable behaviour for which people are held responsible and culpable, for which they are called to account (Martin, 1999). A recurrent theme of the subsequent analysis is therefore how callers make their drinking and other behaviour an accountable matter and attend to this, and also how they attend to their accountability for asking for help to change their behaviour.

The issues of agency and responsibility are therefore very live in the helpline interaction, precisely because they are important issues for the participants. My job will be to start to explicate this. From a discursive psychological
perspective, rather than seeing 'responsibility' as being something that exists and being something that a person can have, take or place elsewhere, the concept is a linguistic resource which is constructed, negotiated and mobilised to perform various types of social action. The next section will therefore survey these complex issues in more depth.

**Accountability: responsibility, culpability and agency**

As explained earlier, DP concerns itself with the constructed nature of knowledge, cognition and reality. As such, the way events are described, accounts are formulated and attributions are made are not viewed as simple reflections of such things, but as situated and occasioned social actions. When delivering an explanation of something, rather than seeing this as an expression of an event constrained by one's memory capacity and the like, descriptions are accounts and versions of events; one of many possible versions, each of which could equally be judged as 'true'. By using linguistic resources, speakers limit or mitigate their own agency in an act. So, rather than an act being viewed negatively and the responsibility of the speaker, it is made hearable as an understandable act and something that anyone might do (Rymes, 1995).

Buttny (1993) suggests that "free choice is presumed to be a necessary condition for responsibility, so if a person can convincingly avow that he/she did not act freely, then the burden of responsibility cannot hold" (p2). As such it is important to consider the work of Austin (Antaki, 1994; Harré, 1995) as an early influence on the study of accountability. Austin took an interest in the study of excuses due to the relationship with "the perennial philosophical problem of free will" (Potter & Wetherell, 1987:75), and made a case for the power and utility of its study "if it were refocused on the kinds of things people treat as interfering with their actions" (Potter & Wetherell, 1987:75). So, exploring how and when people make excuses, or provide accounts, can reveal insights into people's constructions of free will. Investigating talk about freedom, free will, actions, behaviour and the sorts of things which are portrayed as impacting on such things brings to light how and when such constraints and influences are formulated and what this achieves for the speaker within the interaction. Austin made a distinction between excuses and justifications, both of which are strategies available to people when they
are called to account. An excuse is admitting an action or behaviour is 'wrong' or 'bad' but claiming one's behaviour was impeded or influenced or caused by something else. A justification sees the speaker portraying the action as not necessarily bad when viewed in a different light, or perhaps understandable under the circumstances (Antaki, 1994; Harré, 1995).

However, an approach as suggested by Austin seeks to categorise particular ways of talking, which imposes an analyst's theory of 'accounting practices' on a stretch of talk. Rather than seeing this as a particular 'speech act', the DP move is to treat and examine accounts in the context of language function. Accounts and attributions are achieved through descriptions of events, so, events are described in ways that make certain attributional inferences available (Edwards & Potter, 1992). Accounting for one's behaviour can change or modify another's evaluation of one's actions.

The production of an account may not simply be limited to an excuse or justification for wrong-doing. They can include descriptions and explanations that people provide of everyday activities and ordinary actions. As such, a study of accounts may include how people present activities to make them appear normal, understandable, proper and rational. People account in order to make their actions make sense to other people. Buttny (1993) argues that "accounts offer a valuable site for uncovering a culture's taken-for-granted assumptions and folk logic of right action" (p2). People are called to account for behaviour which breaches or deviates from normative social behaviour, hence, one way to account for one's actions is to make them appear recognisable as typical, ordinary behaviour.

Derek Edwards (1994, 1995, 1997) has developed the notion of script formulations as a way of showing how certain formulations in talk can be used to generate what is normal. Writing about script formulations, Edwards (1997:144) explains;

"What we find in discourse is that participants describe the world in [particular] ways. Through naming and narrating them, people descriptively construct events as following, or as departing from, some normative or expected order." (emphasis in original).
Edwards used recordings of marriage counselling sessions to show how people use script formulations to not only depict events as conforming to or deviating from what may be expected, but also to characterise themselves in particular ways, and their behaviour as something ordinary and understandable or unusual and out of character.

The precise ways that people characterise themselves and their behaviour is highly studyable within the data examined in this thesis as accountability is a very real issue for the callers to an alcohol helpline. In order to receive the help that they are asking for they need to show that they are not in a position to simply stop or moderate their drinking alone; rather, in order to achieve that, they need external help. They also need to show that they are an appropriate person to whom help should be offered; that they are a worthy cause. Let us consider some of the issues that need to be managed by callers.

A concept that may be useful here is the notion of social or cultural embeddedness as offered by the Soviet psychologist Lev Vygotsky (Gergen, 2000). This lays emphasis on the idea that all human behaviour and human actions are embedded within a cultural context; that is, not determined by the culture, but embedded within it. This applies to the world of the drinker, suggesting that individuals are not in isolation, even when drinking alone – their behaviour is bound up with cultural expectations and regulations. The data examined in this these is provided by drinkers from a culture which has strongly held but very blurred rules about what drinking behaviour is acceptable and what is not (Martin, 1999; May, 2001). Very heavy, even excessive drinking is deemed to be acceptable or understandable in certain places, at certain times, by certain people. However, drinking which is continually excessive or drinking which causes problems for other individuals or for society generally is not deemed acceptable and is sanctioned and regulated in many ways. Not least of these is morally; problematic drinking is a morally sanctionable activity (Martin, 1999). Blatz (1972) argues that seeing someone as accountable for a morally untoward act is the same as the person being blameworthy. If a person is held blameworthy for a morally untoward act then they are liable to punishment. This has serious implications for problem drinkers who are requesting help.
Morality and discourse

Issues of accountability and responsibility are completely inseparable from a concept of morality. Moral issues can be implicit and embedded or explicit topics of conversation. As 'morality' is embedded in social interaction rather than a notion detached from interactive practices, the analysis presented in this thesis explores morality 'happening' in everyday life and examines how speakers construct and orient to issues of morality. In a 'common-sense' way, morality can be located in two places - either within the person, making them an immoral or bad person, or within the actions that they perform, that is, immoral behaviour. Such a theoretical position makes the assumption that 'morality' is extra-discursive, that is, outside of language. However, this separation can have a degree of utility and, as the analysis in chapter 5 shows, some of the callers make full use of this common-sense distinction so, whilst they orient to an acknowledgement that what they are doing may be morally reprehensible, they construct themselves as not being a 'bad' person.

Research in institutional settings has shown how the professional in such settings marks out issues as being sensitive and essentially moral (Bergmann, 1992). Professionals in certain institutions are trained to take a neutralistic stance and de-moralize issues (Heritage & Lindstrom, 1998). Linell and Rommetveit (1998) argue that when professionals attempt to de-moralise an issue they are in fact taking up a moral position - they are taking a moral stance against a moral stance. This can also be said of me as a researcher; in attempting to analyse how speakers deal with moral issues I take up the position that this is a moral issue about which I have no moral view - which in itself is a moral stance. I make no further comment on, or apology for the position I take.

Conversation Analysis and institutional talk

In this and previous chapters I have provided a quite lengthy and detailed discussion of the theoretical approach taken to the data presented in this thesis. Discursive Psychology has much in common with Conversation Analysis (CA) in terms of their epistemological position and approach to research and methods of analysis. Rather than go into further detail on the broader development of CA, in this section I will outline the method of analysis and focus on some of the more 'technical' aspects of Conversation Analysis.
Conversation Analysis (CA) was pioneered and developed by Harvey Sacks (Sacks, 1992) as a way of discovering and analysing the features of social action inherent in talk. Within the publication of Atkinson and Drew (1979) it became possible to distinguish between two main forms of CA. The first is most clearly demonstrated by the published work of Sacks, Schegloff and Jefferson, and is engaged in the identification of systemic features of the organisation of interaction – the same ‘structures of social action’ (Atkinson & Heritage, 1984) that provide the building blocks for social life. These fundamental features of talk provide the basis for the second type of CA, which explores interaction in social institutions such as educational, legal and clinical settings. Although there is no clear demarcation line between mundane and institutional interaction, the distinction remains useful in shedding light on what can be distinctive about interaction in institutional settings. The general consensus (eg, Drew & Heritage, 1992; Heritage, 2004) is that institutional interaction consists of some adaptation or conversion of ordinary interaction. For example, it would be somewhat alarming if one's therapist provided a second story about her own problems, yet this would not be out of place in ordinary talk. The data examined in this thesis are recordings of calls to an alcohol helpline and, as such, can be considered institutional.

Let us pause to consider this assertion; on what grounds can I make such a claim? In what ways can helpline interaction be considered institutional talk? Heritage (1997, 2004) recommended that deciding the nature of talk best comes from examining the detail of the talk rather than making assumptions based on where the talk is happening, with Torode (2005) echoing this in the case of telephone helpline calls. Chappell (2005) showed that formulations and accounts are significant and regular features of helpline interaction. Formulations are more indicative of institutional talk and are less common in mundane interaction (Hutchby & Wooffitt, 1998). Such phenomena serve to package the previous interaction, for example a second speaker may provide a gloss or the gist or upshot of what has been said by the previous speaker. Although obviously the first speaker can disagree or otherwise problematise the second speakers formulation of their account, it does give some control to the second speaker because it provides the opportunity for the second speaker to select what gets carried forward for continued discussion; it enables the
speaker to topicalise certain aspects of the first speakers talk and disregards others (Potter, 1996). Formulations, then, are typically Janus-faced as they summarise what has previously been said and also provide an indication of what direction the talk may be taking next.

A close examination of the talk reveals that within the helpline context, the roles of 'help or advice seeker' matched with 'help or advice provider' are a collaborative achievement rather than simply something imposed by the environment. Murtagh (2005) highlighted how speakers on a UK mobile telephone help centre call demonstrate to each other their receipt and understanding of the ongoing interaction, thereby revealing that the passing of information and instructions is a collaborative matter. Similarly, rather than being passive receivers of advice, callers to a Swedish Poison Information Centre are active participants in the construction of an advice-worthy problem and appropriate advice (Landqvist, 2005).

Research focused on calls to telephone services have identified further subtleties between types of service; for example whether the service is to do with solving a practical problem or providing more general support which is less specific problem focused. Raymond and Zimmerman (2007) took advantage of a corpus of calls which together represent something of a deviant case, as numerous calls were received about the same ongoing event. They identified that in ordinary calls to emergency services the typical roles of 'caller as service seeker' and 'call-taker as service provider' allocate a set of rights and responsibilities to each speaker. This influences activities such as the directional flow of information; such that the caller as the reporter of the event provides sufficient information for the call-taker to fulfil her/his role of service provider. As the data examined in this study were a series of calls about a progressive emergency, Raymond and Zimmerman (2007) were able to observe that, although callers initially rang to report the event, once it was apparent that the emergency services were already aware, callers began to ask for advice and information. The point of interest here is that although the activities being engaged in were different from normal, changing the direction of information and the roles of the speakers, both parties oriented to the expected order of the emergency service telephone call.
Similarly, Danby, Baker and Emmison (2005) and Emmison and Danby (2007) identified differences between calls to a helpline and emergency services, such that emergency service calls are problem-focused with an appropriate action which can ultimately take place; that is, emergency services can be dispatched. In calls to a children's helpline they observed a distinction between trouble or problem telling, which serves as an overall context for the call, and a reason for calling at that point, which may not be a specific event or exclusively identifiable problem.

The research outlined above has begun to pick out some important differences which begin to demonstrate that although there may be some similarities between calls because they are all institutional talk on a telephone, the specific purpose of each helpline has an overwhelming influence on the interaction. As the above studies demonstrate, whilst not knowing what to do about a range of troubles or problems may be appropriate to call the helpline studied by Emmerson and Danby (2007), this would not be appropriate for a call to the emergency services. Of course, these two are clearly in stark contrast, however, additional studies of helpline interaction have identified further subtleties.

Edwards and Stokoe (2007) showed that a common feature of neighbour mediation calls, was that callers were asked what they have done to resolve their problem prior to ringing the helpline. By asking for the information, Edwards and Stokoe argue that the callers were required to account for making the call and asking for help. We can ask here, what part of requiring help is the accountable thing? Is it specifically asking for help for something that maybe one could be able to sort out for oneself or for having the problem in the first place?

Baker, Emmison and Firth (2005) studied calls to a computer software support helpline. Given that a support number is provided with the software, this may suggest that it is generally accepted that problems may occur and that it is feasible that the user will not know how to correct it; hence there appeared less of a requirement to account for accessing this service. Similarly, Kraan (2005) demonstrated that having different levels of knowledge did not become an accountable matter in calls to a computer helpline. Interestingly, callers to a
healthcare helpline had a delicate balance to strike; they needed to
demonstrate the ‘doctorability’ of their health problem; that is, that the
problem is serious enough to warrant the call-taker’s time and attention, but if
they overstated their case and became too problem-focused the caller was
treated as less trustworthy as a reliable reporter of symptoms (Leppanen,
callers did not appear to be required to demonstrate that they had attempted
to help themselves before calling. So, it would appear that if a matter is
treated as something that can be expected to go wrong; for example, a person’s
body or technical equipment, there is less requirement for an individual to try
to rectify the problem before seeking help, but this is not the case with
something which is treated as less acceptably problematic, such as
relationships with one’s neighbours.

Whilst there appear to be subtle but discernible differences between types of
helpline calls, one thing that they all have in common is that they operate with
one party not being able to see the problem being discussed and neither
speaker being able to see the other person. Research has begun to be
conducted which addresses how these issues are managed. Whilst Murtagh
(2005) demonstrates that ambiguity and misunderstanding do not pose major
interactional problems in UK mobile telephone help centre calls, emotion and
distress in child protection helpline calls need to be very carefully managed
otherwise they can cause serious interactional problems (Hepburn & Potter,
2007)

So far in this chapter, the fundamental conceptual tools of the methodology
and approach taken in this thesis have been introduced and explained. It is to
the analytic tools provided by CA that I now turn my attention. In the
following section I outline the methodological approach provided by CA, as
employed in this thesis, using examples to demonstrate how the concepts are
applied in practice.

**A methodology provided by Conversation Analysis**

CA in itself does not provide a ‘method’ of analysis in as much as it does not
detail what steps should be taken in order to conduct a creditable conversation
analysis; there is no CA ‘recipe’. Crucially what it does provide is a framework
within which to understand talk in interaction, and conceptual 'tools' with which to analyse such data. In order to explore the data and achieve my aim in this thesis, such tools can be effectively employed; hence I will outline them below, which will make it easier for readers to understand the analysis presented in subsequent chapters. To aid us in that task, let us remind ourselves of the snippet of interaction between a caller and an Advice Worker which we looked at in chapter 3.

**Extract 2.1 Don’t/Can’t control**

<table>
<thead>
<tr>
<th>1</th>
<th>Advice Wkr</th>
<th>Right okay and how often would that happen.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Caller</td>
<td>Well it’s not very often ‘cause I don’t go out very often=</td>
</tr>
<tr>
<td>3</td>
<td>Advice Wkr</td>
<td>=Right okay=</td>
</tr>
<tr>
<td>4</td>
<td>Caller</td>
<td>=You know it might be once a: ‘bout once a month or something</td>
</tr>
<tr>
<td>5</td>
<td>Advice Wkr</td>
<td>[Oka::y ]</td>
</tr>
<tr>
<td>6</td>
<td>Caller</td>
<td>[But ( )] er on those occasion erm I don’t control?</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>(0.9)</td>
</tr>
<tr>
<td>8</td>
<td>Caller</td>
<td>I’m unable to con[trol? ]</td>
</tr>
<tr>
<td>9</td>
<td>Advice Wkr</td>
<td>[You’re] unable to control.</td>
</tr>
<tr>
<td>10</td>
<td>Caller</td>
<td>Yes</td>
</tr>
<tr>
<td>11</td>
<td>Advice Wrk</td>
<td>;Okay</td>
</tr>
</tbody>
</table>

**Turn taking and transition relevance places**

In the early development of CA Sacks noticed the surprising orderliness amongst the apparent messiness of ordinary talk. One of his most important observations was to do with turn taking. People generally talk one at a time, hence, there is an amount of orderliness in who talks when. We can see this in lines 2-3 where the closing intonation on the caller’s word happen indicates that his is an appropriate place for the caller to speak; a transition relevance place (Sacks, Schegloff & Jefferson, 1974). It is also apparent in the sequence between lines 14 and 16. Something seems to go awry between lines 4 to 6, and again at 7 to 9, as the Advice Worker appears to interrupt the caller. However, again we can see how this orients to the concept of turn taking because the speaker had provided an answer to the Advice Worker’s question,
and the end of lines 4 and 7 would appear to be appropriate candidate places for the turn at talk to change speaker. However, the caller goes on to provide further information in answer to the question. So, a transition relevance place is so called, because this may be a relevant place for a change of speaker, but that does not necessarily have to happen.

**Adjacency pairs**

As explained in the earlier section, talk is sequential. The justification for this claim is provided by Sacks' observation that certain groups of utterances conventionally appear in pairs, for example a question/an answer, an invitation/an acceptance or declination, a greeting/a greeting, and the like. Sacks labelled these 'adjacency pairs' (Sacks, 1992). Whilst it would appear problematic not to answer a question, respond to an invitation or return a greeting, these activities do not necessarily have to follow immediately. Let me make some observations explicit here; the utterance of the first part of an adjacency pair sets up an expectation of the second part of the pair, hence the onus is on the second speaker to duly provide such a response. Let me reiterate that talk is sequential but not necessarily serial, so, whilst an answer is made relevant by the posing of a question, this does not have to be provided immediately in a strict, regimented way. However, it is expected at some point. Let us look again at our example.

<table>
<thead>
<tr>
<th></th>
<th>Caller</th>
<th>[But (unclear)] er on those occasion erm I</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>don't control?</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>(0.9)</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Caller</td>
<td>I'm unable to control?</td>
</tr>
<tr>
<td>12</td>
<td>Advice Wkr</td>
<td>[You're] unable to control.</td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The caller finishes speaking in line 10, with what is actually the end of the response to the question asked by the Advice Worker. However, she ends with a questioning intonation, making this hearable as the first part of an adjacency pair; a question/an answer. So, whilst this is actually a statement, *on those occasions I don't control*, the questioning intonation indicates that some sort of reply has been made relevant. As a reply is not forthcoming, the caller retakes the turn and rephrases her statement, but again delivers it in a questioning style, again making a response from the Advice Worker relevant.
The extract provided above is quite a complex little exchange; however, further conceptual 'tools' provided by CA allow us to understand what is going on in the talk. They are preference structures, overlaps and repairs. Let us take each of them in turn.

**Preference structures**

As stated previously, the first part of an adjacency pair sets up the expectation or requirement of a second part; so, an invitation sets up an acceptance or rejection. However, studies have demonstrated that different responses are delivered in different ways. For example, turning down an invitation is structured and organised in a different way to an acceptance (Pomerantz, 1984). Sacks used the term 'preference structures' to explain these. An important thing to note is that, in CA, whilst 'preference' may relate to the normative expectation that a question will be answered or that an invitation is extended in the hope that it is accepted, 'preference' is not intended to explicate or refer directly to some internal cognitive motivation on the part of speaker two, or desire on the part of speaker one; the notions of preferred and dispreferred responses are more to do with the way the talk is organised. Let me clarify this. A preferred response design is typically delivered straightaway, generally with no pause or mitigation. However, dispreferred response designs often begin following a delay in responding, are characterised by 'markers' (Pomerantz, 1984) such as 'um', 'oh' or 'well', and usually contain an account or explanation. Consequently, a second turn can be designed as a preferred or as a dispreferred response regardless of the actual semantic content of the utterance.

In our example above, line 11 is clearly a dispreferred response, as, although a reply has been set up by the caller, what follows is a long pause. Conversely, the response in line 13 is a preferred response as it comes in straightaway with none of the characteristics of a dispreferred response. In fact, it comes in early. Let me see if I can explain how that can happen by following our example line by line.
Overlap and projection

I have previously argued that people speak one at a time, and a change in speaker occurs at an appropriate transition relevance place. In lines 12 to 14 something appears to have gone wrong with this.

9 Caller [But ( )] er on those occasion erm I don’t
10 control?
11 (0.9)
12 Caller I’m unable to con[trol? ]
13 Advice Wkr [You’re] unable to
14 control.

The overlapping speech in line 13 would appear to disprove the idea that people take turns and switch speakers at appropriate places. How can CA account for this? Well, rather than disproving anything, this example can provide further evidence of such ‘rules’ of talk. Following the work of Jefferson (1986), Hutchby and Wooffitt (1998: 56) inform readers of a “recognitional onset” of talk, of which the above is an example. They describe a “recognitional onset” as “when the next speaker recognizes what [the] current speaker is saying and can project its completion” (Hutchby and Wooffitt, 1998:56), that is, a potential upcoming transition relevance place. In our example, the caller has previously vocalised some problem with her control over drinking. This was met with no response from the Advice Worker. The caller has a second attempt at vocalising the problem, to which the Advice Worker displays an orientation to this being a second attempt, recognition of what the talk is about and an orientation to the assumption that the turn will soon reach completion. The Advice Worker demonstrates that he is now in a position to respond to the caller’s utterance and provide the second part.

Repairs

I stated on page 81 that the early development of CA was based on describing the orderliness of talk-in-interaction; an orderliness which is clearly no accident or coincidence. One of the many ways that we can see that speakers attend to the organisation of interaction is is by the identification of various types of ‘repairs’ when something does or potentially could break down (Hutchby & Wooffitt, 1998). It is important to note that interactional phenomena described in conversation analytic and discursive work as ‘repairs’
do not only appear when correcting an error; the utterance that gets repaired may make perfect sense, so repair does not necessarily have to be seen as 'correction'. Repairs indicate an orientation to a specific interactional task, therefore identifying what gets repaired, and what it gets repaired to can indicate the nature of the conversational activity or business being attended to. Let us look again at our example in terms of a repair sequence. The utterance on those occasions erm I don't control (lines 9-10) is perfectly acceptable, both grammatically and semantically. However, the lack of response from the Advice Worker suggests that this is in some way problematic. Rather than simply clarifying and providing further information about her drinking and behaviour, the caller alters her account from don't control to I'm unable to control. So, when the account gets repaired to I'm unable this needs to be understood as attending to what work it is doing; what function it is performing for the speaker, rather than correcting an error.

I hope I have been able to show how useful concepts such as adjacency pairs, transition relevance places, preference structures and repairs, as provided by Conversation Analysis, can be when analysing data. We will certainly see how they have aided the analysis presented in later chapters, but before we move on to the subsequent analyses, let us first discover what sort of data have been investigated throughout this thesis.

Data, participants and the organisation

The data
The data collected for this research are telephone calls to an alcohol helpline which is run by the Alcohol Problems Advisory Service (apas) located in a city centre in the Midlands. In total, sixty-nine calls were collected, most of which were approximately twenty minutes long, with a few being much longer. This resulted in approximately twenty-five hours of talk. Just under half of the calls were received from people who were ringing about their own drink problem, with the rest either being from 'significant others' such as partners, parents or friends, and some from social workers, support workers and other such professionals. The data analysed in this thesis are a sub-set of the overall corpus, and include only 'self callers', that is, people who are concerned about their own drinking.
The helpline is advertised on apas's promotional literature where it is given the name 'alcoline'. A typical phrase which appears on the literature is 'For help and advice call alcoline on...', with the telephone number subsequently provided. This service is well used, with 476 people contacting the organisation via the helpline in the period April to June 2001*1 Despite the promise of help and advice, within the organisation Advice Workers (note their job title) are trained only to give advice. However, one could ask whether the callers are looking simply for 'advice' or whether they are looking for something more akin to 'counselling'? As the later analysis shows, it is often possible to detect a mismatch between the agenda of the caller and the agenda of the Advice Worker.

**The participants**

The participants in this research are both the callers and the apas staff. All of the staff are referred to as Advice Workers (AWs), but some are specifically Telephone Advice Workers (TAWs). The TAWs are all volunteers and work solely on the helpline. These are generally the less experienced staff or are people who have no wish to be involved with any of the other services. In addition to staffing the helpline, the remaining Advice Workers also run the other services that apas offers. This group of AWs includes both volunteers and paid staff. Some of the volunteers are social work students who are on placement from a local university as part of their studies. Other students from one of the two local universities, most commonly studying for an undergraduate degree in psychology, also volunteer at this organisation. Of the remaining volunteers, the vast majority comprises people who have themselves experienced problems with alcohol, either through their own drinking or that of a significant other. Arguably, there are both potential strengths and limitations of using ex-drinkers as volunteers, and this issue will be reviewed later in the thesis.

In order to comply with relevant ethical guidelines, a number of issues needed to be considered and procedures carried out. Firstly, informed consent needed to be gained from all participants. In the very earliest stages of the research project I attended a staff meeting at the organisation to provide full details of

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1 *Data provided by apas. This covers part of the period when data collection took place.*
the research to the staff group. I also met with staff individually and talked through the research project and answered questions. Their main concerns were with who at the organisation would hear the recordings and whether they were being 'assessed' in any way. It was agreed that the act of turning on the recorder would indicate that the Advice Worker was giving consent for the recording to be used for training and research purposes both within and outside of the specific organisation, but that their anonymity would be protected in ways that I shall describe below.

In order to gain consent from the callers, the Advice Workers were required to read a permission script. The script was;

We are currently recording calls for training and research purposes, is it ok if I record this call? You do not have to be recorded and you can ask any questions before giving consent.

It was necessary for the Advice Workers to say this at the beginning of the call. The script could be adapted so that the Advice Worker was comfortable with it; they could say it however they chose as long as it covered key elements of recording for training and research purposes, there was no obligation and questions could be asked. Advice Workers were provided with further information which could be passed to callers, including the caller's right to withdraw from the research and contact details of the researcher in case the caller wished to request further information. It is interesting to note that in the eighteen months that recording was taking place, to my knowledge, only one caller refused to be recorded.

The anonymity of participants was protected in numerous ways. All personal or identifying details were changed including people's names, street names, local areas and districts, names of local landmarks and the name of the city. In most cases, these were anonymised by replacing with a pseudonym, however, in the case of transcripts which were given to the organisation the name of the Advice Worker was replaced with the letter AW.

The organisation
Apart from the helpline, apas offers a range of other services. 'Apas Direct' is a drop-in service where people can visit the organisation without an appointment and see an Advice Worker for approximately twenty minutes. This often leads
to an appointment for a fuller assessment. The assessment utilises a psychometric test which determines the extent of a person's drink problem, after which, advice can be offered that is tailored to the client's needs.

Clients can have a regular appointment with an Advice Worker, which was taken up by 434 clients in the period April to June 2001*. This generally takes the form of discussing with the client how the previous week has been and how they intend to control their drinking in the coming week. The staff are not trained to provide more specialist help, but they do have access to literature and materials which can make useful suggestions to clients as to how to deal with their drink problem. Advice Workers are not trained counsellors, nor are they trained in any specific interventional methods or approaches.

At a cost, apas provide clients with a court report. This is for clients who are appearing in court and details the client's drinking history, the clients involvement with treatment services, and what steps they have taken to control their drinking.

Apas organise group meeting for clients, and they also house other groups such as Alcoholics Anonymous. The organisation has no involvement with AA other than to offer a room in which the meetings can be held. In the period April to June 2001 apas ran 25 group sessions involving 690 participants*, including clients, staff, students, volunteers, probation officers, social workers, drug and alcohol professionals, healthcare workers, young people, youth workers, teachers and parents.

The organisation receives a number of client referrals, via routes such as GPs, police, prison and probation services, social workers, teachers and youth workers, solicitors and housing and employment agencies. Clients who are referred through the latter services often enter the New Deal programme and are thereby 'fast-tracked' through services such as this; that is, they are priority cases and do not join a waiting list.

The ethos

The organisation does not have a particular stance or position, neither on the cause of problem drinking, nor on which treatment option is the most
successful. Advice Workers are encouraged to offer all services as they see appropriate, so abstinence based treatments or controlled drinking programmes should not be automatically promoted one above the other. This may initially seem positive and appropriate as different treatment options suit different clients so the organisation can offer a wider range of services and referrals. Apas also claims no particular position on 'addiction' or what a 'drink problem' is, which then would suggest that there is less risk that the Advice Workers may be dogmatic in their dealings with clients. This then leaves the Advice Workers to make up their own mind about such issues and use their own way of conceptualising things. This may have far reaching implications. Given that callers often appear to be asking the Advice Worker to decide if what they are describing is a drink problem, how do the Advice Workers decide how to construct and convey such a 'problem'? As many of the Advice Workers are themselves former problem drinkers, a substantial number rely on their own experiences and are often reluctant to offer services which they themselves did not find helpful. As the analysis shows, others even draw on stereotypical understandings 'alcoholics' and 'alcoholism'. This issue will be returned to later in the thesis.

Now that I have explained the theoretical position adopted in this thesis, both towards the concept of 'drink problems' and the position adopted on talk in interaction, I have detailed the approach taken to conducting analysis, and I have described the data, we are ready to move on to the analysis presented in the following chapters.
Chapter 5

Control over drinking: The addicted 'other'

In the first of the introductory chapters I mapped what I called a 'history of addiction'. If anybody were to embark on such a task they would inevitably find themselves writing much about a disease model of addiction because, as I demonstrated earlier, this has been the most influential conceptualisation of deleterious substance abuse throughout 'addiction's' history. Key factors of a disease model are that it is an incurable, irreversible, progressive condition which affects a discrete sub-group of individuals and is characterised by a loss of, or inability to control substance use.

The original disease model of addiction, as formulated by the likes of Alcoholics Anonymous (1939; 1955; 1976) and Jellinek (1952, 1960) has been challenged (Davies, 1992; Denney, 1976), criticised (Heather & Robertson, 1981, 1985) and in many ways has fallen out of favour in academic circles. Despite this, reformulations in some cases have represented only subtle changes (APA, 1980, 1994, 2000; Edwards, 1977; Edwards & Gross, 1976; WHO, 1975, 1990); and whilst others offer a more thorough reconceptualisation, certain key elements of an original disease model are still clearly apparent in newer theories of addiction (Orford, 1985, 2001; Robinson & Berridge, 1993, 2003; Vuchinich & Heather, 2003). The most notable of these elements is loss of, or impaired control over substance use. In the first introductory chapter I explained that this is one of the criteria that differentiate between substance use and substance dependence in the Diagnostic and Statistical Manual of Mental Disorders (APA, 2000) and the International Classification of Diseases (WHO, 1990). A fascinating observation is that despite issues of control being a cornerstone of a concept of addiction, and being a key factor in people's understanding of the concept of addiction (Walters & Gilbert, 2000), there is no evidence of the existence of 'loss of control' beyond people's subjective descriptions of their experiences.
Frustrated by this lack of success to empirically demonstrate loss of, or impaired control, but spurred on by its seeming existence through repeated subjective reports, researchers moved towards exploring people's accounts of their experiences (Larkin & Griffiths, 2002; Marsh & Saunders, 2000) and argued that in interview settings, the notion of loss of or impaired control is used as a discursive justification for the speaker's excessive substance use (Davies, 1997a; Marsh & Saunders, 2000).

In the literature so far, two things clearly seem to be missing. The first is a detailed examination of how people construct and manage issues of control; what constitutes issues of control and how does 'impaired control' get done? Secondly, the research so far has exploited data generated in a research interview. However, people do not generally spend their lives in interview settings; people spend their time living their lives. As such, how and when do issues of control appear in people's lives when they drink alcohol excessively and are asking for help to stop or cut down on their alcohol intake? A detailed analysis of how loss of control gets done will help us to understand the function of such a construct on the occasion of its use.

As yet, no published research has addressed either of the above issues. The following pages are an attempt to begin to fill that gap, which it is hoped will also shed some light on why this construct is still so apparent in people's talk. The analysis sets out to explore 'control' as a discursively accomplished phenomenon by people who are currently drinking, consider their drinking problematic and are asking for help. It looks at the 'loss of control' or 'impaired control' construct as a reification of a set of accountabilities and discursive practices, such as blaming, justifying and persuading. The analysis begins by highlighting some of the ways that speakers work up control and impaired control. In doing that I explore how callers present themselves as rational, logical people and design their talk in such a way as to demonstrate that their excessive drinking is not of their choosing. A resource readily utilised by callers is the ability to construct more than one 'self', and the analysis explores how this is put to work when accounting for one's behaviour. The chapter ends by exploring possible functions impaired control formulations have within the helpline interaction.
Impaired control

'Impaired control' over drinking is worked up by callers in particular ways. It has a number of elements, although not all are necessarily present every time. Extract 5.1 demonstrates many of these elements.

Positive steps and stupid reasons

Karen, the caller in the extract below, is a mother of four daughters and reports currently drinking a bottle of wine every night. This extract appears approximately half way through a fifteen minute call. Immediately prior to this, Karen expressed a concern that she may turn into an alcoholic. The Advice Worker, Deb, responded by saying that rather than thinking in those terms, if the caller's drinking is affecting your life and causing you a problem ... it is better to do something about it.

Extract 5.1 - DB 11-02 21

361 CALLER 'Cause I m: what I did I did what I did
362 (0.2) do wh- which I thought was a
363 pos’tive st†ep which erm I can’t stop
364 totally but I bought (this-) y’ know
365 one of these smal: bottles of wine
366 which is just two gla:ses
367 ADVICE WKR Mhm
368 CALLER And I was gonna (. ) have that but then
369 for some stupid reason I went to the
370 shop and bought eight cans of be:er
371 ADVICE WKR Mm
372 CALLER And I drank all those last night and
373 this wine
374 ADVICE WKR Yeah
375 CALLER Which I didn’t really want to do an’ I
376 an’ I w’s s(h)itting there thinking I
377 shouldn’t be ↓doing this.
378 ADVICE WKR M:mm

In extract 5.1 the caller, Karen, is talking about an attempt she made to cut down her alcohol intake, and depicts herself as being able to make appropriate decisions. The appraisal of her actions in lines 362-363 (which I thought was a pos’tive st†ep) constructs her behaviour as being subjected
to cognitive scrutiny and following a reasoned plan of action. She accounts for why this is a sensible, indeed positive step, preferable to not buying any, by stating that she can't stop totally (lines 363-364). And I was gonna (.) have that (line 368) reiterates the display of a goal-directed decision making process.

The caller subsequently constructs the buying of more alcohol as being beyond her rational comprehension, so, although there was a reason, it was some stupid reason (line 369). This is followed by a description of her ensuing behaviour (I went to the shop, bought eight cans, I drank all those). The activities to do with buying and drinking the alcohol are in three marked phases. Initially the sensible action of buying a small bottle of wine is thought to be a positive step. Secondly, the buying of more alcohol was beyond her understanding, so although still subject to cognitive appraisal, her behaviour is no longer the result of a sensibly reasoned plan of action. The third act of drinking all of the alcohol in one evening is constructed as simply a behaviour (I drank all those line 372) with no cognitive decision making processes associated with it. So while the caller acknowledges her behaviour, the motivation behind the behaviour, and hence responsibility for the action, is neatly avoided.

Finally, the caller manages the tension between an ever more fragmented rational, cognitively driven actor who makes positive decisions, and a passive entity that drinks too much, by 'splitting the self'. Hence, the rational self has wants (I didn't really want to) and thoughts (I'm sitting there thinking), and is capable of making moral decisions (I shouldn't be doing this), but the behavioural self is otherwise motivated and acts according to a different (unspecified) agenda. The communicating of a 'private thought' (Barnes & Moss, 2007) or the use of active voicing (Wooffitt, 1992) in lines 376-377 – (I shouldn't be doing this) supports this as an objective and accurate account of her actions. Wooffitt's analyses of accounts of paranormal events explicated ways in which speakers construct accounts to appear factual and independent of the speaker. By reporting her thoughts in words as if they were actually said in that way, much like playing a tape recording, the caller suggests that that is how she thought at the time. So, this is not just how she feels now with hindsight, the caller
displays knowledge at the time that she shouldn’t be drinking, which strengthens her claim that her behaviour was against her better judgement and out of her control.

So, in this analysis we have seen how Karen the caller constructs herself as a rational person who makes sensible decisions about alcohol. She draws attention to the imbalance between decisions and action by emphasising the thought processes involved in decision making and by constructing the drinking as simply a behaviour. Thus, the caller problematises the concept of a single actor, or a single ‘self’. Finally, the caller employs discursive devices, such as active voicing, which help to make her report appear a factual representation of the events.

The concept of a self as separate from the drinking can be seen in a number of calls and requires further exploration.

**Separate actions...**

The caller in extract 5.2 reported that she is unsure whether she has a drink problem. She stated that she considers herself to have a problem, but her friend has told her that she does not. She called the helpline so that a person who knows about it that’s independent ... could tell her what kind of problem she has. This extract comes four minutes into a fourteen minute call.

**Extract 5.2 - ML 06-03_2_3**

<table>
<thead>
<tr>
<th>164</th>
<th>Advice Wkr</th>
<th>right (0.3) .hh I mean what- what’s your drinking pattern at the moment</th>
</tr>
</thead>
<tbody>
<tr>
<td>165</td>
<td>Caller</td>
<td>well (0.4) the- (0.2) the- the pr↑oblem that I have is I ca:n’t (1.1) erm</td>
</tr>
<tr>
<td>166</td>
<td>Caller</td>
<td>(0.2) I’m eith- I’ve either gotta drink or I haven’t</td>
</tr>
<tr>
<td>167</td>
<td></td>
<td></td>
</tr>
<tr>
<td>168</td>
<td>Advice Wkr</td>
<td>right</td>
</tr>
<tr>
<td>169</td>
<td>Caller</td>
<td>an’ I’ll I suppose (0.6) what I keep doin’ (0.3) is (1.2) tr- I’ll (0.2)</td>
</tr>
<tr>
<td>170</td>
<td></td>
<td>I’ll (.) it escalates</td>
</tr>
<tr>
<td>171</td>
<td>Advice Wkr</td>
<td>ok[ay]</td>
</tr>
<tr>
<td>172</td>
<td>Caller</td>
<td>[so] when I’ll I’ll give u:p (0.6) drinkin’ (0.7) which is (0.2)</td>
</tr>
<tr>
<td>173</td>
<td></td>
<td></td>
</tr>
<tr>
<td>174</td>
<td></td>
<td></td>
</tr>
<tr>
<td>175</td>
<td></td>
<td></td>
</tr>
<tr>
<td>176</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
177 *"mm=tch=mm=tch=mm=tch"
178 >quite stressful< 'cause i-er causes me
to have anxiety for like the first few
days
181 Advice Wkr [okay ]
182 Caller [an' I'll] give up (0.4) an' then
after (.) so long a week or so (0.7)
I'll think right well I'd I'd just
like to be: like everybody else and
just be able to have the odd drink
183 Advice Wkr right
184 Caller an' i- (0.5) an' I <don't seem> to be
able to do that
185 Advice Wkr you feel that you can't really control
your drinking at the moment
186 Caller no it it 'll (0.6) e- I mean I could
start on one day having one drink an'
then it just over I mean i- a- it goes
up escalates quite quickly (0.3) over
about I'd say two weeks
187 Advice Wkr right
188 Caller [ un]till it gets to a point where
(0.7) <I know> that I'm drinkin' (0.9)
more than: a lot more than: 's healthy
189 Advice Wkr okay
190 (1.0)
191 Caller so it- (0.4) you know I wh(h).h (0.2) I
suppose what I'd like is for somebody
to tell me whether (0.9) it- that is an
alcohol problem or that is just some
problem that I have with my- s(h)e(h)lf
or s(h)elf contro- I don't know
192 Advice Wkr .hh
193 (0.9)

This extract opens with the Advice Worker asking about the caller's drinking pattern. In a response which is characterised by a great deal of self-repair, displaying some trouble formulating an answer, the caller builds a picture of a behaviour which is not under her control. Firstly, she provides an 'all or nothing' gloss of her drinking in lines 168 & 169. In line 168, the caller
repairs *I'm* to *I've ... gotta*. The *I'm* formulates the action as something she is doing, simply a behaviour, as discussed in the previous extract. In Karen's talk (the caller in extract 5.1), this works up the drinking as an uncontrolled activity, something that simply happens, whereas here the caller upgrades to *I've gotta*, something which she is compelled to do, so not simply something inexplicable, but a compulsion.

The caller in extract 5.2 moves on to say *I suppose* (line 171), so rather than reporting her behaviour as a fact; for example: and what I keep doing is..., she marks this out as an assumption or guess. This display of 'figuring out' builds the picture of a behaviour which is not pre-meditated or planned. Furthermore, this is repeated behaviour (*I keep doin'* lines 171-2) in keeping with the pattern asked for by the Advice Worker.

The caller further distances the drinking behaviour from herself in lines 173 with the repair from *I'll* to *it*. To say *I'll...* do something is a behaviour performed by her, however, *it escalates* de-personalises the action and depicts it as separate from her and with its own momentum. This formulation is repeated in lines 194-5, *it goes up escalates*.

The caller makes interesting use of the word 'just'. In line 185 she would simply or merely *like to be: like everybody else*. By using the extreme case formulation (Pomerantz, 1986) 'everybody', the caller appeals to the normative notion of people drinking alcohol. This accounts for her return to drinking – she understandably wants to be a 'normal' person, and *the odd drink* (line 186) is an appropriate or acceptable amount which echoes the 'reasonable', 'sensible' person in extract 5.1. The 'just' in line 194 performs a different function. Here the drinking *just ... escalates*, hence it simply, inexplicably 'just' happens.

In lines 188-9, the caller makes reference to an inability to *be: like everybody else* and *have the odd drink*. The display of confusion with the repeated *an' I* and the slower <*don't seem*> portray this as something perplexing to the caller. So far the caller has not directly said that she has impaired control over her drinking. In her summary of the caller's account, the Advice Worker treats the caller's description as displaying issues of
‘control’ and formulates it into the control construct in lines 190-1 (you feel that you can’t really control your drinking at the moment). Aligning with the caller’s claim that she does not seem able to have the odd drink, the Advice Worker proposes that the caller can’t control her drinking rather than does not, or that her drinking is simply not under control which would avoid issues of agency and ability. Here, then, we see the caller and the Advice Worker co-constructing impaired control.

Following an account of her pattern of drinking, the caller demonstrates what she knows in lines 199-200. The knowledge she claims is that alcohol can be related to health, there is a point beyond which alcohol is unhealthy, she know where that point is, and when she has passed it. By tying up her narrative in this way, the caller conveys her drinking behaviour as a problem. However she then goes on to delineate the problem as either being an alcohol problem or a problem with herself (lines 205-207).

The identification of this separation is of primary importance, not least because it further demonstrates a concept of self as a resource which can be manipulated to perform various discursive activities. The distinction that the caller marks out is highly noteworthy, so let us take a moment to consider it. An alcohol problem (lines 205-6) is enunciated as a straightforward option as to where the problems lies, in which case, alcohol is the underlying root cause. Conversely, a problem with ‘self’ appears as a more troubling option, indicated by the wobbly voice and the interpolated laughter. Here may be evidence of Cohen’s (2000) argument that individualised cultures prize having self-control and not being in control of ones self is a serious problem. This has far reaching clinical implications when working with people with substance use problems because one needs to address notions of where ‘control’ is being placed and questions whether situating the problem at the individual control level is the most helpful thing to do.

So far in the chapter we have seen how callers separate excessive drinking from purported cognitive activity and a sense of self. We have observed that, for the most part, callers construct a self which is rational, reasonable and perplexed by their own drinking behaviour. We ended by witnessing an
indication that depicting a problem with one's self rather than alcohol being the problem was troubling. Let us go on to further explore the management of issues of self, alcohol and control.

...and separate selves

The concept of a self, or 'selves', in relation to control over drinking can be further teased apart. In extract 5.3 the Advice Worker has just been talking with caller 1, Melanie, about caller 2, Aaron's drinking, as she was original caller. Melanie is the mother of Aaron. Caller 1, Melanie, has explained that it's a drinking problem that's steadily got worse, especially over recent months because Aaron's father's died and since then it's got really out of control. This extract comes about half way through the seven minute call, when caller 2 Aaron speaks to the Advice Worker.

**Extract 5.3 - CG 07-02_1_1**

<table>
<thead>
<tr>
<th>Line</th>
<th>Speaker</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>98</td>
<td>Advice Wkr</td>
<td>Hi Aaron it's erm: Craig here I'm I've just speaking to your mum erm (0.5)</td>
</tr>
<tr>
<td>99</td>
<td>Advice Wkr</td>
<td>she's told me b- just a little bit</td>
</tr>
<tr>
<td>100</td>
<td>Advice Wkr</td>
<td>about the (0.2) the problem erm (.) it seems to have got worse in the last few years and (0.6) you've had this terrible trauma that's gone on as well that's accelerated everything</td>
</tr>
<tr>
<td>106</td>
<td>Caller 2</td>
<td>correct</td>
</tr>
<tr>
<td>107</td>
<td>Advice Wkr</td>
<td>erm: (0.8) am a- (0.7) what would be your sort of goal in this would you like to sort of try and get it back under control or [or do y-]</td>
</tr>
<tr>
<td>111</td>
<td>Caller 2</td>
<td>[No def- ]</td>
</tr>
<tr>
<td>112</td>
<td>Advice Wkr</td>
<td>do you feel you ought to stop altogether</td>
</tr>
<tr>
<td>114</td>
<td>Caller 2</td>
<td>Erm there's n- g- this time I definitely can't try and get it back get it back under control</td>
</tr>
<tr>
<td>117</td>
<td>Advice Wkr</td>
<td>Mm:</td>
</tr>
<tr>
<td>118</td>
<td>Caller 2</td>
<td>Cause I don't think- I'd be fooling myself (.) I know I will</td>
</tr>
<tr>
<td>120</td>
<td>Advice Wkr</td>
<td>Yeah</td>
</tr>
</tbody>
</table>
The extract begins with the Advice Worker's gloss on the previous conversation he had with caller 2's mother, followed by a request for information from caller 2, Aaron, on his goal in this. Both the Advice Worker and caller 2 talk about getting it back under control. Hence control over drinking is something that one can have, lose and regain.

In lines 115-6 caller 2 states that he can't try and get it back ... under control, and then provides an account for this. Throughout this account caller 2 'splits the self' three times, the first coming in lines 118 and 119. He starts by saying I don't think which doubts or questions his own ability as a whole. This gets repaired to I'd be fooling myself, hence this self is now divided with one part of the self fooling the other self into believing that he can control his drinking. This is followed by a display of knowledge (I know I will line 119) and caller 2 justifies this knowledge by providing evidence in line 121 I've done it before.

Similarly the second split in line 121-122 I feel good about myself allows one self to be in a position to evaluate or judge the other self, and the third split in line 124 I can convince myself portrays one self as imparting knowledge
and conviction to the other self, constructing two parts of the self which have differing positions.

A further example is provided by Daniel, the caller in extract 5.4. Daniel has told the Advice Worker, Dave, that he used to drink everyday but, for the last three or four months, has no alcohol during the week. However he reports currently having drinking binges at the weekends and wants to stop that too.

Extract 5.4 - DV 07-02_1_1

Advice Wkr (0.4) erm (0.4) #er r-# you know
Remember it's the very first drink that
does the damage not the eighth "hh .hh"
CALLER (((unclear))))
ADVICE WKR [ you ] know because without the
first we don't get to eight
ADVICE WKR (ahuh ha)
CALLER [ or ] twen' y
ADVICE WKR Or twen' y or or wha'ever=
CALLER =I think I'll have one but (.) just
kidding myself
ADVICE WKR Well absolutely an [and ]
CALLER [few hours] later
CALLER I've had (0.4) Christ knows how much

The extract opens with the Advice Worker, Dave, warning the caller to avoid the first drink. The caller orients to the aptness of this advice as he constructs his drinking binges starting with a decision to have just one drink (I think I'll have one line 808). This response to the warning portrays the caller as 'right thinking', limiting himself to an amount portrayed as 'acceptable', which echoes the small bottle of wine in extract 5.1 and the odd drink in extract 5.2. However, this restraint or 'self-control' is an attribute of only one part of this caller as he 'kids' himself that he will just have one drink. This 'kidding' is realised a few hours later when he has had an amount of which he is not aware, and is not even able to vaguely quantify (Christ knows how much line 812).
In some senses, the interactional phenomenon I have labelled 'splitting the self' in effect works in a similar way to the footing work I highlighted in chapter 3 (page 46) (Edwards & Potter, 1992; Goffman, 1981; Potter, 1996). In both cases the speaker can be seen to be distancing themselves from the accuracy or 'truthfulness' of the description they have produced and attending to their own accountability.

In this part of the chapter, the analyses have delved into issues of the 'self' or 'selves'. The implications are that issues of control are worked up by callers and are not simply 'I lose control'. The callers construct elements of the self that are not 'out of control', or never were 'in control'. So, by demonstrating the complexities of the construct, it is not so easy to see 'impaired control' as a simple or unitary entity. Also we have started to look at the function of control talk in this context rather than simply speculating whether callers truly are or are not in control of their lives and drinking habits. As there is currently no other literature on this topic, a new path is being forged here. Let us go on to investigate this further.

**The function of ‘control’ in alcohol helpline interaction**

So far 'control talk' has been explored theoretically, or in the abstract, however, as I argued in the introductory chapters, talk is context bound and functional. Let us examine what 'control talk' can achieve for a caller to this helpline.

**Alcohol and moral judgements**

In an earlier part of this chapter I stated that extract 5.1 demonstrated a number of elements of an 'impaired control' construct. Let me now remind readers of part of that extract and point out what else we can learn from its analysis.

*Extract 5.1b - DB 11-02_2_1*

| CALLER | And I drank all those last night and
|        | this wine |
| ADVICE | Yeah |

1 Borrowing Jellinek's (1952) phrase.
In line 375 Karen, the caller, states that drinking all the alcohol she had bought was something that she had not wanted to do, depicting her behaviour as being against her wishes. Furthermore, in lines 376-7 she enunciates her purported thoughts at the time (I shouldn't be doing this). Wooffitt (1992) argues that reporting one's own speech is a way of characterising oneself, so here it establishes a contrast between herself and the behaviour, which portrays the act as not being freely chosen. In order to demonstrate the direction the analysis is now taking, let me draw your attention to the caller's use of the word shouldn't (line 377). This imports with it issues of morality and what is right and wrong. Excessive alcohol drinking has long been associated with moral issues, and often viewed as a highly immoral act (Martin, 1999; Valverde, 1997). Despite the best attempts of many individuals and groups to remove issues of morality from excessive drinking (see particularly Alcoholics Anonymous, 1939, 1955, 1976), they are still highly apparent.

Let us follow through the logic of this. Bergmann (1998:289) states that “In principle, most kinds of behaviour can be thought of as matters of choice and can therefore be made the object of moral judgement”, whilst Buttny (1993:2) argues that “free choice is presumed to be a necessary condition for responsibility, so if a person can convincingly avow that he/she did not act freely, then the burden of responsibility cannot hold”. Therefore, “if a person can convincingly avow that he/she did not freely choose to drink excessively then they cannot be held morally accountable for their behaviour. In extract 5.1 we observed the caller claiming that her drinking behaviour was not of her choosing, and she oriented to the moral implications of her actions. Thus, within the interaction we can begin to see an impaired control construct marshalled against a potential moral judgement. Let us explore this further.
Sneaky, criminal drinkers

In extract 5.5 the caller and the Advice Worker have been discussing the idea of people using alcohol to take away or dull the memory of drinkin’ a lot the previous day.

Extract 5.5 - RN 08-03_5_8

274 Caller I mean i do that (0.2) in the shop
275 sometimes >sort of< talk myself in the
276 morning saying look this is no good
277 Advice Wkr Mhm
278 Caller I’ve got to stop spending this money
279 Advice Wkr Yeah
280 Caller E:rm (0.3) and then I’ll go to the shop
281 to get milk an’ bread or (. ) [normal]
282 Advice Wkr [Yeah ]
283 Caller shopping
284 Advice Wkr Mhm
285 Caller an I think (1.3) I’ll (0.7) <clo::se>
286 my mind. I <know> exactly what I’m
287 doing=
288 Advice Wkr =Yeah
289 Caller An I don’t even (0.3) I won’t have a
290 thought (0.3) I just go to the fridge
291 an I get (0.4) the eight cans
292 Advice Wkr Yeah
293 Caller An I’m li:ke (.) not thinking.
294 Advice Wkr Yeah (0.3) yeah=
295 Caller =deliberately: (1.1) y’ know (0.4) erm
296 I won’t pud it in my conscience
297 Advice Wkr [Absolutely]
298 Caller [or an an ] my conscience isn’t
299 pricked
300 Advice Wkr Yeah (0.7) it’s just a [ behav]iour
301 Caller [unclear]
302 Advice Wkr you just do it
303 Caller Ye:ah=
304 Advice Wkr =and don’t think about it=
305 Caller =an I feel like erm: (0.6) a criminal
306 Advice Wkr Yeah
307 Caller Erm: (.) you know snea:ky
In extract 5.5 the caller treats her behaviour as morally sanctionable, and employs similar devices as in extract 5.1. The active voicing (Wooffitt, 1992) in lines 276 (*look this is no good*) and 278 (*I've got to stop spending this money*) constructs the caller as a decent person who is 'right-thinking'. Going *to the shop to get milk an' bread or normal shopping* (lines 280-283) depicts her as a 'normal' person. This displays an accountability for the behaviour, as the buying of cans of lager is marked out as not 'normal shopping'.

Between lines 285 and 290 the caller formulates a very elaborate display of 'cognitive disengagement'. As discussed in chapter 4, rather than analysing talk as a reflection of inner mental states, discursive psychologists are interested in the practices that use mental terms and what people are doing with talk of mentalistic states (Edwards, 1997; Edwards & Potter, 1992). The caller starts off in line 285 stating that she *think[s]*, followed by a long pause. This trouble is explained in lines 289-290 when the caller states that she doesn't *have a thought* and again in line 293 with *I'm ... not thinking*. The caller goes on to construct a deliberate closing down of thought processes which ordinarily police, and perhaps control, her behaviour. Once there are no restraints, the behavioural self is free to act, and the caller places emphasis on the actions (*go* line 290, *get* line 291)

The caller subsequently orients to a moral accountability for her actions. In line 296 she states that she *won't pud it in my conscience*. Here this can be heard as a deliberate act of avoiding moral issues associated with the behaviour. This is met with a strong agreement from the Advice Worker (*absolutely*, line 297), however, this is in overlap with the caller's continuing turn. The caller reformulates the act and removes the agent, (*my conscience isn't pricked*, lines 298-299), hence this becomes less hearable as a deliberate act.
The Advice Worker summarises the caller's narrative in line 300-304, which the caller treats as needing justification. The caller asserts a 'moral person' identity by stating that she feels like a criminal and a sneaky person. An important point to note is that the caller enunciates that she 'feels like', rather than suggesting that she is a person of questionable morals. This reinstates the internal mental processes and the 'thinking self' as being superior and in a position to judge the 'behavioural self'. Hence, in common with the caller in the previous extract, this caller draws a distinction between herself and the action, and 'she' is unhappy with what the behavioural self is doing.

So, the analysis has explored how 'control talk' can be utilised to manage moral accountability by constructing a decent, appropriate, 'right-thinking' person, achieved here by using discursive devices such as splitting the self and active voicing. The interpretation of a moral accountability is supported with reference to concepts such as conscience, criminal and sneaky person.

Before continuing let us pause to consider the overall business of the helpline interaction. So far we have seen how impaired control is co-constructed between callers and Advice Workers, we have witnessed callers depicting themselves as rational, moral people and we have observed how an impaired control construct is utilised to account for the caller's drinking behaviour, to manage responsibility and to avoid moral judgements. However, the ultimate point of the helpline is to elicit or provide help and advice. When exploring sections of the data which involved activities related to advice, again I discovered an impaired control construct apparent in the talk. I will now demonstrate how this construct is used by callers in managing, projecting and heading off specific sorts of advice.

'Control' talk and the management of advice

Keith, the caller in extract 5.6, is explaining his previous attempts to resolve his drink problem. This extract appears very early in the call. Keith has just explained that he had been to the organisation previously, but had stopped attending about eighteen months ago. The Advice Worker, Dave, asked the caller what his pattern of drinking [has] gone like over the
eighteen months. The caller constructs a lack of agency and employs a 'lack of control' metaphor, which is recognised by the Advice Worker.

**Extract 5.6 - DV 12-02_1_2**

29 Caller I mean I actually (.) I did try to cut
down on the wine and sort of stuff and
what have you I mean I d- I did for a
bit
33 Advice Wkr Yeah-
34 Caller -But er: it's like y' sort of I'll have
a hiccup and then I'll sort of like go
back to drinking just as much: (.) as
what I was before an y' know sort of
like erm
39 Advice Wkr Mm
40 Caller er it's it's kinda like a cycle of of
habit that I've just sort of got into
42 Advice Wkr Mm
43 Caller I tell you it's rare that I drink
during the day 'cause I don't (0.2)
<tend to> feel as though I need a
drink during the day do y' know what I
mean
48 Advice Wkr Yeah absolutely
49 Caller Erm but I can't I >know I just can't<
break the habit of of drinkin' that
kind of much: (.) y' know on a week
nigh- =an I know it's damagin' my
health and I know (. ) all sorts of
things y' know but erm (0.6)

The caller states that *I did try to cut down on the wine and sort of stuff and what have you* (lines 29-31), so although this list only actually mentions one item it presents it not just as a particular (simply, I cut down on the wine), but he cut down on the category, so showing that it is not just the wine that is the problem, but also an associated *sort of stuff* and *what have you*. The caller goes on to say that he *did for a bit ... but ...*(lines 31-2 & 34) which dovetails with the DSM (APA, 2000:197) “unsuccessful efforts to cut down”. However rather than assuming that the talk simply corresponds to
some past behaviour, the discourse can be seen to relate to interactional activities on the helpline.

The caller's professed inability to stop drinking is worked up in two ways. Firstly, use of the metaphor hiccup (line 35) and the term habit (line 41) provide an elaborate vocabulary of things that cut away at agency. Also, the concept of a cycle (line 40) builds the picture of something which is external to him and has its own momentum, which the caller just sort of got in to (line 41). So, these are portrayed as involuntary behaviours, and external influences over which he has no control. I can't ... break the habit (lines 49 & 05) is emphasised by the repetition I can't I know I just can't (49) which, in a general sense, provides an account for him making the call to a helpline such that, if he could control his drinking he would not have a problem.

The caller here is seen to make full use of the word 'just' in a similar way to the caller in extract 5.2. The just in line 41 and again in line 49 work to present this as simply, inexplicably the case; so getting into the cycle of of habit and being unable to break the habit are presented as matter-of-fact givens. This demonstrates the phenomenal power and utility of this impaired control construct as it renders understandable the illogicality of not knowing why one is doing something but knowing one cannot stop.

The extract ends with the caller reporting what he knows, which effectively heads off certain types of advice or information. On a week nigh[t] (lines 51-2) could be left there and would provide an appropriate place for the Advice Worker to come in and start giving advice. However, the caller holds the floor by not finishing the word 'night' and latching the next word on to it. He displays a claim to the knowledge that it's damaging his health and, importantly, I know all sorts of things (lines 52-4), which again makes his drinking behaviour accountable and provides a warrant for making the call, as despite claiming the relevant knowledge, the caller still reports being unable to stop. This also neatly heads off potential up-coming advice or information, as suggesting to him that he would be well advised to cut down his drinking as alcohol is damaging his health in various ways, or all sorts of other things, is inappropriate as the caller has not only already claimed
This knowledge, he has also stated that this is not something that he can do.

This extract contains a report of the caller cutting down or abstaining from drinking at certain times. This positive indicator needs to be made consistent with contacting a helpline for advice. Again, we see cognitive notions constructed as disparate from and unrelated to behaviour, as the caller achieves this consistency by drawing a distinction between intention and action. His “desire or ... efforts to cut down or control substance abuse” (APA 2000:197) are only partially successful, hence, help is being sought.

**Resisting advice**

What happens when the caller treats the advice as problematic? We have seen how callers head off certain types of advice but if the caller does not do this they lay themselves open to the following type of suggestions.

In this extract, we return to Karen, the caller in extract 5.1. This comes early in the fifteen minute call, and Karen has outlined her drinking, which she reports as normally a bottle of wine every night. The extract begins at a transition point where Deb, the Advice Worker, has started to suggest practical ways of resolving the problem.

**Extract 5.7 - DB 11-02_2_1**

120  ADVICE WKR  "kay" right I mean as I say there's
121    there's quite a few different things
122    you can do yourse:lf
123  CALLER    Right
124  ADVICE WKR  Erm you can try cutting d\own
125  CALLER    Yeah
126  ADVICE WKR  E:\rm (0.7) maybe (.) limiting yourself
127    to sort of half a bottle
128  CALLER    "Yeah\" that's [what I can't do: ]
129  ADVICE WKR    [and see how it goes]
130  CALLER    I can't if I've got a bottle in the
131      house
132  ADVICE WKR    Mhm
The Advice Worker opens by proposing that there are *a few different things* that the caller can do herself, and then goes on to suggest *cutting down* and
limiting her alcohol intake herself. In lines 128 and 130 the caller states that she can't do that, and gives evidence in line 165 with 'I tried this'.

The Advice Worker includes 'internal' words related to the drinking – you have to drink that whole bottle (lines 134-5), a lot of people ... feel that ... they can't stop (lines 140-142) so the advice worker works this up as being motivated from within the person. Also lines 140-143 are formulated as a script (Edwards 1997), so this is what other people do in general. In contrast, the caller's talk is designed very differently. The caller states I'll drink the bottle (line 133), if I open a bottle at midnight I'll finish it before I go to bed (lines 166-7), with no 'internal' words associated with the behaviour and no motivational claim made about it. Thus, this is formulated as what just happens.

Additionally, rather than the caller's drinking being her choice or decision, it is reported as a problem (that's where I feel it's a problem lines 136-137). Here the word 'feel' appears when the caller is talking about her drinking being a problem. So when she offers an evaluation of her drinking it is portrayed as being internally motivated – it is coming from her. But when she talks about her actual drinking, it is constructed as not being internally motivated, it is not coming from her, it just happens.

The caller intimates that, not only is her drinking not her choice, her behaviour is beyond her understanding. In line 139 she asks why can't I just have one glass, thus the caller presents a person who does not know why she can not do that, and constructs a self who has separate thoughts and behaviour, which reiterates the problem with the suggestion to just 'cut down', and justifies her resistance to the advice given. Here then those same characteristic elements of an 'impaired control' construct are formulated to provide resistance to the advice being offered. This relates specifically to the business of the helpline and demonstrates the multi-purpose function of impaired control.

Concluding comments

At the outset of this chapter I noted that two things appeared to be missing from published literature in the field of addiction on loss of or impaired
control over drinking; a detailed examination of how impaired control gets done in people's talk and an exploration of the function of an impaired control construct outside of an interview setting. I claimed that the analysis presented in this chapter made steps towards filling those gaps and began to forge a new path in addiction research.

I began by presenting analyses which scrutinised how people design their talk to depict their control over their drinking behaviour as debilitated. I discovered that people portray themselves as rational, 'normal', moral people, and set this at odds with a behaviour which is irrational, abnormal and morally sanctionable.

There appeared to be two key ways in which these two competing positions could be combined. Firstly callers were seen to construct cognitive notions as separate from action and behaviour. Appropriate behaviours such as buying a small bottle of wine and being like everybody else are reported as being under cognitive scrutiny and associated with purported cognitive activities such as thinking and knowing. However, inappropriate excessive drinking is reported as simply, inexplicably, 'just' happening. Hence, constructing separate and competing thoughts and behaviours begins to manage a person's accountability for their behaviour. This raises the question of how callers deal with the contradiction that, at times their behaviour is portrayed as cognitively driven and at others not. This is achieved by discursively constructing multiple selves, whereby one self can convince, fool or kid another self. The implications here may be that callers construct selves who do not lose control or who never had control in the first place.

The analysis moved on to address a second interest on which there is a dearth of literature; what does an impaired control construct achieve for a caller to an alcohol helpline? Most relevantly, we observed how this construct could be employed to manage, head off and resist certain types of advice.

The analyses presented in this chapter have far reaching clinical and practical implications. Whilst representing problematic drinking as the
action of a separate uncontrollable self or as simply something that just happens may be extremely vague and somewhat 'self-servingly convenient', it is also highly resistant to challenge. This is precisely why the account is designed in such a way. Unfortunately however, this does not lend itself to change in a clinical or other treatment setting; it is clearly incredibly difficult to advise a person to stop a behaviour which they have just claimed they cannot stop and have no control over. The challenge for clinical practice may be to bring about change in a person's drinking behaviour which does not rely on issues of individual control.
Chapter 6
Advice Workers' responses to callers' loss of control over drinking.

In the previous chapter I examined issues of control over drinking and demonstrated that a 'loss of' or 'impaired control' construct can be highly functional for callers to an alcohol helpline. I ended the chapter by making suggestions for clinical practice in light of the analyses, and I noted that an impaired control construct provided something of a challenge for alcohol practitioners as, in essence, they find themselves in a position of suggesting to a client that they should do something which the client has just stated that they cannot do. Completion of the analysis for the previous chapter stimulated my curiosity; how do Advice Workers respond to callers' claims that they are unable to control their behaviour? I returned to the calls from which I had extracted the excerpts of data presented in the previous chapter and discovered that, in each case, the Advice Worker and caller subsequently discussed options of next action and what the caller could or should do. Embedded in the talk were issues of responsibility; who or what had been responsible for the emergent alcohol problem; who was responsible for its resolution; and who would take what action. I then looked at other calls where the Advice Worker was giving advice and found again that issues of agency and responsibility were evident. Before going straight to the analysis, let us consider why this simple observation is important in relation to other work in addiction and treatment.

As previously noted, what followed loss of control was talk about what callers could or should do next. In the treatment of alcohol problems and other addictions, practitioners are obviously concerned with which treatments work best with which types of problems and which types of clients. With little success, much research has focused on this, most notably Project MATCH (1997, 1998) and UKATT (2001, 2005), both of which disappointingly came to the conclusion that the treatments under study all performed at around the same level of success (see also, Hubbard et al, 1989; Hubbard, Craddock, Flynn, Anderson & Etheridge, 1997). Attempts have also been made to identify relationships between treatment characteristics and client characteristics (see for example, Moos, 1997).
Despite such attention researchers note that little is understood about components and processes of treatment programmes, especially in relation to how and why they work, or fail to (Hubbard et al 1989; Yalisove, 2004). So, whilst a particular approach may prove to help a large number of people desist in problematic drinking or other addictive behaviours, it is unclear exactly what properties of the treatment package produce the desired outcome and how.

Such theoretical approaches to both 'addiction' and 'treatment' conflict with the social constructionist position and the discursive psychological approach argued for and adopted in this thesis, but I shall resist returning to the challenges and arguments I presented in the introductory chapters. The two observations I wish to point out are that; firstly research which seeks to assess the outcome of various treatment approaches begin their study at the point at which clients are assigned to one of the treatment variables (for an explanation see UKATT, 2001). My second observation is that a full and thorough assessment is viewed as being of paramount importance before a treatment programme can properly be offered or recommended to a client (Gossop, 2003. See also MoCAM, Department of Health, 2006). My concern is that no account is taken of what has happened before a client reaches these stages. Before a client can be assessed for severity of problem and appropriateness for any treatment package it has to be decided that the individual's behaviour constitutes a problem for which treatment of one sort or another may be deemed appropriate. This is not a transparent, unproblematic process, as the analysis presented in this thesis demonstrates. So far no published research has explored how problem construction and formulation gets done in the earliest stages of a person's involvement with alcohol services. The pages that follow are an attempt to begin to address such issues.

What a close detailed analysis of calls to this alcohol helpline revealed is that, embedded in discursive activities such as problem formulation and advice giving are issues of expertise, responsibility and agency. By examining how that gets done we can explore callers' uptake and begin to see how Advice Workers put across 'advice' as having far reaching implications. Rather than looking at what action is being suggested we
need to examine how this is put together as advice, what notions this advice imparts with it and the implications of this for individual callers.

In the third of my introductory chapters I discussed how ‘responsibility’ has been studied in relation to addiction and substance abuse (See chapter 3, pages 36-7). There I took issue with the traditional cognitivist psychological approach of viewing responsibility as an unproblematic, disembodied context-free entity; a quantifiable and measurable item on a questionnaire. I went on to review literature which considers the concepts of responsibility and accountability as linguistic resources which are constructed, negotiated and mobilised to perform various types of social action. In my approach to analysis, rather than conceptualising responsibility as a property of the person I approached it as a property of the interaction; ‘responsibility’ is something that is co-constructed between the speakers and is a linguistic resource that can be used, resisted and challenged by both parties.

**Responsibility: here, there and everywhere**

The motivation behind the analysis presented in this chapter was to discover how Advice Workers responded to callers’ professed loss of control over their drinking. On close examination I discovered that Advice Workers subsequently discussed what action could be taken to resolve the alcohol problem. In some cases this included a summing up or formulation of the problem. Embedded in discursive sequences of problem formulation and advice giving I detected issues of agency and responsibility. Whilst this was apparent in all cases, I noted three distinct styles or approaches adopted by different Advice Workers.

- Alcohol dependence and mitigated responsibility
- Caller responsibility and action
- Shared or ambiguous responsibility

Below I provide a brief explanation of each of the three styles.

**Alcohol dependence and mitigated responsibility**

Within this approach the alcohol problem is formulated as stemming from an alcohol dependency process which is constructed as an entity separate from the individual. Responsibility for the drink problem and other related problems is removed from the caller and accounted for by the dependency process. Callers are encouraged to rely on external help and support to
resolve the alcohol problem. In response, callers emphasise their inability to resolve their drink problem alone and confirm their need for help.

**Caller responsibility and action**

Advice Workers adopting this approach place responsibility directly on the caller to make decisions about the nature of the problem and its resolution. Where direct practical advice is offered responsibility is placed on the caller to carry out the corrective action and to monitor their own progress. Responsibility and accountability for advice offered is deflected from the Advice Worker. In response, callers restate and emphasise their hampered ability to make decisions and their inability to carry out the action proposed. Responsibility for identifying the problem and making specific offers and suggestions is correspondingly placed onto the Advice Worker.

**Shared or ambiguous responsibility**

A partnership of shared responsibility is oriented to in the final approach adopted by Advice Workers. However, precise responsibility for who will do what is highly ambiguous and Advice Workers are unspecific about exactly what is being proposed. Callers typically respond with an enthusiastic uptake, but orient to confusion about what is to happen and what they can expect.

The analysis presented in the following pages will detail each of the three styles and consider the implications of each for callers to an alcohol helpline.

**Alcohol dependence & mitigated responsibility**

In this section we will look in detail at one particular call where the problem is formulated in a way that mitigates the caller's responsibility. This will allow us to track through in detail and show the upshot of this style of advice.

We pick up Keith and Dave (the caller and Advice Worker respectively in extract 6.1 below) where we left them in the previous chapter. In extract 5.6 of the previous chapter we witnessed Keith the caller constructing a lack of agency and employing a lack of control metaphor which accounted for his problematic drinking. We also heard Keith claiming certain
knowledge which effectively forestalled potential advice simply to cut down his alcohol intake or information on the negative effects of alcohol on Keith's health. At the point where we pick up the call in extract 6.1, the caller has just finished explaining what the problem is right now and what his drinking has been like over the last eighteen months. The Advice Worker goes on to summarise and formulate the problem. Below I provide an extended extract which allows us to fully examine the subsequent interaction.

**Extract 6.1 - DV 12-02_1_2**

49 Caller Erm but I can't I know I jus' can't
50 break the habit of of drinkin' that
51 kind of much: (. ) y' know on a week
52 nigh= an I know it's damagin' my
53 health and I know (. ) all sorts of
54 things y' know but [erm]
55 Advice Wkr [Mm- ]
56 (0.4)
57 Caller hh y' know h I'm currently st-
58 calling from my mum's actually erm
59 (0.3) hh w- er hh can you hear the dog
60 barking in the [((unclear)) ]
61 Advice Wkr [Yeah (0.2) yeah]
62 Caller Erm
63 Advice Wkr are y' are you workin' presently
64 Caller No well there's a problem
65 >unfortunately< that I'm not an' (. )
66 I'm not actually on benefits either
67 because I've got some money
68 Advice Wkr Yeah
69 Caller But it's starting to er get a bit low
70 an'
71 Advice Wkr "Yeah"
72 Caller You know really er it's got to the
73 stage where as er (0.4) hh I've got to
74 really sort it out really erm
75 Advice Wkr Yeah=
76 Caller =But it's affectin'- certainly affects
77 my work I mean I've kind o' like er I
78 lost a lot of confidence in myself,
79 Advice Wkr Mhm=
Caller: er (0.3) .hh a:nd y' know I was workin'
     a property business an'- ((coughs))
     really t' get back into it no:w
Advice Wkr: [Yeah]
Caller: [Erm ] (0.8) it's gonna take a lot a
     doing
Advice Wkr: Yeah
Caller: [So ]
Advice Wkr: [Yeah] well i- it's e:rm .hhh y- you
     know if you recognise that that alcohol
     is actually: you know becoming a
     handica:p an an affecting other areas
     of your lTife then .h you know you're
     right to recognise that it's becoming
     problematic
Caller: Yeah
Advice Wkr: Erm the the process with with alcohol
     dependency: .h i- is that it it takes
     ye:ars sometimes decades to really: (.)
     come to a hea:d .hh er:m what most
     people experience are sort of <crises>
     in their lives o:r .hh y' know rock
     bottoms as some people call 'em or
     emotional lows
Caller: Yeah
Advice Wkr: erm missed opportunities broken
     relationships .hhh possibly ill- ill
     hea:lth, (. ) y' know financial
     difficulties for some people an (0.2)
     but it's such a a a gradual thing it's
     almost a drip drip (0.4) erm until it
     gets to the point that (0.8) y- you
     know it's really taken ↑over an and
     there's not a lot left in people's
     lives
Caller: "Ye[ah° ]
Advice Wkr: [e:rm] an I'm not suggesting that
     for you but it is (. ) you know
     dependency is is a continuum an an and
     there are (. ) you know there's a
     beginning and there's an ↑end sort of
In the previous chapter the analysis highlighted how the caller, Keith, expressed a lack of control over his drinking, which headed off certain types of advice, such as, that alcohol is damaging his health (line 52) and he would be advised to cut down. The Advice Worker, Dave, subsequently aligns with the caller's professed impaired control by working up a complex scenario whereby people's lives are taken over by a covert agentive process. On the surface, this is just about giving the caller information about what the problem is and how the caller has reached this position. However, a closer examination of the data reveals that issues of expertise and responsibility are embedded in this sequence, which have implications for next action. I will focus here on the way that this process is constructed and speculate on what that construction achieves interctionally for both the Advice Worker and the caller.

**Recognising the problem**

In reply to the Advice Worker's question as to whether he is working, the caller conveys difficulties he has experienced, such as, his money getting a bit low, work being affected, losing confidence and the problems of getting back into his previous line of work (lines 69-86). The caller obliquely attributes these difficulties to his drinking behaviour with an indicative 'it'
(it's affectin'—certainly affects line 76). In his response, the Advice Worker takes up this allusion to alcohol as the basis of the problems and makes the caller's orientation more explicit (alcohol is actually...affecting other areas of your life lines 90-3).

At this point, the Advice Worker makes analytically interesting use of the concept 'to recognise'; if you recognise that (line 90); you're right to recognise that it's becoming problematic (lines 93-95). So, this proposes that alcohol is a handicap and a problem in the caller's life, that is the given state of affairs, and the caller, as an observer, sees it. The Advice Worker tells the caller that he is right to recognise it, so it is not just the caller who sees that alcohol is a handicap and a problem, but the Advice Worker can see it too.

Let us take a moment to reflect on what is happening here, as this has important implications. Previously we observed the caller claiming knowledge to all sorts of things (lines 53-4). Here we see the Advice Worker confirming the caller's assessment of his problematic drinking. In attending to his own expertise, the Advice Worker takes on the mantle of someone who is in a position to tell the caller that he (the caller) is correct in his assessment that his drinking is becoming problematic, which works up the concept that the Advice Worker is more knowledgeable about such matters. So, whilst the caller may know all sorts of things the Advice Worker claims the ability to determine whether or not that knowledge is correct. As the Advice Worker's knowledge is now more extensive or more potent than the caller's, this then allows him to go on to explain what is happening, as judged by the 'expert'.

The Advice Worker subsequently moves on to talk about 'alcohol dependency' (lines 97-8 & 119). This introduces a 'technical' or 'medical' term (APA, 2000), which here works to give the caller's drink problem an independent status and reify it. So, this is not just about the caller drinking possibly too much or too often, but about the diagnosis of a nameable 'condition'. The following littering of references to 'it' (lines 98, 110, 111, 113 & 118) continue with this concept that the drinking stems from an entity which is separate from the caller. As such this helps to exonerate the caller for his drinking behaviour as it begins to remove the individual and issues of volition and choice from the scenario. No
this condition has been introduced let us go on to see what the Advice Worker can do with that and what implications this has for the caller.

**The process of alcohol dependency**

The Advice Worker refers to alcohol dependency as a *process* (line 97), so, an ongoing development. Furthermore, the Advice Worker's utterances *it's becoming* (line 94), *takes years sometimes decades* (lines 98-9), *gradual thing* (line 110), *almost a drip drip* (line 111) construct this 'alcohol dependence' as a slow but ever increasing *process* that works in the background. This ties in nicely with the *recognise* as, in this scenario, the process could potentially be working away for *years sometimes decades* unrecognised. The coup de grace of this process is the taking over of the individual's life (*it's really taken over* line 113), so this is an agentive process with an agenda.

Throughout this description the Advice Worker has further removed the individual caller. According to this account, it would appear that the process of alcohol dependence could apparently progress without any volition or agency on the part of the individual. Hence, by focusing on this *process* and backgrounding any other potential contributory factors emanating from the caller himself, the Advice Worker begins to remove from the caller issues of agency; the caller was not the active agent in this situation. Again, we return to Buttny's (1993:2) argument that “if a person can convincingly avow that he/she did not act freely, then the burden of responsibility cannot hold”. Here we begin to see how the Advice Worker is doing this on behalf of the caller, embedded in a sequence which is superficially simply an explanation of a progressive condition.

Later in the extract *dependency* becomes a *continuum* (line 119), and a *scale* (line 123), which are stated as fact (*dependency is is a continuum; on that scale*) and work to further reify this construct, and support the concept of an ongoing *gradual process*.

The Advice Worker corroborates his version with reference to *most people* (lines 100-1) and *some people* (line 109). This type of 'script formulation' (Edwards, 1997) is designed to add weight to the Advice Workers claimed knowledge, with the supporting 'evidence' of what people generally do and
what generally happens. So, this is not just about the caller, or even just about the caller and the Advice Worker, as other people are also in this situation. Whilst the Advice Worker does not directly specify who these people are, they are clearly people who experience problems through their drinking, enunciated by the Advice Worker as crises in their lives (lines 101-2), rock bottoms (lines 102-3) and emotional lows (line 104). These experiences or consequences are further explicated in lines 106-9, and are indexically attributable to the alcohol dependency process rather than the personal failing of any individual.

So far the Advice Worker's account has been designed as an explanation of how a process progresses and how people experience it. He has produced this as a factual account by attending to his own expertise and distanced himself from the version being presented as just being his own opinion by including the reported experiences of other people rather than simply presenting this as his own account. So, it would seem that the caller is being persuaded that this is what has been happening in his life and this is what he can expect. Let us go on to examine a masterly 'twist in the tale'.

**Advice Worker as expert, but not prophet**

In lines 117-8 the Advice Worker states that he's not suggesting that for you. This is very interesting because, thus far, the Advice Worker appears to have been summarising what has been happening in the caller's life, and foretelling what is likely to happen if this process is not arrested. This move is very neat as the Advice Worker is now not to be seen as prophesising. Hence, up to this point, the caller could be disagreeing with how the Advice Worker is characterising the caller's life and experiences, that is, that a process has been working away in the background causing crises in his life such as those listed. However, not suggesting that for you turns this around such that the Advice Worker is stating that he is not trying to sum up the caller's experience, to which the caller could disagree, but merely describing other people's experiences. This is now open for the caller to 'recognise' himself and his experiences within that picture. In lines 123-4, that is just what the Advice Worker imparts that the caller has done (when you recognise as as as you do). This appears to make the talk very specific to the individual caller, which would seem to conflict with not suggesting that for you. On the contrary, this utterance works in a similar way by lessening
the appearance of 'preaching' or the like. In essence this does the work of appearing as the speaker expressing 'this is what others have found and you are saying this is also your experience; I'm just explaining it'

The Advice Worker rounds off his speech with the observation that the caller knows that he need[s] to take some action (line 126). Interestingly, this is immediately followed by that's obviously what we're here for (lines 127-8). Hence, the action that the caller needs to take is not something that he is expected to perform alone, as that is what the Advice Worker is suggesting the service is there for. However, neither the action to be taken nor the service's role in that action are outlined or discussed, as the Advice Worker moves the conversation away from this topic and asks the caller's age (line 130). He then prompts the caller to align with this way of talking and attribute problems in the past to his drinking (lines 135-8). So, earlier (lines 87-91) the Advice Worker took up the caller's previous allusion to problematic consequences of his drinking (lines 69-86) and now encourages a more explicit attribution.

In the analysis so far we have seen how Dave, the Advice Worker has produced himself as the knowledgeable expert. From this position he has provided an account of an agentic process of alcohol dependence. He has positioned the caller as being caught up in this covert gradual process, and as being one of many people in this position. The Advice Worker has removed all responsibility from the caller, other than the requirement to recognise that he is on the continuum or scale; a task in which the Advice Worker confirms that the caller has succeeded. The Advice Worker has imparted that problems in the caller's life are attributable to alcohol and the alcohol dependency process. Finally, the Advice Worker has removed from the caller responsibility for the resolution of this problem, because, whilst they agree that the caller needs to take some action, that is what the organisation is for.

**Implications and uptake**

Let us now explore the caller's uptake and how he manages and deals with the Advice Worker's construction and positioning. In the intervening talk the Advice Worker has invited the caller to the organisation for a one-to-one meeting with him the next day.
Extract 6.2 - DV 12-02_1_2

701 (0.5)

702 Caller [Yeah]

703 Advice Wkr [An] an and we can: (. ) look at other

704 things other sort of support (0.4) erm:

705 that's available

706 Caller Right yeah=

707 Advice Wkr =erm if you wanna do that

708 Caller Yeah I mean that's it I mean I I I

709 couldn't s- I mean I c- I know I can't

710 do it on my own

711 Advice Wkr Mhm mhm

712 Caller You know an I do need some help to

713 get to get me to that point when I can

714 actually sort of like (. ) you know

715 Advice Wkr Yeah

716 Caller You know jus- just do it really [just]

717 Advice Wkr [Yeah]

718 Caller Just stop drinking

719 Advice Wkr Yeah (0.3)

The caller accounts for his acceptance of the Advice Worker's offer by saying that's it (line 708). This effectively aligns with the proposition that other things other sort of support (lines 703-4) is what the caller needs. In keeping with an external entity being responsible for the problem, external support and other things are conveyed as being required. The caller subsequently supports this need for other things and support by appealing to his inability to do it on his own (line 710).

The caller's need and inability are not produced as supposition, as the repair from couldn't to can't (line 709) indicates. Couldn't works up 'in theory', so the caller may be predicting that he couldn't, whereas can't implies 'in practice', hence, the caller is not simply theorising about how difficult it will be for him to stop drinking. Not only does the caller state his inability (I can't) this is strengthened by the knowledge avowal in line 709 (I know I can't)

In line 712 the caller states I do need some help. The addition of the word do is important here, as without it the caller would be stating his position; that position being that he is in need of help. However, I do need some help
affiliates the caller with the line that the Advice Worker has taken, so rather
than being a request from the caller this is now an agreement with, or a
concession to, the Advice Worker's assessment.

In the previous extract (6.1), the Advice Worker identified that the caller
need[ed] to take some action. The action that has been outlined in the
intervening talk is that the caller is to stop drinking. In extract 6.2 above,
the caller displays a lot of trouble when talking about that action. Rather
than saying it explicitly he uses the language of taboo and talks about
do[ing] it (lines 710 & 716). There is an abortive attempt to say what the 'it'
is in line 709 (couldn't s-). Actually sort of like (.) you know (line 714) comes
after reaching the point of mentioning what he can do which involves doing
what he knows he can't do. Finally the 'it' is identified in line 718 as stop
drinking.

The repetition of 'just' in lines 716 and 718 further indicates trouble in the
talk. In these turns of talk, 'just' is synonymous with 'simply' or 'merely'.
Here it works up a contrast between the simplicity of the task (just stop
drinking) with the caller's difficulty in performing that task (I know I can't do
it). So, whilst the caller can state what he wants to do, this is to be heard
as something difficult and potentially beyond his ability. The caller has his
lack of agency confirmed by the Advice Worker in lines 715 and 719 (Yeah).

Let me sum up what we have discovered in this section. We began at the
point where the caller had just finished telling the Advice Worker about his
drinking history. In response the Advice Worker summarised the problem
and provided an account of what many people experience when their
drinking becomes problematic. This then appears to provide a warrant for
the caller asking for help since the Advice Worker appears to suggest that
the caller's drink problem will become progressively worse.

On closer analysis, embedded in this account were issues of agency and
responsibility. The Advice Worker proposed that the active agent in this
scenario was a covert process of alcohol dependence, and also removed
from the caller accountability and responsibility, both for the problems the
caller has experienced in his life and for the resolution of his drink problem.
In response, the caller emphasised what he cannot do and what he needs,
mirroring a lack of agency and his lack of ability to stop drinking without external help, as conveyed by the Advice Worker.

**Caller responsibility and action**

In the introduction to this chapter I explained that the inspiration behind this analysis was to discover how Advice Workers responded to callers' professed lack of or impaired control over drinking. Whilst I discovered that, in each case the talk moved on to what action the caller could or should take next, I noted three distinct styles. In contrast to the previous style where responsibility is removed from the caller, in the pages that follow I will present extracts and analysis of a style of working where Advice Workers deflect responsibility for resolving the problem from themselves and place it squarely on the caller. The subsequent analysis will highlight how callers respond, either by reasserting the problem and restating difficulties in controlling their behaviour, or by appealing to the Advice Worker to take responsibility. The analysis will highlight how these notions are embedded in discursive activities such as offering, asking for and receiving help and advice on an alcohol helpline.

In extracts 6.3, 6.4a and 6.4b below, the Advice Worker attempts to put together a plan or some actions that the caller can follow in order to cut down on her alcohol intake. In contrast to the previous section, the history of the problem is treated as unnecessary for advice to be formulated. In compiling the suggested strategy, emphasis and responsibility are placed directly on the caller to take action and make decisions, whilst accountability for the appropriateness of the advice is deflected from the Advice Worker.

**Trying to give advice**

Here we return to Deb (the Advice Worker) and Karen (the caller) who we met twice in the previous chapter. In the analysis of extract 5.7 (chapter 5, pages 94-5) we observed the caller employing an impaired control construct when resisting the advice proposed by the Advice Worker. Let me remind readers of that exchange.
The previous analysis in chapter 5 (pages 96-7) demonstrated that this advice was not readily taken up by the caller. Let us for the moment move on to examine other parts of this call to see if we can discover what it was about the advice or the way that it was packaged that the caller appeared to resist and mark as problematic.

Below I reproduce and extend extract 5.1 which was the first exchange between these two speakers that we examined (chapter 5, page 78) in order that we can see the Advice Worker’s response to the caller’s professed loss of control over her drinking. Let us survey the interaction as it unfolds over the next few minutes of the call.
The analysis begins at the point where we left the caller in the previous chapter (extract 5.1, page 88-89), where she was stating that she had drunk a bottle of wine and eight cans of beer in one night, despite protesting that she had not wanted to. The closing intonation on line 377 (this.) indicates that the caller has finished talking, to which the Advice Worker produces a minimal response (M:m line 378). Gardner (1997) argues that a response such as this denotes an unproblematic receipt of the prior talk, hence, at this point the Advice Worker does not respond to the caller's stated problem of drinking more than she wanted to or thought she should. In lines 379-380 the caller then orients to the Advice Worker's earlier suggestion in extract 6.3 about cutting down (Line 124 Erm you could try cutting d\down), despite having made a display of the strategy not working.

The Advice Worker’s response does not align with any of the trouble with the ‘cutting down’ strategy (\Mm. (.) yeah line 382). Gardner (1997:132) suggests that the rise-falling contour of the Mm indicates “heightened involvement in the talk”, suggesting a positive or enthusiastic response. So, the Advice Worker's initial uptake of the caller's professed lack of control is to not attend to the caller's lack of ability, or focus on what has previously happened, but instead to concentrate on what the caller could do. This is worked up by the Advice Worker's minimal response tokens when the problem is explained, and the positive response to the caller's apparent
uptake of the advice. This then is clearly distinct from the previous style of aligning with the caller's lack of control and accounting for the caller's drinking behaviour as observed in the previous section. The Advice Worker's strategy here is to focus on actions to cut down the alcohol intake.

In the previous section we observed how notions of mitigated responsibility and accountability were embedded in the Advice Worker's talk. Let us go on to assess such issues with Deb, the Advice Worker in extracts 6.3, 6.4a and 6.4b. Extract 6.4b below continues with the same part of the call as 6.4a. The intervening talk has been about the number of units in different quantities of wine. The talk moved on to discuss how many units per week the caller is drinking.

**Extract 6.4b**

|   | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER | ADVICE WKR | CALLER |
|---|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|-------------|---------|
| 429 | Yeah I mean if (. ) it'd tend to be if you'd sort of done about fifty (0.4) | [ Right ] | [That's quite] a dangerous (1.5) | dangerous amount | Yeah which I probably am drinking at the moment | Mm: (0.3) yeah so I mean try you know you could try that for a couple of days and see how you get on on that | "okay" | Erm: (0.5) you know sort of trying to cut down, (1.2) erm (0.2) and starting to drink later and things like | [Yeah] | (0.7) | You know they all help you t- (. ) t- sort of cut down erm are you in the Northampton area | I'll be yes I am

In the analysis of this call so far we have observed little evidence of the caller and Advice Worker co-constructing a consensual version of the problem. The caller has emphasised her lack of agency in her drinking to which the Advice Worker has produced minimal response tokens. In
extract 6.4b we begin to see that pattern reversed. After a discussion about numbers of units of alcohol, the caller attempts to demonstrate to the Advice Worker how serious her problem is, in that she is currently drinking a dangerous amount of alcohol (lines 434-5 yeah which I probably am drinking at the moment). Again, the Advice Worker produces an unproblematic receipt of the assessment and then moves on to reiterate the prior suggestion about the caller cutting down and having just a small bottle of wine; so the focus here is very much on next action. Let us examine what issues are imported with the advice offered.

I will focus for a moment on two repairs performed by the Advice Worker; that (0.2) you may find that (lines 382-3, extract 6.4a, page 116) and so I mean try you know you could try that (lines 436-7, extract 6.4b above). Both of these turn a direct instruction into a suggestion, the implications of which are to effectively deflect responsibility away from the Advice Worker. Let me explain how that works. Had the Advice Worker simply have said “that would help you”, this assertion would state quite clearly that this is the correct course of action as this is sure to help. Hence, if cutting down to a small bottle of wine did not help the caller then something has gone amiss. However, with the addition of the minimising you may find, this becomes just an idea; the Advice Worker has distanced herself from the certainty of the advice she is offering. Similarly, the repair on lines 436-7 in extract 6.4b above works in a parallel way; had the Advice Worker have given the instruction to “try that”, this would then be a direct proposition as recommend by an Advice Worker on a helpline. The normative expectation would be that if someone in such a position tells a caller to endeavour to carry out a certain action, then that is an appropriate proposition and should be attempted. By adding you could, rather than this being a directive it becomes optional; the caller can try it if she wants to. So, we can begin to see how accountability for the advice being offered is deflected from the Advice Worker and responsibility for choosing what next action to take begins to be placed onto the caller. This strategy is also evident in the advice giving presented in extract 6.3 (page 115). Here again we can see the Advice Worker’s utterances you can (line 124) and maybe (line 126) making these actions optional rather than a direct recommendation.
Let us home in a little more on the word ‘try’ as used by the Advice Worker, to see if we can pinpoint what work it is doing in this interaction. In order to aid us in this task, let me again ponder how the Advice Worker could have said this differently to see if we can determine what try achieves for the speaker. If the Advice Worker had told the caller to ‘do’ that instead of ‘try’ this imports with it notions of tried-and-trusted methods, such that this is an action that if the caller get[s] on on that (extract 6.4b, line 438) this approach will work to solve the problem. In this scenario, if the caller does ‘do’ that, if this does not solve the problem then either the caller has a lot of accounting to do because she was told what to do and clearly has not followed the advice properly, or the caller has followed the instructions correctly but the advice was poor. However, to ‘try’ comes with no such guarantees. This packages the advice as one of a number of options which the caller could ‘try’. In this scenario, if the action fails to resolve the drink problem this does not question the validity of the advice; the status of the advice remains intact, but it is not what the caller can do, or she needs to ‘try harder’. So, in both extract 6.3 and 6.4b the Advice Worker can again be seen attending to her own accountability for the advice she is offering.

Let us consider the element of ‘try’ that suggests that effort on the part of the caller is required, because if she fails perhaps she did not ‘try hard enough’. Couple that with the Advice Worker’s utterances and see how it goes (extract 6.3, line 129) and see how you get on on that (extract 6.4b, line 438); so the caller is to monitor her own progress. We can see that embedded within this advice-giving sequence accountability for the advice is deflected from the Advice Worker, and responsibility for the corrective action, carrying out the action effectively and monitoring her progress is placed directly onto the caller. Indeed, the caller has been left in no doubt that she is to carry out the suggestions unaided as early in the call when the Advice Worker began proposing options she opened by stating that there’s quite a few different things you can do yourse:ýf (extract 6.3, lines 121-2).

In extract 6.3 we saw the caller attempting to resist the advice offered by referring to a declared lack of ability (that’s what I can’t do: line 128). Undeterred, the Advice Worker has continued in this style and repeated the suggestions that the caller can ‘try’. Eventually this is met with a weak
*okay* (extract 6.4b, line 439) from the caller. Despite the seemingly unenthusiastic response, the Advice Worker reiterates the same suggestions, which place emphasis on the caller to take action. Acquiescence from the caller is followed by a long pause (lines 444-5). Either because she has agreement from the caller or because she has nothing new to add, the Advice Worker ties up the advice. Produced as a collective of separate things, *they all* (line 446) makes more of the suggestions offered. For the first time, the Advice Worker initially produces a definite statement about the effectiveness of the strategies she has proposed (*they all help you*). However, this is followed by trouble in the talk demonstrated by the two cut offs (*t-* line 446) and then a hedged *sort of cut down* (line 447). This then makes the Advice Worker’s assurance that *they all help* less hearably certain.

In the talk following extract 6.4b, the Advice Worker gives the caller directions to the organisation’s office, including local landmarks. The Advice Worker offers to send the caller some information which she suggests *You know you can have a read through on your y’know on your own and there’s some helpful tips and things in there.* These continue with the idea that the caller simply needs information and can execute corrective action without further involvement with the organisation.

Let me now sum up what has been demonstrated so far in this section. In response to the caller’s impaired control, the Advice Worker makes practical suggestions, which the caller can choose to follow. Embedded in the advice, responsibility is placed on the caller to carry out the actions suggested by the Advice Worker, and to monitor her own progress. The Advice Worker is non-prescriptive, and so does not have answers, just suggestions. Responsibility and accountability are deflected from the Advice Worker and the possibility of failure is built in, without this representing a challenge to the advice offered.

In the previous section we examined the caller’s uptake of the Advice Worker’s delineation of the problem and next action. We observed the caller aligning with the Advice Worker’s construction of external help being required for the caller to overcome his professed problems with alcohol. Let
us go on to view the callers' uptake when the Advice Worker places responsibility onto the caller.

**Identifying an actual problem**

In the following two extracts the agenda of Anthony, the Advice Worker, appears to be to identify what the problem is and elicit what the caller wants from the organisation. On close inspection we can see that this seemingly straightforward task becomes problematic as both caller and Advice Worker grapple with issues of responsibility which are enveloped in the talk. This makes the exchange highly complex, so I will attempt to unpack the interaction as it develops.

The extract below comes towards the beginning of the call. Prior to this the caller opened the call by stating that his doctor told him to contact the organisation. However, the caller claims to be unsure as to why his GP has recommended this other than to say that the caller thinks that the doctor thinks he has a drink problem causing the depression with which the caller went to consult his GP. Extract 6.5 is drawn from the point where the Advice Worker moves away from talking about the GP.

### Extract 6.5 - AT 06-03 3_3

<table>
<thead>
<tr>
<th>Advice Wkr</th>
<th>Okay (0.5) so (1.2) what are you looking for your actual self never mind what your doctor thinks: what (0.3) what (0.2) do you think about your drinking do you think you’ve got a problem or do you jus::’</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caller</td>
<td>↑Er (0.2) chhhh (1.5) well I- hhh do spend a lot of money on drink yeah it’s a yeah I think I y(h)eah got a pr(h)oblem wi’(h)ih drink yeah</td>
</tr>
<tr>
<td>Advice Wkr</td>
<td>Right and do you actually want help with that o::r (1.3)</td>
</tr>
<tr>
<td>Caller</td>
<td>Well yeah if I can get it yeah I s’pose so yeah I dunn↑o (. ) really (0.3) I mean what can you d↑o really</td>
</tr>
<tr>
<td>Advice Wkr</td>
<td>Right=</td>
</tr>
</tbody>
</table>
Of analytic interest in extract 6.5 are the two questions in lines 59 & 65. Although only one option is proposed, *do you think you've got a problem* and *do you want help*, the Advice Worker orients to other options. Rather than asking as a simple direct question, but instead saying *or*, the Advice Worker formulates both questions as scenarios where alternative interpretations are possible; so the caller may not think he has a problem, or, once established (lines 61-3) he may not want help with it. The question *do you think you've got a problem* asks for an admission from the caller. This imports with it all sorts of issues such as what sorts of behaviour and person this implies, moral issues and so on. We could speculate on these concerns and couple that with the caller's response of spending money rather than simply drinking too much. I will set aside such issues for now in order that we can focus on notions of responsibility for identifying a problem and offering and receiving help. By not offering an alternative to the suggestion offered in lines 59 and 65, but instead simply orienting to the possibility of alternatives, the Advice Worker leaves it open for the caller to make his own suggestion. Thus, responsibility is placed directly onto the caller; this is not for the caller to pick between offers made by the Advice Worker, but to decide for himself. The extended last word of the utterances (*jus:*: '*' and *o:*: *) create a trailing off of the turn of talk, indicating an appropriate place for the caller to respond to the question (Hutchby & Wooffitt, 1998). The caller gives the Advice Worker the opportunity to finish the question, indicated by the pauses at lines 60 and 66. Despite this, the Advice Worker does not continue, the possible implication being that perhaps this is really the only option; the caller does have a problem and he should be wanting help. As these potential conclusions are not voiced by the Advice Worker, onus is directed towards the caller to fill the pauses.

In response to this the caller makes a display of 'thinking', 'working through the idea' and arriving at an assessment, so, the caller produces this as something that he has not previously made a judgement about or a decision on. This is made hearable because the trouble at the beginning of the caller's response (*†Er (0.2) chhhh (1.5) line 60*) frames this as something for
which the caller does not have ready answer. well I- hhh do spend a lot of money on drink (lines 60-61) vocalises the things that the caller is considering before arriving at an assessment.

The addition of think in the repair from it's a (problem?) to I think I ...got a problem (line 62) changes the utterance from a statement to a less preconsidered assessment. The caller does not claim knowledge that he has a problem, just an uncertain 'thinks' he has. Hence, this is proposed as something yet to be established or confirmed. The addition of 'yeah' (line 63) directly ties this in with the question just asked by the Advice Worker and begins to affirm the caller's experience as a pr(h)oblem wi(h)h drink. This is worked up as not something that the caller had already thought, but a revelation or awareness brought about by the prompt from the Advice Worker. The interpolated laughter also encourages listeners to hear this as a surprise or revelation. Let us just pause to consider what this 'buys' for the caller. Possibly 'ignorance', as this then would allow him to suggest that he needs to be led by the Advice Worker rather than come up with his own solution because this is all new to him.

The caller declaring that he thinks he has a problem is treated as insufficient by the Advice Worker for an offer of help as he proceeds to ask if the caller wants help. After the caller's identification of a problem the Advice Worker responds with right (line 64) which indicates a moving on with business; in essence, "we have established that, now the next thing". As an offer of help is not contingent on simply 'having a problem', responsibility is placed on the caller to decide if he wants to do something about it. This is reinforced with the use of 'actual' (your actual self line 55) and 'actually' (do you actually want help line 64), which orient to issues of agency. Your actual self implies 'self' initiated as opposed to 'other' initiated, in contrast with the doctor. Actually want help builds in agency, so the Advice Worker conveys that, rather than a vague half-hearted 'wanting' on a superficial level, what is required is a committed 'actually wanting'.

Let us examine how the caller manages his response. After a long pause, the caller starts with well. The request for help is then qualified with if I can get it (line 67), followed by more hedging (s'pose so yeah I dunno). All of this
makes the caller's reply look like a dispreferred response. This may be because the Advice Worker's previous turn does not look like an invitation or offer of help, so the caller is in a position of asking for help rather than accepting it. If I can get it works to elicit an invitation from the Advice Worker so that the caller can accept the offer of help rather than ask for it. Here we witness the caller casting responsibility for deciding the next course of action back to the Advice worker. This is made more explicit with the caller's question in line 69 (what can you do to really)

Just as a point of interest, the conversation is made more confused and the caller's earlier display of 'thinking' about whether he has a problem is made even more analytically interesting with the caller's announcement in lines 71-3 that he has previously attended Alcoholics Anonymous meetings!

In the extract and analysis above we observed how responsibility for identifying a problem and suggesting an appropriate course of action was passed back and forth between caller and Advice Worker. Whilst the Advice Worker encouraged the caller to make choices and decisions about the situation and what he wants to do, the caller hedged his decisions, made a display of not previously having the relevant knowledge to inform such a decision and put the onus onto the Advice Worker to extend an offer of help and to take responsibility for formulating a potential solution. Despite the caller having enunciated both that he thinks he has a problem with alcohol and that he wants help with it, the interactional problems continue, this time with issues of entitlement to help and access to service. Again we witness notions of responsibility embedded in the talk and being batted back and forth between the two interactants.

**Asking, offering and taking the piss**

In line 69 of extract 6.5 above the caller asks what can you do to really. The intonation on 'do', followed by really, makes this question ambiguous and potentially hearable as either 'what can one do' or 'what can be done'. The Advice Worker responds with right which again indicates that something has been established (that is, that the caller wants help) and the talk is moving on. After a discussion about the caller's previous unsuccessful involvement with Alcoholics Anonymous, the Advice Worker goes on to say
what we do here at [organisation] is... So, the Advice Worker treats what can you do as a request for information on what the organisation can offer.

The following extract comes from the same call, soon after the previous extract. In the intervening talk the caller has stated that he is wastin' a lorra money on beer. He asked if he will have to pay for the services and explained that as he is on sick at the minute his money is as good as gone already. Extract 6.6 below begins with the caller making the point that he had...

**Extract 6.6 – AT 06-03_3_3**

169 Caller [sixty five pound ] this mornin'
170 and e:r I think I've got about a tenner
171 left
172 Advice Wkr Ri:ght
173 Caller So it don't go far I mean I- I don’t
174 wanna (0.5) take the piss out of
175 anybody like
176 Advice Wkr Mhm
177 Caller Y1 know sayin' like I need 'elp an I
178 don't or or (. ) or I don’t need 'elp an
179 I do kind of thing
180 Advice Wkr Ri:ght (0.3) well in in which case an
181 if you’re still in a position of trying
182 t' (0.2) y' trying to decide whether y'
183 actually want to come down here or not
184 we- I can [send you]
185 Caller [↑No it's] not a matter of
186 decidin' come down it’s whether I’m
187 (0.8) people think I’m takin' the piss
188 'cause I come down there (0.2) 'cause I
189 can’t afford it

In lines 177-179 the caller appeals to issues of taking inappropriate action and accessing services. He provides an account for his alleged indecision as the problem has yet to be fully established as a valid drink problem as it has not been confirmed by the Advice Worker. This display orients to the

1 Transcript not reproduced here.
caller's claim of not being a position to make a decision about accessing services, as doing the wrong thing would be to take the piss out of [some]body (lines 174-5), hence his attempts to elicit an offer from the Advice Worker. Rather than treating this as something that the organisation is involved in resolving, the Advice Worker again constructs the caller as the decision maker and as someone who is in control (if you're still in a position of trying t' (0.2) y' trying to decide lines 181-2). The Advice Worker makes relevant the caller's agency by formulating the decision as being about him actually wanting (line 183) to take action. So, the Advice Worker assembles this as not being about what the caller thinks he ought to do or what the doctor thinks he should do, and crucially, avoids the potential issue of the Advice Worker being asked to recommend what the caller should do.

This is met with a negative response from the caller (No it's not a matter of decidin' lines 185-6) who returns to his earlier point (it's whether I'm (0.8) people think I'm takin' the piss lines 186-7), turning this into an issue of accessing services to which he may not be entitled as he cannot afford to pay. Again this can be heard as an attempt to elicit an offer from the Advice Worker, thereby validating his access of the service.

Despite its clearly evident complexity, the main content of this call is typical of calls to this alcohol helpline, in that decisions need to be made as to whether the caller's described behaviour constitutes a drink problem, whether help is appropriate and what form that help should take. The complexity and confusion arise from issues embedded in the talk, as we observed the burden of responsibility being worked up, resisted and passed back and forth between caller and Advice Worker.

**The problem of hidden agendas**

Throughout this chapter the analysis has highlighted how issues of responsibility are embedded in discursive sequences of problem formulation and advice giving on an alcohol helpline. We began by asking how Advice Workers responded to callers' claims of a lack of control over their drinking. We discovered that in response, Advice Workers focused on a next course of action; what the caller could or should do next. This may or may not include the Advice Worker's formulation of what the problem is. On closer
inspection we discovered that, embedded in these discursive sequences of problem formulation and advice giving are issues of responsibility which have far reaching implications for both the caller and the Advice Worker. In the early part of the chapter the analysis revealed how the Advice Worker removed agency and responsibility for the caller's drinking and related problems from the caller and placed it onto an external process over which the caller had little or no control. In response the caller emphasised his inability to resolve the problem and his need for external help. In the second section of the chapter we witnessed two Advice Workers place responsibility directly on the caller to take action, make decisions and monitor their progress. This was met with an unenthusiastic uptake where callers reiterated their own impaired ability and deflected responsibility away from themselves and onto the Advice Worker.

In essence then, these issues embedded in the surface business of the alcohol helpline have the potential to cause complications, in which case it may seem sensible for Advice Workers to avoid assignment of agency and responsibility. In the final analytic section of this chapter we will examine calls where Advice Workers describe a pattern of action where involvement and effort are required from both the organisation and the caller. I will contrast this with the previous two styles we have surveyed and demonstrate that callers initially produce an enthusiastic uptake in response to the proposition but then convey confusion and a lack of clarity about exactly what is being proposed.

**Shared or ambiguous responsibility**

We return to Craig, the Advice Worker, and Aaron, the caller, from the previous chapter. In chapter 5 (pages 84-6) the analysis highlighted how the caller constructed separate and competing selves to account for his problematic drinking. Extract 6.7 below picks up the call where we left it in order to examine the Advice Worker's response.

**Extract 6.7 - CG 07-02_1_1**

130 Caller 2 Two weeks later I'll be (1.1)
131 Advice Wkr [Right
132 Caller 2 [exactly where I started
133 (0.7)
134 Advice Wkr Sure well
Caller 2 If I don’t stop for good this time then
(0.2) I’m gonna [lose ] everything
Advice Wkr [*yeah*]
Advice Wkr Well we c- we can we can certainly
help you because [it sounds like]
Caller 2 [I’ve moved out] the
house anyway
Advice Wkr Mm
Caller 2 Just till I get myself sorted I’m gonna
live at my mum’s for a (. ) [however
Advice Wkr [yeah well
Caller long]
Advice Wkr it ]
Caller it takes
Advice Wkr It sounds like you’re well motivated
anyway anyway Aaron to do something
about it (0.6) erm: and we can help
cause er there’s quite a few things we
can do but (0.8) erm: (1.2) what about
if I I put an information pack in the
in the post to you fi:rst
Caller 2 That’s fine
Advice Wkr That’s the first thing and that’ll
that’ll show you all the different
routes we can take there’s several (.)
ways we can approach it but erm (0.3)
at least that’ll tell you all the
services and supports we offer here,
(0.8) then from there you could give us
a ring and actually (0.3) pop in and
see us
Caller 2 Right=
Advice Wkr =On a (0.3) without an appointment just
pop in we’d have a ch- an informal chat
(0.7) and just see where the you know
how bad the problem is
Caller 2 Okay

In the extract above, the Advice Worker's initial receipt of the caller's problem construction and professed impaired control is to offer an optimistic or positive assessment. The Advice Worker works up the concept
of a menu of options, while the assignment of responsibility for the problem and the next course of action is carefully managed and avoided.

**Positive options**

The Advice Worker begins in lines 138-9 with *we can certainly help you*, so the Advice Worker negates the problem being out of control, in contrast with both the caller and his mother's prior assessment\(^2\), and suggests that there is something that can be done. The assertion 'certainly' supports this display of optimism, and works to instil confidence in the caller that they have contacted the right place with their problem. This is potentially at a point of transition from problem construction to an advice-giving phase of the call. However, in line 140, the caller, speaking in overlap, goes on to give the Advice Worker more background information about his current situation.

Let us pick up points of contrast between this and the style of work we have previously witnessed. In addition to stating that *we can certainly help* the Advice Worker imparts that there are *quite a few things that we can do*. This is produced as a firm offer of action, something that will be done, and is in stark contrast with options that could be 'tried' as suggested by the Advice Worker in extract 6.3 and 6.4b (pages 127-131). Similarly, *quite a few things we can do* (lines 152-3) is far removed from *there's quite a few different things you can do yourself* (extract 6.3, lines 121-2) as the caller in extract 6.3 of the previous section was informed. So, Aaron, the caller in extract 6.7 above is not positioned as being the sole actor, unlike the two callers who featured in the previous section.

The Advice Worker in extract 6.7 above goes on to build a picture of a menu of options. He begins by offering to *put an information pack in the in the post to you first* (lines 154-5). By saying he will do something *first* suggests that there are things to follow, that is, after the first comes the second, and so on. This is repeated with *That's the first thing* (line 157). Additionally, the Advice Worker enunciates *there's quite a few things...* (line 152), *all the different routes...* (lines 158-9), *there's several (.) ways...* (lines 159-160) and *all the services and supports* (lines 161-2). *All the* implies there are a number of *different routes or services and supports*, whilst *quite a few and

\(^2\) See previous chapter, extract 5.3, page 84
several say this more explicitly. The array of available resources portray the organisation as proficient and accounts for the Advice Worker’s certainty in being able to help the caller. Let us again pause to compare this with the advice giving we have seen previously. At this point, and in fact throughout the whole call, the caller is not privy to exactly what these things, routes, ways, services and supports are, unlike the earlier caller who was provided with clear suggestions of limiting herself to half a bottle, buying less alcohol and starting to drink later. So, here, although the organisation is depicted as proficient and well resourced, the exact nature of these resources is kept shrouded until the caller receives the information pack in the post.

In his final turn in this extract, the Advice Worker imparts that they will assess how bad the problem is (line 170). Hence, an organisation outside of the caller himself can assess the severity, despite the caller and his mother previously offering an assessment. This again helps to work up the service’s credibility and expertise, whilst cold, clinical formality are minimised as the Advice Worker suggests that the caller should pop in and an assessment will be conducted through an informal chat.

**A vague partnership**

In extract 6.7 the caller’s motivation is brought to the fore as the Advice Worker voices you’re well motivated (line 149) as his observation. This sequence began in line 139 with it sounds like which is offered by the Advice Worker as the reason that the organisation can certainly help. Hence, within the Advice Worker’s formulation, the caller is required to be active, and the service can help because (line 139) of the caller’s motivation. This is contrastive with the earlier you need to take some action an’ that’s... what we’re here for (extract 6.1 lines 126-8), where the caller’s motivation was not called upon.

The Advice Worker then goes on to state that we can help cause er (lines 151-2), so, the organisation can help, not only due to the caller’s motivation, but also because of all the different routes, approaches, services and supports that they have available. Hence, the Advice Worker works up the notion that the organisation has resources that can help the caller, but the caller’s motivation is also required. This portrait of a partnership,
coupled with the haziness surrounding the nature of the action to be taken, avoids assignment of responsibility directly to either speaker.

Between lines 157 and 162 the Advice Worker talks about courses of action. Interestingly, the 'we' in different routes we can take and again in several ways we can approach it is quite ambiguous. This could either be 'we' the organisation, in which case the service sort it out and are the active agent, or 'we' the caller and the organisation together, suggesting a partnership. This highly functional, and therefore potentially deliberate ambiguity again avoids assignment of responsibility to one or other party.

In this section, in response to the caller's claim of impaired control over drinking, the Advice Worker has offered reassurance that this service is the right place for caller to have rung, and that they can help. However, despite stating that there are various options, none have been clearly proposed or outlined. In contrast to the style of the Advice Workers in the previous two sections, assignment of responsibility is ambiguous.

**Implications and uptake**

As we have done in the previous sections, let us now examine the caller's uptake when Advice Workers avoid assignment of responsibility and work up an obscure course of action. This is the style adopted by Phillip, the Advice Worker in extract 6.8 below, who has just invited Sally, the caller, to the offices to talk to someone over a cup of coffee. He has also informed her that there's all sort of things that we can- we can do but not enunciated what these things are.

**Extract 6.8 - PH 06-03_1_3**

425 Advice Wkr er an' what you find is that you know  
426 once you've done the face to face .h it  
427 sort of sets you on a sord- sord of  
428 more p- permanent line to what you're  
429 going t' do  
430 Caller right  
431 Advice Wkr 'ow does that so:und  
432 Caller yeah (.) that's that's certainly .h  
433 (0.2) I- I'm certainly looking for some
kind of support (.) but I'm just not sure what*

Advice Wkr well as- as I say I mean it's it's always difficult over the phone to go [into the full]

Caller [yeah: ]

Advice Wkr things but 'h y' c- y' c- you c- let-

 Caller okay

Advice Wkr sally

Caller brilliant

The Advice Worker then goes on to give directions to the organisation's office.

In lines 428-9 the Advice Worker is very vague about what the course of action is by referring to it as a... line to what you're going to do. The sord
sord of (line 427) and the re-started p- permanent (line 428) display trouble surrounding the course of action and the set or decided nature of what [the caller is] going t' do.

After being asked 'ow does that sound, the caller responds positively, with certainly (lines 432 & 433) suggesting an absence of doubt that this sounds right for her. However, the caller then makes it hearable that she may be uncertain about precisely what has been proposed. The repair from that's certainly to I'm certainly looking demonstrates an orientation to the unclear nature of what is being offered. So, rather than saying “that’s certainly what I'm looking for” the caller states that she is certainly looking for some kind of support, with an equal measure of vagueness in some kind of support.

The caller makes relevant this lack of clarity in lines 434-435 with just not sure what, with no closing intonation on 'what', thereby indicating that more may be said. The Advice Worker attends to the possibility of the caller asking for clarification or details of what is available, in his next turn of talk. Again, as in the previous extract, the Advice Worker does not state exactly what the permanent line or kind of support could be. He accounts for and excuses not going into detail because it is difficult over the phone (line 437).
The concept of a joint effort in the resolution of the caller's problem is displayed by the caller in line 433. So, while *I'm... looking for* works up the caller being active in the process, what she is looking for is external support.

At the end of this extract, the caller's use of the word *brilliant* (line 444) makes a display of a positive uptake of the Advice Worker's suggestion. The combination of the caller's seeming agency and positive uptake contrast with both the caller in the first section, whose response focused on his lack of own ability and his need for help, and the callers in the second section who again focus on their lack of ability and appeal to the Advice Worker to make further offers of help.

Whilst this approach appears to get a more 'positive' response, is the caller clear about what they can expect from the service and what is expected of them? Callers are given mixed messages about responsibility and the like; for example, 'you choose, but we are the experts'. So whilst the Advice Workers may appear to give choices, actually they do not.

**Concluding comments**

The motivation behind this chapter was to discover how Advice Workers responded to callers' claimed loss of control over their drinking. We observed that superficially the talk summarised what the problem was and addressed actions that could be taken to resolve the problem.

On closer inspection, the analysis demonstrated that enveloped in the general business of the helpline were issues of expertise, agency, responsibility and accountability. The analysis highlighted the ways that these concerns were managed, and demonstrated the fluidity and co-constructed nature of attributions such as responsibility and accountability. Rather than being explicit topics of the talk, the analysis highlighted how such issues were embedded in discursive activities such as formulating the problem, giving advice, asking for help, and accepting help.

Let me now place these observations back into the world of treatment characterised by the research outlined in this chapter's introduction. The analysis has highlighted that the way advice is put across to clients is not a transparent and unproblematic process. In the calls to the alcohol helpline
featured in this thesis the analysis has demonstrated that the way the problem is formulated has implications for what sort of next action is appropriate. By the time clients are being assigned to treatment options this process has been completed but no account has been taken of the implications and possible consequences of that process. Close attention needs to be paid to issues embedded in seemingly straightforward activities.

Where responsibility was placed elsewhere both for the problem and for its resolution the caller or client is positioned as a passive entity. In response we witnessed that caller focusing on his needs, an inability to act alone and his lack of agency. This has implications for a person entering treatment where something more than passivity is required. Where responsibility was placed directly onto the caller we observed an impaired control construct being employed and again a focus on what the caller cannot do. Early research by Richard Eiser and colleagues (Eiser & Gossop, 1979; Eiser & van der Pligt, 1986; Eiser, van der Pligt, Raw & Sutton, 1985) which focused on smoking suggested that people who employ an 'addiction' metaphor, constructing themselves as passive entities and their inability to control their behaviour were less likely to succeed in smoking cessation programmes. The analysis presented in this chapter highlights the importance of analysing the notions that are imported with problem formulations and advice when practitioners work with clients.

Such notions of personal responsibility may not simply be inadvertently imported. The Models of Care for Alcohol Misusers guidelines (Department of Health, 2006) recommend that in "simple brief interventions" (p54) for "hazardous and harmful drinkers" (p53) "simple advice may include:... emphasis on the individual's personal responsibility for change" (p54). Based on the analysis presented in this chapter a recommendation is that practitioners following such guidelines need to proceed with caution as emphasis on personal responsibility can result in clients actively resisting and deflecting such responsibility and rejecting any subsequent advice.

As a final thought, reflecting on the chapter overall and the implications for clinical practice of the analyses I have presented, I would like to raise a potentially serious concern. When people contact an organisation for help with an alcohol problem, some people will go on to access further services,
some into full clinical treatment, some people may receive information and have little more agency contact, whilst still others may have no more contact with treatment agencies after the close of the helpline call. Sensibly it would seem reasonable to assume that this would be to do with the severity of the caller’s problem and what is the most appropriate outcome for the individual; but in light of the analysis I have presented to what degree is whether or not a caller accesses further services influenced by whichever Advice Worker just happens to answer the telephone?
Chapter 7

Who knows what a drink problem is? The role of ‘knowledge’ on an alcohol helpline.

In the previous two chapters we saw an indication of how knowledge claims were important and relevant to the local interactional business being attended to. However, this was not the focus of those analyses, so here I turn my attention to the role of knowledge, or lack of, in alcohol helpline interaction. By paying attention to the epistemics of interaction (Potter, 1996), ‘who knows what’ as displayed in the turn-by-turn interaction can unlock some interesting features of what is getting done here, and how it is accomplished.

Notions of knowledge, expertise and an ‘expert’ identity have been studied in relation to legal settings (Matoesian, 1999) and the world of medicine. Hibbert et al (2003) analyse the talk of palliative care experts taking part in a focus group discussion with doctors from a range of other specialities. The authors demonstrated that the construction of expertise was achieved through speakers’ claims of speciality knowledge and individual expertise. Gulich (2003) studied medical experts conversing with patients suffering from a chronic heat condition, focusing on the interactional techniques employed by the experts and non-experts which established their relative roles and status. Gulich claimed that experts speaking to non-experts are treated as such not simply because of having specialist knowledge, but because “he (sic) behaves like an expert” (Gulich, 2003:254, emphasis in original). Similarly, the patients present themselves as non-experts and are correspondingly treated as such by the doctors. The author concluded that through the use of the interactional techniques identified, such identities are constituted in and by interaction.

At the outset of this thesis I argued that an ‘addiction’ discourse permeated everyday talk; generally speaking people have common versions of what addicts and alcoholics are. Despite this, the analysis presented below shows how participants construct and orient to asymmetries in knowledge, such that the Advice Worker is knowledgeable, or the ‘expert’, when it comes to defining a
drink problem. In common with the work of Hibbert et al (2003) and Gulich (2003), we will see how this is interactionally accomplished and managed rather than just 'a given'. However, the analysis I present also highlights how the Advice Workers deal with a corresponding asymmetry in knowledge as the callers demonstrate their expertise in details of their life and their problem. Descriptions of specifics of their experiences are used by callers to question and challenge the Advice Workers' formulations or advice. Based on such observations I argue that not only are the relative statuses of expert and non-expert constructed in and by interaction, but the relative specialism of the topic, in this case problem drinking, is also interactionally accomplished and constructed. Attention to such asymmetry as a turn-by-turn accomplishment can be mapped throughout the helpline calls, and is achieved throughout this chapter by an analysis of extracts of data where knowledge or a lack of knowledge is claimed either by the caller or by the Advice Worker.

In the first section of this chapter, we begin by looking at how the concept of knowledge is used, and contrasts with other activities that index a speaker's inner 'psychological' life, such as feeling, wanting, needing and thinking. We then move on to explore caller's use of a lack of knowledge, and how that can account for needing help and for making a call to an alcohol helpline. This is followed by a section which tracks how Advice Workers claim knowledge about alcohol use and drink problems, and display skills in identifying such problems, and I suggest possible functions of this action. However, the analysis will show that such knowledge is only effective when the caller indexes an agreement with the Advice Worker's assessment, thereby demonstrating that the Advice Worker's status is co-constructed between the two speakers. In the final section we address the issue of the caller's expertise and the implications for the alcohol helpline interaction.

**On knowing, not knowing and feeling daft**

In the introductory chapters I have stated that this thesis takes discursive psychology as its main theoretical influence. As explained in chapter 4, the basic premise of discursive psychology is that psychological concepts should be treated as discursively constructed objects rather than as mentalistic or cognitive notions existing outside of discourse (Edwards, 1997; Potter & Edwards, 2003; te Molder & Potter, 2005). This respecification of
cognitivist psychology extends from ‘cognitive apparatus’ such as mind, conscience and the like, as seen in chapter 5 (page 90), to ‘cognitive activities’ such as thinking and knowing. The analysis that follows demonstrates a discursive psychological treatment of specific instances of callers’ claims of knowledge or a lack of knowledge and I turn my analytic attention towards examining what function this can serve for a caller to an alcohol helpline.

The first extract comes from the end of a sequence of information gathering and problem formulation. The caller has explained his situation to the Advice Worker and, as yet, the Advice Worker has not suggested a next course of action.

```
Extract 7.1 - CL 07-03_1_4
154 Advice Wkr yeah and 'ave 'ave can you can you cut 
155 down 
156 (1.3) 
157 Caller I don't know (0.2) I wan' 'o (0.3) I need 
158 to 
159 Advice Wkr yeah 
160 (1.1) 
161 Advice Wkr but can you do this 
162 Caller I do- I don't feel as if I can but I know 
163 I need to that's my problem 
164 (0.7) 
165 Caller er in a way I I'm (0.8) I- it's I can 
166 think logically but I just can't actually 
167 do what I know I need to do 
168 Advice Wkr right
```

The Advice Worker begins by asking the caller if he can cut down on the amount of alcohol he is drinking. However, let us look at how this is said. The Advice Worker appears to have trouble formulating this question; the repetition and self repairs suggest that this is problematic, marking this as a potentially delicate topic (Silverman & Perakyla, 1990). As this is posed as a direct question can you cut down (lines 154-5), this makes relevant an answer from the caller. What follows is a long pause indicating trouble with the uptake of the question. The caller verbalises that trouble by saying I don't know (line157). This could question his readiness to undertake action to curb his
drinking, by simply not knowing if he can challenges his commitment, so, this is followed up with I wan’ ‘o. Again, ‘wanting’ does not display a commitment and so this caller may not appear a worthwhile candidate for the time and attention of the organisation. The wanting is upgraded to I need to and this attempt at a more committed assertion is responded to by the Advice Worker (yeah line 159). However, the Advice Worker reissues the question of whether the caller can cut down (can you do this line 161).

In response to the question the caller says I do- I don’t feel as if I can (line 162). This is a very interesting change from not knowing if he can cut down (line 157) to not feeling as if he can. The range of psychological concepts enable the speaker to perform various actions. Feeling allows for uncertainty and the possibility of being wrong, and diminishes the accountability of ‘knowing’; as such, feeling that he cannot cut down accounts for him not yet having done it, but does not write him off as someone who will not be able to. However, ‘feeling’ is a weaker assertion than knowing, hence there is an opportunity for the Advice Worker to simply suggest that he should try. The Advice Worker makes no response to the caller’s statement (lines 162-3) so the caller upgrades his assertion with I just can’t actually do what I know I need to do (lines 166-7). The addition of just makes this straightforward and simple; despite knowing otherwise the caller simply cannot do it and therefore needs help. By knowing what he needs, that is, to cut down (lines 162-3 and 167), the caller attends to the identity and morality of being the kind of person who knows what is right and wrong, but is otherwise controlled. The repetitions and self-repair in line 165 (I I’m (0.8) I- it’s) indicate trouble with formulating this idea of knowing one thing but doing something else, which we observed in chapters 5 and 6. The caller then states I can think logically (lines 165-6), hence portraying himself as not being unintelligent or stupid; so here is a logical, rational person who simply lacks ability rather than sense.

So, in the above extract we can see the utility of being able to produce an ‘inner life’ which has competing features such as knowing, feeling, wanting and needing. The subtle differences between these constructions can perform important interactional tasks.

While the prior extract indicated the usefulness of knowing, despite an inability
to act on that knowledge, the following extracts examine what sort of work claiming a lack of knowledge can achieve in the calls. Extract 7.2 is taken from the very beginning of the recording.

**Extract 7.2** - ML 06-03_1_3

1. Advice Wkr APAS you’re through to Melanie
2. Caller Oh hello erm (0.3) I don’t w- hh >I feel< a bit daft ringing my doctor’s given me your number?
3. Advice Wkr Okay erm just - sorry to interrupt you

**Permission script**

4. Advice Wkr Okay great (0.6) sorry carry on
5. (0.7)
6. Caller Erm my doctor’s given me your number
7. [erm:]
8. Advice Wkr [Okay]
9. Caller ‘cause (0.5) well I think I’ve got a problem with drinking so they give me your number
10. Advice Wkr O:kay

One task for the caller at the start of a call is to provide a warrant for calling. In this extract, the caller orients to this by indexing the possibility of making an unnecessary call, announcing >I feel< a bit daft. She then provides a motivation or justification for ringing by stating that her doctor gave her the organisation’s telephone number. This immediately sets up a contrast; the caller ‘feels daft’ ringing, perhaps feeling that it is inappropriate, but the doctor presumably considers this an appropriate action as s/he has given her the number.

After the interruption of the permission script, the caller explains I think I’ve got a problem with drinking (lines 20-1). The emphasis here is on I, indexing this as her own assessment and perhaps contrastive with the doctor’s. The providing of the telephone number was not portrayed as being based on the doctor’s evaluation, as the caller states that her own judgement prompted the providing of the number. The caller treats her own assessment as insufficient because, despite her thinking she has a problem, she still feel[s] a bit daft ringing the organisation.
So, in extract 7.2, the caller treats her own assessment as insufficient, therefore providing a warrant for seeking an 'expert' opinion. Hence, the identification of a drink problem does not appear to be something just anyone can do. We therefore see the production of, and orientation to knowledge (about one's problem) as something crucial at the start of the call. This orientation to knowledge at the start of the call is a similar finding to Potter and Hepburn (2003), who found that callers use, and downplay, their concerns at the start of their child protection helpline calls. For example, constructions such as 'I'm a bit concerned' or 'I've got a couple of worries' are common at the start of the call, even when callers are reporting the most serious of problems.

At the beginning of the following call, the caller displayed uncertainty as to whether she has a drink problem. Prior to this extract the caller has begun to describe her difficulty in deciding if her drinking constitutes a drink problem. In the following extract she describes the moves she has made to clarify this issue and explains why she is still unsure about the status of her problem.

**Extract 7.3 - ML 06-03_2_3**

<table>
<thead>
<tr>
<th>Caller</th>
<th>I’ve tried talking to er to er to other people about it an’ an’ I kind of kn- know- &gt;not&lt; professional people</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice Wkr</td>
<td>obviously but (0.3) erm well I did mention it to my GP (0.2) but (0.3) her attitude was well you don’t smell of alcohol</td>
</tr>
<tr>
<td>Caller</td>
<td>[I mean ] obviously [that was]</td>
</tr>
<tr>
<td>Caller</td>
<td>in the morning but I don’t drink in the morning</td>
</tr>
<tr>
<td>Advice Wkr</td>
<td>well no I mean you don’t you don’t need to have an alcohol problem you know it- (0.4) that’s (0.4) a sort of misconception really that [people]</td>
</tr>
<tr>
<td>Caller</td>
<td>[mm ]</td>
</tr>
<tr>
<td>Advice Wkr</td>
<td>are drinking all day every day kind of thing [erm ]</td>
</tr>
<tr>
<td>Caller</td>
<td>[yeah] I mean I’ve I’ve spoken to other people and I’ve sort of had (0.9) er the- the- the reactions have have ranged</td>
</tr>
</tbody>
</table>
from I mean I've only spoken to a couple of people I didn't go round and talk to everybody: (. ) who well I spoke to two people (0.5) er an' one person (0.6) yeah you don't have a problem (. ) and the other person yeah you have a very s(h)er(h)ious problem

Advice Wkr right
Caller an it it's a bit h(h)ard t(h)o
Advice Wkr okay
Caller you know gauge
Advice Wkr but I mean obviously if if you feel that it's causing problems to you then .hh then that's more (0.3) erm (1.1)
Advice Wkr you know then=
Caller =yeah=
Advice Wkr =it is something you feel y- [that]
Caller [yeah]
Advice Wkr you need to deal with an' so on I mean what I can do is send you out an information pack which kind of gives you more details about alcohol and sort of talks about the recommended drinking limits
Caller yeah=
Advice Wkr =and er the effects it has on y- (0.4) on yourself an' so [on ]
Caller [I me]an I kn- I know the effects it has on me 'cause I mean I (0.8)
that's why I phoned up today

In order to ascertain whether she has a problem, the caller states that she has tried talking to people about it. She then goes on to say I kind of kn- know (lines 63-4). This beginning of a claim to a particular knowledge, is prefaced with I kind of, so still minimising the certainty with which she has this knowledge. This announcement is halted by an explanation that the other people she has spoken to are not professional people, which would account for her only 'kind of' knowing as this has not been professionally verified. The caller follows this with obviously, so we are to take it that it is obvious that she
has not spoken to a professional person about her drinking, because if she had then she could be more sure of her knowledge, and possibly would not even be making this call as she would have either received the advice that she needs or would not need to be accessing such a service. She then states I did mention it to my GP (lines 66-7). Rather than this suggesting that she does not view her GP as a professional, since she has stated that she has not talked to a professional about her drinking, instead this is just a 'mentioning' rather than a 'talking'. This contrast in the types of conversations accounts for her prevailing lack of certainty about the status of her problem.

The caller then explains why talking to other people has not helped to clarify the issue. Interestingly, whilst one person is reported to have simply said that the caller does not have a problem, the other is reported as stating that she has, with the severity emphasised in the utterance very s(h)er(h)ious (line 88). The potential seriousness of the problem is an added reason why the caller should be approaching a service which could help her to determine whether she has a problem and, if she has, what she can do about it.

So, at this point, the caller has oriented to the Advice Worker's specialist knowledge and has requested a 'diagnosis' as to whether she has a problem with alcohol. Rather than giving a verdict, the Advice Worker states if you feel that it's causing problems (lines 94-5) and is something that the caller feels that she needs to deal with, thereby circumventing the need for such a diagnosis. Here the use of feel does away with the necessity of knowing; if the caller feels that it is a problem, it no longer matters whether it actually is or not in any sort of 'objective' way.

Following the offer of an information pack the caller states I know the effects it has on me (lines 111-2), thereby indicating that the caller's uncertainty is not due to a lack of knowledge about implications or effects. Indeed, she enunciates 'cause I mean I (0.8) that's why I phoned up today (lines 112-3) indexing the effects of her drinking as the motivation for the call. Clearly knowing whether her drinking is having an effect on her is not at issue, but whether the caller has a drink problem appears to be the issue that the caller has sought 'professional' help to determine.
**Advice Workers' claims of knowledge and expertise**

In the previous section we have seen how the flexibility of knowledge accounts for people making a call to the alcohol helpline and orients to the Advice Worker being the 'expert' who can make such a diagnosis. In the pages that follow I will present three extracts and analyses. In each we can see the Advice Worker claiming a certain type of knowledge or expertise. For the helpline staff this may be a useful strategy for making their advice more persuasive as they appear to have a level of knowledge and expertise in their field. However, in the following analyses, the Advice Workers only appear to be able to do this when the caller indicates an agreement with the Advice Worker's assessment, hence, as I have argued previously, rather than expertise being simply a property of the Advice Worker it is a joint interactional accomplishment. We begin by looking at a call where there is evidence of agreement between the two interlocutors, we will move on to see what happens when the level of agreement between the caller and the Advice Worker is unclear, and we end by observing what happens when the caller displays disagreement with the Advice Worker's assessment of the problem.

**From caller's thought to Advice Worker's observation**

Advice Workers can attend to their own expertise by, for example, turning caller's talk into their own observations thereby making themselves appear knowledgeable and skilled. Here we track through this call to see how this unfolds. This extract is taken from the very beginning of the recording.

**Extract 7.4a - PH 08-03_1_8**

1. Advice Wkr through to apas and you're speaking to
   2. Philip how can I help you
3. Caller   er (0.5) I think I've got an alcohol
   4.   problem
   
   Permission script
14. Advice Wkr so as I said you're speaking to Philip
15.   what's what's your name please
16.   Caller  it's mister Steve Filey
17. Advice Wkr Steve Filey is that F I L
18. Caller  E Y
19. Advice Wkr E Y .hh and so s- s- Steve how can I help
20.   you
Caller er well I think I've got a bit of a problem with drink and my wife thinks I've got bi- bit of a problem wi' drink.

Advice Wkr right.

Advice Wkr so er how's how's that affecting things at the moment.

Caller in a big way at the minute I think.

Advice Wkr would you like to talk me throught them.

Caller er takin' time off work.

Advice Wkr [yeah]

Caller [er ] lost me dad two years ago: I think I've just took over 'im- in 'is footsteps if you know what I mean.

Advice Wkr yeah.

Advice Wkr and whereabouts do you live at the moment er [Steve]

Steve, the caller in extract 7.4a, opens by saying that he think[s he's] got an alcohol problem (lines 3-4). This is repeated after the permission script, although downgraded slightly to a bit of a problem with wi' drink and is again prefaced with I think (lines 22-3). 'I think' can be heard as uncertainty, and affords the opportunity to be wrong, as contrasted with possible alternatives such as simply 'I've got a problem with drink'. This is reported to be corroborated by his wife who is described as also thinking that the caller has got bi- bit of a problem wi' drink (line 24). Despite this, the caller's talk can be heard as treating his potential alcohol problem as something yet to be established.

After the uptake from the Advice Worker (right line 25), the pause at line 26 allows the caller time to expand or add to what he has said. Despite the
absence of evidence or further information, Phillip, the Advice Worker, appears not to align with the caller's caution and accepts Steve's assessment, by prompting the caller to explain how his (the caller's) drinking is affecting things at the moment (lines 27-8). This indexes the Advice Worker acceptance of the caller's assessment, due to the absence of any sort of 'why do you think you've got a problem'; yet in effect, he still elicits corroborating evidence by asking how it is affecting things, which does not directly question the caller or clearly treat the 'alcohol problem' as yet to be established.

Following the prompts at lines 27-8 and 32, the caller offers only one outcome (takin' time off work, line 34). The continuing intonation at the end of work, makes this hearable as part of a list, therefore other examples may be available. However, rather than continuing, the caller subsequently offers a candidate explanation for his drinking (lines 37-41). He begins by stating that his father died two years ago: and links this to his father's drinking ('e died frough drinkin' lines 38-9). Interestingly, this is a repair from 'e was an al-. This backing off from the use of the category 'alcoholic' may, again, be orienting to the Advice Worker's expertise in being the one in this helpline interaction who can claim such 'technical' categories. The caller accounts for his own drinking by stating that he has 'taken over' his father in 'is footsteps (line 40). Following a token response (yeah line 42) and a pause (line 43) indicating that no further evidence is to be readily offered, the Advice Worker moves on and asks where the caller lives (line 44). Hence, by this point, both the caller and the Advice Worker treat the problem as having been established.

In the intervening talk, the caller tells the Advice Worker that he has conjunctivitis and has an appointment with his doctor later that morning.

Extract 7.4b - PH 08-03_1_8
154 Advice Wkr  er .hh y' see what I can do is I can tell
155 you information packs send you information
156 packs about what you're doin' .hh er an'
157 an' that er but as I say if if you're
158 gonna continue drinkin' in this manner-
159 .hh an' it may be I mean you made
160 reference to the fact that y' d- y' dad
161 died .hh e:r and you know 'e you say that
that could be the reason for your drinkin’
the there may be: a reason behind the
drinkin’ that your doctor may be able to
help you with and offer you some
counselling
Caller yeah
(1.3)

In extract 7.4a the Advice Worker, displayed neutrality in identifying the cause of the drinking. This is repeated in extract 7.4b above, a little further on into the call, with the utterance *you say that that could be the reason for your drinkin’* (lines 161-2). So this is not a suggestion put forward by the Advice Worker, but a reflection of what the caller has proposed. The Advice Worker subsequently works up a tentative colluding with the suggestion in lines 163-164 (there may be: a reason behind the drinkin’), however, this has become much more generalised, with there being a ‘reason’ rather than a specific event to which the drinking can be attributed. Based on this, the Advice Worker suggests a possible solution to the problem, that is, counselling, which is accessed via the GP; so the Advice Worker claims an ability to identify motivation for the drinking and claims the skill of identifying and suggesting a solution.

Further still in the same call, the Advice Worker becomes more committed to, and takes ownership of the suggestion of a reason for the drinking.

*Extract 7.4c - PH 08-03_1_8*

182 Advice Wkr .hh okay- wha- what I’m going to do is I’m
183 I’m no’- I’m gonna hold fire on things at
184 the moment .hh you know if you go along to
185 the doctor:
186 Caller [yeah ]
187 Advice Wkr [an’ t]ell ‘im what you’ve told me:
188 (0.3)
189 Advice Wkr .hh e:r and y’ know if you want to
190 elaborate a little bit more perhaps about
191 y’ y’ father b- it seems to me there’s an
192 un- un- underlying reason for your
193 drinkin’ ‘ere because sometimes y’ can
In line 191 the Advice Worker states it seems to me thereby claiming this as his own observation. Tagged on to this is because (line 193), so the Advice Worker demonstrates that he is accounting for his observation and subsequently provides evidence on which he has based his judgement (lines 193-4). He subsequently proposes another solution to the problem, drugs (line 197), again accessed through the GP.

Two things are interesting here. Firstly, that the Advice Worker appears to accept the caller's assessment of his drinking as being a problem rather than a matter to be unpacked. Secondly, the interesting move from an initiating factor which motivated the drinking being originally suggested by the caller to an underlying reason being proposed by the Advice Worker as his observation. So, while the Advice Worker treats the caller as someone who is able to decide if they have a problem and does not require specialist help for that, he lays claim to the ability to identify an underlying reason and then suggest solutions. Claiming expertise may be a useful strategy for making the advice more persuasive as the Advice Worker has shown himself to be skilled and knowledgeable.

In the above sequence of extracts we observed the Advice Worker proposing an underlying reason for the caller's drinking behaviour, which has certain implications for the way a 'drink problem' can be conceptualised and what can be done about it with reference to treatment options. In chapter 4 (pages 84-85) I explained that the Alcohol Advisory Service from which these helpline calls were recorded did not have a 'position' on drink problems or on particular treatment options. Advice Workers are encouraged to offer a range of services, therefore, for example, neither abstinence based treatments nor controlled drinking programmes should not be prioritised above the other or any other service. Similarly, the organisation does not have a position on what 'causes'
the problem, therefore Advice Workers are not indoctrinated with a particular theoretical view of drink problems. This would appear to be a good stance; however, it leaves open the question of how Advice Workers conceptualise drink problems when working with clients and what the implications are of this.

**Knowledge and supposition**

In the extract below, the Advice Worker is reviewing and checking the story so far before moving on to advice giving. However, he moves beyond the caller's own narrative and makes additional proposals and suppositions. As we work through the interaction, let us note what sort of knowledge of drink problems the Advice Worker is constructing. In extract 7.5, the caller has told the Advice Worker that when she approached her GP about a drink problem four or five years ago, the GP informed Social Services, as the caller had young children. The caller explained that her reason for ringing the helpline was to ask if she can have another home detoxification without going through her GP.

**Extract 7.5 - MT 08-03_1_8**

308 Advice Wkr .h >y' know< credit to: ye fer sort of
309 steppin' forward an:' (0.1) ye know s-
310 (0.4)
311 Caller yeah
312 Advice Wkr s- a- askin' for- (0.1) f- for the help
313 ↑y' know: .hh ↑how
314 [↑how long 'ave] you been drinkin'
315 Caller [ "yeah" ]
316 Advice Wkr at this sort of level then
317 (0.7)
318 Caller e::rm, hh well.ah'd sa:y (0.6) prob'ly a-
319 (0.3) bout the last three weeks really
320 Advice Wkr an' before that you were abstinent,
321 Caller yeah.
322 Advice Wkr .h so it's- so y'- so y' detoxed, you've
323 been abstinent for five years, .hh
324 Caller y[ehah.]
325 Advice Wkr [an'] then you've sort've started (0.3)
326 e::[rm]
327 Caller [ye]ah
Advice Wkr: drinkin' again an' it's sort've crept up

Caller: 'as it. t' th- [t' this]

Advice Wkr: level over the three: wee:ks an'-

Caller: .h[ h h ]h

Advice Wkr: now ah- >ah suppose< you'll be findin'

Caller: mm:. .

Advice Wkr: erm

Advice Wkr: tch .hh ↑so- (.) the- (0.4) the- (0.2) f-

Caller: yeah

Advice Wkr: erm

Advice Wkr: tch

At the beginning of this extract the Advice Worker praises the caller (credit to: ye line 308), and suggests that steppin' forward (line 309) and asking for help are commendable things to do. In a general sense, it may possibly be due to the potential moral implications of having a drink problem that the Advice Worker proposes that it is to someone's credit that they acknowledge that they have a problem and ask for help. However, this may be particularly pertinent to this caller, given the risk of social services being reinformed. Such 'congratulating' can also potentially be seen as orienting to the concept of 'addiction' and the problems associated with stopping drinking, such that this is a difficult thing to do.
The Advice Worker goes on to summarise what the caller has said previously; however, the caller only stated that she was drinking this amount, so the idea of the amount ‘creeping up’ is proposed by the Advice Worker but is worked in with the summary, as if this is what the caller has said and then checked out by the Advice Worker asking ‘as it’ (line 330). The caller responds to this question with an agreement in lines 331 and 334. So, in this sequence, the caller appears to be indicating to the Advice Worker that his supposition that the amount has crept up is correct or otherwise unproblematic.

The Advice Worker subsequently makes assumptions about the caller’s current state (lines 335-7 >ah suppose< you’ll be finding y’ know you’ve got a bit of physical (0.1) dependence. an’ you- y’). Notice the difference between this sequence and the previous one (lines 330-4). When talking about the amount having crept up, the caller responds in overlap with the Advice Worker (line 331) and the yeah in line 334 is a clear indication of agreement. Contrast this with the response to the Advice Worker’s supposition; the caller responds after a pause (line 340) and offers a token agreement (*Mm.:* line 341). We could guess at why this may be a less enthusiastic agreement, maybe the caller does not understand the question, is confused, bored or distracted. Alternatively it could be something to do with what the Advice Worker has said that the caller finds problematic. In line 335 the Advice Worker enunciates that what is to follow is a supposition (ah suppose). The completion of physical (0.1) dependence. is a candidate transition relevance place, made hearable by the closing intonation. However, the Advice Worker continues to talk so the caller does not come in with an assessment. A potential statement (an’ you- y’) is turned into a question, do you get withdrawal symptoms (lines 337-338) making a reply from the caller relevant. The caller does not project the end of the question and respond, and the Advice Worker continues, with repeated words, a cut off and a repair (if y’ if y’ tr- if you don’t). So, this is in clear contrast with the previous sequence where the caller projects the completion of questions and speaks in overlap. Following the pause (line 340) comes the token response from the caller (*Mm.:* line 341). The contour of the response, in addition to the quieter sound, indicates a very weak or problematic agreement (Gardner, 1997). As we have suggested, there may be a number of reasons why the caller does this which may not be related to the preceding talk. However, it is important to remember that the Advice Worker also does
not know what prompted the weak agreement, but has to deal with it. After a pause (line 342), the Advice Worker utters an elongated e::rrm, followed by a longer pause and then the troubled turn of the advice worker (tch .hh ↑so- () the- (0.4) the- (0.2) f- >an' another thin-< an- () >one of the-< () there's a few things lines 345-347). Following this, further trouble in lines 350-353 precedes the advice that follows, which is to do with gradually cutting down the intake and the strength of the alcohol suggesting that the Advice Worker had a problem formulating this advice.

Let us stop to consider the implications of this analysis. As in the previous sequence of extracts and analyses, the Advice Worker has laid claim to a certain type of knowledge; but what is being worked up here is a classic 'disease model' of addiction evidenced by the concepts of difficulty in stopping drinking, increased intake, physical dependence and withdrawal symptoms. It is also evident in the language used, such as abstinence and dependence. So, the Advice Worker has claimed knowledge of what often happens or what can be expected, and made assumptions based on that. Despite this claim of expert knowledge, in contrast to the previous Advice Worker, there is a clear indication of trouble formulating the advice. Another disparity with the previous sequence is that, in extract 7.5 above, the caller appears to be less in consensus with the Advice Worker's assessment, so the level of agreement between the caller and the Advice Worker is unclear. Hence, we can propose that, despite claiming knowledge and expertise, such status needs both interlocutors to co-construct that status before it can be used. With reference to the suggestion that Advice Workers claiming knowledge may be a useful strategy for making the advice more persuasive, we can now ask whether the advice is more persuasive not simply if the Advice Workers demonstrate their skills and expertise, but if the caller indexes an agreement with the knowledge proposed by the Advice Worker?

So far we have observed two scenarios, in both of which the caller has demonstrated his claim to certain knowledge and skills; firstly where the Advice Worker claimed knowledge of possible causes of drink problems and the skill of identifying potential underlying problems, and we witnessed the caller and Advice Worker building a consensus between them. In the second scenario the Advice Worker claimed expert knowledge of a specific account of problem
drinking and the ability to use such knowledge to make suppositions about the caller based on what generally happens. However, the level of agreement between the two speakers was unclear which had implications for the Advice Worker's use of the status and his ability to formulate advice. Let us observe what happens when the Advice Worker claims generalised knowledge of the way people use alcohol, and the caller and Advice Worker do not appear to agree about the assessment of the caller's problem.

**A reassuringly common problem**

The caller in extract 7.6 below has told the Advice Worker that she drinks a full bottle of wine every night and has for approximately six or seven years. Earlier in the call the Advice Worker began to propose strategies that the caller could employ to cut down her alcohol intake. These suggestions were subsequently rejected by the caller, who claimed that she had tried various methods but cannot cut down. In the following extract the Advice Worker claims wider knowledge of why or how people use alcohol and characterises the caller's drinking as scripted (Edwards, 1997) or commonplace.

**Extract 7.6 - DB 11-02_2_1**

303 CALLER I was working full time and then .hh and
304 that was y' kno- in the eve- it was a very
305 s:stressful job and that was t' (0.2)
306 re[la]x:
307 ADVICE WKR [Mm]
308 CALLER (0.6) me after working I'm I'm using it as
309 a crutch I know I am
310 ADVICE WKR Mm
311 CALLER Sort of escape
312 (1.0)
313 ADVICE WKR Ye:[ah]
314 CALLER [es]cape thing
315 ADVICE WKR But p:people do:
316 (0.6)
317 CALLER [Yeah]
318 ADVICE WKR [ Tha]t's what people tend to use alcohol
319 for so * .hhh* [erm ]
320 CALLER [mean if:] (.) th- what I'm
321 really worried about is I what I don't-
322 (.) y' know I mean I (.) can I turn into
In the extract above the caller explicitly offers explanations for her drinking through using alcohol to relax, as a crutch and an escape (lines 305-314), which is met with the Advice Worker aligning with this as an account for a person's drinking. The Advice Worker states that people do; (line 315) and that's what people tend to use alcohol for (lines 318-9) thereby characterising the caller's drinking as 'scripted' (Edwards, 1997), hence, the behaviour fits into a pattern and therefore can be seen as usual or commonplace. By talking about what 'people' do the Advice Worker claims the ability to identify a problem and claims knowledge about drinking and people generally, which may be used to suggest that it is normal to have problems like this. This can be seen as a potential attempt to offer reassurance to the caller in two ways. Firstly it encourages the caller to see herself as engaging in an activity in which others engage in the same way, therefore the caller should not consider herself abnormal or exceptional as it is routine for people to have these sorts of problems. Also, the caller may be expected to take reassurance from the portrayal that the Advice Worker recognises this as an example of a generalised activity or behaviour, thereby demonstrating knowledge of 'people' and 'uses of alcohol'; so the Advice Worker portrays herself as an appropriate person for the caller to talk to as she claims knowledge of such things.

An interesting analytic point is the so in line 319 which is left 'hanging' followed by a breathy pause and erm. Firstly the so suggests that it is possible to draw conclusions from other's normative behaviour, possibly to admonish the caller for simply doing what 'people do'. However, this is not articulated by the Advice Worker, who allows the caller to draw her own conclusions from the 'what people tend to do' statement.

On closer analysis it would seem that such scripting or generalising has the effect of minimising the seriousness or problematic aspect of the caller's behaviour and has characterised the caller's concern as unwarranted; if the caller is just doing what people do, then why does this person need to stop, or have help to stop? The caller displays an orientation to this with can I turn into
an alcoholic (lines 322-3) and prefaces this with what I'm really worried about (lines 320-1) thereby legitimating her call. So rather than ringing about something that 'people do', hence appearing to be not in need of help and possibly wasting the organisation's time, the caller states her worries as being about the potential outcome of her behaviour, and something that is recognisable as a problem, ie, being an alcoholic. In the above sequence the caller and Advice Worker do not display agreement about the status of the problem, so the Advice Worker's knowledge is challenged as the Advice Worker proposes this as generalised common-place behaviour and the caller indicates that this is potentially an uncommon, problematic 'alcoholism'.

At the outset of this chapter I argued that the Advice Workers' status as a knowledgeable 'expert' was an interactional accomplishment built in situ between the two speakers. The analysis presented in this section demonstrates that such a status relies on speakers co-constructing a consensual version of who is knowledgeable and what they can claim knowledge of. Initially we observed the smooth flow of interaction where caller and Advice Worker participate in symmetrical asymmetry, such that the Advice Worker treats the caller as being the expert in details of his life and providing an appropriate assessment of his drinking as problematic, and the caller reciprocates by treating the Advice Worker as the appropriate person to confirm the assessment and identify a potential underlying reason for the caller's drinking.

The later analysis detailed how this breaks down without an indication of full agreement between the two speakers. The second Advice Worker claimed knowledge of the specific nature of problem drinking and applied knowledge of what can generally be expected for people in this situation directly to the caller. This was not clearly indexed by the caller as apposite knowledge and this was followed by evidence of the Advice Worker's trouble in formulating advice. So, without the caller's co-construction of the Advice Worker as a knowledgeable expert, this status could not then be used by the Advice Worker. The third Advice Worker claimed knowledge of 'people's' drinking behaviour and uses of alcohol. This was responded to by the caller reformulating the problem and emphasising its potential seriousness, thereby challenging the Advice Worker's knowledge and skills in identifying a drink problem.
This may suggest something about the appropriateness of the knowledge claimed by the Advice Worker and the relevance to the individual caller. This then begins to bring in issues of the caller's expert knowledge of their own situation and problem. We have seen how Advice Workers attending to their expertise and claiming knowledge may be a strategy for making the subsequent advice more persuasive, but let us go on to review what happens when callers attend to their own expertise and challenge Advice Workers with their own knowledge claims.

**Expertise versus caller's normative knowledge**

In the final extract (7.7 below) we explore the use of normative knowledge to resist advice. The caller indexes her own knowledge and uses that to challenge the advice offered and cast it as inappropriate. Let us examine how the Advice Worker deals with this challenge.

Earlier in the call the Advice Worker recommended that caller would be advised to see her GP who could run a few checks to see if the caller has caused [her]self any long term injury. This was not taken up by the caller. Immediately prior to this extract the Advice Worker has taken details from the caller in order to send her an information pack and has provided the caller with contact details of alcohol service in her local area.

**Extract 7.7 - SM 11-02_1_2**

<table>
<thead>
<tr>
<th>Line</th>
<th>Role</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>379</td>
<td>Advice Wkr</td>
<td>Okay that’s all I really need to know so</td>
</tr>
<tr>
<td>380</td>
<td>(0.6) do try giving them a call</td>
<td></td>
</tr>
<tr>
<td>381</td>
<td>Caller</td>
<td>Yeah=</td>
</tr>
<tr>
<td>382</td>
<td>Advice Wkr</td>
<td>and I would recommend you seeing your</td>
</tr>
<tr>
<td>383</td>
<td>GP</td>
<td></td>
</tr>
<tr>
<td>384</td>
<td>Caller</td>
<td>Mhm what to see if there’s liver damage or</td>
</tr>
<tr>
<td>385</td>
<td>something</td>
<td></td>
</tr>
<tr>
<td>386</td>
<td>Advice Wkr</td>
<td>Yeah I mean [you know if]</td>
</tr>
<tr>
<td>387</td>
<td>Caller</td>
<td>[Wouldn’t I ] know if I had</td>
</tr>
<tr>
<td>388</td>
<td>that then</td>
<td></td>
</tr>
<tr>
<td>389</td>
<td>Advice Wkr</td>
<td>Sorry</td>
</tr>
<tr>
<td>390</td>
<td>Caller</td>
<td>Would would I not [ ] know (. ) if I was ( . )</td>
</tr>
<tr>
<td>391</td>
<td>ill like that</td>
<td></td>
</tr>
</tbody>
</table>
Advice Wkr: 
Erm (.) it it can be a bit difficult I mean I'm obviously I'm not medically trained-

Caller: No-

Advice Wkr: but erm (.) the GPs normally would take a blood sample and er=

Caller: Right=

Advice Wkr: do er liver function tests=

Caller: Right=

Advice Wkr: that (.) erm: (0.4) but the the er helpful thing about the liver function test is that if you do cause yourself any damage=

Caller: Mm=

Advice Wkr: the liver has the ability to repair itself

Caller: Right

Advice Wkr: Erm but you know you really do need to speak to your [GP about] the medical [Yes okay]

Caller: No no I understand that

Advice Wkr: Erm we're not really qualified to give

Kath the caller lives in a neighbouring county, so the Advice Worker has given her details of an organisation local to her and suggested that she tries giving them a call (line 380). He then returns to his earlier advice about the caller seeing her GP, displaying an orientation to the notion that alcohol can cause medical problems. The caller asks if this would be to see if there's liver damage, thereby delineating this as knowledge that this is a potential complication of long term or high alcohol intake. The caller then questions the relevance or appropriateness of this suggestion in line 387 (wouldn't I know) and again in line 390 (would I not know). Here the caller can be heard attending to a normative entitlement to knowledge about her own health, which questions the Advice Worker's recommendation, since she may reasonably be expected to know if she required medical treatment.

Let us pause to consider this as a number of things appear to be happening here. We can see this as a potentially potent way of resisting the advice
offered; and it is by observing the Advice Workers next turn that this becomes apparent. Let me attempt to unpack this. In response to the caller's question, the Advice Worker buys himself a number of ways out of this situation by stating that it can be a bit difficult (line 392). Potentially he could rebuff the challenge by suggesting that it may be a bit difficult for the caller to detect, as her liver may be damaged but still functioning sufficiently to not be producing noticeable symptoms; hence she would not necessarily know if she was ill like that and the advice to see her GP would still hold. Interestingly he continues his turn with I'm not medically trained (lines 393-4) thereby making the difficulty indexically attributable to him. In an interesting move, he prefaces the announcement that he is not medically trained with obviously (line 393), hence this is something that could be expected. This then treats the caller's question as requesting knowledge which is understandably out of his area of expertise.

The caller's challenge to the Advice Worker by making relevant her expert knowledge about herself and what would or would not be advisable for her changes the expected order of things. What follows is a demonstration of what knowledge the Advice Worker can claim, as he explains how the test is done, and displays knowledge of the liver. He maintains that the test is potentially helpful (line 402), thereby revalidating his recommendation as appropriate because, although he cannot say that the test is necessary, due to his understandable lack of specialist medical knowledge, he can say that it would be helpful, and therefore still relevant.

At the end of this extract the Advice Worker reaffirms that the caller would need to speak to her GP about medical matters, stating that we're not really qualified to give (line 412). By saying we're (line 412) the Advice Worker invokes the institution, that is, the alcohol advisory service, so this is not just him, but the organisation. The Advice Worker's turns from line 409 to line 412 completes this turning of the situation such that it is no longer that he has offered possibly inappropriate advice, but that what the caller is asking for is understandably out of his area of expertise.

As suggested at the outset of this chapter, paying attention to displays of 'who knows what' can unlock interesting features of the interaction, as in the
analysis above which demonstrates the constructed and negotiated nature of expertise and the possibility of using such a status. By indexing her entitlement to knowledge of herself and appropriate actions, the caller resisted the advice offered and challenged the Advice Worker's status as someone who is skilled in identifying problems and able to supply appropriate solutions. In return the Advice Worker delineated the caller's request for information as being outwith the area of knowledge he could reasonably be expected to possess.

**Concluding comments**

Within this chapter I have explored the notion of knowledge. Rather than conceptualising knowledge as information stored in cognitive apparatus I have approached the study from a discursive psychological perspective and explored how notions of knowledge are displayed in interaction and used to perform various interactional tasks.

In the early part of the chapter the analysis brought to light the considerable utility of having available to a speaker a psychological thesaurus of contrasting activities such as thinking, knowing, wanting and needing. There I drew attention to the various functions of such a thesaurus for callers to an alcohol helpline.

The chapter moved on to challenge the taken-for-granted assumption that helpline operatives are the knowledgeable expert or are always assumed to be so or treated as such by the caller. The analysis demonstrated that, despite specific skills and knowledge being claimed by Advice Workers, their status as knowledgeable 'expert' is only made available when callers index an agreement with the Advice Worker. The analysis also identified that whilst Advice Workers may claim knowledge as a strategy for offering reassurance or making their advice more persuasive, callers may equally display a claim to knowledge as a way of challenging Advice Workers or rejecting the advice offered.

In returning to the study by Gulich (2003) outlined in the introduction to this chapter, an element of departure witnessed in the data I surveyed is the observation that the Advice Workers could only make use of the status as 'expert' when callers indexed an agreement with the knowledge claimed by
the Advice Workers. This element appeared to be missing from the interaction between Gulich's expert doctors and non-expert patients. We could speculate that this denotes a difference between the status of specialist knowledge afforded to the medical world and aspects of common knowledge of alcohol problems and addiction. It would seem that not only is expertise constructed in and by interactions, but how 'specialist' is a topic is also an interactional accomplishment.
Chapter 8

A supportive helpline:

Applications of the research project.

Given the range of books available on 'applying' discourse analysis (see, for example, Bloom, Obler, de Santi & Ehrlich, 1994; Richards & Seedhouse, 2004; Willig, 1999), this would seem to be something of an academic concern. Also, when writing a PhD thesis, one hopes that one's efforts will result in something more than just a dusty, hardbound collection of pages sitting on a library shelf. Fortunately for me, I was able to 'give something back' to the organisation who had allowed me access to their helpline and hopefully make a difference, at least in some small way, to people whose lives had been affected by their own or someone else's problems with alcohol; hence my own concern with 'application'. In this chapter I will detail ways in which I was able to apply my research within the alcohol services agency, whilst also demonstrating the 'applied' utility of conducting a close, detailed analysis of calls to an alcohol helpline.

The biggest input I had into the organisation was in training Advice Workers, including both paid staff and volunteers¹. As is often the case in organisations who make use of voluntary workers, there can be a high turnover of staff; social work students reach the end of their placement term, undergraduate students complete their studies and look for paid employment in common with other volunteers who, having once gained practical experience, seek paid employment. As such, there are regular training courses. Of the two week training course, I ran three sessions which focused on the helpline and came under the rubric of 'telephone techniques'. I was able to prepare and conduct such sessions by drawing on four areas; firstly, I used the data I had collected as a resource, as I will make apparent later in this chapter. Secondly, I applied the knowledge I had gained about how talk in interaction works. Thirdly, I drew on applications of my analysis and findings. Finally, learning from each other's skills can be very valuable, so being able to 'eavesdrop' on a range of

¹ For a description of who volunteers at this organisation, please see page 72
calls and Advice Workers enabled me to identify useful and effective words, phrases, ideas and advice.

Let me briefly explain the three training sessions I conducted before we go on to work through the activity provided to trainees in the second of my training sessions. The three sessions I provided, in the order that they were presented, are:

1. The construction of 'cue cards'
2. A case study; focusing on one call
3. Role play

Use of cue-cards
In the first session I encourage trainees to compile 'cue-cards' for different types of calls which can act as 'memory-joggers'. Preparation for this session was greatly enhanced by being able to hear styles of working of a number of different Advice Workers.

Role play
Role play is often initially unpopular with people on training courses, however, trainee Advice Workers find it highly useful once they have completed the session; so, initially unpopular, but worth doing. If trainees are asked to devise their own problem scenario when acting out the role of a client, they very often either make the problem devilishly difficult (as real problems often are, but such issues can be worked up to through training and supervision) or very simple and straightforward. Other weaknesses of allowing trainees to provide the problem include the limitation that there is no way for the trainees to know how someone else may have handled the call. By supplying a scenario based on an actual call, trainees can then be provided with an anonymised transcript of the original call so that they can see how the Advice Worker dealt with the problem at the time. Also, when 'being a client', people generally stay within their own frame of reference. Often it is useful to challenge people's assumptions and confront trainees with situations which may make them consider their own views and any prejudices or biases they may harbour. The issues raised in the sessions I provided were to do with homelessness, child protection and sexuality. For some trainees, this may mean speaking from a different gender or sexuality from their own.
In the remainder of this chapter I will focus on the second of the training sessions I provide. This is the study of one particular call which appears to have some weaknesses and problems. The rationale is that, while evidence of good practice is always useful, we can often learn a great deal from things that do not go so well. Trainees can discover what sorts of things may not go well and how we may know when things are not going well. This provides an opportunity to discuss how the issues may have been handled differently.

Trainees are provided with a copy of a transcript of a call. The transcription is simplified to make it easier for the trainees to read. However, as so much important information is lost by doing this, which is a serious limitation of a weak transcription method, the anonymised recording of the call is played through so that trainees can hear the delivery. Readers will recall a condition of the permission to use the call for training and research was that the speakers' anonymity must be protected. As a sound recording was played, affording more opportunity for the speakers to be recognised, additional procedures needed to be carried out in order to comply with this ethical obligation. The sound recording was altered using digital sound editing software in order to disguise the voices. The speakers' names were 'reversed' so that the word was said backwards, making a nonsense sound. Longer sections of confidential information such as addresses and telephone numbers were silenced. It may also be worth noting that this particular Advice Worker no longer worked at the organisation at the time the recording and transcript were being use for training. The trainees were given no information about the Advice Worker other than the fact that she was no longer involved with the organisation.

As the recording of the call is played, the trainees are encouraged to make notes on how they think things are being said. This can appear highly arbitrary and subjective as each trainee may hear something differently; however, in this case, I do not see this as a problem; once they start working on the telephones, they will make up their mind about how something was said, without the aid of a transcript or a second opinion about what was said, how it was vocalised, and what it might be doing in the talk, so I think it useful

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See appendix A for a copy of the transcript
for trainees to practice that straightaway. And of course, this is what we do in ordinary life; in essence, everyone is a discourse analyst, so the trainees will be used to doing it. The timing of the 90 minute session breaks down as follows;

- 5 minutes – introduction to the session
- 15 minutes – play call
- 20 minutes – read on own
- 10 minutes – discuss with next person
- 30 minutes – group feedback and discussion
- 10 minutes – how could we do it better?

**Implications of the analysis of helpline calls**

While we leave the trainees to read through the transcript, let us contemplate some wider implications of the research project. The analysis of this one call has shown to be very useful for training, but there are further implications that we can draw from this call. At an institutional level what are the implications of a close detailed scrutiny of transcripts for this particular organisation?

Let us consider how the helpline is advertised. In the organisation’s promotional literature ‘Alcoline’ promises to offer help and advice, but what form does, or should, that ‘help’ take? The helpline operatives are not trained counsellors; they are referred to as Advice Workers and as such are trained to give advice. However, are the callers looking for just ‘advice’ or are they looking for a different sort of service? Is it clear quite what the callers are looking for? Is there a mismatch between what the helpline operatives are trained to do and what the callers appear to be wanting from the service? In chapter 6 (extract 6.8, page 147) we witnessed the caller state;

**Caller**

yeah (.) that’s that’s certainly .h (0.2) I- I’m certainly looking for some kind of support (.) but I’m just not sure what*

So, is support what callers are looking for from the alcohol helpline? In the above extract we can see that the caller claims to be unsure about what kind of support she is looking for, so is this the case with other callers?

These are issues that are managed and negotiated between speakers on the helpline, which, when a consensual version of ‘help’ or ‘support’ is constructed, everything runs smoothly. However, what happens when speakers do not
construct a consensual version of what constitutes ‘help’? We have seen evidence of calls which seem to go awry and I have begun to identify some of the issues which may account for the apparent trouble in the talk.

I have posed a number of questions which, in light of the analysis that follows, I will address later in the chapter. In the call that we are about to examine we will see further examples of problematic exchanges. As we work through the analysis I will highlight where and how we can see this trouble. To conclude the chapter I will review what the trainees may have learned from this exercise and I will also discuss implications for the organisation and the helpline that it operates.

**Introducing Deb the Advice Worker and Sue the caller**

Please refer to the uninterrupted transcript in appendix A

*The giving and receiving of a problem*

As is often the case in the calls analysed in this thesis, the first part of the conversation focuses on the amount of alcohol the person is drinking, how often they drink and for how long they have been drinking at this level. As we can see in this call, up to line 93 is about getting the information and identifying a problem with alcohol. The Advice Worker has asked what ‘makes’ the caller think she has a problem. In effect, this places the onus on the caller to account for why she is making this call and ‘prove’ that there is a problem. The caller’s reply of [I] *drink too much* is treated as insufficient by the Advice Worker who then goes on to collect further details of the alcohol use, such as amount and strength of the alcohol, and duration of the ‘problem’. The ‘problem’ continues to be treated as contestable by the Advice Worker who makes offerings of the sorts of symptoms the caller may be suffering. As these offerings are rejected by the caller; she does not *get the shakes*, she has never *blacked out*, the caller changes the topic of talk away from attempting to identify a problem which specifically relates to the amount of alcohol and physical reactions. Hence, whilst we can see the agenda of the Advice Worker is to establish an alcohol problem, the callers concern is to provide a problem with which she can receive help. Identifying a problem and providing a problem ought to be compatible activities or agendas, however, we can see evidence of discord here and we may wonder why this is so. Let us survey the
following extract which comes immediately after the sequence of identifying a problem directly related to amount and effects of alcohol.

**Extract 8.1**

86  (0.9)  
87  ADVICE WKR You can’t say y’ you do actually have  
88  (1.6) there are actually voids in y’  
89  night where you don’t realise what  
90  you’ve done  
91  CALLER Mm  
92  (0.8)  
93  CALLER See (0.3) I’m frightened (0.7) because  
94  erm: (1.2) I’m I’m having a really I’ve  
95  got a child with that’s autistic  
96  ADVICE WKR Mmm  
97  CALLER And (0.4) erm things aren’t going  
98  particularly well for her at the moment  
99  at school  
100  ADVICE WKR Mmm  
101  CALLER And I take antidepressants  
102  ADVICE WKR Mmm  
103  CALLER E:rm although I’ve been working very  
104  hard to reduce the number of  
105  antidepressants that I take  
106  (0.8)  
107  CALLER But I- (1.3) I’m I’m (0.5) I’m starting  
108  to feel suicidal at night time  
109  ADVICE WKR Mmm  
110  CALLER And I’m frightened that I’m gonna do  
111  something because I’ve been drinking  
112  ADVICE WKR Mmm  
113  (2.1)  

In line 93 the caller changes the topic by talking about her fear. This is introduced and followed by the beginning of an explanation of why she is frightened (*because erm:* lines 93-94). However, this is delayed by a little insertion sequence which gives more context to her fear, that is, information about her autistic daughter who is having trouble at school, her attempts to reduce the antidepressants she takes and her suicidal feelings. She returns to why she is frightened at lines 110-1 by saying that she is frightened that she’s
gonna do something and then relates it to the specific helpline she has called by saying because I've been drinking. So, for the caller, identifying whether or not she has a problem with alcohol due to the amount she drinks or the physical outcome of her drinking is not a topic which she pursues, but is changed into something for which she is required to provide less 'proof' or which is less contestable.

This is an important change, so let us pause for a moment to consider the implications of this change. Initially we saw how the agenda of the Advice Worker (identifying a problem) and the agenda of the caller (providing a problem) appear to be compatible discursive activities. The nature of the problem has become an unresolved issue and has implications for both speakers. A problem directly related to alcohol requires the caller to provide sufficient evidence to warrant her behaviour being confirmed by the Advice Worker as a drink problem worthy of the organisation's time and attention. A problem based on symptoms of excessive drinking, for example, fear and suicidal ideation, circumvents this; the caller's drinking then becomes worthy of attention due to the serious nature of the effects or outcome of her drinking. For the Advice Worker, a problem with alcohol which is based on the amount drunk, the strength of the alcohol and the frequency with which it is imbibed may be rectified with straightforward advice. However, reducing fear and dealing with suicidal ideation are less able to be dealt with by advice giving, hence arguably, the caller may be better served with some form of counselling. As previously stated, not only are the staff on this helpline not trained counsellors, they are encouraged simply to give advice and where appropriate offer further services within the organisation. Let us look at how this particular Advice Worker deals with this change.

<table>
<thead>
<tr>
<th>Extract 8.2</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>107  CALLER</td>
<td>But I- (1.3) I'm I'm (0.5) I'm starting</td>
</tr>
<tr>
<td>108  CALLER</td>
<td>to feel suicidal at night time</td>
</tr>
<tr>
<td>109  ADVICE WKR</td>
<td>Mmm</td>
</tr>
<tr>
<td>110  CALLER</td>
<td>And I'm frightened that I'm gonna do</td>
</tr>
<tr>
<td>111  CALLER</td>
<td>something because I've been drinking</td>
</tr>
<tr>
<td>112  ADVICE WKR</td>
<td>Mmm</td>
</tr>
<tr>
<td>113  ADVICE WKR</td>
<td>(2.1)</td>
</tr>
<tr>
<td>114  ADVICE WKR</td>
<td>How old's your daughter</td>
</tr>
</tbody>
</table>
115 CALLER She’s eleven
116 ADVICE WKR Eleven
117
118 ADVICE WKR Are you on your own with her
119 CALLER No
120
121 ADVICE WKR You got a partner
122 CALLER Yes I have me husband
123

The Advice Worker receives the announcement that the caller is feeling suicidal
and frightened with the response token (McCarthy, 2003) Mmm (lines 109 and
112) followed by a long pause in the talk (line 113). In what seems on first
analysis to be a very strange response to such a confession, the Advice Worker
then asks the caller how old her daughter is and whether she is on her own
with her child. Issues of child protection may be uppermost in the Advice
Worker’s mind at this point and so felt that it was important to establish the
safety of the daughter before proceeding further. Again, then we can see how
the differing agendas of the caller and Advice Worker influence the talk.
However, are differing agendas the only issue which appears to be causing the
discord observable in this call? We have seen how the caller has reformulated
the problem into something which is less easily rectified with straightforward
advice, so is it more of a supportive service that the caller is looking for? As
noted earlier, the elicitation of the child’s age came after a long pause, and
again once this information had been provided the silence was broken after 3.4
seconds (line 117) with the Advice Worker asking if the caller is the sole carer.
With such long pauses between questions it may be less easy to see that this is
an immediate concern which the Advice Worker wishes to clarify before moving
on. Is this a live concern or is this an attempt to change the subject? We may
speculate on what the Advice Worker may be doing which would account for
these pauses; for example, she may be making notes on the story so far.
However, what is of central relevance is that the caller does not know what the
Advice Worker is doing so these pauses may simply appear as lapses in the
conversation. How is a caller to interpret that? Does this appear as evidence
of disinterest? Let us continue to track through this call to see if we can clarify
these points and to explore how the Advice Worker manages the caller’s
potential request for something other than advice.
Avoidance

The following extracts come shortly after the talk about the caller's daughter and sees the Advice Worker focusing on the practicalities of offering further services to the caller.

**Extract 8.3**

139 (1.1)
140 ADVICE WKR Do you live in Northampton
141 CALLER Yes
142 (1.5)
143 ADVICE WKR E:rm (0.6) do you fancy coming up to
144 s:ee us
145 CALLER Yeah
146 (0.5)
147 ADVICE WKR Yeah
148 CALLER Yeah
149 ADVICE WKR .hh hh wonderful hhh right you know if
150 you a-er- come in as a walk in
151 CALLER Mhm
152 ADVICE WKR (0.9) e:rm you'll get to see erm: (0.9)
153 an advice worker twenty minutes what
154 they'll do is they'll take a bit more
155 history from you (1) e:rm (1.1) erm see
156 if we can: (0.6) like get you booked in
157 for an assessment A S A P
158 CALLER Yeah
159 (0.5)
160 ADVICE WKR and e:rm
161 (0.4)
162 CALLER I don't always feel suicidal
163 ADVICE WKR No
164 (1)
165 CALLER Erm
166 (1.9)
167 CALLER I did last night
168 (0.2)
169 ADVICE WKR Mhm
170 CALLER I did erm (3) on (2) well (0.8) it- it
171 just scares me
The extract above begins with the Advice Worker inviting the caller to visit the organisation's offices in the city. The service the Advice Worker is offering is known as the APAS Direct service whereby people can drop into the offices and will be seen by an Advice Worker straight away. These are generally short consultations where the member of staff takes details of the client's situation and either directs them to other more appropriate services or books an appointment for a more thorough assessment. This service is generally provided by either paid staff, the social work students or more experienced volunteers. This particular Advice Worker does not staff the APAS Direct service despite having been a volunteer at the organisation for over eighteen months. Locally, within the organisation, clients who access the APAS Direct service are known as a 'walk-in' and this is the term that the Advice Worker uses in this extract. She then goes on to explain what the caller can expect if she comes in as a walk in (line 150). Additionally, after some display of thinking (1) erm (1.1) erm (line 155) the Advice Worker offers to get [the caller] booked in for an assessment (lines 156-157) and declares that this should be done as soon as possible, suggesting an urgency to the situation and not something to be dealt with over the telephone. In response to this the caller states that she does not always feel suicidal (line 162) which defuses the urgency of the situation and potentially makes it something which could be discussed within this call.

The offering of further services at this point does not appear to be all the caller was looking for as her suicidal ideation and her fear that she is gonna do something have not been addressed. Despite being offered an assessment appointment, from line 162 the caller returns to these issues, but again the
Advice Worker does not engage in the interaction.

After a very long pause at line 178 the Advice Worker returns to the possibility of the caller coming to the offices which the caller states is not possible for her on that day. This extract contains the first of a series of similar utterances through the call and is an important observation; the caller asks *do y' know what I mean* (line 176), hence the caller is checking out that the essence of her story has been understood by the Advice Worker. We could speculate on why the caller asks this, perhaps because the Advice Worker has not provided the type service that the caller is looking for? If the Advice Worker had not understood the problem this may account for why she is not providing an appropriate response, so the caller's question works to confirm or eliminate this as an explanation.

So, to summarise the above extract, the caller has produced emotion talk, demonstrated that the offering of future services is not sufficient at this point and has checked that the service provider has understood. In reply the Advice Worker has avoided responding by producing minimal uptakes and focusing on practicalities, so we can begin to see evidence that the Advice Worker is unable or unwilling to provide the sort of support that the caller appears to be looking for. Let us observe what happens next.

**Minimal 'little things'**

Extract 8.4 below continues the call where we left it in extract 8.3

*Extract 8.4*

<table>
<thead>
<tr>
<th>Line</th>
<th>Speaker</th>
<th>Utterance</th>
</tr>
</thead>
<tbody>
<tr>
<td>179</td>
<td>ADVICE WKR</td>
<td>Can you get in today</td>
</tr>
<tr>
<td>180</td>
<td>CALLER</td>
<td>(1.1) I can't</td>
</tr>
<tr>
<td>181</td>
<td>ADVICE WKR</td>
<td>You can't</td>
</tr>
<tr>
<td>182</td>
<td></td>
<td>(4.5)</td>
</tr>
<tr>
<td>183</td>
<td>ADVICE WKR</td>
<td>When can you get in do you think</td>
</tr>
<tr>
<td>184</td>
<td>CALLER</td>
<td>(1.9) it'll it'll not be till ne- (0.3)</td>
</tr>
<tr>
<td>185</td>
<td></td>
<td>this sounds terrible dun't it (.) erm</td>
</tr>
<tr>
<td>186</td>
<td></td>
<td>(1.6) I mean (0.3) I feel (0.3) that I</td>
</tr>
<tr>
<td>187</td>
<td></td>
<td>function</td>
</tr>
<tr>
<td>188</td>
<td></td>
<td>(0.5)</td>
</tr>
<tr>
<td>189</td>
<td>ADVICE WKR</td>
<td>Mmm</td>
</tr>
</tbody>
</table>
After a short exchange about the caller visiting the offices, the caller again returns to talk indexing emotions and feelings, with an emphasis on *feel* (line 186) again demarcating this as an issue for discussion now. In the intervening talk the caller provides evidence of her functioning by explaining that she runs a play scheme for children with disabilities. Here is how the call continues.

**Extract 8.5**

201 (0.6) 
202 CALLER Erm I mean I feel like I function
203 ADVICE WKR Mm-
204 CALLER =Relatively (0.6) normally really (1) but I know that I drink too much
205 (0.6) 
206 ADVICE WKR Mhm
207 (0.6) 
208 CALLER And I know (0.2) that (1.3) hh I get (0.2) well I get scared (3.4)
211 CALLER But do you know what I mean (0.7)
213 CALLER th- the rest of the time I feel I function (1.2) alright (0.4) which is probably ridiculous 'cause I probably don't (3.9)
218 ADVICE WKR Erm (0.4) no I think y' know I think you do function (0.3) but erm in in most things but it it actually seems to be erm (0.5) wearing you down?
222 CALLER Mm-
223 ADVICE WKR You sound like you do an awful lot?
224 (0.6) 
225 CALLER Yeah I do (0.6) 
226 ADVICE WKR And er (0.9) yeah it sounds like its really wearing you down
228 CALLER Mm
229 ADVICE WKR Erm (0.6) 'right lets just have a look* (2.9) I: (0.7) I can send you out (0.4) I know you can't get in till next week but I can send you out a pack
233 CALLER Yeah
In the above extract the caller can be seen laying claim to various types of knowledge. As I have argued previously in this thesis, this can be a useful way of heading off inapt advice, so, the caller states that she knows that she drinks too much, respecifying this as no longer a contestable issue and not something with which she needs help to determine. By claiming that she knows that she gets scared, the caller marks this out as the problem to be addressed. However, the opportunity to respond to this issue is passed up by the Advice Worker (line 210) so again the caller asks a clarificatory question; does the Advice Worker know what the caller means? The caller attempts to make her problem specific to her alcohol use by stating that she feels she functions the rest of the time; that is, when she is not drinking, and then proposes the possible ridiculousness of this suggestion. Within this sequence the caller appears to be striving to set the agenda. She has closed off a negotiation of whether her alcohol intake is problematic and deployed the emotion category fear. When this topic is not taken up by the Advice Worker, the caller offers the revised agenda of a contrast between times when she gets scared and times when she functions. When this agenda again does not appear to be readily engaged in, the caller removes any subtlety and makes explicit the contrast by presenting one as ridiculous in light of the other. The caller reassigns her description of her relatively normal and alright functioning as highly questionable and therefore open for discussion.

At this point the Advice Worker responds to the caller’s apparent request for something more than the offer of an appointment. However, the Advice Worker has been provided with no specific training by the organisation on how to provide this service, so the Advice Worker displays a limited repertoire and relies on platitudes such as wearing you down and doing an awful lot (lines 221 & 223). With the questioning intonation, these are offered as candidate suggestions to account for the contrast between the relatively normal functioning and the frightening drinking. The Advice Worker demonstrates that these two suggestions are all that are available in her repertoire as she repeats it’s really wearing you down (line 227). This is prefaced with And er (0.9) yeah so, although the and suggests that something additional is coming, the pause followed by yeah creates the image that after consideration really wearing you down sums up the situation. Once stated, the Advice Worker characteristically avoids further discussion of the caller’s fear and functioning
by returning to practical issues; this time sending *out a pack* (line 232). The *pack* that the Advice Worker is referring to is a pack of information sheets and leaflets produced by the organisation. The telephone call continues as follows.

**Extract 8.6**

<table>
<thead>
<tr>
<th>Line</th>
<th>ADVICE WKR</th>
<th>CALLER</th>
</tr>
</thead>
<tbody>
<tr>
<td>234</td>
<td>Yeah so you can be getting on with that reading it and everything</td>
<td>Yeah</td>
</tr>
<tr>
<td>235</td>
<td>And you can phone here every day until your appointment if you want to just to talk to somebody [just to]</td>
<td>[Mm ]</td>
</tr>
<tr>
<td>236</td>
<td></td>
<td>mean</td>
</tr>
<tr>
<td>237</td>
<td>get it off your chest do you know what I</td>
<td>Mm-</td>
</tr>
<tr>
<td>238</td>
<td></td>
<td>(0.8)</td>
</tr>
<tr>
<td>239</td>
<td></td>
<td></td>
</tr>
<tr>
<td>240</td>
<td></td>
<td></td>
</tr>
<tr>
<td>241</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Curiously, in extract 8.6 the Advice Worker appears to offer a service more akin to the type to which the caller is orienting; a service which is readily available and will provide a person for the caller to talk to. The inclusion of *just* (lines 238 & 239) is very interesting. It does the work of minimising what is required, so *just * talk*[ing]* to *somebody and just *get*[ting]* it *off your chest are *depicted as simple, basic requests and the Advice Worker portrays a service which is happy to provide some such facility. However, platitudes such as *just to talk to somebody and to get it off your chest also minimise the problem and contrast sharply with the more serious fear and suicidal feelings created by the caller.

Here then, rather than expecting to receiving anything from the Advice Worker, the caller is encouraged to see this as an opportunity for her to talk and get her fears 'off her chest'.

So far we may have speculated that what the caller is looking for is some form of counselling, however, I have argued that this is not what is being requested and have proposed that the caller is looking for something we could describe as 'support'. In the analysis of extract 8.7 below I will attempt to justify my claim. In the intervening talk the Advice Worker has offered to provide the caller with
the telephone number of Families Anonymous; an organisation which is more usually accessed by the families of drinkers rather than the drinker themselves. The Advice Worker asked about the caller’s support with her daughter. The caller has explained that despite having that support and indeed running a support group, she suffered from depression. We pick up the call from that point.

Extract 8.7

268 CALLER And I started to have counselling which I still have
269
270 ADVICE WKR Oh right
271 CALLER And (0.3) but I never ever speak about the fact that I drink (0.9)
272
273 ADVICE WKR Right
274
275 CALLER It’s like that’s a different bit of me (3)
276
277 CALLER Am I making sense or am I (2.8)
278
279 CALLER [No no ] you’re making sense erm [No no ] you’re making sense erm (1.1) maybe that’s maybe you’re just not ready to talk about that just yet (0.6)
280
281 CALLER Well:=
282
283 ADVICE WKR =Had you thought of that
284
285 CALLER (0.7) Yeah
286
287 ADVICE WKR ‘Cause there’s it sounds like you’ve got a hundred and one other things that you’re dealing with a[s(10,13),(993,980)]
288
289 CALLER Mm [Mm ]
290
291
292 ADVICE WKR Erm (1.9) and you know also the fact that you don’t (. ) discuss the fact (0.4) that you drink
293
294 CALLER Mm-
295
296 ADVICE WKR Might be because you don’t want him to know you don’t want to admit it (0.5)
297
298 CALLER maybe because that’s ‘cause it’s your little thing do you know what I mean
This extract begins with the caller's announcement that she currently receives counselling but that she has not spoken to her counsellor about her drinking. The Advice Worker demonstrates that she has received the news (oh right line 270; right line 274) but makes no further comment on it. As an account for why she has not spoken to her counsellor about her drinking, the caller states that it's like that's a different bit of me (line 276), echoing the separate selves we were introduced to in chapter 5. What can we make of this, as this would suggest that the caller is not asking for counselling here as she already receives it elsewhere? What does this ‘bit’ of her require? As the Advice Worker again makes no response at all, the caller questions the sense she is making (line 278-9) which works as an indirect request for reassurance or support from the Advice Worker. In response, the Advice Worker reassures her that she is making sense and works up a reason for why the caller has not spoken to her counsellor about her drinking. Whilst this is initially proposed as a suggestion (maybe you're just not ready to talk about that just yet line 281-2) the Advice Workers continuation of had you thought of that (line 285) reformulates this as the reason.

Potentially undoing any reassurance that the caller might have taken, the Advice Worker goes on to offer a further account for the caller not being ready to talk about which might be because she does not want to admit it (line 297). Here admit could be seen as synonymous with 'confess' and portrays the drinking as something shameful or a guilty secret. This image is echoed in it's your little thing (lines 298-9); a secret 'something' specific to the caller.

Further danger bedevils the expression your little thing in that it minimises the activity; if it is merely a little thing can it really be such a big problem? This may allow the caller to justify and continue her drinking as it is just a small idiosyncrasy; her little thing.

Let us address how the caller responds to this.

Extract 8.8

<table>
<thead>
<tr>
<th>Line</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>296</td>
<td>ADVICE WKR Might be because you don’t want him to</td>
</tr>
<tr>
<td>297</td>
<td>know you don’t want to admit it (0.5)</td>
</tr>
<tr>
<td>298</td>
<td>maybe because that’s ‘cause it’s your</td>
</tr>
<tr>
<td>299</td>
<td>little thing do you know what I mean</td>
</tr>
</tbody>
</table>
300  CALLER  Mm I said- I told my husband last night
301  CALLER  I was going to ring you today
302  ADVICE WKR  Yeah (0.5) what did he say
303  CALLER  Fine
304  ADVICE WKR  Is he supporting you
305  CALLER  Yeah
306  ADVICE WKR  Yeah (.) wonderful=
307  CALLER  ='Cause I just said I drink too much
308  ADVICE WKR  Yeah
309  CALLER  I said I think I’ve got a drink problem
310  CALLER  (1.2) and he just said yes (0.5) I think
311  CALLER  you’re right

In response to the Advice Worker's minimisation of the caller's drinking to her 
*little thing* the caller goes on to impart that she has spoken to her husband 
about her drinking and her decision to access help for her drinking. By stating 
that *I said I think I’ve got a drink problem* (line 311) and that her husband 
agreed with her assessment, the caller reasserts this as a more serious issue 
and supports that with corroborating evidence from her husband. In this way 
the caller reformulates this as not just some *little thing;* this is a drink problem.

Let us sum up what has happened so far. The Advice Worker has attempted to 
avoid offering a supportive service at this point, but has proposed that further 
services can be accessed. She has also made moves which minimised the 
problem. In response, the caller has reasserted that the issues about which 
she has called are serious and has indexed a desire to discuss them now 
rather than waiting for an appointment.

**Being practical and feeling barmy**

As the Advice Worker has been trained to advise this may be an activity that 
she is more comfortable with and can claim skills in within the interaction. Let 
us go on to assess how advice-giving works as a strategy for providing a service 
to the caller.
ADVICE WKR: E:rm (1.1) well I don't know what to say about (0.2) I wouldn't stop taking (0.4) your antidepress[ants]

CALLER: [No ] I'm not going to

ADVICE WKR: E:rm (1) and you could try: and (0.6) cut down on the amount (0.3) that you're drinking you know for every (0.8) do you drink them out the can or do you drink it out of a glass

CALLER: A glass

ADVICE WKR: For every glass: of lager you have can you try and have (.) a drink of water as well (0.9) 'cause it's actually because y' it's dehydration that gives you a hangover

CALLER: Yeah

ADVICE WKR: So what I'm thinking is if you have a glass of lager (1) and then have a glass of water straight after the same amount (0.8) it might actually help

CALLER: Mm-

ADVICE WKR: Might also (0.4) help you cut down a little bit as well 'cause you'll be f-filling up with fluid

CALLER: Mm

ADVICE WKR: Erm: (1.6) if you can cut down to like two (1.6)

CALLER: Mm

ADVICE WKR: Erm: and see how you go (0.6) an' (0.4) come here and see us next week at your first per- first possible opportunity

CALLER: Yeah

ADVICE WKR: Erm just say you phoned up and that (0.9) e:rm ↑0:↓r (2.4) I just wondering
if I can (0.4) make you an assessment appointment now

ADVICE WKR "just hold the line I'll go and see if there's anything free"

In the previous extracts the Advice Worker has demonstrated her limited repertoire of counselling type support that she can offer. In the extract above the Advice Worker accounts for another long pause by claiming a lack of knowledge on what to say, and then comments on the antidepressants. She then attempts to provide the type of advice that she may be more comfortable with, that is, directly to do with cutting down on alcohol use. However, unfortunately the Advice Worker shows herself to be limited in her competencies here too. In lines 333 and 340 again the Advice Worker uses a 'try' formulation as we saw in chapter 6 (pages 131-132), which, as we observed, comes with no guarantees. The Advice Worker suggests drinking water in addition to the caller's lager, but imparts that this suggestion is to rectify the caller's hangover. Again, this advice comes with very little confidence as the Advice Worker can only assert that this might actually help (line 348). She then goes on to suggest that this could also help the caller to cut down on the amount of lager that the caller is drinking, although again, the Advice Worker displays doubt surrounding this as it might also (0.4) help you cut down a little bit (line 351-2), thereby mitigating her accountability for the advice she is offering. She then relates this to the caller's physical capacity (lines 352-3) suggesting that bodily limits can be called upon to reduce the caller's alcohol intake. This simple solution can again be seen as a minimising strategy, implying a simple problem, and is met with little uptake from the caller. Towards the end of this extract, the Advice Worker avoids further discussion and returns to passing the caller to another person by suggesting that the caller should visit the offices at her first possible opportunity (line 362), and then offering to make a specific appointment for the caller.

The intervening talk between extracts 8.9 and 8.10 focuses on making an appointment for the caller. Despite the Advice Worker's efforts so far, the caller does not appear to portray herself as feeling any better, as we can see in extract 8.10
Right I’ll get this sorted out get back to you on the telephone

Erm but I’ll start processing (0.3) erm you paperwork and try and get you in a- and get you a pack sent out

Right

Yeah (0.4) so can I just take your address

Yes its ((gives address)) ...

I feel barmy now

W(h)hy hh hh

Because (0.8) you know I’m just like (0.7) you know quite a normal sort of functioning (0.5) person

Mhm

Who does lots and lots of different things (0.9) and then it’s like (0.3) at night time I’m different (0.7) ’cause I drink this beer (1.7)

Erm (1.1) maybe its just your release (0.4) d’y’ know (0.2) because you you b- you do like you said y- you function so well in the dayt[i]me

Yeah (0.9)

And then come the night time it’s your time to relâªax

Yeah (1.1)

An (0.6) maybe that’s what you do (0.8)

Yeah (3.1)

But erm:

It is (. ) I drink (0.2) far too much (0.9)
After the giving and receiving of the address, this is potentially a point at which the call could end; the caller has been invited to drop into the office and the Advice Worker is going to send a pack of information to the caller. The caller however, makes relevant a desire to continue the call with a repeated attempt to elicit some support and she again shows that this call is not going in a way that one would hope by stating I feel barmy now (line 464). An important word there is now; that is, at this point. This is contrastive with previous times when she did not feel barmy, hence, the caller portrays herself as feeling worse now than she did before she rang.

It would appear that the caller can no longer be deflected from the more supportive service which she seems to be requesting and the Advice Worker concedes by again attempting to offer reassurance. Between lines 466 and 473 the caller describes a conundrum; through the day she is a normal sort of functioning person but at night time she is different. Her drinking is offered as an explanation (cause I drink this beer), although this is indexically linked to her being different; so whilst the caller employs the drinking as an explanation for why she is different, the implicit question of why she drinks is left unanswered. The Advice Worker offers a candidate explanation as to why the caller drinks with maybe it's just your release (line 475), with the inclusion of the significant, minimising just. She sets this in a reasonable context that come the night time it's your time to relax (lines 481-2), with the offer of an account that drinking alcohol is the way the caller relaxes. This is a formulation of the 'that's what people do' type which we saw in chapter 7 (extract 7.6, page 173) making this behaviour appear understandable and 'normal'. In common with the caller in chapter 7, the caller here problematises this by saying I drink far too much (line 490), with the utterance respecifying this as an unacceptable or unreasonable behaviour, hence, there is still a problem here to be resolved. The Advice Worker responds to this by saying try not to beat yourself up about it (line 492), another platitude which has the effect of minimising the issue, in keeping with the earlier get[ting] it off your
The talk that follows is the caller restating the extent of the problem and its repetitious nature; so again, minimising platitudes are rejoined by a reassertion of the problem.

**Issuing warnings**

In much of the analysis so far we have witnessed the caller and the Advice Worker struggling to agree on the nature of the problem, with the Advice Worker's repeated attempts to minimise the issues and the caller's corresponding reassertion of a problem. As the minimising strategy does not appear to be well received the Advice Worker begins to concur with the caller that this is a serious concern.

**Extract 8.11**

533  CALLER  It's (0.2) I don't want anybody to know  
534     really that's why I won't go and see me  
535     doctor  
536  ADVICE WKR  Mhm  
537     (2.5)  
538  ADVICE WKR  I'm sure the doctor won't (0.3) I don't  
539     y' d- your doctor won't condemn you  
540     (2.7)  
541  ADVICE WKR  I mean that's really what they are there  
542     for in't it is to help  
543  CALLER  I don't want it on my notes  
544     (1.3)  
545  ADVICE WKR  Right  
546  CALLER  Does that sound stupid  
547  ADVICE WKR  No I don't think it does  
548     (2.9)  
549  ADVICE WKR  Its erm (1.1) well it's entirely up to  
550     you  
551     (2.2)  
552  ADVICE WKR  But  
553     (6.1)  
554  ADVICE WKR  I think if you (1.6) I think the more  
555     that you (3) self loath (0.5) because of  
556     what you are doing  
557  CALLER  Mm=  
558  ADVICE WKR  =The worse it will become  

180
The Advice Worker begins by saying that she does not think that the caller's doctor will condemn her (line 539). This sets up a scenario whereby a person potentially could be condemned, but the Advice Worker describes herself as being sure that the doctor will not do that because that is what they are there for... to help (lines 541-2). In effect then, it is professionalism which prevents judgement rather than this not being a behaviour which attracts judgement. Rather than worrying about condemnation, the caller imparts that she does not want a record of her relationship with alcohol (line 543), although indicates that this may not work well as an account. The Advice Worker appears to do little to reassure the caller that not wanting it 'on her notes' as a reason not to speak to her doctor about her drinking does not sound stupid. The Advice Worker initially produces an acceptance of the account (line 547) but then goes on to highlight an entirely individual element to this decision (lines 549-50) respecifying this as not a decision that everyone might make. The Advice Worker's subsequent utterance (but line 552) indicates that there are consequences to this decision, which she is about to expose.
Following the longest pause so far (6.1 seconds; line 553) the Advice Worker attempts to engage in some deeper, more 'psychological' talk; and in turns fraught with trouble indicated by the many pauses, attempts to formulate a problem. *Self loath* (line 555) sounds like a pseudo-psychological term, which appears out of place here as the caller has not mentioned loathing herself. The Advice Worker issues a warning that increased 'self-loathing' will make the situation worse. This receives a minimal uptake from the caller so the Advice Worker reworks the notion to press home why this will make it worse. The Advice Worker portrays the problem as being a circle (line 563), then delineates how that circle is perpetuated by the drinking leading the caller to hate herself which prompts further drinking and continued self hatred. The Advice Worker ends by focusing on what is at the heart of the circle, which is something that the caller is *not dealing with properly* (line 573-4). This sounds very critical of the caller, who clearly is positioned as someone who should be dealing with things properly instead of drinking and self-loathing as constructed by the Advice Worker.

The Advice Worker offers an account of why this has been happening in line 576. She begins by saying that *the only...* which suggests that this is the case for all; this is *the only way*. However, this is repaired to *your only way out*, making this specific to the caller and opening up the possibility that there are other 'ways out'. After issuing such a dire warning and painting a somewhat desperate picture, the Advice Worker suggests that this terrible outcome is not necessarily the case for the caller and attempts to offer reassurance in the following extract.

**Extract 8.12**

579 **ADVICE WKR** But you know you phoned up here today

580 (3)

581 **ADVICE WKR** 'Cause if you was that bad I'd um sure

582 you could've carried on a bit longer

583 **CALLER** If what sorry

584 **ADVICE WKR** Say if you was that bad (0.5) I'm sh-

585 you know I think you would have carried

586 on a bit longer (0.9) before phoning

587 somebody or maybe you wouldn't have done

588 (0.3) but you've actually reached out
and said you know I’ve got a problem
please help
(2.4)
Mm
So that’s really positive
Yeah
(7.8)
So what I’ll do then Sue is I’ll get
(0.6) I’ll go and chase up some erm
(1.4) advice workers and see if they’ll
put their names in the diary so let me
just write this down so y’ Monday (1.1)
A M
Mm

The Advice Worker lays claim to the skill of identifying alternative options, and points out that the caller has herself opened up another way out by calling the alcohol helpline (line 579). However, the caller makes no response to this and the Advice Worker goes on to construct this as being encouraging (lines 581-2). Unfortunately this is not put across very well, and is very unclear as to what the Advice Worker is trying to convey. This is indicated by the caller’s request for repetition or clarification (line 583) which is met with an equally unclear statement about the fact that the caller has contacted the agency at this point rather than leaving it until later or maybe not at all. After another long pause the minimal uptake from the caller prompts the Advice Worker to make more explicit that this should be seen as really positive (line 593). This appears to fall very flat so as the caller has not indexed the Advice Worker’s success in demonstrating the skill claimed, the Advice Worker returns to the business of getting the caller to visit the office to speak to someone else.

So, in the analysis presented we have seen how the caller made repeated attempts to elicit a form of support from the telephone Advice Worker. In response to that the Advice Worker made moves to formulate certain problems, attempted to offer reassurance by using platitudes and minimising the problem, provided general advice related to alcohol and avoided problematic issues.

What are the implications of this mismatch between the Advice Worker and the
caller? Let us pick up the training session where the trainees have identified and are discussing these observations. In the paragraphs that follow I will outline what the trainees can learn from this exercise and address the implications of the observations we have made. Please join us in our group discussion.

Implications and concluding comments

At a general level, what can trainees learn from having transcripts of calls available to them which they can read through and reflect on? Let me pick out some broad observations from the call we have studied in this chapter.

On a number of occasions the Advice Worker featured in this chapter focused on either practicalities such as making an appointment to see a different Advice Worker or on practical suggestions to cut down on the alcohol intake. Let us consider the implications of the Advice Worker’s focus on making an appointment. Despite spending considerable time discussing optional dates, an appointment could not be made, mainly due to the unavailability of staff. This gives the impression that the organisation is very busy. In addition to the offer of an appointment the caller was invited to ‘walk-in’ to the offices without an appointment. However, as the Advice Worker indicated that staff were unavailable for appointments, how encouraged would the caller feel to simply ‘drop in’? As it may be unlikely that if a client ‘drops in’ staff ‘drop everything’ in order to see them, the caller may not be reassured that this would be a worthwhile pursuit for her.

Staying for the moment on the topic of practical tasks, throughout the call we observed numerous long pauses and within the analysis it became apparent that such pauses had implications and needed to be accounted for. I speculated that the Advice Worker may have been writing notes which may have explained the earlier pauses, however, the caller would have been unaware of this. Through engaging in the training session, trainees should become aware that pauses are accountable discursive events and, as their caller cannot see them, their silence may be interpreted in various ways by the caller.
Two of the main activities that Advice Workers engage in on the alcohol helpline are formulating a problem and giving advice. Let us consider what light a close detailed analysis can shed on these discursive activities.

In the analysis we observed that practicalities and straightforward practical advice were met with a restatement and re-emphasis of not only the drink problem but other related problems such as the caller's fear and suicidal feelings. The problem addressed by the Advice Worker was alcohol focused whereas the problem presented by the caller was a much broader parcel of issues. Problem formulation is a central concern for both callers and Advice Workers on the alcohol helpline. An analysis of how both speakers engage in this activity, and whether other issues and concerns are formulated as part of the overall problem, as a symptom of the caller's drinking or a cause of the drinking may begin to unlock some of the trouble noted in some calls or shed some light on the smooth flow of interaction observed in others.

In the call featured in this chapter we could see the caller display repeated attempts to elicit some sort of supportive service from the Advice Worker. In response, the Advice Worker appeared unwilling or unable to provide the service that the caller seemed to be looking for and used a number of strategies to deflect the caller from such a service. Initially, the Advice Worker focused on the amount and strength of the alcohol consumed and the duration of the drink problem. An alcohol specific problem formulation was met by an apparent request for more than alcohol specific advice and with the caller describing an alternative problem which is not directly alcohol specific.

Avoidance of the issues by focusing on practicalities was met with the caller restating the problem and a request for a more immediate service. Avoidance through no uptake from the Advice Worker was met with the caller checking the Advice Worker's understanding and the caller questioning the sense she was making.

The Advice Worker appeared to make attempts to reassure the caller. However, platitudes received little response from caller, whilst minimising the problem was met with the caller re-emphasising the significance of the problem. These strategies projected the image that the caller was not being taken seriously and
in response the caller oriented to the fact that the solution to this problem is not simple.

Advice-giving is a fundamental feature of this alcohol helpline. What the analysis has identified is that what is important is not just what advice is given, but how something is packaged as advice. The analysis of this call also brings to attention areas overlooked in research. Let me outline some of concerns that have received analytic attention before addressing the insights that this analysis offers.

As explained in chapter 6 (pages 99-100) addiction treatment practitioners are concerned with what sorts of treatments work best and how treatment services can be improved (see particularly Rist, Randall, Heather & Mann, 2005). Variables which have been studied as having important implications on treatment success involve treatment characteristics (Heather, 2005) including level of intensity of the intervention (McKay, 2005); therapist characteristics, such as practitioners' attitudes towards working with problem drinkers (Anderson et al, 2004) and client characteristics (Justus, Burling & Weingardt, 2006; Kayman, Goldstein, Deren & Rosenblum, 2006), including a questionnaire measured level of impaired control (Heather & Dawe, 2005). In light of the analysis presented I would argue that one of the most important issues for consideration are 'interactional characteristics'; however, rather than suggesting this should be treated as an additional 'variable', researchers need to see 'therapy' as an interactional accomplishment. In order for this to be taken seriously, a close detailed analysis of interaction between client and practitioner is required in addiction research, and this chapter has begun to illustrate what important insights can be gained from such work.

Similarly I have argued that this type of analysis can be invaluable to the organisation in assessing whether their training meets their clients' needs. This also has wider implications. Again, research has focused on how to train practitioners and measure their competence in specific approaches (Copello, Williamson, Orford & Day, 2006; Frost-Pineda, VanSusteren & Gold, 2004; Tober et al, 2005), mainly based on outcomes such as whether individuals sustain unproblematic drinking or abstinence (Copello, Templeton & Velleman, 2006. For a discussion of problems associated with determining 'outcome
measures’ see Donovan, Mattson, Cisler, Longbaugh & Zweben, 2005 and Sobell, Sobell, Conners & Agrawal, 2003)). Again, I would recommend that close attention needs to be paid to the interactional intricacies of communication between client and practitioner in addiction treatment services as a way of unlocking important work being performed but currently overlooked.

Finally, I would like to return to an earlier point that whilst most research becomes interested in clients once they engage in full agency contact the analysis in this chapter demonstrates that what happens in initial agency contact has such far reaching implications that this is an important site for study. These brief points will be addressed in more detail in the following chapter.
Chapter 9
Discussion

This thesis had few specific aims. My intention was to explore telephone calls to an alcohol helpline. My plan was to identify issues which appeared relevant and important in the talk. Hence, whilst there was a general aim to provide an empirically grounded exploration of this talk, the approach that I took to data analysis, and the research project generally meant that I did not have specific outcomes in mind. The aim was not to provide evidence or support for particular theories or to test different approaches to treatment.

As I have stated, I take seriously the position espoused by John Booth Davies (Davies, 1997a) and other constructionists (Cohen, 2000; Hammersley & Reid, 2002; Peele, 2000; Reinarman, 2005) that a concept of 'addiction' does not exist beyond the descriptions people provide of their behaviour. However, whilst this questions the 'reality' of the construct of addiction, for callers to the alcohol helpline, alcohol problems are very 'real'. This sentiment appears to be analogous to the argument proposed by Larkin and Griffiths (2002) who go on to recommend that researchers should explore the 'lived reality' of such people's lives. My intention was to take a very different position. To explore people's 'lived realities' suggests that talk represents and reflects some such experience, which reifies the experience of addiction, thereby reifying 'addiction'. This is at odds with what I believe. Whilst not seeking to deny the reality of subjective experience, my interest was in how people construct their reality as addiction. If such a concept exists only in a network of people's descriptions of it, how do people organise their talk in such a way that does construct 'addiction'?

For many years people have questioned deleterious substance abuse; how should we understand it and what can be done about it? As the classic notion of addiction has been challenged and abandoned by so many (See for example, Cohen, 2000; Fingarette, 1988; Heather & Robertson, 1981, 1985), why is there still so much evidence of an 'addicted' way of talking? Again, I concur with Davies (1997a) that this way of talking is still so apparent because it is functional and valuable for so many people. I was intrigued; in what ways was
it functional? What could such a function be? Who was it useful for? This thesis set out to address such questions.

I have also explained that the position adopted throughout this thesis is constructionist and positions itself in the realm of discursive psychology. An intention of the research was to make a contribution to the literature on addiction by showing the insights that this approach can offer, and also to contribute to the theoretical and analytic aspects of discursive psychology.

The analysis presented in this thesis provides a great deal. Contributions can be made to the addiction literature in two ways; firstly by showing that research of this nature has much to offer. The analyses I have presented are new in this field and begin to mark out an untrodden path in addiction research. As a second contribution, specific findings of the research can enhance areas of interest adding an extra dimension to current understandings of the concept of addiction or problem drinking.

The approach taken to analysis and the findings that emerged by using this type of data, prepared for analysis in this way, and examined using conversation analytic tools add much to the practice of qualitative research on a general level.

As stated earlier, for many people problem drinking is a 'real' issue which brings with it real problems. The aspiration of much of psychology is to engage in helping people, and whilst this does not have to be the only acceptable outcome of research in addiction, it is often a desire on the part of the researcher that they can add something which will be of use. I also found that desirable, and whilst it was not a main aim or specific intention of the research project, it has been possible for me to do that. The findings generated by the analysis have clinical implications and can provide much in the way of practical applications.

A fascinating and unexpected outcome of the research is that issues have arisen which promote questions and open up the possibility of debates which were not anticipated at the outset.
The following discussion will begin by returning to the first introductory chapter to remind readers of the points raised therein. In each case I will provide a discussion of how my analysis replies to relevant challenges, questions and issues introduced in the earlier chapters. I will move on to discuss clinical implications of the work I have presented. As we progress through this chapter I will discuss exciting novel issues raised by the analysis and suggest areas where innovative further research may begin a new voyage of discovery. I will close by concluding the arguments I have developed individually and draw attention to the overall argument of the thesis.

**The motivation**

The second introductory chapter mapped a history of the construct of addiction. I began by looking at the birth of the disease model. This proposes that addiction to alcohol is characterised by loss of or impaired control over drinking and is an incurable, irreversible, progressive condition which afflicts only a sub-group of individuals who are very different from other people. A central feature of this theory is the notion of loss of or impaired control over drinking. Through focusing on published literature we discovered that little evidence of such a notion could be found beyond people's descriptions of their subjective experiences. Yet, such accounts of the experience of impaired control were in abundant supply, which fuelled the supposition that this should be included in a theoretical explanation of substance abuse.

After detailing challenges and criticisms which flag up the weaknesses inherent in the disease account, I went on to explain that the notion still has some currency due in part to elements still being apparent in two very important and influential publications; DSM (APA, 2000) and ICD (WHO, 1990). Following an outline and evaluation of newer theories of problem drinking and substance abuse I moved on to present an argument for adopting a social constructionist, epistemologically relativist stance towards addiction and ultimately stated that throughout this thesis I take the position that the concept of addiction is built in a network of people's descriptions of their own and others' behaviour. Starting from this position I will discuss how my analysis fits in with and adds to the previous literature and begins to address the questions that motivated the study.
Theories of addiction

In earlier parts of this chapter and thesis I have stated that my interests are how people organise descriptions of their situation and behaviour in such a way that pieces together a concept of 'addiction', who builds such a notion and what it achieves interactionally for the speaker. One of the most notable overall observations of the thesis is that not only do both callers and Advice Workers draw heavily on some notion of addiction, but that elements of a disease model of addiction are still clearly apparent. By paying close attention to the details of the interaction and examining what discursive actions were embedded in these sequences, it has been possible to pinpoint some of those elements and address the function and implications of their use in helpline interaction. In the early part of chapter 6 we saw how the Advice Worker removed responsibility for the problematic drinking away from the caller and placed it onto some 'alcohol dependence process' which had been taking over the caller's life without his awareness. This way of conceptualising drink problems neatly fits the account of addiction espoused by Alcoholics Anonymous (AA, 1939, 1955, 1976) and other advocates of a disease model (Edwards & Gross, 1976; Jellinek, 1952, 1960). Let us take a moment to marry together the analysis with the theory to show how this notion is constituted in the talk investigated in this thesis. In chapter 6 (pages 103-108) the Advice Worker I have named Dave constructed an agentive alcohol dependence process with an agenda which, if left unrecognised, would take over a person's life. This nicely characterises the theoretical 'progressive condition' espoused by disease model proponents. In chapter 7 (pages 147-150) we witnessed the Advice Worker Matthew constructing an account of the caller's drinking which increased in the amount of alcohol intake and had physical symptoms which would purportedly be evidence of physical dependence. The Advice Worker recommended that the caller should abstain from alcohol entirely and the caller and Advice Worker discussed steps towards reaching that goal. Hence the Advice Worker articulated a dependent relationship which would only be corrected by divorce from alcohol altogether; that is, an incurable, irreversible condition unless alcohol is removed.

Let us pause to ask what this achieves for the Advice Workers. I do not see it as unrelated that the Advice Worker Dave is himself a member of Alcoholics
Anonymous; a ‘recovering alcoholic’. It then becomes apparent that this Advice Worker has a vested interest in this account. This is a version by which Dave can not only account for his own drinking past but also for his own current abstinence from alcohol and his regular attendance at AA meetings. Edwards and Potter (1992; Potter 1996) argue that when speakers have a stake in the version being presented one of the ways that this can be managed is by presenting a description which is made to appear factual, believable and separate from the speaker. Dave the Advice Worker achieves this by claiming an ‘expert’ status, corroborating his account with talk of ‘other people’s’ experiences and encouraging the caller to collude in and co-construct the story.

Whilst this may give us some idea of what Dave achieves from constructing this version, the Advice Worker Matthew does not have the same personal motivation. Hammersley and Reid (2000) argue that a concept of addiction provides a clear answer; hence, in the case of illegal drugs they suggest that restrictive laws controlling psychoactive substances are accounted for and justified by a concept of addiction whereby innocent individuals are taken over by a drug induced agentive process. On the telephone helpline this allows the Advice Worker to formulate goals and advice; the goal being to stop drinking and the advice being various steps towards achieving that. Hence for Matthew the Advice Worker a concept of addiction enables him to fulfil his role as advisor by constructing a problem for which he can formulate advice.

Possibly more analogous to a constructionist position on addiction was the Advice Worker I have called Deb whose calls I explored in chapter 5 (extracts 5.1 & 5.7, pages 78, 87-8 & 94-5), chapter 6 (extracts 6.3, 6.4a & 6.4b, pages 113-4, & 115), chapter 7 (extract 7.6, pages 151-2) and was the main focus of chapter 8. This Advice Worker does not appear to take caller’s ‘impaired control’ talk as reflective of some real inability. This approach to ‘addiction’ then would appear to align with the position I take on ‘addiction’, so, my approach may be that whilst Dave and Matthew above attribute the caller’s problematic drinking to some mere construct, Deb is correct in not doing that and not reproducing a disease model account. However, if I were not to unpack

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1 This is commonly known within the organization and his anonymity is not something that this Advice Worker protects, so I do not feel that any confidentiality has been broken here.
Deb’s account and ask what this achieves for the speaker I would be falling into the trap of supposing that ‘attributions are just attributions, but the truth is simply the truth’; a notion which I labelled misguided in the third introductory chapter. Deb may appear to be treating the caller’s description as a motivated account, which blends with the ethos of ‘addiction’ talk being functional. As a discursive analyst I would again ask what this achieves for the Advice Worker. Firstly, this simplified the task. If pleas of inability are rejected, the logic is crystal clear; excessive alcohol intake is causing problems, therefore reduce the intake and the associated problems will dissipate. During training, Deb was provided with strategies for reducing alcohol consumption and so can readily pass on this wisdom to callers. On a more immediate level, as we saw in the analysis, this managed the Advice Worker’s responsibility and accountability for the advice she was giving, as options were proposed as a potential remedy to all of the problems described.

For a moment I want to reflect on the style of the two Advice Workers who have featured most prominently throughout this thesis and who adopt contrasting techniques in their work. As mentioned above, the Advice Worker Dave constructs a disease model of addiction with which callers appear to readily align themselves. This contrasts quite clearly with the style of the Advice Worker Deb with whom we observed that often direct practical advice was offered, but responsibility was deflected from the Advice Worker and placed squarely on the caller not only to carry out the alcohol reducing strategies suggested by the Advice Worker, but also to monitor their own progress. The central point to note here is that whilst Dave’s calls appeared to flow quite smoothly, Deb’s calls often appeared to go somewhat awry, and there was less evidence of agreement between the callers and the Advice Worker than observed in other calls. It may be the case then that the smooth functioning of the helpline relies on the caller and Advice Worker co-constructing some notion of ‘addiction’. Let us see if we can tease this apart a little more. When Advice Workers drew attention to purported physical symptoms, this attracted a reserved alignment as observed in chapter 7 (pages 147-150) and chapter 8 (page 163), so we can ask whether aspects of this model work well as an account for a person’s behaviour, but as physical signs are an outward display, they have other implications attached.
However, if, as Davies (1997a) proposes, people use alcohol and illicit drugs because they choose to and see more reason to carry on than to stop, then maybe the onus is on the drinker themselves to resolve any associated problem. Crucially, the analysis in chapter 6 demonstrated that when callers are faced with this, accounts are produced which manage their accountability and deflect responsibility for such action away from themselves. Here, the callers not only provide further evidence of the discursively constructed nature of problem drinking and 'addiction', but also demonstrate the powerful utility of an 'addicted' way of talking as this becomes the means by which they manage issues of responsibility and attempt to elicit help, advice and support from the organisation. The implications of this may be that practitioners in initial agency contact need to circumvent issues of accountability and responsibility.

**Control**

Loss of, or impaired control has always been a key feature of the way people talk about drink problems and has played a central role throughout the history of 'addiction'. Fundamentally, the question of 'control' is one of the principal concepts that distinguishes between substance abuse and substance dependence in DSM (APA, 2000) and ICD (WHO, 1990). In the introductory chapters I drew attention to problems defining 'impaired control' and finding empirical evidence for it. I then went on the explain that evidence suggests that it is still a very important concept in people's understandings of addiction, as Walter & Gilbert's (2000) research showed with 'experts' in the American Psychological Association's Division on Addictions and clients enrolled on drug abuse education classes.

As a response to the difficulties associated with studying this slippery concept, I explained that the field of addiction studies has witnessed a move towards studying what issues of control mean to individuals. Marsh and Saunders (2000: 263) argue that "loss of control explanations are attributions to justify and explain drinking to excess". This sentiment echoes Davies's (1997a) argument, who claims that talk of loss of control is a discursive justification; however, so far no published research details how this gets done. The analysis I have presented in this thesis starts to fill that gap, in the context of helpline interaction where support is being requested. This has enabled us to see more
clearly the discursive actions and interactional business inherent in such accounts.

**Callers and control**

*My* analysis showed that people construct themselves as rational, logical people and portray themselves as people who have knowledge about the negative aspects of alcohol, they 'know' that drinking excessively is not good for them, and therefore is not something that they, as rational logical people would choose to do. Associated with this is the observation that callers separate cognition from behaviour, so while everything else they do is paired with putative cognitive activities such as thinking and knowing, excessive drinking is reported as simply something that happens without any associated cognition.

Another strategy involves 'splitting the self'. Callers talk about 'kidding myself', 'convincing myself' and 'fooling myself'; hence, there are separate selves, one which is in a position to 'kid', 'convince' and 'fool' and another which is the intended recipient. Importantly then, callers construct elements of the self that are not 'out of control' or never were 'in control'.

The analysis reveals that talk about control over drinking is meticulously designed for the interactional work that it is doing. In order to receive help for their problem callers need to demonstrate that they are not simply choosing to get drunk. As callers separate excessive drinking from purported cognitive activity and a sense of self it may be the job of clinical practice to draw these disparate notions together.

Having detailed how 'impaired control' gets done, the analysis in chapter 5 moved on to explore when it gets done and I made suggestions as to the function of such talk at that point.

As previously stated, researchers have argued that a loss of control construct works to justify problematic or excessive drinking. Such research is based on data generated in a research interview setting, where arguably the main interactional concerns for interviewees are to tell an interesting story and to provide an account of their behaviour for social consideration. In conducting
this research my interest was in how and when people construct notions of impaired control outside of research interviews, and my data afforded this opportunity. In chapter 5 I proposed functions of impaired control talk for callers to an alcohol helpline. The analysis demonstrated how callers use this way of talking to manage potential moral judgements which may be made of them and about their behaviour. This is an important strategy on a helpline as callers attempt to demonstrate that they are a person worthy of the organisation’s time and attention and worthy of help. Callers are able to account for making the call and asking for help by appealing to issues of control which formulate this as a difficult problem to resolve because, despite having the necessary knowledge and having previously tried to stop drinking callers ‘can’t’ because this is out of their control, thus accounting for ringing the organisation to ask for help. Finally, this way of talking manages the advice being offered or potentially offered, heading off straightforward information or recommendations to perform actions without assistance.

Advice Workers and control

We can begin to see the powerful utility for callers of this way of talking; however, the callers are not the only ones who use a control construct. In the introductory chapter 3 on page 51 I presented a small data extract and proposed the idea that the Advice Worker may have been stuck for ways to advise a person who simply does not control their drinking, but can begin to fulfil their role as an advisor once the caller produces an ‘impaired control’ account. Whilst this would require further exploration to substantiate such a claim, there is evidence that this may be functional for Advice Workers. Unfortunately within the corpus of data there are no further examples of callers explicitly stating that they ‘do not’ control their drinking rather than ‘cannot’ control it, which in itself is a very interesting observation. However, the analysis has highlighted that often callers talk about their drinking problems but do not package it within a control construct, at which point the Advice Workers generally do. A clear example of this is extract 5.2 of chapter 5 (pages 80-1). The caller has explained that she either has to drink or not, that her drinking escalates, she experiences anxiety when she stops drinking and then starts to drink again because she wants to be like everyone else. The Advice Worker summarises this as you feel you that you can’t really control
your drinking at the moment; hence the description is packaged into an ‘issues of control’ formulation.

Whilst this observation may be interesting, at this stage, without further analysis, I could only speculate that this is functional for the Advice Workers because it packages the caller’s description of their behaviour as something which is recognisable, that is, a problem with control over drinking, and something which the Advice Worker has been trained to deal with.

The above discussion considers the way the callers’ and the Advice Workers’ talk can map onto academic theories of problematic drinking, and we have reviewed the function of various formulations. Let us stay for a moment with ways of constructing the problem, with a critical interest in how complex a problem it is made to appear.

**Complexity and utility**

Towards the end of the introductory chapter which outlined a history of addiction I presented an argument proposed by Blomqvist and Cameron (2002), Harris (2005) and Martin (1999). Seemingly there is a great deal of money to be made from treating people with a difficult problem to sort out, from privately owned treatment centres through to large multinational drug companies. The more complex the problem, as addiction is formulated to be, the more expensive the treatment. This would suppose then that Advice Workers should construct a highly complex problem, and yet the analysis I have provided has seen a reversal of that assumption, with Advice Workers often presenting a straightforward, even simple situation and callers problematising such a construction. In many cases we have seen the caller assigned the task of providing evidence of an alcohol problem. The Advice Workers ask for information on the amount and strength of the alcohol, the frequency with which it is drunk and physical evidence such as withdrawal symptoms, ‘the shakes’ and ‘blackouts’. I have suggested that this then allows the Advice Workers to formulate alcohol specific advice for which they have been trained. Such advice would consist of strategies to cut down on the alcohol intake and often a goal of abstention from drinking alcohol. We have also witnessed the minimising of the problem, reducing it to the caller’s ‘little thing’, a way of relaxing and just something that ‘people do’.
In contrast to the minimal, straight-forward alcohol problem often proposed by Advice Workers, it is the callers who add further complications to the mix, as we saw for example in extract 8.1 (page 164), and reassert the difficulty inherent in correcting their drinking behaviour. Throughout the analysis I have suggested that this highly complex problem enables callers to account for their previous drinking behaviour, to provide a warrant for making a call to a helpline to ask for help with aspects of their life, and to demonstrate that they are a person in need of external help and support. So whilst it may arguably be to the advantage of private treatment service providers and the like that alcohol problems are conceptualised as being Byzantine and difficult to resolve, I have begun to uncover the vested interest that callers to this helpline also have in such a complex account.

Selection of participants in addiction research

In the first of my introductory chapters I outlined four imaginary case studies and I pondered how we should define or categorise these people; a 'heavy drinker', someone with a bit of a problem, or an 'alcoholic'. In the 'grand scheme of things' perhaps it does not matter how we label them; but in the 'grand scheme' of research it clearly does. In the third introductory chapter I raised concerns about how people are categorised in recruitment to research studies (page 41). Let me now draw your attention to the data examined in this thesis to illustrate my point and the consequent implications.

In chapters five, six and seven we met two callers: Keith (extracts 5.6, 6.1 & 6.2, pages 92, 103-5 & 110) and Karen (extracts 5.1, 5.7, 6.3, 6.4a, 6.4b & 7.6, pages 78, 87-8, 94-5, 113-4, 115 & 151-2). Both expressed concerns about their drinking, hence making the call to the helpline; both claimed to be drinking an excessive amount of alcohol; problems arising from the drinking, including relationship or family problems and financial concerns were vocalised by both callers; previous unsuccessful attempts to cut down and 'loss of control' over their drinking were described by both parties. At this point we might want to presume that their 'lived realities' or subjective experiences are remarkably similar. Despite this, in one case Alcoholics Anonymous was promoted as an appropriate resolution to the caller's drinking which, if the caller takes up the suggestion, he then becomes eligible for inclusion in addiction research as an 'alcoholic'. In the other case, suggestions were made
as to how the caller could cut down her alcohol intake and it was suggested that she should monitor her own progress. The caller was informed that she could expect to receive an information pack from the organisation, but no further services were offered. As such, when the call ended addiction researchers would have no further interest in this person. What the analysis I have presented revealed is that the difference between these two callers are not intrinsic qualities of the person, or of their behaviour; and yet potentially, one goes on to become an 'alcoholic' and the other does not. The analysis demonstrated intrinsic differences in the interaction between caller and Advice Worker and thus demonstrates, as I have claimed, that an identity of alcoholic or problem drinker is negotiated and constructed. This observation also highlights the implications of the various positions and styles adopted by the Advice Worker and it begins to suggest that initial contact with alcohol services is a very important site of study. This is a point I shall reassert many times throughout this discussion.

In the above section I have provided a detailed discussion of some of the findings of the analysis, I have addressed the questions that primarily motivated the study and I have begun to raise awareness of issues in relation to the selection of participants for research and exciting and important new areas for study. This has been made possible due to the approach taken to analysis, inspired by discursive psychology. I will now address this theoretical underpinning more directly.

The theory
Throughout the introductory chapters I have made a case for adopting a social constructionist, epistemologically relativist stance towards the analysis of telephone calls to an alcohol helpline. Having previously justified my decision, I will now discuss the implications of such an approach to the data and will review what has been learned by approaching the research from this position which would not have been available or accessible had I have adopted another approach.

A discursive psychological thesaurus
The thesis is inspired by discursive psychology (Edwards & Potter, 1992) and as such affords an approach to the data which enabled me to unlock some of
the subtleties of the interaction. Rather than viewing talk as reflecting some hypothesised internal apparatus or activity, discursive psychology promotes the study of cognitive notions as the business of interaction (Edwards, 1997). An interesting observation within the helpline calls is how cognitions are treated differently at different times; sometimes treated as getting in the way of business and at other times being called on as a requirement for business.

In extract 7.1 of chapter 7 (page 136) the Advice Worker asked the caller if he could cut down his level of drinking. In response the caller ran through the thesaurus of cognitive notions, such as knowing, wanting and needing. This performed important work for the caller in attempting to index motivation and provide a warrant for making the call. However, the Advice Worker re-issued the question, indicating that such a display of cognitive activity was not what was being requested. Conversely, the Advice Worker in extract 6.5 of chapter 6 (pages 119-20) asked what the caller thinks of his own drinking and whether he thought it was a problem, as contrasted with 'what the doctor thinks'; so the production of a 'thought' is required before business can continue. A few lines further on more internal attribution is required, this time 'wanting', although not just any 'want', this is a specific sort; an 'actual' want is necessary. This fishing for cognition has also been demonstrated by Antaki (2006) where again, a specific sort of cognition was required for the interactional business in hand. Whilst the Advice Worker we observed requested 'actual wanting', Antaki's speaker sought an indexing of 'knowledge'.

**Cognitive notions and helpline interaction**

In chapter 7 we saw cognitive resources being produced as separate and competing thoughts and feelings. This interesting way of producing cognitive activities as discrete and opposing entities within a 'self' appeared to be highly functional within the interaction. This echoed the talk explored in chapter 5 where thoughts and decisions were at some points produced as directing behaviour, at some points policing behaviour and at other times distinct and removed from behaviour. The analysis highlighted the utility of having this psychological thesaurus available and how such notions could be marshalled to perform various tasks.
In addition to contributing to the theoretical and analytic aspects of discursive psychology, this observation has important clinical implications for those working with problem drinkers. Whilst producing separate and competing thoughts, feelings and behaviours may be useful in producing and understanding ‘self’ and behaviour, are they useful for changing behaviour? Cognitive behavioural therapies, including such interventions as Motivational Interviewing (Miller, 1983; Rollnick & Miller, 1995) and Motivational Enhancement Therapy (Miller, Zweben, DiClemente & Rychtarik, 1992) are designed to change thoughts and feelings with the belief that this will then change a person’s behaviour; but if cognitive entities are produced as not only competing and separate from each other, but also unrelated and even in opposition to ‘behaviour’, how can this help to change a person’s actions? Discursive psychology would suggest that ultimately the problem needs to be situated discursively away from putative inner states of those suffering from excess alcohol intake. If therapy works, it works precisely because it is an interactional phenomenon.

The data
Naturally-occurring talk and initial agency contact
In the first introductory chapter I stated that two strengths of the data were that, firstly they represent naturally-occurring talk and secondly, they come from a point very early in a person’s contact with alcohol services; often the first contact callers have had, with most claiming never to have spoken to any sort of professional about their drinking before. I claimed that this afforded novel insights as previous research had predominantly recruited participants who are receiving or have received some form of treatment or intervention. In this section I will highlight the benefits of investigating this untapped resource and demonstrate some undiscovered activities embedded in initial agency contact, ending with the argument that this is an important site worthy of further exploration.

Training in ‘addiction-speak’.
In chapter 3 (page 51) I presented a short extract of data. My intention at that point was to demonstrate the importance and utility of focusing closely on the data. However, I also made a tentative suggestion that some callers may be
"trained" in 'addiction-speak'. By that I mean that callers learn ways of speaking which then produce the results that they want; that is, help with their drink problem. My overall argument is that this could then explain why, when people travel through the provision of services and treatments they end up talking in very similar ways; that is, like an 'addict'.

This has not been a direct focus of this thesis; however, by reviewing the analysis presented, enough evidence is apparent for me to begin to make such a claim. Before we can review the evidence it is first necessary for me to define what I mean by 'addiction-speak' or an 'addicted way of talking'.

In his analysis of interviews with drug users and drug 'addicts', Davies (1997a) identified different 'discourses' or different ways of talking which he organised into a five-stage model. The third discourse that Davies identified was what he described as an "addicted" type of discourse. Davies identified key features of this type of talk:

"Discourse of this type makes open reference to loss of volition and control. Any reference to hedonism or enjoyment is lost and is replaced instead by negative statements about the consequences of drug use. ... Drug use will be described as an inevitable outcome of certain physiological or constitutional factors over which the individual has no control, and have existed over a period of time; or as a forced consequence of negative life events and situations which again have a history" (Davies, 1997a: 96)

The central features then can be summarised as:

- Loss of volition and control
- Drug use is associated with problems rather than pleasure or positive outcomes
- Drug use is a consequence of negative life events or underlying problems or factors
- There is an element of progression or history to problems and use

Davies (1997a: 96) also notes that:

"Our data suggest that type 3 discourse may in some sense be a prerequisite for agency contact, since those who entered full agency
contact during the course of the study were employing type 3 discourse
prior to such involvement."

The fundamental point here is "those who entered full agency contact" (my
italics); so it is the people who go on to receive treatment who talk in this way.
The question this raises is; do these people receive treatment because they talk
in this way, hence do they use this way of talking in order to get treatment;
that is, does it serve that function?

If this is the case, how do people learn this way of talking? Let me reassert my
claim that some callers to the alcohol helpline explored in this thesis may learn
this 'addicted' way of talking from the Advice Workers. Let us review the
evidence.

Loss of volition and control
I have demonstrated previously that if callers do not use a 'control' construct,
then Advice Workers do; that is, the caller's description of their problems with
alcohol are summarised as being problems with controlling their intake of
alcohol. Let us remind ourselves of the exchange between the Advice worker in
extract 5.2 of chapter 5 (pages 80-1) and also page 196 in this chapter where
the Advice Worker summarised the caller's description of her problems with
alcohol within a control construct and importantly suggests that the caller is
unable to (can't) control rather than simply does not.

Further evidence is provided in extract 5.3 (pages 84-5). The Advice Worker
has spoken initially to the drinker's mother, and then speaks to the drinker.
At the beginning of the change of caller, the Advice Worker summarises the
caller's drinking history as told by the mother. He then asks whether the
caller's goal is to get his drinking back under control, which suggests two
things; firstly that the caller's drinking has not been under control and
secondly that controlling his drinking is a potential goal. Here again, we can
see that issues of 'control over drinking' are made relevant by the Advice
Worker, and by viewing the subsequent talk we see the caller immediately
framing his account with that notion.
Drug use is associated with problems rather than pleasure or positive outcomes.

The analysis presented in previous chapter has shown numerous times that callers have described their drinking in such a way that the Advice Worker has suggested that this is a 'normal', 'common' or understandable use of alcohol. As the analysis showed, callers tend to restate their problem and up-grade it to something more than just 'what people do', thereby learning that their problem needs to be sufficiently significant and portrayed as causing serious problems to warrant attention. Let me cite the evidence to support this claim.

In chapter 7 (extract 7.6, page 151-2) the caller accounted for her drinking by stating that she was using it as a crutch and a sort of escape thing. Clearly then this account contains positive outcomes of the caller's drinking; support and escape. At this point the Advice Worker replied but people do and that's what people tend to use alcohol for. Similarly in chapter 8 (extract 8.10, pages 178-9) the Advice Worker offers an account of the caller's drinking as being the caller's release and associated with relaxation. In both cases the caller's drinking is formulated as understandable, scripted (Edwards, 1997) or 'commonplace' and associated with positive outcomes; and most importantly, help to alter the caller's behaviour does not seem likely to be forthcoming. Similarly, in both cases, the Advice Worker's 'minimising' or 'normalising' of the caller's drinking is met with the caller reasserting the problematic aspects of their drinking. The analyses then show that when the requested help does not appear to be offered as a response, the caller asserts that their drinking is problematic and more associated with problems than positive outcomes, and as such, they are in need of help and advice.

In addition to this the analysis provides evidence of Advice Workers issuing warnings that continued drinking will lead the caller to hate herself and self-loath (chapter 8, extract 8.11, pages 180-1). Furthermore, the Advice Worker in extract 6.1 of chapter 6 (pages 103-5) proposed that missed opportunities, broken relationships, ill health and financial difficulties could all be attributed to the caller's drinking. The extract ended with the Advice Worker directly encouraging the caller to attribute problems in in in the past to his drinking.
By reviewing the extracts of data presented in earlier chapters we can begin to see how callers may learn that associating their drinking with problems rather than pleasure or positive outcomes is rewarded by the Advice Worker with advice or an offer of further services.

**Drug use is a consequence of negative life events or underlying problems or factors.**

Following his analysis of drug users' discourse, Davies (1997) proposed that talk of drug use as a consequence of negative life events or underlying problems was an element of an 'addicted' way of talking. Davies further argued that this addicted discourse was a pre-requisite to full treatment agency contact. Again, in the analyses I have presented in previous chapters there is evidence of Advice Workers intimating or suggesting that these sorts of notions are associated with the caller's drinking.

I return to chapter 5 (extract 5.3, pages 84-5) and the Advice Worker I discussed earlier in this section with reference to control over drinking (page 234). The summary of the mother's account is reproduced below.

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**Advice Wkr** Hi Aaron its erm Craig here I'm I've just speaking to your mum erm (0.5) she's told me b- just a little bit about the (0.2) the problem erm (. ) it seems to have got worse in the last few years and (0.6) you've had this terrible trauma that's gone on as well that's accelerated everything

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The *terrible trauma* that the Advice Worker refers to is the death of the caller's father. The Advice Worker recounts *you've had this terrible trauma... that's accelerated everything*, which the caller confirms. The accelerated drinking is indexically linked to the *terrible trauma*, so, here we can see the Advice Worker accounting for the caller's increased drinking as a consequence of a negative life event. This style of proposing excessive alcohol use as an outcome of negative events or underlying problems can be seen throughout the exchange between caller and Advice Worker in extracts 7.4a, 7.4b, and 7.4c (pages 142-146) whereby the caller began (extract 7.4a) by stating that his father *died frough drinking* and he thought that he had *just took over 'im in 'is footsteps.* By extract 7.4c this has been transformed into an *underlying reason* as observed by the Advice Worker. The Advice Worker then encourages the caller
to tell his GP about his father as this purportedly seems to the Advice Worker to be an underlying reason for the caller's problematic drinking. Essentially then, the caller's drinking has been discursively manipulated to become attributable to the negative life event and underlying reason of his father's death. Hence, if the caller follows the Advice Worker's instruction we can assume that when the caller speaks to his GP, this underlying reason will have become an important factor in the caller's attempt to elicit the counselling service or medication that the Advice Worker has informed the caller that the GP can potentially provide to help resolve the drink problem described by the caller.

Further suggestions of underlying reasons motivating the drinking were proposed by the Advice Worker in chapter 8 (extract 8.11, pages 180-1), who stated obviously there's something going on that (2.5) that you're not (0.5) that you're not dealing with properly. Here, not only does the Advice Worker bring up the notion of an underlying problem, but illuminates the obviousness of this proposal; hence it is formulated as being apparent to anyone that there are covert issues motivating the caller's drinking.

So far we have been able to find evidence of callers potentially learning three of the four components of an 'addicted' discourse. Let us go on to address the fourth and final ingredient.

There is an element of progression or history to problems and use

Davies (1997) suggested that a final element of an 'addicted' discourse is the notion that the drinking and the associated or underlying problems have a history to them; and again, in the analysis I have presented we can witness caller's potentially learning this facet of the discourse from the Advice Workers.

Let us reconsider extract 6.1 of chapter 6 (pages 103-5). The Advice Worker proposes that the caller is right to recognise that it's becoming problematic and in the chapter I discussed the implications of the Advice Worker stating that the caller is correct in his observation, thereby reinforcing the idea that this has been going on for some time and the caller has finally recognised it. I also pointed out the important implications of the Advice Worker's use of the word recognise. In the analysis in chapter 6 we observed the Advice Worker explaining to the caller that the process of 'alcohol dependence' takes years sometimes decades, additionally it is a gradual thing it's almost a drip drip until
the point where it's really taken over. Utilising the concept of script formulation (Edwards, 1997), we could see how this process was portrayed as something which is usual and regular in alcohol dependency. In this way, the caller is offered an account of a progressive condition, which is then turned by the Advice Worker into the caller's observation or recognition. As noted earlier, this extract ends with the Advice Worker encouraging the caller to co-construct a progressive process which has a history of problems associated with it and attributable to the caller's drinking.

At the beginning of this section I quoted Davies (1997) who argued that an 'addicted' way of talking may be a pre-requisite to people gaining access to full alcohol agency services. In the paragraphs that followed I have submitted evidence from the data and analyses presented in this thesis which suggests that callers may learn not only an 'addicted' way of talking, but also that use of this language results in the offer of help, advice and further services, which, at times when they do not describe their behaviour within these terms, do not seem to be forthcoming. All of this has only been possible because I have analysed data from people at the very beginning of their journey through alcohol services. It would not have been possible to see this if I had collected data from people who had already received some form of treatment; therefore this again shows how this research has demonstrated something fresh and important, and once more indicates that initial agency contact has many novel insights to offer.

So far I have discussed how my research has added to academic literature, provided novel and important insights relevant to the study of addiction, and has indicated that it has much to offer clinical practice. As we move into the final sections of this discussion I wish to draw readers' attention to the implications of the research for practitioners in alcohol treatment agencies.

**The implications**

Whilst evidence of good practice is very useful for organisations when training staff, what arguably needs to come before that is an exploration of where staff need to be skilled and training is required. The analyses and arguments presented in this thesis propose that Advice Workers need to be highly proficient. The requirement of skills have been most apparent when engaging
in discursive activities such as formulating a problem, giving advice and offering reassurance to callers. A simple recommendation then is that initial agency contact needs to be seen as a very important stage in alcohol treatment services and as much training, experience and finesse is required here as at any other stage of the provision.

As a caveat to the suggestions and recommendations I have proposed, I will now provide a discussion of issues that the analyses suggest may have an impact on training people to become Advice Workers at this alcohol service agency.

**To commit or not to commit**

As I explained in chapter 4 (pages 74-5), the organisation from which the helpline calls explored in this thesis were recorded takes no explicit position on many issues related to problematic drinking. A question one could ask is whether it is a positive move for an organisation to have no particular position or ethos? I am unable to provide an answer to this question, and after surveying the evidence provided by the analysis can only make the question more perplexing. Taking an 'open-minded' stance ought to denote that, during training, Advice Workers are not indoctrinated with a particular view. As I proposed in chapter 4, this should mean that Advice Workers are less dogmatic in their dealings with clients. I suggested that this then leaves the Advice Workers to make up their own mind about such issues and use their own way of conceptualising things, and I argued that this may have far reaching implications. Given that callers often appear to be asking the Advice Worker to decide if what they are describing is a drink problem, how do the Advice Workers decide how to construct and convey such a ‘problem’? A potential outcome of an intransigent approach may be that Advice Workers rely on ‘what typically happens’ or ‘what can be expected to happen’ within a very narrow frame of reference. The analysis has demonstrated that this may not always be a successful strategy, as a reserved alignment was observed, with callers laying claim to knowledge of their own circumstances as a challenge to the version of the problem being presented by the Advice Worker. In contrast, with insufficient or inadequate training or direction, Advice Workers can display generalised normative knowledge of ‘what people do’ or ‘what alcohol is
generally used for'. The analysis revealed that this again can be an unsuccessful strategy.

Another issue of central relevance here is that client choice is recommended and encouraged within this organisation; that is, during training Advice Workers are directed to elicit from the caller what they (the caller) want from the organisation or how they think their problem should be resolved. The analysis presented here has implications for such policies of client choice. The analysis in chapter 6 indicated that when the onus is placed on callers to actively take part in proposing and planning options at this early stage, this can be met with resistance as observed in extracts 6.5 and 6.6 (pages 119-20 and 123). Whilst client choice is a noble aspiration, if one takes seriously the observations presented in this thesis, perhaps policy makers need to consider how this can be implemented successfully in the special case of initial agency contact where many other concerns and issues are apparent and are at stake.

The ideal volunteer: a ‘tabula rasa’ or a ‘seasoned survivor’?

Many organisations such as the one featured in this thesis operate in the voluntary sector and are registered charities. Also in common with most others this organisation employs many Advice Workers on a voluntary basis. This raises a number of interesting questions; for example, what motivates volunteers to volunteer? Do different experiences and motivations have a bearing upon the way a person works? Could this have something to do with the different styles adopted by Advice Workers that we witnessed in chapter 6? Here I would like to consider such questions in light of the analysis presented in this thesis.

Very many of the people who volunteer in alcohol services are former ‘problem drinkers’. Let us consider the potential strengths and limitations of employing ‘ex-addicts’ in such an organisation. The ideology of Alcoholics Anonymous is based on the conviction that alcoholics are a separate group of people from all others. Consequently, they argue that only an alcoholic can truly understand another alcoholic. Following this, they believe in self-help and are sceptical, even critical of other forms of intervention, especially controlled drinking programmes. The AA programme of recovery contains twelve steps based on the experiences of the fellowship’s founders, and which a ‘recovering alcoholic’
is encouraged to work through. The last of these steps is ‘Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs’ (Alcoholics Anonymous, 2002). Furthermore, the fellowship of AA embraces Twelve Traditions’ the fifth of which is ‘Each group has but one primary purpose; to carry its message to the alcoholic who still suffers’ (Alcoholics Anonymous, 2002). In essence then, AA members are actively encouraged to help other drinkers as part of their own recovery programme. This helps to account for a large number of AA members volunteering at organisations such as the one featured in this research. In chapter six we saw a clear example of an Advice Worker formulating the caller’s description of his experiences within a disease model account as espoused by Alcoholics Anonymous, followed by AA being recommended as the most appropriate course of action for the caller. I related this to the Advice Worker’s own status as a member of Alcoholics Anonymous.

Another group of people who appear regularly are other ex-drinkers who accessed the services of this or similar organisations and have resolved their drink problem by whatever method. Their expressed desire is to ‘put something back’ into the service that ‘gave them so much’. A person who is able to overcome life problems of whatever description, by whatever method is to be credited, and this is certainly the case for ‘ex-addicts’; however, what effect does this have on the service that they subsequently offer? Can they detach themselves from their own experiences sufficiently to support a client in a programme to which they do not affiliate, indeed, may even have bad memories and experiences of? Many people find the AA ideology unpalatable, with its emphasis on spirituality and lifelong abstinence. Others have experienced the ‘failure’ of controlled drinking programmes with a return to deleterious drinking. How wedded to their own preferred method of ‘recovery’ are such people and how far can training persuade them that all options are open to all callers, regardless of the Advice Worker’s experiences and beliefs?

By posing these questions in this way, this would suggest that I have doubts about the appropriateness of ex-drinkers volunteering in such organisations. Let me redress the balance. Given the vast number of callers who ask if the Advice Worker had a drink problem, this appears to be of interest and relevance to the clientele. Being persuaded that the person one is talking to
'really knows what I mean' may make an important difference to the caller and the credibility of the Advice Worker and organisation. There may be some strength in the AA argument that personal experience counts for more than training. The observation of an Advice Worker's reluctance to accept on face value callers' claims of an inability to control their drinking may be a result of the Advice Worker's lack of personal experience and hence an absence of stake in that particular version. However, whether this is 'right' or 'wrong' is not a debate that I shall pursue.

Entitlement to knowledge and expertise have been shown in the analysis to be claimed by people in various ways. However, which carries more weight or is a more effective persuasive strategy when offering advice: 'I know because I've been trained' or 'I know because I was there'? Perhaps this is an issue for future analysis.

**Concluding comments.**

This thesis has opened up a new path in addiction research and has begun to make inroads into areas where there is a dearth of literature. By taking discursive psychology as its main theoretical influence, not only does this thesis add to the body of work which examines cognitive notions as resources for performing interactional business, but takes it into a new area of studies on alcohol abuse. Other work on substance abuse is enhanced by the novel insights that an approach to research inspired by discursive psychology affords.

Utilising telephone calls to an alcohol helpline represents a significant move away from reliance on interviews as a means of generating data for study in the field of addiction and problem drinking. By exploring naturally occurring talk I have begun to explicate functions of specific ways of talking when people are engaged in the business of eliciting or providing help with an alcohol problem. The analysis presented highlighted the utility for callers of notions such as loss of control and a lack of agency associated with their problematic drinking. An important observation was that Advice Workers also made use of such notions in enabling them to formulate a problem for which they have been trained to give advice. More use needs to be made of naturally occurring talk on this
topic in order for researchers to uncover practices as they happen which would be excluded from study when relying on other types of data.

Examination of the data exposed the important work being undertaken on a helpline. The analysis revealed how callers and Advice Workers collaborate in constructing the problem and negotiate appropriate advice. A detailed exploration of the skills involved and required by helpline operatives drew attention to areas where extensive, dedicated training is imperative.

Many of the callers recorded in the corpus of data claim never before to have sought help or advice regarding their drinking. As such, this thesis examines initial agency contact and highlights this as an acutely overlooked, yet exceptionally important site of study.
References


American Psychiatric Association (1952) Diagnostic and Statistical Manual of Mental Disorders. Washington DC: American Psychiatric Association


215


Davies, J.B. (2004) The meaning of your drinking is the story that your drinking illustrates. *New Directions in the Studies of Alcohol.* 29: 45-50


217


Herbert, I. & Akbar, A. (2002, 20 July) It is possible that he was addicted to killing. *The Independent*. P.1


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Appendix A

APAS DB 11-02_1_1

1 ADVICE WKR Right I just ask y' something erm we
2 actually are re- at the moment
3 recording calls for erm: (1.7) research
4 an: d erm future training
5 CALLER [Mm ]
6 ADVICE WKR [I won]der if it’d be possible to erm
7 just have this call recorded you don’t
8 have to you don’t have to feel
9 [obligated ]
10 CALLER [((inaudible))] 
11 ADVICE WKR No you’re alr=Tight=
12 CALLER =Yeah
13 ADVICE WKR .hh thank you .hh
14 CALLER What did you say your name was
15 ADVICE WKR Deb
16 CALLER Okay
17 ADVICE WKR Right what’s your name
18 CALLER Sue
19 ADVICE WKR Liz
20 CALLER Sue
21 ADVICE WKR Sue sorry=
22 CALLER =mhmm
23 (0.8)
24 ADVICE WKR Right what m- wha- what makes you think
25 you’ve got a problem Sue
26 CALLER Drink too much
27 (0.6)
28 ADVICE WKR Ha- how much is too much
29 CALLER (1) erm I drink every n:i:ght
30 ADVICE WKR Okay
31 CALLER E:rm (2.1) anything from (0.7) three
32 (0.3) cans of lager large cans of lager
33 ADVICE WKR Mm
34 CALLER to more than that aherrm (1.1) I wake up
35 every morning with hangover (0.6) I
36 feel crap
37 ADVICE WKR Know the lager is it just normal
38 strength lager or are we talking (0.8)
39 CALLER It’s
40 ADVICE WKR Extra strong
41 CALLER It’s not extra strong no
42 ADVICE WKR No
43 (2.5)
44 ADVICE WKR Alright so you’re waking up (0.3)
45 hangover in the morning
46 CALLER Mhm
47 (2.2)
48 ADVICE WKR An how are you treating that hangover
49 (1)
50 CALLER Erm
51 (1.4)
52 ADVICE WKR Are you not having another drink=
53 CALLER =N- oh no [no
54 ADVICE WKR [No
CALLER: I'd sometimes like to
ADVICE WKR: Mm?
CALLER: But I don't
ADVICE WKR: How long has this been going on for?
CALLER: Oh quite a long time
ADVICE WKR: Years
CALLER: Erm (1.3) Yes
ADVICE WKR: Yeah
CALLER: I don't always have a hangover
ADVICE WKR: So just if you don't have a drink do you get any symptoms d'y'
CALLER: Well I don't know because I always ni- I always have a drink don't- you wouldn't know if you get the shakes or anything [like that
CALLER: [N- oh no n- I- I would say I don't get the shakes
ADVICE WKR: Right an you've never blacked out or anything
CALLER: No
ADVICE WKR: Can't really remember going to bed
CALLER: (0.9)
ADVICE WKR: You can't say you do actually have (1.6) there are actually voids in y' night where you don't realise what you've done
CALLER: Mm
ADVICE WKR: See (0.3) I'm frightened because erm: (1.2) I'm having a really I've got a child with that's autistic
ADVICE WKR: Mmm
CALLER: And (0.4) things aren't going particularly well for her at the moment at school
ADVICE WKR: Mmm
CALLER: And I take antidepressants
ADVICE WKR: Mmm
CALLER: Erm although I've been working very hard to reduce the number of antidepressants that I take
CALLER: But I- (1.3) I'm (0.5) I'm starting to feel suicidal at night time
ADVICE WKR: Mmm
CALLER: And I'm frightened that I'm gonna do something because I've been drinking
ADVICE WKR: Mmm
CALLER: How old's your daughter
CALLER: She's eleven
ADVICE WKR: Eleven
(3.4)
ADVICE WKR: Are you on your own with her
CALLER: No
(0.8)
ADVICE WKR: You got a partner
CALLER: Yes I have husband
(1.6)
ADVICE WKR: E:rm (0.5) the thing is (0.2) you’re
taking antidepressants and al- alcohol
is an antidepressant (0.9) so you’re
actually (0.6) not really getting
anything from your tablets
CALLER: No
(1.2)
ADVICE WKR: So you’re kind of stuck in a vicious
circle
CALLER: Yeah
ADVICE WKR: Mm (0.6) have you been to your d:doctor
about this
CALLER: No
ADVICE WKR: No (0.6) and you don’t want to
CALLER: No
(1.1)
ADVICE WKR: Do you live in Northampton
CALLER: Yes
(1.5)
ADVICE WKR: E:rm (0.6) do you fancy coming up to
s:see us
CALLER: Yeah
(0.5)
ADVICE WKR: Yeah
CALLER: Yeah
ADVICE WKR: .hh hh wonderful hhh right you know if
you a-er- come in as a walk in
CALLER: Mhm
ADVICE WKR: (0.9) e:rm you’ll get to see erm: (0.9)
an advice worker twenty minutes what
they’ll do is they’ll take a bit more
history from you (1) e:rm (1.1) erm see
if we can: (0.6) like get you booked in
for an assessment A S A P
CALLER: Yeah
(0.5)
ADVICE WKR: and e:rm
CALLER: I don’t always feel suicidal
ADVICE WKR: No
(1)
CALLER: Erm
(1.9)
CALLER: I did last night
(0.2)
ADVICE WKR: Mmm
CALLER: I did e:rm (3) on (2) well (0.8) it- it
just scares me
(0.4)
ADVICE WKR: Yeah
CALLER: That I’m gonna do something
ADVICE WKR: Mmm
CALLER: An:d e:rm (1) do y’ know what I mean
ADVICE WKR: Mm

ADVICE WKR: Can you get in today?

CALLER: (1.1) I can't

ADVICE WKR: You can't

ADVICE WKR: When can you get in do you think?

CALLER: (1.9) it'll it'll not be till ne- (0.3)

ADVICE WKR: This sounds terrible don't it (.). erm

CALLER: (1.6) I mean (0.3) I feel (0.3) that I

ADVICE WKR: function

CALLER: (0.5)

ADVICE WKR: Mmm

CALLER: I mean you know the reasons I can't

ADVICE WKR: come in today is I'm doing a (0.2)

CALLER: course on child protection

ADVICE WKR: Right

CALLER: ['Cause I run a play scheme for

ADVICE WKR: children with disability

CALLER: Erm Friday I've got to go and see the

ADVICE WKR: clinical psychologist about my

CALLER: daughter

ADVICE WKR: Mmm

CALLER: Erm I mean I feel like I function

ADVICE WKR: =Relatively (0.6) normally really (1)

CALLER: but I know that I drink too much

ADVICE WKR: Mhm

CALLER: And I know (0.2) that (1.3) hh I get

CALLER: (0.2) well I get scared

CALLER: (3.4)

CALLER: But do you know what I mean

CALLER: (0.7)

CALLER: th- the rest of the time I feel I

CALLER: function (1.2) alright (0.4) which is

CALLER: probably ridiculous 'cause I probably

CALLER: don't

CALLER: (3.9)

ADVICE WKR: E:rm (0.4) no I think y' know I think

ADVICE WKR: you do function (0.3) but erm in in

ADVICE WKR: most things but it it actually seems to

ADVICE WKR: be erm (0.5) wearing you do?n?

CALLER: Mm-

ADVICE WKR: You sound like you do an awful l?ot?

CALLER: Yeah I do

ADVICE WKR: And e:rm (0.9) yeah it sounds like its

ADVICE WKR: really wearing you down

CALLER: Mm

ADVICE WKR: E:rm (0.6) e:right lets just have a

ADVICE WKR: look (2.9) I: (0.7) I can send you out

ADVICE WKR: (0.4) I know you can't get in till next

ADVICE WKR: week but I can send you out a pack

CALLER: Yeah

ADVICE WKR: Yeah so you can be getting on with that

CALLER: Yeah

reading it and everything
And you can phone here every day until
your appointment if you want to just to
talk to somebody [just to]

get it off your chest do you know what
I mean

[Erm: 2.4] I mean I’ve got other phone
numbers but you’ve prob- you sound like
you’ve probably got a load yourself

[0.8]

Mm-

[Erm: 2.0] I mean I’ve got other phone
numbers but you’ve prob- you sound like
you’ve probably got a load yourself

[1.3]

Mm

[Erm: 0.5] but I can give you families
anonymous: [2]
have you [have you]

[I feel ]

Have you got any support (0.5) for your
you know for all (0.2) with (0.2) for
other with other parents for y’ for
your daughter

I mean well (0.6) you know I actually
run a support group

Mmm

With a with a friend for this play
scheme thing that we do (0.9) and (1)
twelve months ago I was really really
depressed I was (0.3) er in a bit of a
(0.4) bad (0.5) way

Mmm

And I started to have counselling which
I still have

Oh right

And (0.3) but I never ever spe:ak about
the fact that I drink

(0.9)

Right

[3]

It’s like that’s a different bit of me
(2.8)

Am I making sense or am I
talk[ing crap]

[No no ] you’re making sense erm
(1.1) maybe that’s i- maybe you’re just
not ready to talk about that just yet
(0.6)

Well:=

=Had you thought of that

(0.7) Yeah

‘Cause there’s it sounds like you’ve
got a hundred and one other things
that you’re dealing with a[s we’ll]

[0.6]

Mm-

[Erm: 1.9] and you know also the fact
that you don’t (. ) discuss the fact
(0.4) that you drink

Mm-

Might be because you don’t want him to
know you don’t want to admit it (0.5)
maybe because that’s ‘cause it’s your little thing do you know what I mean
I said- I told my husband last night I was going to ring you today
Yeah (0.5) what did he say
Fine
(0.8)

Is he supporting you
Yeah
Yeah (.) wonderful=
‘Cause I just said I drink too much
Yeah
(0.5)

I said I think I’ve got a drink problem (1.2) and he just said yes (0.5) I think you’re right (0.8)

‘Cause er that’s really important (1.1) that you’ve got (0.3) you know somebody supporting you or (2.1) or just being there for you=
Mm (0.9) he’s lovely
Good
(2.7)

well I don’t know what to say about (0.2) I wouldn’t stop taking (0.4) your antidepress[ants]
No I I’m not going to
and you could try: and (0.6) cut down on the amount (0.3) that you’re drinking you know for every (0.8) do you drink them out the can or do you drink it out of a glass
A glass
For every glass: of lager you have can you try and have (...) a drink of water as well (0.9) ‘cause it’s actually because y’ it’s dehydration that gives you a hangover
Yeah

So what I’m thinking is if you have a glass of lager (1) and then have a glass of water straight after the same amount (0.8) it might actually help
Mm-
(0.9)

Might also (0.4) help you cut down a little bit as well ‘cause you’ll be filling up with fluid
Mm
(0.9)

(1.6) if you can cut down to like two
(1.6)
359 CALLER Mm
360 ADVICE WKR Ern: and see how you go (0.6) an’ (0.4) come here and see us next week at your first per- first possible opportunity
363 CALLER Yeah
364 ADVICE WKR Erm just say you phoned up and that (0.9) e:rm ↑o::r (2.4) I just wondering if I can (0.4) make you an assessment appointment now (2.1)
369 ADVICE WKR ‘just hold the line I’ll go and see if there’s anything free’ (13)
370 ADVICE WKR You say you can’t (0.7) you can’t get in till next week (1.1)
375 CALLER Was gonna get((unclear)) (18.4)
377 ADVICE WKR What about (1.7) Wednesday the fourth of December (0.8) a[t th]ree o’clock
379 CALLER (Yeah)
380 CALLER No I can’t that’s school (0.6)
383 ADVICE WKR School
384 CALLER Yeah ’cause I’ve got a five year old as well
386 ADVICE WKR Right okay what about (0.9) Thursday the fifth at ten thirty
388 CALLER No I can’t do that
389 ADVICE WKR Ahh hh hh
390 CALLER That’s me birthday
391 ADVICE WKR Oh ri:ght
392 (4.7)
393 ADVICE WKR Now Saturdays no (0.7)
394 ADVICE WKR No good on Saturday (2)
397 CALLER That is difficult Saturday (1.6) because my big one’s here then
399 ADVICE WKR Right okay
400 CALLER It’s very difficult for one person to cope with (0.4) [her ] [Yeah]
403 CALLER and the other one as well (1.9)
404 (2)
405 ADVICE WKR ‘Ri:ght’
406 (2)
407 CALLER What about Monday morning the second
408 ADVICE WKR I’m just having a look (2.2)
409 (2.2)
410 ADVICE WKR You see I’ve got nothing written in the diary at the moment bu:it (0.8) that don’t mean to say that nothing will be so (0.6) tell you what I’ll do (0.5) I- can I take your phone number
415 CALLER Yeah
416 ADVICE WKR A:nd (0.4) I’ll get hold of a (0.6) see what the advice workers are doing get somebody to pencil something in so
419 (0.7) Monday (0.8) A M
CALLER Yeah

ADVICE WKR Would be good for you yeah

CALLER Yeah

(2)

ADVICE WKR Right o' hh

(1.5)

CALLER Did y' say this Friday

(2.2)

CALLER The twenty nineth

ADVICE WKR No

CALLER Oh=

ADVICE WKR Like next fri- next week I said

CALLER Right sorry

ADVICE WKR Yeah erm

(0.7)

ADVICE WKR Right so what's your what's your

surname for a start

CALLER Ilkman I-L-K-M-A-N

ADVICE WKR I-L-K-M-A-N

CALLER Yeah

(1.6)

ADVICE WKR And your a- telephone number

CALLER ((gives number))

ADVICE WKR ((repeats number))

CALLER Or I can give you me mobile number

(0.5) "that's" (0.5)

ADVICE WKR Go on then

CALLER ((gives number))

ADVICE WKR ((repeats number))

ADVICE WKR Right (0.7) what I'm gonna do (1) is I

will (0.4) get this sorted out (0.5)

this are you in this morning

CALLER Mhm

ADVICE WKR Right I'll get this sorted out get back

to you on the telephone

CALLER Yeah

ADVICE WKR Erm but I'll start processing (0.3) erm

you paperwork and try and get you in a-

and get you a pack sent out

CALLER Right

ADVICE WKR Yeah (0.4) so can I just take your

address

CALLER Yes its ((gives address))

... 

CALLER I feel barmy now

ADVICE WKR W(h)y hh hh

CALLER Because (0.8) you know I'm just like

(0.7) you know quite a normal sort of

functioning (0.5) person

ADVICE WKR Mhm

CALLER Who does lots and lots of different

things (0.9) and then it's like (0.3)

at night time I'm different (0.7)

'cause I drink this beer

(1.7)

ADVICE WKR Erm (1.1) maybe it's just your release

(0.4) d'y' know (0.2) because you you

b- you do like you said y- you function

so well in the dayti[me

CALLER (0.9)
And then come the night time it's your
time to relax

Yeah

An (0.6) maybe that's what you do

Yeah

But erm:

It is (.) I drink (0.2) far too much

(0.9)

Try not to beat yourself up about it

(1.3)

Because (0.7) it really does make it
worse

(1.6)

I know that sou- it might sound daft

but (0.4)

Every night it's I'm not going to have a
drink tonight

Hh

(not going to have a drink tonight

(2.9)

Then I think well Wednesdays me day I
go counselling and I always find that
hard so I'll have a drink tonight

(1.3)

Tomorrow never comes

(0.7)

Well right at this present moment I
think you just (0.3) you gotta say
your going counselling today or you've
been

Tonight [I go]

[Tonight

Yeah

So you know (1.4) I don't know
really you could appro- is he te- do
you get on really well with your
counsellor

(0.9) Yeah I think so

Yeah

Yeah

Have you tried maybe broaching the
subject

I don't want to

You don't want to

It's like I don't want (0.4) her to know

Right

It's (0.2) I don't want anybody to know
really that's why I won't go and see me
doctor

Mhm

(2.5)

I'm sure the doctor won't (0.3) I don't
y' d- your doctor won't condemn you

(2.7)
I mean that's really what they are there for isn't it is to help

I don't want it on my notes

Right

Does that sound stupid

No I don't think it does

It's erm well it's entirely up to you

But

I think if you I think the more that you self loath because of what you are doing

The worse it will become

Erm and then you you s- you y' know your already in a circle gonna get worse 'cause you're gonna hate yourself so you're gonna (0.6) you know what I mean

[Drink and then you're gonna have a drink and that'll make you hate yourself and it's just (1.1) you know obviously there's something going on that (2.5) that you're not that you're not dealing with properly

And the only your only way out of it is to have a drink

But you know you phoned up here today (2.7)

'Cause if you was that bad I'd um sure you could've carried on a bit longer

If what sorry

Say if you was that bad I'm sh- you know I think you would have carried on a bit longer (0.9) before phoning somebody or maybe you wouldn't have done (0.3) but you've actually reached out and said you know I've got a problem please help

(2.4)

So that's really positive

Yeah

So what I'll do then Sue is I'll get (0.6) I'll go and chase up some advice workers and see if they'll put their names in the diary so let me just write this down so y' Monday
Mm

(1.4)

Erm I’ll (0.4) see what I can get hold of and then I’ll give you a ring back

(0.7)

[Uhu

[And I’ll see if we can confirm it

Yeah

Okay then=

Okay then

(0.3)

Alright

Alright then thank you

[I’ll speak to you in a bit

Okay then

Bye=

Bye