Problematic eating and its public accountability: the discursive construction of agency in radio talk

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PROBLEMATIC EATING AND ITS PUBLIC ACCOUNTABILITY: 
THE DISCURSIVE CONSTRUCTION OF AGENCY IN RADIO TALK

by

SAMANTHA BROOKS

submitted in accordance with the requirements
for the degree of

DOCTOR OF PHILOSOPHY

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DECLARATION

“I declare that Problematic Eating and its Public Accountability: The Discursive Construction of Agency in Radio Talk is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references.”
ABSTRACT

This thesis is a discursive psychological and conversation analytic examination of discourse and interaction about food, weight and eating behaviours. The data corpus consists of approximately twenty eight hours of talk recorded from UK radio broadcasts between 2002 and 2007, the majority of which were found through online archives. Within this corpus are a variety of different radio shows where the topic under discussion is body weight or eating behaviours. Data was transcribed using the Jeffersonian method which was developed for conversation analysis (CA). After transcription was complete, CA was used to examine the design and function of the interaction, in particular its sequential organisation within the institutional setting of a radio show. Using CA I explore how radio hosts, guests and callers orient to each other's turns in talk; examine what they make relevant in their descriptions of eating behaviours; and identify patterns of social interaction within the data. Membership categorisation analysis has been used to examine how individuals develop and employ categories within their talk. I have used membership categorisation analysis to focus particularly on how identity work is done in first turns, in 'scene-setting' and in hosts' questions. Throughout the four analytic chapters contained within this thesis, insights from discursive psychology (DP) have also been used, to examine the ways in which individuals use language to construct versions of events, and orient to issues of agency and accountability.

In the first analytic chapter I examine the opening sequences of radio shows; that is, greetings between the host and the caller or guest, how the caller or guest is introduced by the host for the benefit of the listeners, and the caller's or guest's subsequent introductory turn. I explore these introductory turns – which invariably take a long, 'narrative' form – and discuss the identity work that is achieved within them. In the second analytic chapter I focus on one particularly salient type of identity construction; that is, the 'ordinary' identity in 'extraordinary' circumstances. The third analytic chapter explores participants' use of both 'medical' and 'moral' language. Using DP I examine the 'psychologising' done by participants (i.e., their use of 'professional' psychological or medical language) and its location in a sequence or narrative, and consider the function of the language in terms of identity and accountability. I also discuss the morality embedded in much of the participants' talk, and consider how medical language and moral language might both function in
similar ways to manage accountability. In the fourth and final analytic chapter, I examine participants’ grammatical and metaphorical constructions of agency. I identify several different ways in which participants work linguistically to negotiate personal responsibility for eating behaviours.

Therefore, this thesis is an exploration of how accountability is managed in talk, using DP and CA to unravel some of the discursive practices deployed to negotiate accountability for eating behaviours. The findings contribute to the small, yet growing, body of research using ethnomethodological techniques to explore talk about food and weight, and form the foundation for further inquiry into the conceptualisation of agency in eating behaviour talk. The findings also add to existing research on the sequential organisation of radio talk.

Key Terms: Eating disorders, eating behaviour, the body, qualitative research, conversation analysis, discursive psychology, accountability, radio talk

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PREFACE

"An eating disorder is not usually a phase, and it is not necessarily indicative of madness. It is quite maddening, granted, not only for the loved ones of the eating disordered person, but also for the person herself. It is, at the most basic level, a bundle of contradictions: a desire for power that strips you of all power. A gesture of strength that divests you of strength. A wish to prove that you need nothing, that you have no human hungers, which turns on itself and becomes a searing need for the hunger itself. It is an attempt to find an identity, but ultimately it strips you of any sense of yourself, save the sorry identity of 'sick'. It is a grotesque mockery of cultural standards of beauty that ends up mocking no one more than you. It is a protest against cultural stereotypes of women that in the end makes you seem the weakest, the most needy and neurotic of all women. It is the thing you believe is keeping you safe, alive, contained - and in the end, of course, you find it is doing quite the opposite. These contradictions begin to split a person in two. Body and mind fall apart from each other, and it is in this fissure that an eating disorder may flourish, in the silence that surrounds this confusion that an eating disorder may fester and thrive."


I approached my PhD having recently completed my undergraduate dissertation, a qualitative examination of the role of the media in body image dissatisfaction. I was - as I had been throughout the entirety of my degree in psychology - interested in eating behaviours, problematic relationships with food, disturbances in body image and conditions of disordered eating, and particularly fascinated by how opinions and identities related to this were constructed and portrayed in talk.

My interest in food- and weight-related discourse stemmed from my dissatisfaction with the quantitative measures prevalent in eating disorder research. Given that the general perception of eating disorders is that they are methods by which individuals strive to assert their identity and personal control, it seemed to me that it would be somewhat ironic for me to write about someone’s struggle for an identity whilst simultaneously ignoring their first hand experiences and denying them a ‘voice’ in the research.

Having spent my final semester as an undergraduate carrying out interviews with other students on how they felt about food, the current ‘diet culture’ and their own body image, I maintained an interest in ‘food talk’ but was frustrated by the
interview process and the features of my data which I felt were bound up with my position as interviewer, my relationship with the interviewees and the questions I had opted to ask. The subjectivity and potential biases involved with me, as a researcher, guiding the talk I was interested in seemed to go against the principles of the analysis I wanted to do. I wanted instead to examine talk occurring outside of the context of an interview specifically set up for research purposes; talk which would occur whether my research existed or not. It was while researching various qualitative methodologies during my dissertation that my interest was piqued by the (often overlapping) areas of conversation analysis and discursive psychology.

My desire for ‘naturally’ occurring interactions revolving around food and weight – that is, interactions which would be taking place regardless of whether my research existed – coupled with my developing interest in conversation analysis and discursive psychology led me to first consider the practicalities of various ways of obtaining naturalistic conversations about problematic eating. I initially considered the possibility of recording calls to a helpline for individuals worrying about eating behaviours or weight, since a great number of helplines exist today, including several devoted to various eating disorders and weight issues. However, after several months of trying to negotiate access to two particular helplines it soon became clear that the ethical issues and time constraints that would be involved in such a process would be problematic, and this led me to consider a different type of phone call, one already existing in the public domain: the radio call-in.

Radio call-ins occur every day, on countless different radio stations, and cover a wide range of different and topical issues - from politics to religion to health, and most interestingly for me, to issues regarding weight, diet and body image. Ironically, having devoted my dissertation to the problems with the relationship between individuals and the media and being very critical of the media in terms of promoting unrealistic ideals, I was now actually examining a form of media and the voice it gave to the people who featured on it. As I started collecting recorded call-ins through online archives, I found another interesting type of radio show which I will refer to throughout this thesis as “talk radio”; and so my data corpus began to grow. Both types of radio talk will be discussed further in Chapter 2.
I feel it should be stated here that I, rather like the individuals whose talk I have analysed in this study, have personal experience of disordered eating. Rather than biasing or hindering my work, I feel that this may actually serve to facilitate my research; as Mills (1959) suggests, it may be useful for one to apply their life experiences to their intellectual work. Padgett (1998) suggests that for someone involved with social research, it may be useful to draw upon one's own personal interests and choose to examine situations one is familiar with in order to have 'a head start in knowledge about the topic' (ibid., p. 26). I feel that along with bringing my analytic skills and psychological knowledge to this research, my personal experience with an eating disorder means I also bring sensitivity and compassion to my work as well as a deeper understanding of the issues discussed in this thesis than I would have if I were simply a researcher 'on the outside' of the issues I seek to examine. Reflexivity has therefore been an ongoing concern, which will be discussed further in Chapter 2.
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1. Introduction

This thesis is a discursive psychological and conversation analytic investigation of discourse and interaction around food, weight and eating behaviours. The data corpus for this research consists of talk recorded from UK radio broadcasts between 2002 and 2007. The corpus includes radio shows on a wide variety of topics related to eating behaviours; for example, shows focussing on obesity, anorexia and bulimia nervosa, dieting, and body image. The focus of the thesis is on both patterns of interaction between radio callers/guests and hosts, and the personal 'narratives' that members of the public deliver on the radio. Remarkably salient in these personal stories are issues of accountability, agency and responsibility; therefore, this thesis explores how individuals manage issues of accountability in their talk.

This introductory chapter will provide an introduction to the research topic through descriptions and evaluations of existing academic literature in the field of body image and eating behaviours. I will briefly outline various studies in this area, critically considering the theoretical bases of the analyses. This meta-analysis will be used to justify the context of my own study and the various analytic tools used therein. As my research focuses on talk about problematic eating behaviours, there are frequent mentions of food, diet, weight and body image in my data. Therefore I have reviewed a wide range of literature on both ‘eating disorders’ and ‘body image’.

This chapter will discuss how research into problematic eating behaviours has progressed over the years. I will begin by discussing ‘problematic eating’ and how it has been conceptualised in academic literature, before examining existing literature on the concept of ‘body image’. I will then argue the benefits of taking a more ethnomethodological approach to the topic, describing how conversation analysis and discursive psychology could be applied to research by outlining several other studies which have used this kind of approach to study eating behaviours. Finally, I will give an overview of what you the reader can expect from the analytic chapters of this thesis.
Therefore, this chapter will include:

- An overview of existing literature relevant to my research, including research on eating behaviours and on body image;
- Analysis of this existing research, locating how my own study fits into this;
- Finally, an overview of the structure of this thesis as a whole.

1.1 The conceptualisation of 'problematic' eating

Recent years have seen a vast increase in the prevalence of disordered eating, making this an extremely relevant and important area to research. There currently exists in the western world (and, increasingly, globally) mass dissatisfaction with body weight and consequently problematic eating behaviours, particularly among women. Dieting, defined as a “collection of practices centred on attempts to eat less in order to be thinner”, has become commonplace (Booth, 1994, p.145). It has been suggested that 25% of men diet at some point in their lives (Rozin & Fallon, 1988), compared to 95% of women (Ogden, 1992).

I want to begin by giving a brief description of what is meant by the term ‘eating disorder’ (for detailed discussions, see Abraham & Llewellyn-Jones, 2001; Slade, 1984). There exist multiple interpretations of eating disorders in academic discourse. The term ‘eating disorder’ is generally assumed to refer to severe disturbances in eating behaviour, such as ‘anorexia nervosa’ (extreme reduction of food intake) and ‘bulimia nervosa’ (where food intake is followed by ‘purging’ behaviour, either through self-induced vomiting or laxative use). The existence of anorexia nervosa has been noted for centuries; early interpretations of the condition saw starvation as being related to religion, as in the twelfth and thirteenth centuries it was considered ‘saintly’ and spiritually pure to exist without nourishment and so women who fasted for prolonged periods of time were highly esteemed (Hepworth, 1999). Nowadays, anorexia nervosa is described as one of the most common chronic illnesses among young women (Touyz & Beaumont, 2001) and cases of anorexia have been rising steadily in recent years. Currently, anorexia nervosa is classified as a
psychiatric disorder, and is said to have the highest mortality rate of all ‘psychiatric
disorders’ (Gremillion, 2003) and one of the highest ‘relapse’ rates (Kennedy &

Eating problems may not only express themselves as anorexia or bulimia
nervosa but also as compulsive over-eating and obesity. Obesity and extreme thinness
are rarely written about together, though people who compulsively overeat may go
through many of the same experiences as those who restrict and/or purge their food;
this thesis aims to examine talk from people at both ends of the spectrum, as well as
those in between.

It may seem at first that individuals could be classified straightforwardly as
either ‘eating disordered’ or as having a ‘normal’ relationship with food. Indeed,
Malson (1998) suggests that anorexics are seen as ‘different’ from the non-clinical
population. The dominant conceptualisation of eating disorders in psychology is as a
psychopathology (Hepworth, 1999), with eating disorders generally thought to be
disorders of thinking marked by disturbed attitudes towards eating (see De Silva,
1995). The majority of literature on eating behaviours stems from clinical research
using the particular pathologised group of eating disordered ‘patients’ and is
concerned with ‘abnormal’ eating practices, such as starvation or purging (e.g. Lopez,
Tchanturia, Stahl & Treasure, 2008; Madigan & Goldner, 1998), overlooking the
hugely pervasive ‘ordinary’ weight management practices such as dieting and joining
slimming clubs which, rather than being pathologised, are frequently presented as
desirable.

However, in recent years there has been a shift away from individualistic
notions of seeing disordered eating as ‘pathology’ (see Hepworth, 1999; Malson,
1999). The symptoms, thoughts and experiences of ‘patients’ with ‘eating disorders’
may well be familiar to many individuals not classed as ‘eating disordered’ according
to the clinical definition, and certainly body image disturbance does not seem to be
unique to eating disordered patients (see Frost, 2001; Meadow & Weiss, 1992). There
is some disagreement among researchers as to whether eating disordered individuals
should be seen as a specific clinical group (e.g. Orbach, 1993) or conceptualised as
being at the extreme end of a continuum (e.g. Chesters, 1994). Studies highlighting
the prevalence of body image dissatisfaction emphasised the importance of studies of the non-clinical population; for example, Garner, Olmsted, Polivy and Garfinkel (1983) examined the ‘normal’ population as well as ‘clinical’ population and found little difference in body (dis)satisfaction between eating-disordered participants and ‘normal’ participants, which suggests that food and weight concerns may pervade the lives of many individuals considered part of the ‘normal’ population. So while research has mainly focused on those diagnosed with ‘disordered eating’, this population represents the extreme end of a continuum of people experiencing body dissatisfaction and disturbances in eating behaviour, with many other people sharing a greater or lesser dissatisfaction with their appearance, with related problematic and contradictory relationships with food (e.g. Ackard, Fulkerson & Neumark-Sztainer, 2007; Cash, Winstead & Janda, 1986; Grogan, 1999; Malson, 1998; Polivy & Herman, 1985). This is known as ‘body image disturbance’, which originated as a diagnostic criterion for eating disorders but is now widely used to describe body dissatisfaction among non-‘clinically’ eating disordered women, and refers to a subjective unhappiness with one’s appearance (Thompson & Stice, 2001). Concerns about eating, food, the body etc are said to be intricately woven into experiences of womanhood from early adolescence (Dawson, 1990) and some commentators go so far as to suggest that periods of self-starvation, purging and bingeing are normative features of being female (Chesters, 1994).

Malson (2000) calls for ‘disordered eating’ to be redefined in such a way as to stop the classification of eating behaviours as either ‘normal’ or ‘abnormal’. If disordered eating is to be redefined, with focus shifted to experiences, it is important to examine people’s talk about food, weight and eating. This thesis analyses talk from individuals who would fit the traditional classification of ‘normal’, as well as those who would generally be considered part of a clinical population. Using conversation analysis and discursive psychology to focus particularly on identity construction, this thesis examines the identity categories that participants give to themselves. Using radio talk has allowed me access to a wide variety of personal narratives from individuals with different experiences, so within my data corpus are narratives from those who would be traditionally considered ‘normal’ as well as those who would be traditionally considered ‘disordered’.
Before I move on, I want to make clear the theoretical position that I adopt with regards to the eating-related conduct central to this thesis. It is important to you, the reader, that I explicitly state here the stance this thesis takes on the ontological status of the construct ‘disordered’ or ‘problematic’ eating. Firstly, throughout this thesis, I frequently use the phrase ‘problematic eating behaviours’ to describe all manner of eating ‘problems’, including extreme starvation, ‘yo-yo’ dieting, ‘picky’ eating, and over-eating. Any medical terminology used within this thesis is used only when made relevant by the participants themselves – for example, where participants have described themselves as being clinically diagnosed as ‘anorexic’, I occasionally use the term ‘illness’ to describe anorexia, simply as a reference to the diagnosis which has been previously applied to them. In some instances, I use the term “illness” – in quotation marks – where participants imply that some sort of medical diagnosis has been made but where the participants themselves do not take up this ‘ill’ identity. Secondly, in the introduction to this thesis I talk about psychiatric ‘illness’, ‘sufferers’, ‘causes’ and ‘diagnoses’ but only with regards to how other, earlier research has treated the concept of ‘problematic eating’. I would advise readers to keep in mind the critical view held by proponents of ‘anti-psychiatry’, i.e. that the conventional psychiatric definitions of what constitutes a ‘mental illness’ are not objective or value-free descriptions; that the definitions of and criteria for ‘mental illnesses’ are vague and potentially harmful and demeaning to individuals; and that, therefore, current ‘treatments’ may be unhelpful. I would also urge readers to consider both under- and over-eating (and all forms of ‘problematic’ eating in between) as not necessarily ‘illnesses’ but as equally important ‘problematic’ forms of conduct, the constructions of which are negotiated and managed in talk in a variety of ways. Currently, extremely underweight individuals are traditionally classified as ‘mentally disordered’, with a body mass index of 17.5 or lower enough to classify one as medically ‘anorexic’, while extremely overweight people are not considered to be ‘mentally disordered’. Why are dangerously underweight individuals classified as ‘mentally ill’, especially if dangerously overweight individuals are not? It is unnecessary, impractical and unhelpful to individuals to apply a diagnostic label to them based on their weight. Therefore this thesis treats all forms of ‘problematic eating’ as not illness but merely as what they are – ‘problematic’ forms of conduct. While I do discuss ‘illness’ in Chapter 5, it is in terms of where and how illness is
made relevant by the participants themselves, and considers a) not only how illness is constructed but how it may be rejected; b) variability in talk; and c) illness as metaphor (see Sarbin, 1990).

1.2 Body image

It would be impossible to discuss weight and eating behaviour without also considering the concept of ‘body image’, and therefore this section will discuss literature pertaining to the concept of body image.

Recent concerns about rising levels of problematic eating behaviours have brought the issue of body image to the fore as negative body image is associated with the development of disordered eating. Body image has therefore been given a great deal of attention in recent years, particularly within feminist debate (e.g. Grogan, 2006).

To date, there are no known, proven causes for the development of body image disturbance, though there exists a wealth of research exploring the possibilities. While it is acknowledged that eating disturbances and body image dissatisfaction may be attributed to a variety of factors (Thompson, Heinberg, Altabe & Tantleff-Dunn, 1999), much attention has been devoted to the examination of socio-cultural factors. For example, the contemporary media and its promotion of an unrealistically thin ideal is widely believed to be an important factor (Anderson & DiDomenico, 1992; Cusumano & Thompson, 1997; Stice & Shaw, 1994), as mass media is believed to be an important social educator and the most pervasive tool of communicating social standards (Heinberg, 1996). I now want to briefly discuss research on the media and its effects on body image and eating behaviour, as this makes up a large part of recent research in the area.
1.2.1 The media and body image

The media is seen as a powerful tool in creating and conveying social norms, particularly norms of attractiveness (Silverstein, Perdue, Peterson & Kelly, 1986; Wiseman, Gray, Mosimann & Ahrens, 1992). Although it is hard to quantify the role of the media in creating body image dissatisfaction, many researchers assert that the media does play a significant role: in advertising, thinness is frequently equated with happiness, beauty and success; society is bombarded with thin images and messages reinforcing the idea that thinness is the ideal (Cusumano & Thompson, 1997; Stice & Shaw, 1994). The mass media in western society has been attacked for increasingly idealising thinness and generating negative stereotypes of overweight people, with the criticism that this has resulted in mass dissatisfaction with body weight and shape (Tiggemann & Rothblum, 1988; Wolf, 1991) which may in turn result in disturbed eating patterns, unhealthy weight control behaviour and eating disorders (Bessenoff, 2006; Brumberg, 1989; Engeln-Maddox, 2006; Harrison & Cantor, 1997; Lindberg, Hyde & Mckinley, 2006; Powell & Kahn, 1995). It is claimed that current social norms pressure women to strive to achieve the ‘ideal’ appearance and conform to dieting behaviours in order to do so (Blau & Gullotta, 1996). A growing body of research has discussed the role of magazines and television in the etiology of eating disorders (e.g. Anderson & DiDomenico, 1992; Harrison & Cantor, 1997; Myers & Biocca, 1992; Silverstein, Perdue, Peterson & Kelly, 1986), suggesting that the ideals promoted by the media encourage unhealthy eating attitudes and body image dissatisfaction. The rise of the fitness industry in recent years has added a further dimension to the idea of the ‘ideal body’, implying that not only does one have to be thin but also perfectly toned (Guendouzi, 2004).

There is much evidence to support the notion that the media does promote thinness as an ideal: content analyses of media output have indicated an increasing gap between the body weights of the general population and the body weights of women in the media who serve as role models (Garner, Garfinkel, Schwartz & Thompson, 1980), and Wiseman, Gray, Mosimann and Ahrens (1992) note a decline in the weights of models appearing in women’s magazines, with the average model nowadays weighing significantly less than the average woman (National Eating Disorders Association, 2002). There seems to be increasing pressure from the media.
to conform to the thin ideal they present, with an increase in recent years of magazine articles about dieting (Garner et al., 1980), exposure to which has been associated with psychosocial distress and unhealthy weight control behaviours (Levine, Smolak & Hayden, 1994; Utter, Neumark-Sztainer, Wall & Story, 2003).

Researchers have warned that by promoting an ideal impossible to achieve the media is creating an increased dissatisfaction (Favaro & Santonastaso, 1996). There have been many studies demonstrating greater body image disturbance following exposure to thin images rather than average of neutral images (e.g. Groesz, Levine & Murnen, 2002; Heinberg & Thompson, 1995; Pinhas, Toner, Ali, Garfinkel & Stuckless, 1999). Further evidence of the media's impact comes from countries newly exposed to western media culture, such as the study examining the impact of the introduction of television in Fiji (Becker, 1995). It was found that poor body image and eating disorders increased significantly following the introduction of television. Becker, Burwell, Herzog, Hamburg & Gilman (2002) found that, three years after the introduction of television, dieting had become commonplace in a country where larger body shapes and good appetites had previously been celebrated; it was suggested that girls living in houses with television sets were three times more likely to show symptoms of eating disorders.

Despite the consistency of findings in the area, the relationship between exposure to media images and body image disturbance is clearly not straightforward and likely to be mediated by how people view, evaluate and interact with the media material they are exposed to. A number of recent studies examine the role of individual characteristics in an attempt to assess which type of person is most affected by exposure to the thin ideals in the media, with many mediating factors being offered, including a negative body image prior to exposure (Posavac, Posavac & Posavac, 1998); comparison of one’s appearance to that of others (Van den Burg, Thompson, Obremski-Brandon & Coovert, 2002); and greater internalisation of media ideals (Thompson et al., 1999). There has been wide support for the idea that excessive comparison of one’s appearance to those ideals promoted by the media has a detrimental effect on body image. Stacey (1995) suggests we currently live in a culture of celebrity worship where women in particular tend to hero-worship other women and desire to look like them; Greer (1999) remarks that media industries give
the message to women that "she is a failure if she is not beautiful" (ibid., p. 19). The girls in Becker’s (1995) study who demonstrated body image disturbance freely admitted in interviews that they admired certain television characters and tried to emulate them. Myers and Biocca (1992) suggest that the media promotes ideals to serve as points of comparison, and that women configure an internalised ideal body with body image satisfaction depending on nearness to this ideal. Similarly, Furnham and Greaves (1994) propose that the core of body image dissatisfaction is a discrepancy between a person’s perception of their own body and perception of the ideal, with failure to match up to the ideal leading to lower self-worth. This idea of trying to meet the ideal can be related to Festinger’s (1954) theory of social comparison, in which it is implied that people make comparisons between themselves and people they perceive to be similar to themselves in some way. This model would predict that people use media figures they relate to as standards for comparison and make negative self-evaluations if these standards are not met.

Another factor which has been proposed as a mediating variable in the relationship between the media and body image is the extent to which individuals buy into societal ideals of attractiveness, termed ‘thin-ideal internalisation’ (Thompson et al., 1999). Thin-ideal internalisation generally tends to be assessed by use of the Sociocultural Attitudes Towards Appearance Questionnaire, or SATAQ (Heinberg, Thompson & Stormer, 1995) which measures the tendency of an individual to strive to reach social standards of appearance and has been well validated (Smolak, Levine & Thompson, 2001). The revised edition, the SATAQ-3R (Thompson, Van den Burg, Keery, Williams, Schroff, Haselhuhn & Boroughs, 2000) contains two scales: awareness (simple acknowledgement that media pressures exist) and internalisation (endorsement of media pressures in relation to appearance), along with the subscale of social comparison. Several researchers have provided support for the notion of thin-ideal internalisation playing a role in body dissatisfaction, with higher levels of internalisation predicting body dissatisfaction (e.g. Cusumano & Thompson, 1997; Stice, Schupak-Neuberg, Shaw & Stein, 1994; Stice & Shaw, 1994; Stice, Ziemba, Margolis & Flick, 1996). Stice, Shaw and Nemeroff (1998) suggest that low self esteem may be one of the factors affecting an individual’s vulnerability to media influence, an idea which is supported by findings of a positive correlation between body satisfaction and self esteem (e.g. Mintz & Betz, 1986; Ricciardelli & McCabe,
2001). Myers and Biocca (1992) suggest that body image is ‘elastic’, conceptualising it as open to change depending on self esteem or stress.

Some studies report finding a relationship to media exposure and concerns about body weight for women but not men (e.g. Murray, 1999; Cusumano & Thompson, 2001; Tiggemann & Ruutel, 2001) and it has been proposed that this is because women make more social comparisons than men (Jones, 2001). Research has found adolescent girls to be more affected by body image than boys (Polce-Lynch, Myers, Kilmartin, Forssmann-Falck & Kliwer, 1998), which is mirrored in adulthood where women show greater psychological investment in their appearance (e.g. Cash & Brown, 1989; Cash & Hicks, 1990; Jackson, 1992; Pliner, Chaiken & Flett, 1990). Other studies challenge the notion that males are not as vulnerable to media pressure and suggest that exposure to media ideals does result in greater body image dissatisfaction and dieting behaviour in males (e.g. Harrison & Cantor, 1997; Ogden & Mundry, 1996). It is clear that the issue is still under debate – some researchers even report that males view the media as having a positive effect on their body image (Ricciardelli, McCabe & Banfield, 2000). One argument is that, rather than differing in terms of how media ideals are internalised, there is actually less pressure on men to look a certain way and that this accounts for gender differences in body image disturbance. It has been found that diet advertisements and articles appear ten times more frequently in women’s than men’s magazines – a figure which closely reflects the ratio of incidence of eating disorders for women to men (Anderson & DiDomenico, 1992; Nemeroff, Stein, Diehl & Smilack, 1994). While there is ongoing debate as to how much pressure the media puts on men to look a certain way, relatively little attention has actually been paid to media representations of the ideal male body. Dittmar, Lloyd, Dugan, Halliwell, Jacobs and Cramer (2000) found that adolescents described the ideal woman in terms of beauty and thinness, whereas the ideal man was described in terms of athletic body and physical prowess. Mishkind, Rodin, Silberstein and Striegel-Moore (1986) agree that a muscular body type functions as the male ideal.

While the wealth of literature pertaining to people’s feelings about their weight in terms of the internalisation of socially defined ideals of beauty and thinness is undoubtedly an interesting and important part of ‘eating behaviour’ research, it is
disappointing in that it views women as passive, assuming they are submissively exposed to and influenced by media ideals (c.f. Hollway, 1989). It is interesting to note here that the literature discussed in this section polarises between active/passive and social/individual dilemmas. These ideas are addressed in the analytic chapters of this thesis (see section 1.7 for an overview); in particular, I look at how individuals can construct themselves as both active and passive in their talk, and how these seemingly polarised constructions can occur simultaneously in talk in an unproblematic way.

1.2.2 Changes in the ‘ideal’ body

It is possible to trace a cultural change in the idealised images of feminine beauty – images in art and the media of what constitutes the ‘ideal’ body have varied over time. In the middle ages voluptuous figures were celebrated, with plumpness seen as erotic and fashionable; roundness and curves were idealised by artists at the time, including Rubens and Manet, the latter of whom once had a painting criticised due to the subject not being sufficiently plump (see Myers & Copplestone, 1985). Prior to the twentieth century, being overweight was generally seen as a sign of wealth and power, with obesity taken to be the result of an abundant food supply (see Booth, 1994). Asexual flapper fashion after World War I celebrated an androgynous look, but during the 1930s - 1950s, the ideal turned back to a more shapely figure. The trend for thinness arguably did not properly begin until the 1960s with model Twiggy (see Freedman, 1986). Then the late 1990s saw the rise of ‘heroin chic’, glamorising a sickly, exhausted look with waiflike models not only having super-thin figures but black eye make-up, tangled hair and pale skin to look like the stereotypical heroin user.

It should be noted that the images of ‘ideal’ bodies I have discussed have generally been confined to those of women. While some researchers argue that the social pressure on men to look a certain way is less extreme, men are generally presented in art and magazines as muscular and toned (Gauntlett, 2002). Bordo (1993) suggests that society’s ‘ideal’ female body is thin, contained and firm while the ideal
male body is muscular, with the ideal for both genders emphasising firmness and toned bodies with no excess flesh.

I should also note that the images of ‘ideal’ bodies discussed have generally been assumed by most researchers to be the ‘ideal’ for young women in particular. While there has been a substantial amount of literature on body dissatisfaction in the general population, most research has concentrated on young women and adolescents, neglecting the experiences of older women. Of the research that does consider older people, findings have been contradictory. Hetherington and Burnett (1994) suggest that body image dissatisfaction is prevalent across the lifespan, but that older women may not feel this dissatisfaction as strongly as younger women. Lamb, Jackson, Cassiday and Priest (1993) suggest that older women’s ideal body size is larger than that of most young women’s. Adams and Laurikietis (1976) argue that women are often ashamed of ageing because it is linked with becoming less attractive. Ussher (1993) suggests that women feel culturally defined as useless when they have reached the end of their reproductive years. Tunaley, Walsh and Nicolson (1999) argue that body image dissatisfaction and the desire to lose weight, as well as feeling social pressure from others, are cross-generational phenomena.

Over the years women have been encouraged to change shape or size according to the current ideal even if this includes physical pain; for example, the wearing of restrictive corsets in Victorian times or the foot-binding trend in China. Nowadays, it is becoming more common for women to choose cosmetic surgery and/or strict diets and exercise regimes to conform to the societal ideals of slimness and attractiveness. Recent years have seen a significant increase in the number of individuals using cosmetic surgery (for example, liposuction) as a means of changing body shape (Pruzinsky & Edgerton, 1990; Wolf, 1991). Davis (1995) interviewed women who had undergone cosmetic surgery and found that participants often viewed the surgery as a way of taking control of their lives. There is also an increasing likelihood for men to resort to cosmetic surgery, as well as rising use of anabolic steroids to alter the body (Wright, Grogan & Hunter, 2000).

So, what other social effects has this recent obsession with thinness had? It has undoubtedly created the powerful diet industry that currently exists – as a society we
are inundated with books and magazines dedicated to losing weight, weight loss exercise regimes (with emphasis on losing weight rather than getting fit), radical diet plans (such as the recent Atkins diet phenomenon), low-calorie and low-fat foods, and television programmes devoted to weight loss, from healthy eating to weight loss surgery. Ogden (1992) suggests the dieting industry creates dissatisfaction and then offers to solve it; in this way, it is the 'perfect industry'.

Recent years have also seen a surge of controversial websites explicitly encouraging extreme thinness, often glorifying anorexia and giving tips on how to lose weight. These communities are commonly known as 'pro-anorexia' websites, or as simply 'pro-Ana', with 'Ana' being the nickname frequently given to anorexia by its sufferers as a way of personifying and familiarising the condition (see Davies & Lipsey, 2003; Pollack, 2003). The individuals frequenting such sites tend to advocate anorexia not as an illness but as a 'lifestyle choice' and they typically encourage extreme dieting behaviour and severe weight loss while being dismissive of recovery. Tips are often given on how to lessen the appetite, how to engage in bulimic behaviours and how to hide these behaviours from others. The sites also typically contain many images of thinness, from arguably 'healthy thin' celebrities to extremely emaciated 'anorexia' photographs, and often include a forum or message board where users can connect with like-minded individuals. The views of individuals within the 'pro-anorexia' movement are various, ranging from the denial of anorexia as a disease, to admitting that anorexia is an illness but stating that choosing not to recover is a personal choice which should be respected (see Bardone-Cone & Cass, 2006; Reaves, 2001; Taylor, 2002).

1.2.3 Socio-cultural aspects of the body

In recent years a number of researchers have begun to explore society's influence on disordered eating (see Hepworth, 1999; Malson, 1998), including the potential negative effects of societal or familial emphasis on thinness and physical appearance and stigma against obesity (e.g. Lieberman, 1995; Wertheim, Paxton, Schutz & Muir, 1997) and the oppression of women by global culture (see Chapkis, 1986; Chernin, 1981). Chernin (1985) suggests that women, afraid to grow away from
their mothers and gain their own independence, seek identity from an obsession with food. Orbach (1978) suggests that the body is a vehicle of self-expression; women become fat or thin to make statements with their bodies that they are otherwise unable to express.

Dolan and Gitzinger (1994) suggest that the change in ‘ideal’ body shape reflects the change in women’s socio-political position. They discuss the idea of being ‘rounded’ or ‘curvy’ in terms of this kind of body shape’s connotations of fertility and the ability to reproduce, in comparison to the ‘thin’ body which they suggest may be a statement that women should not be valued solely on their ability to reproduce. Similarly, Bennett and Gurin (1982) note the shift from the maternal figure as the ideal to the thin figure as the ideal, and suggest that this is symbolic of the expression of female sexual liberation; slimness, they propose, is opposed to fertility, and symbolic of androgyny and independence. Selvini-Palazzoli (1974) highlighted the link between anorexia nervosa and women’s multiple roles in society, emphasising the social pressure to conform to these roles. Grosz (1994) argues that anorexia is a protest against the social meaning of the female body. Orbach (1978) argues that there are confusing social expectations of women – for example a taboo on feelings of anger, and conflict around sexuality – and suggests that these conflicts could cause disordered eating.

Thinness has also frequently been linked to ‘power’. For example, Charles and Kerr (1986) suggest that women feel powerless in society and therefore take control of their bodies as a way of exerting power over something. Dolan and Gitzinger (1994) discuss the dichotomy of what the ‘thin’ body represents – on one hand it is seen as a symbol of power and freedom, but paradoxically thinness may also be disempowering as it reduces a woman to the shape of a child. Much of the early research on anorexia nervosa theorises anorexics as being devoid of power, though more recent research focussing on the ‘pro-anorexia’ movement (see section 1.2.2) acknowledges that anorexia may represent control and power (e.g. Ward, 2007). Wolf (1991) also explores the idea of thinness being disempowering, describing the drive for thinness not as an obsession with female beauty but as an obsession with female obedience.
A further dichotomy lies in feminist theories of disordered eating: on one hand, some theorists suggest that anorexia nervosa occurs as a result of the suppression of women in a patriarchal society (e.g. Chemin, 1983), with women conforming to hegemonic feminine beauty ideals. On the other hand, some theorists view the anorexic body as a protest against society’s ideals for women (e.g. Bordo, 1993; MacSween, 1993).

Crawford (1994) suggests that to be healthy is to be a good and moral person; to transgress advice on healthy living is to risk a stigmatised identity (Benford & Gough, 2006). There is moral pressure to conform to current ‘healthy’ norms of not smoking, drinking only in moderation, and – most relevant to this thesis – eating healthily.

What is lacking in these socio-cultural explanations for eating and dieting behaviours is an examination of individuals’ own constructions in talk. For example, it is one thing to suggest that a thin body may symbolise power or, conversely, disempowerment; but what is there within people’s interactions that illustrates this? Do eating-disordered individuals allude to this empowerment, or disempowerment, within their interactions with other people and if they do, how and why? Overall the theories I have glossed over in this section provide some interesting ideas but it would be far more useful to examine if and how these ideas are actually drawn upon in talk.

1.2.4 Physical appearance and the self

Several researchers have investigated the idea of physical appearance being representative of one’s inner self (see Granberg, 2006; Hepworth, 1995; Malson, 2000). Different body shapes have frequently been associated with different personal attributes. Bordo (1993), discussing the media and its potential to socially reinforce the desire to live up to an ‘ideal’, points out the media’s tendency to link thinness with positive attributes and favourable personality traits. Bruch (1978) agrees that television conveys the message that one can only be loved and respected when slender, and found that thin bodies represented in the media tend to be associated with youth and positive personality attributes. Frost (2001) suggests that the media
represents perfected bodies and stimulates desires to emulate these, and also that
dvice and imperatives to lose weight within the media reinforce the idea that being
thinner equals being a better, more loved person.

* Becker (1995) suggests that one’s physical appearance is seen to be a
reflection of the self; thinness is associated with restraint and control, while obesity is
equated with indulgence and laziness. Bordo (1993) agrees that slim bodies are
believed to imply that one cares about one’s appearance, suggesting willpower,
energy, and control. It has also been suggested that thinness is associated with
discipline, control, and assertiveness (Horesh, Apter, Ishai, Danziger, Miculincer,
Stein, Lepkifker & Minouni, 1996); virtue, goodness, morality, worth and kindness
(Bordo, 1990); success and morality (Brownell, 1991); attractiveness (Tunaley, Walsh
& Nicolson, 1999); confidence (Grogan, 1999) and youth and elegance (Orbach,
1993). Similarly, for men, being slim and muscular is associated with confidence and
control (Ogden, 1992) and strength and happiness (Kirkpatrick & Sanders, 1978).

If thinness is associated with control and morality, then consequently being
overweight is associated with being out of control and moral ‘badness’ (Evans, 2003;
Gard & Wright, 2001; Gordon, 2000). Obesity is generally looked down upon in the
modern western culture which glorifies thinness and stigmatises the overweight
(Schwartz & Brownell, 2004). Being overweight is associated with laziness and lack
of discipline (Bordo, 1990) and lack of self control (Guendouzi, 2004), as well as
greediness and general ill-discipline and unreliability (Allon, 1976). Crandall and
Martinez (1996) discussed attitudes towards body size in relation to attributions of
blame. They investigated attitudes toward the overweight among students and found
that American students in particular had an ‘anti-fat’ attitude and believed that
overweight people had little willpower and were lazy. They inferred that if an
individual can be seen as to ‘blame’ for being overweight because of laziness or lack
of willpower, then surely thinness would be associated with the opposite traits, i.e.
self denial and self control.
1.3 The complexities of eating behaviour

Eating disorders belong to the category referred to by Stainton Rogers (2000) as 'contested illnesses'; they are problematic to the medical profession because of the interrelationship between physical and psychological factors. It is becoming more apparent from research in recent years – particularly qualitative research listening to the voices of sufferers themselves, which I will go on to discuss later in this chapter – that eating disordered behaviour is complex and serves much greater purpose than to simply modify weight. In fact, it is now widely accepted that anorexia nervosa, originally nicknamed the 'slimmer's disease', often has very little to do with food or weight and much more to do with issues of control and identity. Lester (1997) describes anorexia as "an elaborate and sophisticated self-technology which has gone awry" (ibid., p. 488). It has been suggested that for many women their bodies have become arenas for expressing feelings that they don’t deal with or resolve in other ways (see Edut, 1998). For example, Fox, Ward and O’Rourke (2005) suggest that anorexia nervosa is a ‘sanctuary’ for escaping from other problems; Hornbacher (1998) suggests that anorexia is an attempt to "escape the flesh, and, by association, the realm of emotions" (ibid., p. 93).

Eating behaviour has frequently been linked to control: diet is one aspect of life over which the individual can exercise control (Bordo, 1993). Bruch (1974, 1978) suggests that anorexia may be an attempt to assert control over the body in response to feeling out of control in other ways: for those who are described as being “deficient in their sense of identity, autonomy and control” (Bruch, 1978, p. 39), the ability to control one's eating provides the opportunity to assert perceived control over the body. It has been suggested that symptoms of disordered eating tend to recur more in times of stress (see Newton, Freeman & Munro, 1993; Nagata, Matsuyama, Kiriike, Iketani & Oshima, 2000), whilst other studies report finding that snacking may be increased during stressful times (e.g. Conner, Fitter & Fletcher, 1999). These suggestions imply that food may be tied up with emotion and that disordered eating behaviour may be a way of asserting control when other aspects of life seem chaotic and stressful and a strategy for dealing with emotional distress.
Some researchers suggest that chronic dieting leads to feelings of being out of control with food, and to a cycle of starving and bingeing that leaves the individual feeling ashamed and guilty – for example, Keys, Brozek, Henschel, Mickelsen and Taylor (1950) studied a group of men who spent three months ingesting half the amount of calories they would usually consume. During the study the men showed an increasing preoccupation with food and, after the study when they were allowed to eat freely again, they reported bingeing and feeling out of control. This was replicated by Warren and Cooper (1988) with both women and men, and supported by self-reports from dieters (e.g. Charles & Kerr, 1986). These studies suggest there is a complex and dynamic relationship between dieting behaviour and (dis)satisfaction with the body.

The discourses of eating disorders are said to be bound up with moral and religious discourses (Bruch, 1988; Hornbacher, 1998). Madden and Chamberlain (2004) explored the discursive construction of food and healthy eating in texts in various women’s magazines, and found complex constructions of nutritional health interwoven with discourses of both morality and feminine beauty. In modern western culture, food and the female body are linked not only to physical behaviour but moral behaviour (Lawrence, 1979). Lawrence suggests that anorexia nervosa illustrates simultaneous physical control over weight and moral control through self-denial. At the same time, anorexia is illustrating a lack of control both physically and morally, due to the overwhelming fear of both gaining weight and of behaving in a way that is morally wrong. This kind of paradox is also commented on by Hornbacher (1998), who describes eating disorders as a bundle of contradictions: a desire for power, strength and identity which ultimately strips the individual of all three. Bruch (1974) suggests that eating disturbances are also bound up with the idea of control; she suggests that eating issues will arise when individuals feel that they have no control over their lives. The implication here is that women use food and dieting to construct and express the ‘self’ - control of food intake, and subsequently weight, can provide an artificial sense of ‘control’ and a sense of identity. Malson (2006) suggests there are multiple meanings of anorexia. She suggests that self starvation can be a way of asserting control, of numbing the self, of self annihilation, and of constructing one’s identity.
1.4 Examining body dissatisfaction

Many ways of assessing body dissatisfaction were originally designed to assess women diagnosed with anorexia or bulimia nervosa. This thesis explores the talk of women who have not necessarily been diagnosed with either of these conditions, as just because people may not fit the criteria for a clinical ‘eating disorder’ does not mean their relationship with food is unproblematic. In this section I therefore want to focus particularly on studies which have looked at body image in women picked entirely at random, or from opportunistic samples, and so may or may not be considered ‘eating disordered’ in the traditional sense of the term.

One widely used measure of body dissatisfaction is the ‘silhouette technique’ (originally by Fallon & Rozin, 1985) where silhouettes ranging from very thin to very large are shown to female participants, who have to select that which they feel is most similar to their own body as well as that which is most similar to their ideal body. The discrepancy between the two is an indication of (dis)satisfaction. Fallon and Rozin also asked individuals to choose the silhouette they thought men would choose as the most attractive. The results showed that the majority of participants chose their current figure as the heaviest, followed by that which men would find attractive, with an even thinner figure as their ideal. The results of this study have been replicated by other silhouette studies (e.g. Lamb et al. 1993; Tiggemann & Pennington, 1990) and by studies using photographs rather than silhouette drawings (see Huon, Morris & Brown, 1990; Wardle, Bindra, Fairclough & Westcombe, 1993) – overall, studies where women are asked to pick their ‘ideal’ figure consistently show that a huge percentage of women would like to be thinner than they perceive themselves to be.

Many silhouette studies with male participants have yielded different results, with no significant discrepancy between men’s ideal, women’s ideal, and current shape (e.g. Fallon & Rozin, 1985; Zellner, Harner & Adler, 1989; Lamb et al., 1993; Tiggemann, 1992). However, the data is scored by averages, and doesn’t take into account those dissatisfied because they feel too thin, only too fat. In fact, Mishkind et al. (1986) found that 75% of men showed some discrepancy between their current shape and ideal shape. Men were equally likely to pick a thinner ‘ideal shape’ as a larger one, whereas women are more likely to pick a thinner ideal.
Another method of body image (dis)satisfaction assessment is the self-report questionnaire; for example, the Body Cathexis Scale (Secord & Jourard, 1953; Furnham & Greaves, 1994), the Body Shape Questionnaire (Cooper, Taylor, Cooper & Fairburn, 1987), and the Body Attitudes Questionnaire (Ben-Tovim & Walker, 1991), all of which assess satisfaction with various parts of the body. Data from questionnaire studies has generally supported the results of silhouette studies.

Much of the research I have thus far discussed has been carried out within the methodological and epistemological framework of experimental psychology. However, such research reduces individuals and their experiences to numeric data and ignores the meaning and function of constructions of body image and food in an individual’s life. The estimates of body image dissatisfaction I have mentioned fail to tell us the reasons for dissatisfaction, how extreme the dissatisfaction is, how it affects the individual’s life, and so on. Far more fruitful would be analysis of what the participants themselves make relevant about their bodies, and the best way of investigating this is through looking at their talk. Another criticism of the various techniques of measuring body image that I have discussed is that all assume body image is a measurable construct – i.e., that ticks on a questionnaire will correlate with some kind of static mental entity or process. Also, none of the studies I have considered thus far have considered participants’ own words about their bodies. Therefore, in the next section of this chapter I want to examine some of the literature that does consider participants’ own words. This kind of qualitative research allows access to ambivalences and complex belief systems which would have been missed in questionnaires or surveys.

1.5 Qualitative research on eating behaviours and the body

Ironically, given that sufferers are the experts on their own conditions – they are the one living the experience, after all – what is absent from the majority of the research I have discussed so far are the patients’ own words. It has been suggested that the best way to examine human psychology is to look at real talk (Harré & Secord, 1972). An increasing amount of psychological research has paid attention to
narrative, especially in the health and illness field (e.g. Crossley, 2000; Murray, 1997, 2000), and Radley and Billig (1996) argue that individuals' views of their own health and illness are understood best as accounts that they present to others. Qualitative studies have emphasised the importance of understanding illness in terms of the patient's own interpretation, therefore enabling psychologists to understand the 'personal experience' of health and illness. The particular importance of revealing and exploring participants' subjective experiences of disordered eating through qualitative research has also been argued (c.f. Chan & Ma, 2002). Studies trusting participants' ideas and giving them their own voices have provided rich understandings (see Bruch, 1978), and so in this section I want to discuss some of the qualitative research carried out in the field.

Body image (dis)satisfaction and eating behaviours have been examined through the use of interviews (e.g. Germov & Williams, 1996; Hesse-Biber, 1996). I want to point out here that when interview studies are employed, the investigator must acknowledge that they serve as an instrument in the collection and analysis of data (Mason, 1996). One example of an interview study in the area of eating behaviour is that of Charles and Kerr (1986) who carried out semi-structured interviews with women about their dieting experiences and feelings about their bodies. They found that most women were dissatisfied with their bodies, the majority worried about their weight and had dieted at some point in their lives, and many did not accept themselves as they were and wanted to lose weight. While being slimmer was linked with good health, the majority of interviewees cited looks rather than health as their reason for wanting to lose weight. This was supported by Tunaley, Walsh and Nicolson (1999). Charles and Kerr's interviews also found that most women reported dieting in cycles – losing weight, then gaining it when they started eating normally, losing it again, and so on. Dieting was constructed as a long-term behaviour, though they often indulged in short-term similar behaviour (e.g. starving for a day before a night out) which they didn't class as a diet. Grogan (1999) also interviewed women about how they felt about their bodies. She reported that women were easily able to describe what they felt was wrong with their bodies, but found it harder to name anything satisfactory. Many of Grogan's participants suggested that their lives would change for the better if they lost weight and their self-confidence would increase, whereas if they gained half a stone, they would hide away and feel ashamed.
Zdrowski (1996) interviewed women who categorised themselves as 'overweight' about their experiences of eating in public, e.g. going out for a meal. Zdrowski found that women compared their eating behaviours to those of others, and that many found it difficult to eat in public, fearing being judged on their food choices. Interviews have also been carried out with particular reference to social pressures on body weight and appearance (e.g. Boughtwood, 2005; Grogan & Wainwright, 1996). Interviewees in these studies often presented complex and contradictory views – they aspired to be slim, but extreme thinness and extremely thin models were seen as unhealthy and inappropriate.

Tunaley, Walsh and Nicolson (1999) used interviews to examine the subjective meanings of body size for a sample of women aged between 63 and 75 years. They found that many of their participants were dissatisfied with their body size, although they tended to adopt a more laissez-faire attitude towards body size and eating than has been found in studies using younger participants, largely rejecting or rebelling against social pressures regarding weight and diet. Tunaley et al. found that this attitude was related to constructions about their time of life; they saw it as a time of freedom and a time where weight gain was inevitable, and many participants implied that they believed they had reached an age where they should be able to stop worrying about their weight and enjoy eating, rejecting social pressures to be slim and control their diet. Tunaley et al.'s research also illustrates other interesting themes, such as the idea of 'forbidden' food which their interviewees expressed a desire to eat but feelings of guilt after doing so.

In this section I have discussed several studies which have used qualitative methods of analysis, and while I do not wish to denigrate any of this research, I was disappointed with the number of studies relying on interviews and glossing responses to produce generalisations. While the interview studies I have described above do allow for richer analysis than the quantitative studies discussed earlier in this chapter – which are restrictive in that they only allow yes/no or scale-measurement answers – the reliance on researcher-generated questions and glossing of responses fails to fully explore the contradictions and complexities of real talk. Potter and Hepburn (2005) discuss various limitations of interview studies, for example the failure of researchers to consider interviews as interactions and the 'deletion' of the interviewer in
representations of talk. The traditional use of interviews also focuses on examining consistent ‘attitudes’ expressed in responses, ignoring the variability in participants’ talk (see Edwards, 2004). It is disappointing that the majority of interview studies make generalisations without considering the context in which the responses were given, or what function the responses might have. By this I mean that the focus of analysis tends to be on descriptions of and about experiences, rather than on the actual conversations themselves and the embodied practices within these interactions through which negotiation of eating behaviours happens. Interview responses are treated as representations of internal states; there is no analysis of language as action and what talk is actually doing, i.e. what its function is. As an example, Tulaney, Walsh and Nicolson (1999) refer to one interviewee’s comment about eating chocolate: “I’m ashamed of myself really” (ibid, p.749) as showing “strong feelings of guilt and self-blame”; however, without having access to the entire transcript, it seems to me that it is equally as likely that the interviewee’s comment exists merely to let the interviewer know that she is aware it is not a behaviour to be proud of, or to quickly get the ‘shame’ out there before the interviewer can imply it. It seems that a conversation analytic technique would be more useful, examining the context of the interview and the interaction with the interviewer as well as the actual words spoken.

1.5.1 Ethnomethodology and eating behaviour research

Though there is clearly a substantial amount of existing literature concerning eating practices, the majority of research in this area gathers its data from either questionnaires, surveys or assessment scales (e.g. Bardone-Cone & Cass, 2007; Cusumano & Thompson, 2001; Thompson et al., 2000) or interviews (e.g. Brooks, LeCouter & Hepworth, 1998), both of which overlook the interactive context in which food and weight are discussed (see Wiggins, Potter & Wildsmith, 2001). There is relatively little research examining how such discourse is actually managed, or rather, how people make sense of the various social constructions of eating disorders at an everyday level. The studies I have discussed so far also fail to consider the way in which language is action-oriented. Having discussed several quantitative studies as well as some of the literature on interview studies, I now want to examine studies which deploy a more ethnomethodological, post-structuralist approach, and discuss
how advocates of conversation analysis and discursive psychology treat eating behaviours. According to Davies and Banks (1992), people move through multiple positioning during interactions; positions are discursively and interactively constituted and are open to shifts. The value of ethnomethodological research therefore lies in explicating the complex ways in which eating behaviours are defined, negotiated and defended in talk.

For example, Malson (1995) examined the way the ‘thin body’ is constructed within discourse and found that participants tended to draw upon a ‘romantic discourse’ when talking about their illness, constructing anorexia and the thin body as a signifier of passivity and of a “childlike, meek delicate femininity” (ibid, p.108). However, the participants simultaneously worked discursively to construct themselves as powerful and in control, with self-starvation emphasised as a technique for self-production rather than self-destruction. Brooks, LeCouter and Hepworth (1998) found that bulimic patients showed a similar dichotomy in their talk; while emphasising individual attributes such as willpower, participants also formulated themselves as ‘victims’ of society or of the illness itself.

Wetherell (1996) identifies several interpretative repertoires in the talk of teenage girls about body shape: ‘individualism’, for example, refers to participants’ attempts to rebel against societal pressure; ‘body processes: the natural self’ relates to the girls’ tendency to equate dieting with healthy eating; ‘personological discourse of fatness or thinness’ refers to talk involving attributing body weight/size/shape to either character traits or environmental factors; and ‘the confessional: pathological discourse’ is a moral discourse reflecting a negative social identity of a weak and wicked self. These interpretative repertoires are supported by Guendouzi’s (2004) research, which also illustrates examples of pathological confession of a lack of self control over appetite to deal with potential loss of face.

Keski-Rahkonen and Tozzi (2005) examined what sufferers of eating disorders mean by the word ‘recovery’ by looking at the various contexts in which the term was used in messages posted in a Finnish online eating disorders group. The concepts of ‘willpower’ and ceasing to identify with eating disorders were seen as essential in order to recover. Feelings towards recovery tended to be ambivalent, with many
individuals emphasising motivation to recover, without stating concrete plans of action. Recovery was pervasively seen as “hard work” (ibid, p.582). Weight or weight gain as a component of recovery was rarely mentioned, and Keski-Rahkonen and Tozzi use this fact to suggest that their study supports previous observations that weight should not have excessive attention instead of emotional aspects. However, it is likely that this lack of reference to weight is due to group rules discouraging competition between members and ‘triggering’ other individuals by referring to specific numbers.

Warin (2004) examined the everyday experiences of anorexics at an ethnographic level. Warin distinguished anorexia from other conditions in terms of how it may be seen as ‘empowering’ and even desirable; there are very few—if any—other illnesses where one may actually desire the condition. Warin suggests that individuals may resist the pathologising stereotypes assigned to their condition, but still further knowledge is needed of how anorexia is constructed as a social identity and how anorexic subjectivities are managed, resisted or taken up across various social contexts.

Murakami (2001) uses conversation analysis to examine ways in which World War II veterans talk about others of different cultures or ethnic origins, and in particular how rice is constructed as a culturally emblematic category and how participants display their cultural understanding of rice in the diet and establish the relevance of it. Mycroft (2004, 2007) uses conversation analysis on discourse obtained from commercial weight management groups to show that successful dieting is oriented to and treated both as an accountable matter and as an accomplishment. Several studies examine the interactional nature of eating (e.g. Ochs, Pontecorvo & Fasulo, 1996; Wiggins, 2002). Wiggins, Potter and Wildsmith (2001) published findings highlighting an interactional approach to eating practices. They used a discursive, social constructionist approach (e.g. Edwards, 1997; Edwards & Potter, 1992; Potter & Wetherell, 1987) to examine the constructive nature of food/eating discourses in naturally occurring conversational data recorded from family mealtimes. Mealtimes were suggested to be interactive events, where there is a strong sense of involvement between individuals and bound up with eating practices are interactions—talking about food, negotiating, urging to eat, offering, and so on. Lyons, Mehl and
Pennebaker (2006) explored the linguistic markers of differences in internet self-presentation of self-identified anorexics of two types: those who defended anorexia as a lifestyle ('pro-anorexics') and those in recovery. Dias (2003) explored the narratives of women who visited pro-anorexia websites, focusing particularly on the women’s rationale for being present on such sites.

Guendouzi (2004) recorded interactions involving a group of teenage girls (who recorded weekly get-togethers at one of the girls’ homes) and a group of teachers (who recorded ‘break time’ conversations in a school staff room), with the aim of exploring whether the need to live up to a socially acceptable or ‘ideal’ body size is evident in naturally occurring conversations. The analysis considered whether women oriented to or resisted the socially sanctioned ideal of the ‘thin woman’ (see Wetherell, 1992) and concluded that while the teachers focused on talk about weight and food, the teenagers were more concerned with achieving a toned ‘ideal’ body. Guendouzi found that the women in her study had complex relationships with their bodies. Their talk oriented to perceived social pressure in relation to their size and their ways of trying to achieve a socially acceptable (and satisfactory to themselves) shape. The data also suggested that the participants viewed other women as potential comparative threats to themselves in terms of presentation of physical self, which often led to making negative associations about the ideal of the thin woman (for example, some of the younger girls referring to bulimia, and the older women parodying the threat posed by a peer). Participants engaged in co-operative verbal play with each other in order to deal with threats to self-image. The older women frequently made polite comments to each other, for example, questioning another’s need to diet, which was not mirrored in the interactions between the teenagers. Guendouzi’s study was one of the main inspirations for this thesis, in terms of its focus on naturally occurring talk — i.e. real talk rather than, say, interview responses which may be influenced by the researcher. However, despite being impressed by Guendouzi’s naturalistic approach to data collection, I was left disappointed by the analysis, which consists of generalised statements about the two groups of participants rather than detailed explorations of what is actually being done in the talk. For example, Guendouzi makes broad statements about the teenage girls being more likely to talk about achieving a ‘toned’ body than the teachers, which she suggests is to do with media images of ‘ideal’ toned bodies available to the teenagers. Rather than
making generalised statements like this, a better analysis would involve detailed examination of how talk about food and weight is produced and managed, and what the participants themselves chose to make relevant.

Another key study informing this thesis is that of Malson, Finn, Treasure, Clarke and Anderson (2004) who asked participants who had been hospitalised at least once for either anorexia or bulimia nervosa about their experiences of treatment. A feminist post-structuralist approach to discourse analysis was used to focus on how the identity of the ‘eating disordered patient’ was constructed. An inconsistency was found within these interviews; while participants constructed themselves as ‘having an eating disorder’, they also frequently articulated constructions of themselves as normal, healthy, and as not having a problem. Participants were therefore simultaneously constructing themselves as not having a problem and yet needing to change their behaviours; their talk was found to be contradictory and ambiguous, shifting through multiple subject positions. The study showed participants not to have stable, fixed attitudes and beliefs but as having complex, often contradictory, discursively constituted subject positions, whose accounts could be seen not as simple reflections of psychological states but as instances of social practice wherein multiple realities were actively constituted and negotiated in the context of a wider discursive field of psychological discourses. I was interested to examine my own data for similar inconsistencies to those found in Malson et al.’s study, particularly the ‘normal’ versus the ‘disordered’. The data used in this thesis shows many instances of ‘doing being ordinary’, but rather than constructing the self as ‘normal’ and healthy as Malson et al. suggest, participants tended to do this in a reflective way, taking into account their extraordinary circumstances. While there was some emphasis on being an ‘ordinary’ person, participants also frequently used medical terms and talked about ‘illness’ (see chapter 5). So, similarly to Malson et al.’s data, I found variability in participants’ talk: frequently they were constructing themselves as ordinary in some ways and as ‘ill’ people in other ways. However, this thesis focuses on different aspects of this, looking at interactions in a detailed, fine-grained way rather than the more ‘global’ analysis of Malson et al., who focus on broadly examining discourse for general trends. Using conversation analysis and discursive psychology, this thesis explicates the function of both ‘doing being ordinary’ and ‘doing being ill’, and argues that these seemingly paradoxical constructions both function in some way to
manage accountability — especially in the specific institutional context of the radio phone-in, where eating problems tend to be constructed in extraordinary ways by the shows’ hosts. So, whilst supporting Malson et al.’s findings about the contradictory weave of accounts, this thesis extends Malson et al.’s research by situating these accounts in a particular context with specific interactional demands of the ongoing turns at talk.

Tapsell and Brenninger (2000) used conversation analysis to analyse interview data on diet history with overweight participants attending an outpatient clinic. Their analysis revealed a consistent pattern in reporting diet histories as well as three conversational features indicating problematic reporting: the phrase ‘it depends’, denoting variability; ‘probably’, denoting guesswork; and elaborated talk on certain foods, distinguishing ‘sensitive’ topics from safe topics. Terms like ‘it depends’, ‘depending’ and the like were frequently used and denote hedging (i.e. mitigating the force of utterances) in describing consumption patterns, as well as indicate links between social context and food choice. ‘Probably’, ‘possibly’ and so on acted as qualifying devices in attempts to define amounts and frequencies. These were more notable when describing lunch and dinner (as opposed to breakfast); lunch and dinner seemed to be the most difficult meals to report on. Food items simply listed in response to questions or described with no prompting tended to be items of “low-fat, high-carbohydrate nutrient composition” (ibid, p.821). Descriptions of high-fat foods and take-out or eat-out foods were frequently elaborated on. The ‘moral order’ associated with diet was displayed by responses such as hesitations, pauses and laughter, which occurred commonly in discussions on ‘sensitive topics’. Chocolate, take-out and eat-out foods, butter and margarine, and red meat were all reported on in this way (ibid, p.823). These, along with alcohol, were the least likely to be listed without prompting by the interviewer.

Several other recent studies have applied conversation analysis to talk about food and diet; for example, Smith (2002) found that participants distinguished between good/healthy and bad/unhealthy products, listing fruit and vegetables as ‘good’ and junk food and sweet snacks as ‘bad’. Sweet snacks, whilst constructed as ‘bad’, were also referred to as things of comfort. The same idea of an unhealthy addiction being a comfort has been illustrated in studies of smoking (e.g. Johnson,
Rozin, Ashmore and Markwith (1996) reported categorisations of foods into 'good' and 'bad' groups, with 'bad' foods tending to be high in calories and not nutritional. Benford and Gough (2006) conducted interviews with five self-confessed 'chocoholics' (individuals addicted to chocolate) to examine how the ostensibly unhealthy act of eating chocolate is defined and defended. Analysis yielded four main discourses: chocolate as dangerous; chocolate as pleasure; self-surveillance; and addiction. Chocolate consumption was generally seen as both dangerous and sinful, and linked to indulgence and greed, therefore giving the participants a dilemma in terms of how to justify their chocolate consumption whilst protecting their moral status. This was generally accomplished by recourse to the medical lexicon of addiction, for example discourse about cravings, surrogate substances and withdrawal; participants manoeuvred themselves into a position where they may be perceived as “sick” rather than “sinful” (ibid, p.432). Chocolate was also frequently constructed as a reward, i.e. something deserved after achievement. This idea of ‘treating oneself’ is related to the theme of morality, in that it implies that chocolate is only to be enjoyed when the right to do so has been earned. Benford and Gough also report finding themes of self-monitoring and compensatory activities in their participants’ talk. Participants frequently mentioned doing culturally sanctioned compensatory practices such as physical exercise after eating chocolate to ‘feel better’, to burn off calories and to ‘make up’ for their indulgent behaviour and reclaim an acceptable self. Feelings of guilt were frequently oriented to, which were more related to body shape than to physical health. Several researchers of food talk suggest that accounts are structured by both moral judgements and religious terminology, constructing certain foods as sinful (see Nemeroff & Cavanaugh, 1999; Rozin, Fischler, Imada, Sarubin & Wrzesniewski, 1999).

Rich (2006) examined the everyday experiences of individuals living with anorexia, and the discursive practices involved in resisting stigmatisation. Using semi-structured interviews with women experiencing either anorexia or bulimia nervosa, Rich found that all of the young women participating in her study reported feeling that their disorder was pathologised or medicalised by others, with focus being on weight gain or loss rather than the social and emotional dimensions of the illness. While Rich points out the fact that individuals of a ‘normal’ weight may be suffering from the same day-to-day problems with their bodies and bodily experiences, there is still no
attention paid to a 'non-clinical' group – all of Rich's data is taken from interviews with young women sufficiently unwell to have been hospitalised. Therefore this thesis aims to fill a gap in the literature by examining talk from both medically diagnosed individuals and people belonging to no particular clinical group.

This chapter has involved meta-analysis of various analytic techniques for examining eating behaviour, and it is clear that it is those studies taking a more ethnomethodological approach which have been able to best access the ambivalences and contradictions that exist in talk about eating (see Lawrence, 1984). Many of the previous studies examining discourse have tended to view discourse as a way of inferring stable, internal constructs such as attitudes, rather than examining the discourse itself for what it is. This approach overlooks the shifting constructions of the self and of behaviours and fails to explain why inconsistencies and contradictions exist in people's talk. Research focusing on the close examination of the talk of the participants has widened the scope of cultural understanding, allowing for the examination and discussion of paradoxes and dichotomies in talk, and of the differing, often opposing, constructions that are mobilised for action in talk. This thesis therefore utilises a conversation analytic and discursive psychological approach to focus on what participants make relevant in their talk and what actions are being done through talk.

1.6 Media research

As this thesis uses data from radio broadcasts, it is relevant to discuss existing literature on the media as a forum for discussion. The media provides a public forum in which issues about food, weight, eating and diet can be discussed. Several researchers have investigated various types of media representations of health – for example, newspapers (Coyle & Sykes, 1998); magazines (Lyons & Willott, 1999); and television documentaries (Lyons, 2000). These studies have examined the ways in which issues are constructed by media professionals (i.e. journalists) as well as by health professionals appearing in the media (for example, on documentaries or as the 'expert' on talk shows). Mass media is an important social educator (Hodgetts & Chamberlain, 2006); Corner (2000) suggests that people are influenced by what they
see and hear in the media. Therefore talk on the radio and on television provides not only a way of expressing a voice for the individuals appearing on talk shows or phone-ins, but a way of shaping public opinion. It is particularly important to examine discourse as occurring in contemporary media forms such as talk shows as, in recent years, more and more people are appearing on television to discuss social and personal issues. Carbaugh (1988) suggests that talk shows help to construct understandings of the self as an individual through the conventions of talk, and Gilligan (1982) suggests that audience participation on such shows is vital for the construction and maintenance of a gendered, cultural identity.

Livingstone and Lunt (1994) carried out a study of audience talk shows shown on British television. They see the talk show format as empowering for the lay public because it gives them a chance to challenge authority figures (academic ‘experts’ who also appear on the show) who are constructed as equals within the context of the show. Giles (2003) performed a narrative analysis of an episode of the talk show Kilroy about obesity. Giles analysed two different narratives from two guests on the show, one of which Giles suggests “fails to work” (ibid, p.322), and one of which is seen as more successful. Both narratives are structured around the same central idea (that of there being a ‘turning point’ leading to successful recovery from obesity), but differing in terms of what ‘recovery’ really is. Giles closely examined not only the narratives presented by the participants but the format of the show; for example, noting that while the show has no script there is a clear structure, with guests whose contributions have been planned in advance through telephone interviews with researchers, and that there is no spatial distinction drawn between expert guests and lay guests – academics and professionals are seated in with the rest of the audience to erode any distinctions of power. Giles noted several interesting things about the talk – for example, one guest made a reference to having a bowl of pork dripping in his fridge, symbolic of gluttony and raising a laugh from the studio audience. Giles also points out that the talk show host tries to get the guest to attribute blame for his obesity, and construct it as something self-inflicted rather than something he is not to blame for (e.g. genetic disposition). Giles suggests the first narrative is unsuccessful partly because the narrative constructs a passive identity for the guest, who is seen as a victim of circumstance rather than an individual in control of his own situation. The second narrative in the analysis, which Giles refers to as “successful” (ibid, p. 322),
refers to the guest’s decision to stop regarding her body as essentially problematic and by taking back control. She reveals that she decided to take control by exercise, rather than by weight control. Giles notes that this rejection of ‘going on a diet’ was greeted by rapturous applause in the studio audience, and so was clearly a popular idea. Both narratives construct eating as a problem – which accounts for why they are appearing on the show in the first place – that needs some sort of a ‘turning point’ in order to be successfully dealt with. It was concluded that transformation or recovery narratives may be seen as liberating by fellow sufferers in the audience or watching at home, although some sort of post-viewing discussion would be needed to ascertain this.

1.6.1 Radio talk

As well as television shows, there also exists a wide range of phone-ins and chat shows on the radio which offer a cultural forum for individuals to debate social, moral and political issues (see Collins, Curran, Garnham, Scannell & Wingate, 1986, p.212). While discourse in the press (and to a lesser extent on television) has received considerable attention from researchers, radio discourse has been paid relatively little attention, despite it being an essential form of communication and of shaping ideas and beliefs due to the vast number of people who listen to the radio. In fact, radio has been referred to as a “relatively forgotten medium” (Tolson, 2006, p.3).

The main studies of radio discourse include Hutchby’s (1996) examination of the management of live interaction on radio interviews and phone-ins and Goffman’s (1981) essay on radio talk. Page and Tannenbaum (1996) use a public sphere framework to explain the contribution to debate and discussion of radio phone-ins as well as talk shows on television. Thompson (1995) describes the radio broadcast as a quasi-interactive situation, provoking a form of active listening for the hearing audience.

The use of the radio as a public space for individuals to air their views has become widespread in recent years, and a wealth of radio features and call-ins focused on problematic eating behaviours have been broadcast. But while television
interactions related to eating behaviours have been investigated (e.g. talk show narratives, Giles, 2003), as has the internet as a space for eating-related interactions (e.g. Dias, 2003; Winzelberg, 1997), the radio as a space for discussing food, weight and the body has not yet been explored. Therefore my thesis fills a specific gap in the area of ‘how eating behaviours are discussed in public forums’ – by focusing on radio interactions. Examining the ways in which callers and guests talk about eating behaviours on radio shows, and what they make relevant in their talk, as well as the skills drawn on by the hosts in order to prompt the speaker and what both parties attend to during radio shows may be extremely useful to research, but radio broadcasts focusing on eating behaviours have – with the exception of this thesis – attracted no attention from researchers.

While television and internet interactions are a form of ‘public’ interaction like radio talk, different interactional contingencies situated within these different types of interaction will result in analytic differences. For example, online interactions do not capture the same ‘live’ aspect of radio talk – there is no immediacy of response involved in online interactions, and examining radio talk will allow me to examine recipient design and detailed turn-taking organisation which is lacking in online interactions. Television interactions also differ, in that the participants are face to face and can use non-verbal cues in their interactions.

1.7 Overview and structure of thesis

I want to conclude this introductory chapter with an overview of the analysis contained within this thesis. In contrast to the traditional psychiatric conceptualisation of disordered eating which pathologises and medicalises the experiences of individuals, this research is informed solely by the data – i.e. the interactions between participants, and their personal narratives – and focuses on their own constructions. I began with no preconceived ideas about what the analysis might focus on, and from the data, the recurrent theme of ‘accountability’ emerged and it is this theme that underlies and ties together the four analytic chapters. Accountability has been touched upon previously in studies of mealtime interactions, which have illustrated accountability about food that is eaten or not eaten (e.g. Sneijder & te Molder, 2004).
Mycroft (2007) also discusses accountability, suggesting that successful dieting is constructed as an achievement while unsuccessful dieting prompts an account as to why weight loss has not been accomplished.

Specific points of analytical interest include how individuals construct themselves and their eating behaviours; how they manage accountability and negotiate personal responsibility; and how they interact with the radio show host. The institutional context of the radio programme is considered throughout the analysis.

The first analytic chapter examines the ‘openings’ of radio calls, starting with the initial greeting sequences between caller and host, and moving on to look at what happens after these greeting sequences - how the host elicits a narrative from the caller, and what goes on in these narratives. These narrative turns that follow the greeting sequence tend to be long, and I have paid particular attention to how identity construction and membership categorisation are done in these turns. I also relate my analysis to existing literature on call openings, greetings, and identity construction, and this placing of my own analysis into the context of existing literature is a pattern that I follow in each of the subsequent analytic chapters.

The second analytic chapter continues the examination of identity work, focusing particularly on constructions of the self as ‘ordinary’ and ‘rational’. I relate my data to previous literature on ‘doing being ordinary’ (see Sacks, 1984; Jefferson, 2004a) and in particular build on the literature on ‘doing being ordinary in extraordinary circumstances’ (see Wooffitt, 1992). I began by collecting all the instances in my data of what could be seen as ‘doing being ordinary’, wherein participants constructed their behaviours as rational and ‘ordinary’, and found that what was also being done was an emphasis on circumstances being extraordinary. For example, in talking about how her problematic eating behaviour is a response to stress, a participant refers to ‘stresses’ and ‘pressures’ with circumstances such as work, family life and money – everyday ‘stresses’ which the majority of people would be able to relate to – but emphasises just how tremendous the pressure is. The implication is that she is doing what anybody in her situation would do (therefore, is ‘ordinary’, or ‘normal’) but that the situation itself is actually extraordinary in a way. In other words – the participant refers to ordinary life stresses, but suggests that they
are occurring in her life to an extraordinary degree – and that she is reacting to these in a way that anyone would if faced with the same situation. In this chapter I also consider identity construction in relation to agency and accountability, arguing that ‘doing being ordinary’ functions to manage accountability.

The third analytic chapter looks further into these ideas of accountability and agency, and considers these in terms of ‘illness talk’ and the medicalisation of behaviour. The chapter begins by considering why there might be this need to ‘account’ for behaviours, using the radio show hosts’ introductions to demonstrate this (for example, one host opens the show by commenting that ‘many people see eating disorders as trivial and self-inflicted’ – and indeed participants seem to be actively working to construct their behaviours as not self-inflicted). One feature of radio (and television) programmes, such as the call-ins this thesis examines, is that they routinely begin with an opening, contextualising statement by the host, often dramatic in style, to set up the programme’s topic and draw out its relevance for the audience. These initial dramatic narratives have seldom - if ever - been the subject of analysis; yet they provide an ideal and ‘naturally occurring’ method for considering the practices of caller accountability. Therefore this thesis examines the way callers manage accountability with respect to these opening narratives. I look at how the concept of ‘illness’ is made relevant, negotiated or resisted in talk and consider how behaviours are made sense of and justified through the deployment of medical terms. I consider previous conversation analytic literature on medical terms in talk, for example the use of medical terms in doctor-patient interactions and the ‘asymmetry’ in this kind of talk, as well as existing literature on the concept of ‘addiction’. I argue that talk about problematic eating behaviours may particularly require justifications and accounts that other ‘illness’ talk may not, in that disordered eating may be seen as self-inflicted and ‘easily curable’ to outsiders, and may consequently involve a discourse of shame and guilt. Interestingly, research on lay constructions of both anorexia nervosa and obesity has shown that it is common for sufferers to be held responsible for their condition (Benveniste, LeCouter & Hepworth, 1999; Crandall & Martinez, 1996; Lupton, 1996). I consider the use of medical language in terms of discursive psychology’s concerns about the ‘psychological thesaurus’ and lay people’s use of ‘expert’ psychological and medical language. As well as closely examining how psychological and pathological matters are worked up and handled as
actions performed by talk this chapter explores moral talk and participants’ orientation to morality. I argue why it is important to consider both ‘medical’ and ‘moral’ talk in the same chapter, and relate the findings from my own data corpus to existing literature on morality.

The fourth and final analytic chapter is a close examination of how agency and passivity are negotiated, managed and resisted linguistically. I examine how agency is grammatically constructed, focusing on the subject-object-verb construction of sentences and how these function to emphasise agency or passivity. I also examine how agency is constructed through metaphor, looking at metaphors for passivity such as ‘slipping into bad habits’ or ‘sliding out of control’, as well as ‘prison’/’trap’ metaphors and ‘battle’/’fight’ metaphors, all of which appear frequently in the data corpus.

Chapter 7 of this thesis brings together the four analytic chapters and gives an overview of the findings. I reflect upon the chosen methodology, and suggest directions for future research.

Throughout the analysis of the data in this thesis I have had to keep in mind the context in which the data has been produced. Conversation analysts see context as important in terms of how participants themselves orient to the context of the interaction (see Horton-Salway, 2001; Schegloff, 1997) and so this thesis pays attention to how participants orient to, for example, the radio situation or the audience. The individuals whose talk I have been analysing are, generally, only talking to one other person but are aware that they are also effectively talking to an invisible, silent audience – a fact which is frequently oriented to throughout the talk, by both hosts and callers (for example, it has become clear through examining hosts’ introductions of callers that the various ‘call-relevant’ and ‘topic-relevant’ identities made relevant by the hosts are for the benefit of the listening audience). Throughout the analysis I also discuss the radio hosts’ rhetorical management of the interaction. It may be that some features of the talk are unique to radio interactions, and properties of ‘media discourse’ have therefore been considered throughout the analysis (see Giles, 2003).
This thesis will contribute to the fields of conversation analysis and radio talk as well as to my broader topic of eating behaviours. In terms of topic, my research fills a gap in existing literature through examining real talk occurring outside of the context of this research, rather than relying on interview responses, for example. Throughout this introductory chapter I have been critical of the interview techniques prevalent in qualitative research in this area, and of analyses which use generalisations rather than focus on detailed explorations of the functions of talk. In terms of approach, my thesis contributes to, for example, conversation analytic research on ‘doing being ordinary’ and also builds on existing ‘radio talk’ literature by closely examining greeting sequences and how radio hosts do category work in bringing in new callers (c.f. Fitzgerald & Housley, 2002; Housley & Fitzgerald, 2007). My thesis will also add to the growing body of conversation analytic and discursive psychological literature on eating behaviours (c.f. Wiggins, 2001, 2004, who has used conversation analysis to explore the social nature of eating; how eating is not just about food but is bound up with social relations, and how food evaluations are oriented to actions e.g. offering food) by closely examining how talk about eating behaviours is constructed and used in interactions. One key concern throughout my thesis has been the challenge of studying a particular topic by a means other than interviews, and of how to capture and study this ‘topic’ using conversation analysis. Stokoe and Edwards (2007) discuss how conversation analysts may study ‘topics’ or categories, suggesting that these phenomena can occur in the same kinds of turns, doing the same kinds of actions, and can therefore be examined as accountable matters in everyday talk. So, this thesis analyses how formulations of eating behaviour are systematically embedded in radio interactions.
2. Research Design and Methodology in Collection and Analysis of Data

2.1 Introduction

Having placed my study in the context of current eating behaviour research, in this chapter I will specify how I carried out my research, explaining in detail how I collected, transcribed and analysed the data.

I will begin by explaining the aims I had for my research and the types of data I considered. After justifying my choice to examine radio talk, I will describe the different types of radio talk which will be analysed, before explaining how I collected the data. The ‘participants’ of the study will be discussed in the context of ethical guidelines. I will then go on to describe in detail the method of transcribing data and explain the basic principles of the Jeffersonian method of transcription used (see Jefferson, 1994, 2004b). I will give an outline of the procedural frameworks of conversation analysis and discursive psychology and how they informed the process of analysis.

2.2 Aims

In contrast to typical studies in the realm of social psychology, I did not set out with a range of specific aims or hypotheses other than to closely examine the ways in which people talk about food, weight, and their bodies. As described in the preface to this thesis, I began this research with a broad interest in how individuals talk about food, weight, diet, and eating.

Even qualitative work in the area of problematic eating behaviours has focused mainly on interview responses and has overlooked the interactive context in which food and body shape are discussed. Previous studies in the field of eating disorders/body image have their limitations in that they overlook the conversational practices that people engage in to talk about eating, diet and weight (see chapter 1). Interviews are limiting in that the interviewer sets the agenda (see Potter, 1997) and...
interview data is therefore likely to be a product of the researchers' bias or manipulation (see Atkinson & Heritage, 1984). I was therefore interested in using conversation analysis and discursive psychology to closely examine these conversational practices. Later in this chapter (see section 2.7), I will explain the foundations of discursive psychology and conversation analysis which formed the theoretical roots of my research and guided my analysis.

I do not aim to examine what may be underlying 'causes' of disordered eating, nor do I intend to assess discourse as being 'true', 'false' or 'representative'. The purpose of the study is to gather rich, valuable insights into the discursive practices used in interactions and the unique experiences of participants which may or may not be similar to the experiences of others - I do not claim to assess representativeness or generalisability.

Gibbs (2001) suggests that the participants of studies are themselves often forgotten in the research process. In this study, however, the participants are valued as knowledgeable about their own situations and are seen as the 'experts' on their own lives.

2.2.1 Considering sources of data

There exists a wide range of phone-ins and chat shows in the media which offer a cultural forum for individuals to debate social, moral and political issues (Collins et al., 1986, p. 212). Despite the wealth of health- and diet-related radio shows that are broadcast frequently, radio talk about eating behaviours has until now received no attention from researchers. This thesis therefore fills a gap in existing literature by examining the radio as a public forum in which issues about food, weight, eating and diet can be discussed.

Radio programmes (along with other forms of media, such as television shows, internet forums and magazine articles) allow researchers access to very personal narratives, paradoxically in a very public space. They also encompass a multitude of topics and allow for stories to be told by a wide variety of individuals.
with different experiences. For example, in the area of disordered eating and body image, radio (or television) may feature on the same show some individuals with clinically diagnosed disorders such as anorexia nervosa; some individuals who are having issues with weight or diet without being part of a clinical population; individuals who are underweight; who are overweight; who have overcome disordered eating and have advice to share; and many different variations on the theme. This allows for the study of a variety of different individuals with different problems, as opposed to (for example) collecting data from an ‘anorexia helpline’ which would limit the data to ‘talk between anorexics and professionals’. This was important to me because I am interested in both mundane dieting behaviour and clinical ‘eating disorders’. Radio data offers social scientists unique and privileged access to a wealth of discourse and radio shows were therefore an attractive source of data, not only due to the variety of different topics and experiences discussed within but because the multitude of online archives of radio shows allowed me access to shows taking place over a period of five years which could be analysed at my leisure.

The central feature of these kinds of shows is talk. The very fact that people opt to phone in to radio stations and talk to a host they presumably do not personally know (as well as address a huge listening audience) suggests there is something appealing about conversationally engaging with someone.

The possibility of using video data in addition to the radio data was considered, as several television ‘talk shows’ were collected and, though contrasting in style, were comparable in content. However, it was decided to focus purely on radio talk as not only was the radio data corpus large enough without the addition of further data, but television shows are rarely completely live and have often gone through a meticulous editing process whereas radio talk has more ‘natural’ qualities. Let me elaborate on this – what we hear from callers and guests on radio shows is a real-time record of conversation, live and relatively unscripted. The different parties within a radio interaction – i.e. the hosts and their callers or guests – typically have no prior or subsequent interactions: their entire relationship is constituted within the broadcast. Although there is undoubtedly some interaction we are not privy to – radio hosts and guests talking during ‘commercial breaks’, for example, or callers giving details to a switchboard operator prior to going on air – for the most part, we are
hearing a ‘complete’ interaction. This is not quite the case with other forms of media output, such as television talk shows and documentaries which tend to be heavily edited and shortened to fit a certain time-frame. Radio programmes – particularly phone-ins and other live broadcasts – are therefore far more ‘natural’ than a pre-recorded, edited television show.

The study of radio interactions regarding eating behaviours also fills a gap in existing conversation analytic/discursive psychological research. The use of radio as a public space for individuals to air their views has become widespread in recent years, and a wealth of radio features and call-ins focused on problematic eating behaviours has been broadcast. Radio talk therefore forms a huge category of social interaction which is readily available for researchers to explore. But while television interactions related to eating behaviours have been investigated (e.g. talk show narratives, Giles, 2004), as has the internet as a space for eating-related interactions (e.g. Dias, 2003), the radio as a space for discussing food, weight and the body has not yet been explored.

2.2.2 ‘Naturally occurring talk’ versus ‘institutional talk’ versus interviews

Much of the work using conversation analysis favours ordinary, mundane, ‘naturally occurring’ data – that is, forms of interaction not confined to specialised settings. Another type of interaction conversation analysts examine is referred to as ‘institutional talk’ (see Drew & Heritage, 1992; Heritage & Greatbatch, 1991). This refers to interactions in more restricted environments, where talk may be institution-specific or activity-specific, and many conversation analysts do use this ‘institutional’ talk as data – for example, recent research has examined helpline interaction (e.g. Potter & Hepburn, 2003); television talk shows (e.g. Stokoe & Wallwork, 2003) and neighbour mediation (e.g. Stokoe & Edwards, 2008). There is in fact ongoing debate amongst conversation analysts and discursive psychologists about what constitutes ‘naturally occurring’ talk, and whether this can even exist (see Speer, 2002a, 2002b). Nevertheless, radio data is generally seen as institutional talk as there is typically a specific topic of discussion set up on which people are invited to share their views.
While institutional talk is not as ‘natural’ as, for example, a spontaneous conversation between acquaintances, it is still ‘natural’ within the context of a research study in that the data is ‘uncontaminated’ by the researcher’s aims and objectives. Regardless of whether I were writing this thesis or not, these radio shows would still have taken place and been aired exactly as they were; the interactions forming my data corpus were entirely independent of and unaffected by the confines of this study and I have not interacted with the participants in any way. In fact, radio talk can perhaps be seen as bridging the gap between institutional talk and mundane conversation – it is an institutional form of talk which, at the same time, is highly conversational (see Tolson, 2006, p.20).

Some radio shows may be seen as similar to interviews, particularly in situations where the hosts pose specific questions to their guests. In contrast to interviews, however, radio shows are generally informal and fairly unstructured, with the guests leading the direction of conversation more than the host (who, rather than taking on the role of ‘interviewer’, may choose to become involved in the conversation to the point of giving his or her own opinions on the topic at hand). Nevertheless, any potential similarity to interview data does not make the data any less accessible for discursive analysis; Edwards (1997, p. 89) suggests that a social science interview as a whole can be taken as talk-in-interaction, with principles of conversation analysis applied to the interaction as a whole rather than just the respondents’ turns.

2.3 Radio talk

Radio call-ins occur daily, on countless different radio stations across the world, and cover a wide range of different and topical issues from politics to religion to health. After I began collecting call-ins through online archives (see section 2.4) I found a different type of radio show which will be referred to throughout this thesis as ‘talk radio’. This kind of programme, rather than merely inviting members of the public to phone in, features a variety of guests who generally sit in the studio with the show’s host. (Sometimes, the guests may be on the phone, but typically they are face-to-face with the host and each other.) Additionally, some talk radio shows will have
members of the public calling in – in addition to the guests – who will interact with the guests and the host.

The two types of radio talk – ‘talk radio’ and ‘phone-ins’ also differ in that the callers to phone-ins may be any individuals who have tuned in to the show and desire to air their views, whereas the guests on talk radio are specifically invited to be on the show due to having some connection with the issue being discussed. Also, it must be considered that the context of the interactions is different, with some taking place over the phone and others taking place face-to-face.

The two types of radio talk analysed in this thesis – ‘phone-ins’ and ‘talk radio’ – both generally start with a brief introduction by the show’s host. Below is an example of the typical show introduction (see Appendix 1 for an explanation of transcription symbols):

1 H: 4and there’s been a warning from the eating disorders association that it can be a dangerous time when students can slip into (.) eating problems. 5hh they’re hoping for better facilities in universities to give young people better supports. 6hh well Anne is head of counselling and advice centres at the university of Westminster, 7hh Pam is from the ee dee ay [EDA - Eating Disorders Association] and is in Norwich, and Emma (last name) became bulimic when she first went to university.=she 9 joins us .hh from Birmingham.

The host (referred to as ‘H’ throughout all transcripts) introduces the show by emphasising its relevance to the general public by referring to statistics, research, or in this case ‘a warning from the eating disorders association’. The guests who will be appearing on the show are all identified by name and their association with the topic to be discussed.
2.4 Collecting data

My raw data consisted of approximately twenty eight hours of radio talk, broadcast in the UK between 2002 and 2007 (see Fig. 1). Choosing this period of time allowed me to explore a wide range of older broadcasts already existing in archives as well as more recent broadcasts.1

Much of the data I used was archived online on the websites of radio stations, accessible by anyone, and other broadcasts I recorded myself. I used as wide a variety of different radio shows as I could - that is, shows broadcast on different radio stations and featuring different hosts - to allow me to make claims about robust patterns in the data. This radio talk formed a very large corpus of data, mostly already recorded and archived. Candidate programmes were identified by looking through the ‘health’ archives of various radio stations’ websites, searching for terms such as ‘diet/dieting’, ‘eating disorders’, ‘anorexia’, ‘bulimia’, ‘obesity’, ‘food’, ‘nutrition’, ‘weight’, ‘eating’, ‘body image’ and ‘exercise’.

2.4.1 Recording data

The majority of the radio shows transcribed were found in online archives. Using the digital audio editing software Audacity, I was able not only to play my sound files but could also easily pause them, erase or reverse certain parts (such as names, to ensure anonymity), measure pauses in speech, and examine the pitch and frequency of the voices in close detail.

The interactions recorded ranged between forty five minutes (one or two guests talking throughout an entire radio show) and just two minutes for some of the shorter calls. The broadcasts themselves generally last for an hour, with each guest or caller typically taking up only a small segment of that time.

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1 25 broadcasts were collected from online archives. I also recorded new shows which were broadcast during the period of time I worked on this thesis, adding another 8 broadcasts to my data corpus.
<table>
<thead>
<tr>
<th>Title</th>
<th>Participants</th>
<th>Length</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio 4 call-in</td>
<td>17 callers (16 female, 1 male)</td>
<td>1 hour</td>
<td>Body shape</td>
</tr>
<tr>
<td>Radio 1 call-in</td>
<td>7 callers (5 male, 2 female)</td>
<td>1 hour</td>
<td>Exercise for the unfit</td>
</tr>
<tr>
<td>Radio 5 call-in</td>
<td>6 callers (1 male, 5 female)</td>
<td>30 minutes</td>
<td>Eating disorders</td>
</tr>
<tr>
<td>Radio 4 call-in</td>
<td>4 callers, 2 guests (female)</td>
<td>1 hour</td>
<td>Views on anorexia</td>
</tr>
<tr>
<td>Radio 4</td>
<td>5 guests (4 female, 1 male)</td>
<td>1 hour</td>
<td>Plastic surgery and body image problems</td>
</tr>
<tr>
<td>Radio 4</td>
<td>2 guests (male)</td>
<td>1 hour</td>
<td>Male attitudes to diets</td>
</tr>
<tr>
<td>Radio 1</td>
<td>1 female</td>
<td>15 minutes</td>
<td>Interview with former anorexic</td>
</tr>
<tr>
<td>Radio 4</td>
<td>2 guests (1 male, 1 female)</td>
<td>45 minutes</td>
<td>Pro anorexia websites</td>
</tr>
<tr>
<td>Radio 1</td>
<td>1 guest, 1 caller (female)</td>
<td>1 hour</td>
<td>‘Pro anorexia’</td>
</tr>
<tr>
<td>Radio 4</td>
<td>2 guests (female)</td>
<td>1 hour</td>
<td>The politics of fat</td>
</tr>
<tr>
<td>Radio 5 call-in</td>
<td>4 callers (female)</td>
<td>20 minutes</td>
<td>Size 0 debate</td>
</tr>
<tr>
<td>Radio 4</td>
<td>2 guests (female)</td>
<td>1 hour</td>
<td>Eating disorders and young people</td>
</tr>
<tr>
<td>Radio 4</td>
<td>1 guest, 1 caller (female)</td>
<td>1 hour</td>
<td>Anorexia in middle age</td>
</tr>
<tr>
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<td>11 callers (female)</td>
<td>1 hour</td>
<td>Eating disorders: views</td>
</tr>
<tr>
<td>Radio 4</td>
<td>11 guests (female)</td>
<td>45 minutes</td>
<td>Body shape and the elderly</td>
</tr>
<tr>
<td>Radio 4</td>
<td>4 guests (female)</td>
<td>45 minutes</td>
<td>Body shape and the</td>
</tr>
</tbody>
</table>

Fig. 1
<table>
<thead>
<tr>
<th>Radio</th>
<th>Participants</th>
<th>Duration</th>
<th>Topic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radio 5</td>
<td>1 caller (female)</td>
<td>15 minutes</td>
<td>menopause</td>
</tr>
<tr>
<td>Radio 4</td>
<td>4 guests (female)</td>
<td>1 hour</td>
<td>Anorexia</td>
</tr>
<tr>
<td>Radio 4</td>
<td>4 guests, 2 callers (female)</td>
<td>1 hour</td>
<td>Body shape post-pregnancy</td>
</tr>
<tr>
<td>Radio 4</td>
<td>1 caller, 2 guests (female)</td>
<td>45 minutes</td>
<td>Losing weight</td>
</tr>
<tr>
<td>Radio 4</td>
<td>8 callers (7 female, 1 male)</td>
<td>45 minutes</td>
<td>Eating disorders and university</td>
</tr>
<tr>
<td>Radio 5</td>
<td>1 guest, 2 callers (male)</td>
<td>45 minutes</td>
<td>Men and food</td>
</tr>
<tr>
<td>Radio 4</td>
<td>5 guests (4 female, 1 male)</td>
<td>1 hour</td>
<td>Obesity</td>
</tr>
<tr>
<td>Radio 1</td>
<td>2 guests (1 male, 1 female)</td>
<td>20 minutes</td>
<td>Obesity</td>
</tr>
<tr>
<td>Radio 4</td>
<td>2 callers, 1 guest (female)</td>
<td>1 hour</td>
<td>Eating disorders and shoplifting</td>
</tr>
<tr>
<td>Radio 4</td>
<td>3 guests (2 male, 1 female)</td>
<td>1 hour</td>
<td>Atkins diet</td>
</tr>
<tr>
<td>Radio 4</td>
<td>4 guests (female)</td>
<td>1 hour</td>
<td>School and eating disorders</td>
</tr>
<tr>
<td>Radio 4</td>
<td>3 guests</td>
<td>45 minutes</td>
<td>A biological link to anorexia?</td>
</tr>
<tr>
<td>Radio 4</td>
<td>3 guests (female)</td>
<td>45 minutes</td>
<td>Body shape and teens</td>
</tr>
<tr>
<td>Radio 4</td>
<td>1 female</td>
<td>15 minutes</td>
<td>Interview with former anorexic</td>
</tr>
<tr>
<td>Radio 4</td>
<td>3 guests (2 female, 1 male)</td>
<td>1 hour</td>
<td>Children and obesity</td>
</tr>
<tr>
<td>Radio 4</td>
<td>8 callers (female)</td>
<td>1 hour</td>
<td>Too fat or too thin? Your views</td>
</tr>
<tr>
<td>Radio 4</td>
<td>9 guests (female)</td>
<td>45 minutes</td>
<td>Body shape</td>
</tr>
</tbody>
</table>
2.4.2 Ethical considerations

Any study involving human or animal participants needs to consider ethical issues. Here I will discuss various ethical considerations I had to take into account before allowing my research to go ahead.

2.4.2.1 Informed consent

"Due to the context of the data, informed authorised consent from the participants was not possible. Ethical guidelines generally insist upon informed consent being obtained but an exception to this principle is 'observational research' - behaviour observed within the public domain - which may be researched without consent (BPS, 2006). Though the privacy and psychological well-being of participants must always be respected, it is accepted that behaviour performed within the public domain where one can expect to be observed by strangers may be observed by researchers without consent:

"Unless informed consent has been obtained, restrict research based upon observations of public behaviour to those situations in which persons being studied would reasonably expect to be observed by strangers, with reference to local cultural values and to the privacy of persons who, even while in a public space, may believe they are unobserved."


Similarly, the American Psychological Association states that psychologists may dispense with informed consent when a study involves "only anonymous questionnaires, naturalistic observations, or archival research for which disclosure of responses would not place participants at risk of criminal or civil liability or damage their financial standing, employability, or reputation, and confidentiality is protected" (APA, 2002). Radio archives are available to anyone and therefore constitute material that is considered to be in the public domain. All participants are clearly aware that their talk is publicly available there is no ambiguity when appearing on the radio that anything said becomes public discourse.

The data used in the current study may be viewed as a combination of 'observational research' and 'archival research' of publicly available data that pre-dates the research project. In the case of recording live radio transmissions, my
research may be classed as observational, in terms of observing individuals in a place where they would expect to be observed by strangers — or in this case, where they would expect their talk to be observed by strangers (and not merely ‘strangers’, but potentially thousands of listeners). The collection of older recordings taken from online archives dating back to 2002 may be considered archival research, which is permitted to be used in research with no formal permission required as the data is already openly accessible to the public (see Sixsmith & Murray, 2001; Robinson, 2001). Archival data gives researchers the opportunity to observe a great wealth of data which has already taken place; this is appealing as it is clear that the data has been produced outside of the influence of the researcher’s own agenda.

Generally, when data is publicly available to anyone, the usual ethical procedures do not have to be adhered to; Robinson (2001), examining the ethical considerations in online research, suggests that if data comes from a site which can be accessed by anyone, then the researcher is exempt from gaining informed consent. The data for the current study fall into a similar category — the radio shows forming the data corpus were broadcast across the country and then archived online for literally anyone in the world to access, without needing to register with any websites or provide a password. My data source, whether it be regarded as observational, archival, or both has no direct risk to participants.

Further ethical considerations may arise if the manner in which participants are being monitored is so unobtrusive that they may forget, or even be unaware in the first place, that they are being monitored. However, this clearly is not the case with radio data, where the interactions are taking place specifically as a way of airing views to the public, and where guests or callers make the conscious decision to go on air to tell their stories.

2.4.2.2 Confidentiality and protection from harm

The issue of ‘protecting participants from harm’ was not something to be considered in this study, as all data came from interactions which had already, naturally occurred before I began looking for it. The main ethical issues to be
considered therefore related to the discursive presentation of talk and anonymisation of individuals.

With most psychological or sociological studies, the issue of confidentiality is very important, with participants having the right to remain anonymous and have any identifying details removed from the data. The issue of confidentiality in my study seemed rather unclear at first, given that a) all interactions had been broadcast over the radio potentially to the whole of the UK, so names and any other identifying details had already willingly been given to the public, and b) I was not actually involved in the process of the data ‘becoming’ data, and so I was not privy to any information which participants may have wanted to be kept confidential anyway. Eventually it was decided that, though individuals had chosen to make the details public on the radio and that these broadcasts are archived online for anyone to listen to or use in any way they wish, they had not specifically given permission for their names to be used in any written analysis. It would be quite literally impossible to track down callers and guests to ask how they felt about their details being written in a thesis. Therefore, every phone-in caller has been given partial anonymity in the form of a pseudonym, as has every ‘lay person’ appearing as a guest on the show. Similarly, in all audio recordings, names were either removed or reversed using audio editing software so as to make them incomprehensible. Radio hosts are simply referred to throughout the transcripts as ‘H’. Some guests who are already ‘in the public domain’, such as individuals who had written books about their experiences or professionals working for various associations have not been given pseudonyms, as they are already known in the public domain. Age and any other identifying features have been preserved, as without names I do not feel that any other features would compromise anonymity.

2.5 Participants

In typical social psychological reports, a methodology chapter would clearly define recruitment and sampling methods and what, exactly, the participants ‘did’ in the study, to enable replication of the research. With this type of ethnomethodological study, however, the only aspect of research which one would set out to replicate
would be the methods of *analysis*, rather than attempting to obtain a similar set of data from similar participants. It is therefore most important that I accurately describe transcription conventions and analysis methods, rather than *how* the data was obtained and *who* the data came from. Nevertheless, I will briefly describe the ‘participants’ in this study.

Naturally the ‘participants’ were the individuals featured on the various radio shows that I collected. Each interaction involved the host of the particular show along with a number of either callers, guests, or both.

The ‘sampling’ method used in this study was clearly opportunistic. The term ‘sampling’ may not be entirely appropriate for this study as the aim was never to acquire a ‘representative sample’ of, say, people with problematic eating behaviours. It is the *interaction* between individuals rather than the individuals themselves that is of interest, and therefore no attempt was made to standardise the selection of participants – such as choosing shows featuring a range of people of different ages, genders, ethnicities, geographic locations and so on – as would be done in traditional, experimental studies. In fact, even the term ‘participant’ in its usual context sits rather uncomfortably in research of this type as it implies that individuals ‘participated’ in a specific study whereas in my research, individuals are seen rather as ‘participants of a conversation’.

Each radio broadcast features a host, who is typically only minimally involved in discussions. In most of the transcribed shows, the hosts give a brief introduction and closing as well as introducing each guest or caller while the rest of their role in the interaction is minimal – mostly posing questions or asking someone to clarify a point, though at times the host may join in the conversation giving his or her own thoughts on the topic. Shows are ended by the host referring listeners to some practical information, usually in the form of a website address or a phone number.

In ‘phone-ins’, the callers may be any members of the public who opt to phone in to voice their opinion, tell a personal story, or ask for advice. On ‘talk radio’ shows, invited guests include professionals in the field of health, nutrition, or diet; individuals
suffering from eating disorders or body image disturbance; and the families and carers of sufferers.

2.5.1 A note on gender and age

Using pre-existing data, I was not able to obtain contextual information about the backgrounds of the individuals featured or their specific ages; the only contextual information I have is that which they chose to disclose on air. I view this as positive, as the fact that I did not have access to any details except those broadcast on air meant that I appreciated the talk as it was meant to be heard; I know nothing more or less than any other member of the listening audience.

Most studies on weight, body image and eating disturbances have focused on females, due mostly to the fact that women in general are significantly more dissatisfied with their bodies (Cash & Roy, 1999) and are more likely to suffer from disordered eating. I did not set out to examine one particular gender, nor did I intend to do a comparison between the two. As it turned out, the majority of the participants in this study were in fact female, with the few male participants tending to be invited guests rather than callers to phone-ins. Also, many participants did not state their age. Most opted to generalise, for example, saying ‘I’m in my fifties’ rather than referring to an exact age.

2.6 Transcribing data

Having described the data collection process, it is now necessary for me to discuss the transcription process, before going on to describe my analytical techniques.

Initial, very basic transcripts were made first, recording verbatim only the actual words each person said, which allowed me to get a sense of the basic content of the interactions. Once these initial transcripts were done, I listened again to the sound files, recording more detailed features such as lengthy pauses, false starts, in- and out-breaths and particularly noticeable volume and pitch changes.
After repeated reading of the early transcripts and my preliminary notes on them, those particular portions of data identified as particularly rich in terms of the study’s interests were selected for further, more detailed, discursive analysis. I then went back to my sound files and re-transcribed the selected recordings in much greater detail according to transcription notation conventions adapted from the meticulous style developed by Jefferson (1984a, 2004b) alongside conversation analysis, designed specifically to capture conversation analytic phenomena (see Appendix I for an extensive list of different notations used). This system allowed me to record not only what was said but how it was said, representing para-linguistic features of talk such as pitch and volume changes, slow or speeded up talk, pauses, intonation, emphasis, repetitions, hesitations, repair, and overlaps.

To clearly illustrate the difference between data transcribed at the most basic level and data transcribed using Jefferson’s approach, I will now show my transcription of a small fragment of data, using both approaches.

Example of data transcribed at a basic level

1 H: But did you still love yourself when you were seven stone overweight.
2 A: Well I’m six stone overweight now and yes I did and I do now. Yes. After the therapy. Yeah.
3 H: But do you feel healthy. At six stone overweight.
4 A: More recently I begin began to think well long term health this isn’t good for me. So I’ve made changes to my lifestyle and my weight is going down. But that’s as a result of changing my lifestyle, it’s not my main focus.

The same example transcribed using Jefferson’s transcription method

1 H: But- †did you >still love yourself< when you were seven stone overweight.: hh
2 A: Well I’m: (. ) I’m six stone >overweight now< °and yes (. )

Following many readings of the data corpus as a whole, it became clear to me that instances of accounting for behaviour and negotiation of agency were prevalent and of particular interest to me.
It is clear that there is a great deal going on within the interaction that is not captured using the basic transcription method. The transcript using the Jeffersonian method allows for the analysis of intonation, non-lexical turns and gaps in talk that may well be interactionally significant but which would not be picked up in a basic transcript (see Hutchby & Wooffitt, 1998; Hepburn, 2004).

I was not only interested in the interactional organisation of talk, but also in the ways in which participants described themselves, their lives, their relationship with food and with their body, their dieting history and so forth. The detailed level of transcription, showing both what was said and how it was said, reflects these dual interests and allows for extremely rich analysis. It should be noted that this detailed style of transcription can be extremely time-consuming³, which is why not every minute of talk was transcribed at the same level of detail.

Participants were given pseudonyms where appropriate (see section 2.4.2.2) which were generally shortened to three-letter abbreviations in the transcripts. In some of the call-ins some clicking noises in the background could be heard, perhaps related to phone lines, which have been transcribed simply as ‘((mechanical click))’. 

³The amount of detail in a Jeffersonian transcript means that transcribing can be an extremely lengthy process, depending on the skill level of the transcriber and various other factors such as the number of people involved in the recorded conversation, the quality of the recording, and so on. For example, in the current study a fifteen-minute radio segment took on average around three hours to transcribe to Jefferson standards.
2.7 Analysing data

After transcribing approximately twenty eight hours from thirty three different radio shows and repeated re-reading of transcripts to allow familiarisation with the data, the margins of the transcripts were used to make notes on various features of the interactions, encompassing both discursive elements such as recurring words and themes and conversational features such as overlaps, laughter, hesitations, and repairs.

The transcripts were analysed using a combination of discursive psychological analysis, conversation analysis and membership categorisation analysis. I have already discussed examples of studies in the area of food, weight and eating behaviours which use insights from conversation analysis and discursive psychology (see chapter 1). I will now briefly describe the theoretical underpinnings of these approaches. Further descriptions of various conventions established in conversation analysis and discursive psychology will also be given in the analytical chapters where appropriate.

2.7.1 Conversation analysis

Conversation analysis (referred to hereafter as CA) is an approach to the study of the social organisation of conversation. It developed in the 1960s-70s, principally by Sacks (1972, 1992), inspired by a branch of sociology called ethnomethodology which examines the ways in which people make sense of their social world (Garfinkel, 1967). CA’s early development in the 1960s-70s was a rejection of the prevalent, more traditional view of language at the time. Communication was seen as a neutral process of transmitting ideas from one person to another, with language a mere neutral medium in this process and it was generally believed that everyday language was inappropriate to examine due to being too disordered (c.f Chomsky, 1965). Sacks, dissatisfied with this idea, drew on similarities with Goffman’s (1959) examinations of the presentation of self in face-to-face interaction and ethnomethodology (Garfinkel, 1967), which focuses on naturally occurring interactions and the ways in which social order and organisation are established, to develop CA, which is now seen as a unique sub-discipline in its own right.
The focus for conversation analysts is talk or, more accurately, talk that is produced during the course of everyday interaction. The talk produced in everyday situations is referred to by conversation analysts not as conversation but as talk-in-interaction (Schegloff, 1987).

Conversation analysts show, over the course of empirical work, that talk-in-interaction is coherent, systematically organised and deeply ordered (Hutchby & Wooffitt, 1998.) They study the patterns of conversational activity, examining talk in terms of the structural organisation of turns, how speakers manage sequences and how participants accomplish turn-taking. According to Hutchby & Wooffitt (1998) the aims of CA are chiefly the explication of talk’s procedures, to examine the ways in which participants produce and interpret talk-in-interaction, and to “reveal the tacit, organised reasoning processes which inform the production of naturally occurring talk” (ibid, p.1.) The aim of CA is to examine how ordinary talk is organised, how people coordinate their talk in interaction and the role of talk in wider social processes.

The analysis of conversational activity is not constrained by prior theoretical assumptions. CA is empowering in that the speaker is regarded as the analyst of their own talk and focus is on the participant’s own sense of what is happening within the interaction, rather than the analysis being based on the researchers’ assumptions.

2.7.1.2 Key features of CA

- CA views talk as a phenomenon worthy of analysis in its own right, and language as both functional and constructive.

- CA addresses intersubjectivity (Hutchby & Wooffitt, 1998) - shared meanings constructed by people in their interactions with each other and used as a way of interpreting these interactions to make sense of the social world.
Talk is composed of sequences, and CA is a disciplined procedure for examining the sequential structure and organisation of interactional episodes, by analysing talk at the micro level.

CA can be distinguished from all other approaches to language in the social sciences by its focus on action (Sidnell, 2005). Conversation analysts see talk as methodic, suggesting that talk makes things happen, with utterances being objects used by the speaker to accomplish certain things within interactions – talk consists of a collection of actions, such as assessments and repair initiations for example. Any phenomenon in talk-in-interaction can be examined in terms of what happens as a result of talk, in its specific position within the interaction.

### 2.7.1.3 Turn-taking

Actions accomplished in interactions get done in turns-at-talk. Conversation is collaborative; it has been suggested that it takes, minimally, two turns to have a conversation (Sacks, Schegloff & Jefferson, 1974). It is also suggested that generally only one speaker tends to talk at one time, and that turns are taken with as few gaps and overlaps as possible (ibid., 1974).

One aim of CA is to discover how individuals understand each other, and respond to one another, in their turns at talk. Therefore a central focus of CA is on identifying, documenting and explaining the ways in which people exchange opportunities to speak and how these sequences of actions are produced and organised within interaction. In these sequential turns within a conversation, individuals demonstrate arrival at an understanding of what was meant by the prior turn. This understanding may or may not correspond with the actual meaning intended by the speaker, but whatever understanding is gleaned from the prior turn is displayed in the next turn of the sequence by how the speaker has constructed their turn to be a suitable response to the prior turn. This, one of the most basic of tools used in CA, is known as a ‘next-turn proof procedure’ (Sacks et al., 1974) and allows for analysts to
be confident that their explication of the orderly properties of talk is based on oriented-to accomplishments of participants, rather than merely the analysts’ own assumptions.

Turns consist of ‘turn construction units’ (see Sacks, Schegloff & Jefferson, 1974) which take the basic shapes of sentences, clauses, phrases, or lexical items. It is at the end of a turn construction unit (referred to hereafter as TCU) where another individual may begin their next turn. This next turn may be ‘self-selected’ or may be appropriated by the previous speaker through, for example, a direct question. The organisation of turn-taking gives the possibility for responsiveness. Two turns, by different speakers, placed one after the other in an interaction are referred to in CA as ‘adjacency pairs’. The first turn of an adjacency pair, or ‘first pair part’ is an utterance initiating an exchange (for example, asking a question). The second turn, or ‘second pair part’, is responsive to the action of the prior turn (for example, responding to the question) and displays the current speaker’s understanding of the prior turn. There are, of course, instances when the conventions of turn-taking are not adhered to and when an individual may not make the response one would expect. Such deviations can also be examined using CA, and may be particularly interesting to analyse in terms of what a deviant action is accomplishing.

Another central concept, related to this idea of the importance of turn-taking, is that of the ‘adjacency pair’ (Sacks et al, 1974). The basic idea of this is that turns come in pairs and that the first turn of a pair creates certain expectations. The first turn of an adjacency pair, or ‘first pair part’ is an utterance initiating an exchange (for example, making a request). The second turn, or ‘second pair part’, is responsive to the action of the prior turn (for example, granting or declining the request) and displays the current speaker’s understanding of the prior turn. Therefore, what is said in the first turn has implications for the second turn, limiting the number of responses which are appropriate. Adjacency pairs exist in many different forms, such as question/answer, invitation/acceptance (or rejection), blame/defence, complaint/apology, greeting/replied greeting, and accusation/denial, to name a few. All adjacency pairs have both preferred and dispreferred potential responses (Pomerantz, 1984; Schegloff, 1995). CA has noted many interesting patterns in responses to previous turns where there are two potential responses, dependent on
whether the person is giving the preferred response or not. For example, the adjacency pair of invitation/acceptance or refusal. The preferred response is generally one of acceptance or granting, and in such cases where a preferred response is given, the TCU is likely to be short and to the point. Conversely, it has been found that rejections of invitations tend to be elaborated (see Schegloff, 2007), for example, an invitation may be declined by the first component of the TCU may be an appreciation of the invitation about to be declined. Rejections may also be mitigated or attenuated, for example, delivered after a pause with the disagreement weakened as much as possible (Kitzinger, 2000). Similarly, responses which go against the preferred response to an assessment (generally, one of agreement, unless the assessment is ironic or self-deprecating) tend also to be delayed, weakened disagreements (Sacks, 1987). Generally, dispreferred responses are commonly accompanied by (among others) accounts, excuses, disclaimers, hedges, apologies, and appreciations.

The existence of adjacency pairs highlights talk being a ‘social action’ and shows that individuals are constantly ‘analysing’ the prior speaker’s utterance in terms of what the appropriate response is, and so turns perform some sort of action in relation to the prior turn.

Related to the concept of adjacency pairs is that of ‘sequential implicativeness’ (Schegloff, 1987) – awareness by the speakers of the interactional meaning in the sequence. Basically, each turn in a conversation is essentially not only a response to the preceding turn but an anticipation of the kind of talk which is expected to follow. In formulating a turn at talk, the speaker demonstrates their understanding of the previous turn and implies what they expect the next turn to be. This concept of sequential implicativeness demonstrates participants’ own awareness and understanding of what they are doing, by the way the display this to each other during interaction. This allows for a dynamic view on conversational activity. In addition to adjacency pairs and sequential implicativeness, there are other points of interest of conversational speaking examined in CA, such as invitation-refusal sequences, story prefacing, the ways in which participants respond to interruptions or silences, and ways in which individuals may pass the opportunity for a turn at talk.
2.7.1.4 Membership categorisation analysis

As well as the sequential organisation of talk-in-interaction, conversation analysts are interested in how people use categories in their talk (Sacks, 1992) — the ways in which they opt to describe themselves and others as members of various categories in order to define and identify themselves and other people, how categories are managed and made relevant (Edwards, 1997), and how individuals work up their entitlement to membership of these categories in talk. The words chosen have strong implications dependent on people’s stereotypes of said categories. Categories used in talk-in-interaction — such as gender, for example — provide a discursive resource for people to make assessments of identity (Edwards, 1998). Categories also provide a set of inferential resources we can use to understand and interpret a person’s actions/behaviour; they are inference-rich (Sacks, 1992, p. 41).

This thesis uses CA to examine the sequential organisation of the radio interactions — that is, how ‘turns’ are taken by the callers and hosts, and how these turns are treated and oriented to by the other member(s) of the interaction. This thesis also examines if, and how, membership to various categories is worked up in talk.

2.7.2 Discursive psychology

I will now go on to briefly discuss discursive psychology (see Edwards & Potter, 1992) which is interested in talk not as a means to infer internal constructs such as ‘attitudes’, but in the actual discourse itself. Discursive psychologists, like social constructionists, assume identity as a social practice that speakers are constantly negotiating within their interactions (see Potter & Wetherell, 1987). The ‘self’ has been addressed as a concept given ontological status primarily through social interactions. Conversations, then, can be seen as an interactional site in which speakers enact social roles and negotiate identities.

Discursive psychology (referred to hereafter as DP) draws upon the various theoretical frameworks of discourse analysis, rhetoric (see Billig, 1987), ethnomethodology (see Garfinkel, 1967), post-structuralism (see Derrida, 1976) and
conversation analysis. The focus of this paradigm is on talk itself, what individuals are doing in their talk and how talk is used to construct versions of reality (see Edwards & Potter, 1992; Potter & Hepburn, 2007). DP rejects the view of discourse held in mainstream psychology; that is, discourse as merely an expression of thoughts, intentions, cognitive processes and mental states, and language as a ‘doing nothing’ expression of speakers’ mental states. Instead, DP allows for the examination of how individuals build, manage and make relevant ‘psychological’ constructs in talk (for example, how mental events like biases, motives, and intentions are constructed).

‘States of mind’ are the topic and business of talk, rather than the cause of talk. DP takes discourse to be constructive (i.e. peoples’ accounts of the world are seen as constitutive of that world). So cognitive notions like ‘scripts’ and ‘attitudes’ are, rather than a reflection of some ‘inner world’, in fact part and parcel of participants’ interactional work (see Edwards, 1997; Edwards & Potter, 1992; te Molder, 1999; te Molder & Potter, 2005). Language does not represent a fixed reality or fixed attitudes but is reformulated as talk-in-interaction, with language used to do things; talk is seen not as a reflection of some mental state but as constructing a version of events. With DP it is vital to start with participants’ own understandings as they are displayed in interaction (c.f. ‘next-turn-proof-procedure’).

Particular focus is given to how individuals manage their stake and interest within interactions (Edwards & Potter, 1992; Potter, 1996), and how talk is used to construct accounts as valid rather than merely a reflection of this stake and interest. DP also considers how individuals manage issues of agency and accountability in their talk (see Potter & Edwards, 1992) and these insights have guided the way my analysis has been carried out.

The ‘rhetorical’ principle of DP suggests that people talk rhetorically in ways designed to deny or counter alternative ‘attacks’ on them. Discursive psychologists are also concerned with how speakers attend reflexively to their own subject-object issues, for example, how they deal with the possibility of being considered biased or emotionally involved with regards to what they are saying.

Discursive psychologists analyse talk semiotically; that is, they ask ‘what is not being said here, that could have been said?’ – the selection of a particular word is
analysed by imagining plausible alternatives and the subtle differences between similar words/constructions can be examined to unpack why a certain word might have been chosen.

This thesis uses the discursive paradigm to explore what is made relevant in talk by speakers. As will be illustrated in the data, individuals frequently display inconsistencies in their talk, rather than showing a stable constant attitude. With data based around the complex topic of eating behaviours, I was particularly expecting to find contradictions and paradoxes in the talk, and insights from DP allowed me to examine in detail the ways in which individuals use language to construct versions of events. Using a combination of CA and DP, this thesis examines talk with respect to action as well as topicality – that is, both what aspects of talk are doing, as well as what the talk is actually about, are discussed.

### 2.7.3 Reflexivity

It has been suggested that when interview studies are employed, the investigator must acknowledge that they serve as an instrument in the collection and analysis of data (Mason, 1996). While the present study used naturally occurring data and so I did not influence the collection of the data, all interpretations of the data discussed in the analyses are subjective and may have been influenced by my own assumptions or preconceptions as a researcher. Banister (1994) emphasises the importance of acknowledging that there are multiple realities and that plurality of interpretations is always a possibility.

### 2.7.4 Identifying areas of interest

Initial examinations of the data corpus gave rise to several potential analytic chapters; however, with such a large quantity of data, I needed a principle on which to select extracts to analyse.
I was initially interested in identity – specifically in how this might relate to issues of food and weight, and how identity might be bound up with body image or eating behaviour – and in morality. I had not actually considered ‘agency’ and ‘accountability’ prior to collecting data, but having read and reread my transcripts, I felt there was no way I could exclude ideas of responsibility and agency from this thesis as these seemed to pervade every interaction. So, examination of the data resulted in the identification of one major theme of interest – the management of agency and accountability in talk – which I have divided into four sub-themes, which will be explored in the analytic chapters to come (see chapters 3, 4, 5 and 6).

2.7.5 Overview of analysis

CA (see Sacks, 1987) allowed me to examine the minutiae of talk and explicate its function (see Heritage, 1997), and to specifically focus on its sequential organisation, how participants orient to each other’s turns and what they make relevant in their descriptions. Membership categorisation analysis (see Sacks, 1992) was also used, to examine how individuals develop categories within everyday talk, locate the central categories underpinning talk about food and weight, and explicate the deployment of cultural knowledge through the subtle use of these membership categories. Finally, insights from DP (see Edwards & Potter, 1992) were used to examine the ways in which individuals used language to construct versions of events.

2.8 Concluding remarks

This chapter has provided an overview of the process of data collection, transcription and analysis, and has shown how the analytic process was driven by the data itself. The latter part of this chapter has given a brief overview of conversation analysis and discursive psychology and explained why I chose to draw on these analytical frameworks.

Having now introduced background literature as well as explained the methodological rationale behind this study, I will now move on to the analysis of the
data. The following chapters will explore the ways in which speakers account for their eating/dieting behaviours and the discursive techniques they use to manage and negotiate accountability. I will first consider identity construction, focusing particularly on the opening of calls and shows (see chapter 3). I will then consider how "ordinary" identities are made relevant and negotiated (see chapter 4), before moving on to consider both medical and moral discourse (see chapter 5) and finally the ways in which agency is grammatically and metaphorically negotiated (see chapter 6).
3. Opening Sequences

3.1 Introduction

In this first analysis chapter, I will focus particularly on the opening sequences of interactions, examining the organisation of turns within these sequences and the interactional work done within them.

Much research on conversational ‘openings’ has been carried out by conversation analysts, from the early work of Sacks using data from a suicide prevention helpline (see Sacks, 1992), through to more recent studies examining, for example, telephone call openings (e.g. Schegloff, 1979), mobile phone call openings (e.g. Arminen & Leinonen, 2006); helpline call openings (e.g. Potter & Hepburn, 2003; Emmison & Danby, 2007); the opening turns of tutors in university tutorials (e.g. Benwell & Stokoe, 2002); and the opening turns of service calls (e.g. Wakin & Zimmerman, 1999). Baker, Emmison and Firth (2001), in their examination of the openings of calls to a software technical helpline, found that call-takers’ opening turns tended to be very general (e.g. ‘How can I help you?’), leaving it up to the caller to design the way the problem is presented. In this chapter I examine radio show hosts’ opening turns to see if, and why, they differ from this general ‘How can I help you?’ type opening question. Why might hosts’ openings of radio calls be different? Well, firstly, radio hosts are working on the agenda of having a radio show with a time limit and an audience; secondly, the caller has already been through a switchboard which we don’t get to hear – the hosts obviously have some idea of what the problem is already.

However, there appears to be relatively little research on opening sequences in radio interactions. Even within the little existing research examining radio opening sequences, focus is given to how callers use their opening turns to authenticate their right to speak about the topic and how hosts might use their sequential turn to build up an argument to the caller’s prior turn (e.g. Hutchby, 2006). There appears to be no research on greeting sequences on the radio or on how the caller is actually encouraged to deliver their opening turn. While radio phone-ins have some similar
features to other types of institutional talk done over the phone – for example, helplines – they are of course unique in the fact that the participants of the interaction are only talking directly to one other person but they are aware that their talk is being broadcast across the country. It will therefore be interesting to examine the opening sequences of radio calls, which may have similar features to other types of call openings, but may well have different features unique to radio broadcasts. This chapter aims to explore the opening sequences of radio calls to fill this gap in the literature of openings.

In this examination of opening sequences, I will discuss the following:
• How each new caller is introduced
• Greetings
• Ways by which the host elicits a certain story or question from the caller
• The caller’s first extended turn after a greeting.

3.2 Introducing the caller and exchanging greetings

I first want to examine how callers to radio phone-ins are actually introduced by the host, and analyse the ‘greeting sequences’ that are generally done in these opening turns. It seems appropriate for the first analysis chapter of this thesis to start by looking at the very first exchanges in the interactions that formed my data corpus. Further, much of the research on phone calls using conversation analysis has focused on call openings as a particular point of interest.

Whereas in a ‘real’ phone call the initial ‘hello’ can be seen not only as a greeting but as a response to the summons of the ringing telephone (see Schegloff, 1972, 2007), in all of the radio phone-ins I collected the callers were first put through a switchboard and then waited to go on air with the host. There is no ringing telephone for either the host or the caller to treat as a summons. I was therefore interested to see if, and how, greeting sequences were done. According to Sacks (1967), greetings are generally organised as utterance pairs, with the occurrence of the first greeting making relevant a returned greeting from the second member of the conversation. In doing a greeting, a call-taker therefore sets constraints on what the caller’s next turn can appropriately be. Despite the fact that generally only two
people participate in each of the interactions in my data corpus, both parties are aware that their interaction is being broadcast to potentially millions of people, and so I was also interested in whether this was addressed in greetings sequences - would there be some acknowledgment of the listeners in the opening turn, or would the turn directly address only the other member of the conversation?

I will now present several extracts which typify the opening sequence of a phone-in call. In the first fragment, the radio show host (referred to as H throughout all extracts) of a BBC Radio 4 phone-in on 'body image' is talking to Natalie, who is the first caller of the day to this particular show. Having briefly described what the show will be about, the host gives out the station's phone number and brings in the first caller.

(Extract 1) NAT-1
1 H: Call us now on >oh eight< seven hundred. (.)
2 (.) one hundred. (0.3) ↓four four
3 four.=Natalie Bell: has done that, good
4 morning Natalie,f
5 (.)
6 NAT: ↑Good morning.
7 ((mechanical click))
8 H: What's >your< point:. 
9 NAT: .hhh Um (. ) >well I've< struggled with (.)
10 with food all my life

We see the host first introducing Natalie for the benefit of the audience - 'call us now...Natalie Bell has done that'. This is clearly for the benefit of the listeners, so that they know the show is going to its first caller and that this caller is a woman named Natalie - we would not get this sort of introduction were the interaction not being overheard by people not actually involved in the interaction. After this brief introduction for the sake of the audience, we get a 'good morning Natalie' from the host which is reciprocated by Natalie - 'good morning' - after only a minimal pause. The placing of the host's 'good morning' as the first utterance actually directed at Natalie means that the utterance acts as a greeting and is analysed as such by Natalie, as shown through her reciprocation of 'good morning'. Rather than seeing Natalie
launch straight into her story, instead we get another turn from the host, encouraging Natalie’s account by asking ‘what’s your point’. This use of an open-format ‘wh’ question (these are questions beginning ‘who’, ‘what’, ‘where’, ‘when’ or ‘why’) as opposed to a closed-format yes-no question gives Natalie the license to tell her ‘story’ in her own terms. This kind of initial question format allows the respondent a choice about how to enter into the talk, and suggests that any number of forms of first turn by Natalie would be appropriate. The onus is therefore on Natalie to competently design her next turn. I will return to Natalie’s call in section 3.3, paying closer attention to the design of Natalie’s turn after the host’s question.

The organisation of talk in this extract illustrates what is a regular pattern in the call openings of this data corpus. I will now show several more extracts which demonstrate this pattern.

(Extract 2) L-1

1 H: Well Felicity thank you very much indeed er for calling us, .hhh I’ll bring Laura Taylor in now >hello Laura<.
2 L: Hello:.
3 H: What’s your point.

Here we have an opening sequence with the same structure seen in Extract 1. The host tells the audience who is the next person on the line, giving both the caller’s first and last name. The host then greets the caller by name, and the caller reciprocates the greeting. The host’s next turn is then a question to elicit a ‘point’ from the caller.

In the following three fragments, we have identical introduction-greeting-reciprocated greeting-question formats:

(Extract 3) S-1

1 H: Suzanne, thank you very much indeed er for calling us er <we go to> Sarah Baker no:w.
2 >Hello Sarah<.
3 S: Hello:.
4 (.)
5 H: What’s your point:. 

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In each of the three above fragments, we see the host introducing the next caller to the listeners using first and last names. We then see a ‘hello’ from the host with the caller’s name attached, showing that the ‘hello’ can be seen as a greeting directed at the caller. There is then a reciprocation of this greeting from the caller – in each of these three fragments, the reciprocation is a direct echo of the greeting with each of the callers repeating the ‘hello’ rather than, say, responding with ‘hi’ or ‘good morning’. After the greeting from the caller, the host asks the question ‘what’s your point’ suggesting that the caller’s next turn should account for why they are calling, i.e. what ‘point’ they wish to make.

I now want to look at a fragment which follows the same pattern, with two slight differences.

(Extract 6) MEL-l
1  H: .hhhh well Catherine thank you very much
2  indeed for calling us: (. ) this morning .hh er
3  <Melissa Chase> is on: the line now ;hello
4  Melissa.
5  MEL: Hi: Jenni.
6  H: >What did you want to ["say."<
7  MEL: [er really two things
In this extract, the introduction of the caller and the greeting sequence follow the same format we have seen in previous extracts, although the greeting from the caller is slightly different in that she addresses it directly to the host — 'Hi Jenni' — rather than simply uttering a 'hello' which could be seen as a greeting to both host and audience.

The host’s second turn — 'what did you want to say' is different in wording to the previous examples but does similar interactional work to 'what's your point'. Both 'what did you want to say' and 'what's your point' are questions which clearly mark the end of the host's turn and invite the speaker to take the floor. Both questions also give the caller a certain amount of freedom with regard to their response. The questions are fairly specific — asking for the 'point' and 'what...you want to say', and given that the callers have chosen to phone in we can only assume they do have a specific point to make — however, they are rather general questions in that they don't explicitly specify a topic.

The above extracts all come from call-in shows which centre around callers telling personal stories or adding opinions to a debate, rather than asking questions. However there were some call-in shows in the data corpus where the host was joined by an expert in the field of health, nutrition or exercise and where callers were invited to phone in with questions. If we examine the opening sequences of these calls, we can see a similar pattern:

(Extract 7) B-1

1  H:  Beth Reynolds joins us first from Exeter in Devon. Hello Beth.
2  B:  Hello.
3  H:  And your question please.

Again we see the host introducing the caller to the audience using both first and last name, before greeting the caller personally — 'hello Beth'. This greeting is reciprocated by Beth, and the host then encourages Beth’s question by specifically saying 'your question please'. Asking for simply 'your question' rather than 'your question about xxx' is similar to the host in the previous extracts asking for 'your
point’. It encourages the caller’s next turn to be the utterance of a particular point or question, but leaves it to the caller to state what this point or question is actually about.

I now want to look at another call where the caller is phoning in for advice, rather than to tell a story:

(Extract 8) D-1

1 H: Thank you very much for the call. We’ll (. ) go on- (. ) we have a caller in Weston Super Mare, “Dawn is waiting”, !hello Dawn.
2 D: .hh !Hello!.
3 H: And (. ) what’s your question please.
4 D: “Hi” we’ll I’m in my late fifties, I’m diabetic .hhh and two and a half years ago I had a triple bypass (0.3) and I was told (. ) er you know eventually I should be walking three miles a day.

Again we have the host introducing the caller by name and then greeting the caller, the caller returning the greeting, and the host asking for a question. This request for the caller’s question takes basically the same format we saw in the previous example – ‘what’s your question please’, compared to ‘and your question please’. It assumes the caller has a question and makes the voicing of this question the relevant next turn, but does not suggest what this question might be about. It is also interesting to note Dawn’s response – despite being asked for ‘your question please’, Dawn does not immediately ask a question. Instead she does some identity and categorisation work which will be discussed further in section 3.3.

The extracts discussed thus far have demonstrated how the host can encourage the caller’s next turn to be the making of a ‘point’ or the asking of a question, but without restricting what this ‘point’ might be by asking about a specific topic or event. The pattern that each of these extracts has followed can be summed up as:

→ host closes previous call and introduces the next caller by name
→ host greets the caller by first name
→ the greeting is returned by the caller
the host asks a 'wh' question asking for a 'point' or a 'question' but without displaying any prior knowledge of what the 'point' or 'question' may be about.

I now want to look at several extracts which follow a similar pattern but show a different format of 'opening question' from the host. In the next extract, note that there is no explicit hearable 'greeting'; rather the host introduces the caller and then poses a question with no 'hello' in between.

(Extract 9) SE-1

1  H:  Natalie, stay on the line >cos I'm< going to bring: (.) Serena Matthews in:. (.) u:m
2  (.).hh who I >think has had a< a
3  similar problem but has found a way of (.)
4  .hh of dealing with it (.). Serena you were
5  a yo-yo dieter, *yes*?
6  SE:  ["yes,"
7     (.)
8  SE:  $hello$
9  (.)
10  SE:  yes I was (.). for (.). about (.). seventeen years.

This fragment shows the opening of the call directly after Natalie's call, the opening of which we looked at in Extract 1. The host's turn on lines 1-6 above is the only 'interlude' between the two callers. As we can see, she moves from talking directly to Natalie, the first caller – 'Natalie, stay on the line' to introducing the second caller – 'I'm going to bring Serena Matthews in'.

What happens after this is different to the pattern which we have seen in previous examples. Rather than the host and caller greeting each other before the host requests information from the caller, here we get no greeting from the host; her first utterance directed to Serena is 'you were a yo-yo dieter, yes?' Despite the lack of greeting, we do get a 'hello' from Serena, but she then goes on to begin her account with only a minimal pause.

In this fragment, rather than leaving it to Serena to inform the audience of her reason for calling, we get the host telling us that Serena 'has had a similar
problem [to Natalie] but has found a way of dealing with it’ and introducing Serena as a ‘yo-yo dieter’. Here, the host gives the caller a rather more specific question than we saw in the previous extracts; she presents Serena with the membership category ‘yo-yo dieter’, adding ‘yes?’ in the form of a question which allows Serena to accept or resist this identity as a ‘yo-yo dieter’. This is a ‘yes-no interrogative’ (see Raymond, 2003) with preference organisation (see Garfinkel & Sacks, 1970) – the host actually projects the preferred response in the question, for Serena to simply confirm. Serena answers this with an (overlapping) ‘yes’, then inserts a greeting – ‘hello’ – despite not being greeted by the host.

The next extract shows the third call in the phone-in show that Natalie and Serena featured on. We see the host thanking the previous two callers before introducing the third caller, Kelly.

(Extract 10) KEL-1
1  H:  We'll Natalie, and Serena, thank you both
2   (. ) very much indeed for starting us off
3   hhh this morning or we're gonna go to
4   TKelly Brian now, hello Kelly.
5   (. )
6  KEL:  Hi, Jenni.
7    (0.3)
8  H:   You've had surgery yes?

In the fragment above we see the host effectively ending her communication with the first two callers – ‘well Natalie and Serena thank you both very much indeed’ and introducing the third caller to the audience. We see the host greeting the third caller by name – ‘hello Kelly’. As seen in previous extracts, this greeting is reciprocated by the caller –‘hi, Jenni, which is followed by a pause – the caller waits for a question from the host rather than going straight into a story. Here we get the caller addressing the host by name, echoing the format of the host’s greeting – ‘hello Kelly’ / ‘hi Jenni’. There is then a question from the host which echoes the format of the question posed to Serena in the last extract I discussed – in that extract, we saw the host asking ‘you were a yo-yo dieter, yes?’ In this extract, the host’s question takes a similar form –
‘you’ve had surgery, yes?’ The host is clearly defining the topic that the caller’s next turn will take – in the previous example, the caller’s next turn would accept or reject the label ‘yo-yo dieter’, while in this example, the host’s question means that the caller’s next turn should be about the surgery she has had. Both extracts show a question with topicality specified, rather than something like ‘what’s your point’ which does not actually state the topic.

I would now like to look at another extract which demonstrates this same question format:

(Extract 11) AL-1
1 H: .hh Becky. (. ) Thank you very much indeed
2 (. ) er for calling us: (. ) this morning.
3 .hhh E: r we go to (. ) ↑ Ally Smith now, = hello
4 Ally.
5 (. )
6 AL: Hello.
7 (0.3)
8 H: .hh Y-you have (. ) theories > about the
9 menopause< yes:.
10 (. )
11 AL: .hhh Yeah

The above extract follows the same format as the first examples we looked at: we get the host closing the previous interaction, introducing the next caller using both names for the benefit of the audience, and greeting the caller by name. The caller returns this greeting and there is a brief pause before the host asks a question, referring to an issue the caller has presumably stated prior to going on air. It is after this initial question that the caller goes into an extended turn (not shown in full here). The question asked by the host here – ‘you have theories about the menopause, yes’ takes the same form as the questions we saw in the previous two extracts, embodying presuppositions for the caller to either confirm or deny. This kind of ‘tag ending’ of a question makes an acknowledgement of the question relevant in the co-participant’s next turn.
Let us now examine another fragment showing this type of question from the host.

(Extract 12) F-1

1 H: Lindsay thank you very much indeed for calling us this morning. hhh um <Felicity Darvill: er is on the line \(\text{\_hello Felicity\_}\).
2 F: \(\text{\_Hello}\)
3 H: I think you had a problem with your mum as well [yes?]
4 F: [.hhh

Here we can see the host drawing on prior knowledge of the caller's background, which presumably the caller has told to the switchboard prior to going on air – 'I think you had a problem with your mum'. The 'as well' refers to the previous caller's story.

The questions in these four extracts are structured in the same way: 'you have this/are this, yes?' The preferred next turn then would be for the caller to confirm this statement with a 'yes'. These questions from the host are asked 'as if for the first time', although clearly the host has prior knowledge of the caller's situation, to be able to ask them about something specific such as 'a problem with your mum'. This illustrates the subtle way the radio hosts work to edit while producing their shows – the shows are broadcast live, and the hosts are working 'on the spot' to clearly attend to both the overhearing audience and their callers.

The extracts presented thus far as typifying this pattern have all been from phone-ins inviting personal stories and opinions rather than questions. However, the pattern can also be seen in interactions where the host is inviting a question, rather than an opinion. For example:

(Extract 13) J-1

1 H: Okay, we\'ll take a walk to Lancashire, at least er in \(\text{\_cyber space, we(h)'ll g(h)o heh}\) to: John Thomas. hh \(\text{\_who is waiting for us}\)
2 now<. \(\text{\_Hello John and you've got a question I}\)
think about a <treadmill>.

( )

J: Yes, good afternoon.

H: [Hello:]

J: Hello. I'm sixty years of age and fourteen stone, I recently bought a treadmill and have been on it for an hour a day.

Here, we see the host inviting John's question and in doing so stating what he knows the question to be about—i.e., we get 'you've got a question I think about a treadmill' (emphasis mine) instead of, say, 'what's your question please'. This is similar to the three fragments I have just discussed, although structured slightly differently in that we don't get a 'yes?' tagged on at the end of the host's question. The 'I think' may be functioning here in the same way as the 'yes?' in the previous examples—it shows that the host doesn't know what the exact question is, he merely thinks it is about a treadmill, and therefore encourages John to elaborate on this in his next turn. The very fact that the host is aware that John wants to talk in some way about a treadmill demonstrates that there has clearly been some off-air information given by John, likely to a switchboard operator—but the host invites John to provide the specific details, allowing John to construct the problem, and thus not appearing to 'put words in the mouth' of the caller. The host's question construction here gives the overhearing audience an idea straight away of what the caller will be talking about—in this case, a treadmill—but leaves it to the caller to elaborate on this.

Note also the details John gives before he mentions the subject of his question, the treadmill—he states his age and weight. We will return to this fragment in section 3.3 and examine John's turn in closer detail.

It seems then from the extracts we have examined so far that there are two general patterns for the opening sequence of radio calls. Both patterns begin with the introduction of the caller for the benefit of the audience and there is generally then some form of greeting sequence from both host and caller. There is then a question from the host, which can take one of two forms: an open-
ended “wh” question which asks for a ‘point’ or a story of some sort; or a question referring to a specific topic or event which has clearly already been mentioned by the caller when going through the switchboard.

Having demonstrated the general pattern that greeting sequences in the data corpus tend to follow, I now want to look at two cases which are slightly different in that we get two greeting utterances from the caller.

(Extract 14) CAT-1
1 H: Well Laura, thanks very much er for calling us, .hhh er Catherine (.). Collins is on the line, hello Catherine.
2 CAT: Hello, good morning.
3 H: What’s your point.

The above extract, which does follow the same basic pattern as the previous examples discussed, shows a slightly different turn from the caller. Rather than just a simple reciprocated greeting as seen in the previous examples, we get two greeting utterances in quick succession -- 'hello, good morning'. What might be the reason for using two greeting utterances? One instance where we might expect to see two greeting utterances is if the speaker were addressing two people and directly greeting them both in turn. Of course, there are complex issues going on in radio interactions because, while the speaker is generally only talking to one other person, they are aware that many listeners are also hearing the talk. There are no examples in the data corpus where the listeners are clearly mentioned in a greeting sequence, but might it be the case that where two greeting utterances are positioned in quick succession, one of them is directed at the audience? I went through the data corpus looking for more examples of this and only found one other, which can be seen below.

(Extract 15) LIN-1
1 H: Lindsay (.). Raven is on the line now >hello Lindsay.<
2 LIN: Hi there, hi Jenni.
3 H: What’s your point.
This extract is interesting in that it follows a similar pattern (host introduces caller using both names, greets the caller with their first name, gets a reciprocated greeting and then asks a question) but the reciprocated greeting itself is slightly different. Lindsay says ‘hi there, hi Jenni’ which is the only other example in the data corpus of an individual using two greeting utterances. If we examine the structure of the turn prior to these utterances, we see the host first addressing the audience – ‘Lindsay Raven is on the line now’. The host then addresses Lindsay personally with the greeting ‘hello Lindsay’. It may be that Lindsay’s turn is echoing the format of the host’s just-prior turn – an utterance directed at the audience followed by an utterance directed at the co-participant of the conversation. This would explain the presence of two greeting utterances. The second of these utterances is obviously directed at the host, as Lindsay uses the host’s name – ‘hi Jenni’. The first utterance is a more general ‘hi there’. Saying ‘hi there’ (emphasis mine) does not sound out of place within the context of the radio phone-in but were we to imagine that the ‘hi there’ was being uttered in a naturally occurring two-way conversation, not being broadcast, it would sound rather strange. ‘Hi there’ would imply that either a) the speaker did not know the name of the co-participant, and was using ‘there’ to substitute where the co-participant’s name would usually be positioned in a greeting, or b) the speaker was addressing more than one other person, and using ‘there’ to direct the greeting at all of the other people without having to name them all individually. In the context of a radio show, then, it may be that ‘hi there’ is a way of addressing the audience as a whole.

The extracts discussed in this section have clearly demonstrated the pattern for call openings which is routinely employed by hosts and callers in this data corpus. That is, the host introduces the caller for the benefit of the audience; the host greets the caller by name; the caller reciprocates the greeting; and the host asks a question – either specific or general – which the caller responds to.

So, as we have seen so far, radio call openings generally follow this same format of introduction, greeting, returned greeting, question (where the question can take one of two general formats). I now want to look at two deviant cases where we do not actually get a question from the host after the caller’s returned greeting.
3.2.1 Deviant cases

In these two deviant cases, we get the usual introduction and greeting from the host followed by the reciprocated greeting from the caller but then no question from the host prompting the caller's story. So I was interested to examine: is there a marked pause where the host could come in, but doesn't, leaving it to the caller to go ahead with their account? Or does the caller maintain the floor and begin their account immediately? Is there any similarity in the callers' turns in these two deviant cases which might explain why there is no turn from the host where we might expect one?

Let us turn to the first of these two extracts:

(Extract 15) BE-1

1 H: Kelly. (.) thanks very much. (.) for joining
2 us. .hhh Becky: Rose hh (.) is on the line
3 hello Becky.
4
5 BE: Hello(h) ↑Jenni. .hhhh Um: I'm- I'm still
6 slightly in shock from the last lady that
7 was speaking. Heh heh heh

Above we see the host ending the interaction with the previous caller - 'Kelly thanks very much for joining us' - and introducing the next caller for the benefit of the audience - 'Becky Rose is on the line'. We again see the host greeting the caller by name - 'hello Becky'. This again is reciprocated by the caller, who says 'hello Jenni'. However, in this example, the caller does not wait for the host to ask her a specific question; rather, she continues her turn, informing the host and the listeners that she is 'in shock from the last lady that was speaking'. This is the first example we have seen where, after a greeting from the host, the caller has gone into their story in the next turn, rather than simply returning the greeting and waiting for a question. So what features of this interaction might explain this? If we examine Becky's first turn, we can see that rather than beginning with some 'fact' about herself (as seen in the previous examples), Becky makes reference to the previous caller, saying that she is 'in shock' from it. The fact that Becky wants to make a comment about the previous
call accounts for the lack of 'pause / waiting for question' in this extract: obviously, the host would not know Becky’s thoughts on the previous call, as it is happening live, and so had Becky waited for a question from the host, it would not be 'what did you make of the previous call?’ – it would be either a ‘what’s your point?’ type of question or would refer directly to some issue of Becky’s. By holding the floor (with an in-breath and an ‘um’ as well as a laughter particle at the end of her ‘hello’) rather than waiting for a question from the host after her reciprocated greeting, Becky manages to steer the interaction in her own way, referring to her thoughts on the previous call rather than her reason for calling.

The following extract is the only other example in the data corpus where the caller has an extended first turn without waiting for a question from the host.

(Extract 16) HAN-1

1     H:    Well Maggie thank you very much for that
2        (. ) historical perspective . hh er and we go
3          to: Hannah Ainsworth now, $hello Hannah$.
4     HAN:  Hello:. (. ) um I >just have< (. ) been
5        listening to the debate with interest and um
6            I’ve sort of thought that no one’s considered
7       whether (. ) um food has become a new
8      addiction.

Again, there is no noticeable pause where the caller might seem to be waiting for the host to come in. Rather, we have an elongated ‘hello’, only a beat of silence and an ‘um’ before the caller makes her first comment, the first few words of which are speeded up. These facts together suggest that rather than waiting for the host to come in with a question, the caller is in fact intentionally holding the floor. So, both of these deviant cases show the caller working to maintain the floor, rather than waiting for a question. These are the only cases where the caller does not wait for a question – so what makes these callers different?

If we look at what the callers are actually talking about, we can see that they do not begin with a personal anecdote, the way the majority of callers in this data
corpus do. Instead, they both make a comment about the radio show itself. The first caller refers to another caller on the show, and in the second case, the caller refers to the debate that has been going on in the show. This is similar to what Maynard and Zimmerman (1984) refer to as “setting talk” – that is, talk about the setting of the conversation, for example, the location of the co-participants. Maynard and Zimmerman suggest that this type of pre-topical sequence is designed to generate mentitfnables for subsequent elaboration. The co-participant’s next turn can either topicalise the setting talk or close it down. It is important to note that these two ‘deviant cases’ are not the only examples within the data of a caller referring to previous callers (see Extract 24 of section 3.3, for example) – but it is remarkable that in the only two cases where callers do not wait for a greeting, their first comment is a reference to a previous caller’s comments.

3.2.2 Overview

In this section I have demonstrated two general patterns for introducing and greeting callers and then encouraging them to tell their story or ask their question – in other words, encouraging them to say whatever it is they have called in to say. The introductions and greetings in these two patterns are the same, but the host’s next turn after the greeting sequence differs. In both types of sequence, the pattern begins as follows:

→ Introduction of the caller by the host, for the benefit of the audience (this involves stating who is on the line, usually using both first and last name of the caller and often their location)

→ Greeting from the host directed at the caller (this consists of a greeting utterance such as ‘hello’ or ‘hi’ followed by the caller’s first name)

→ Reciprocated greeting from the caller

We then get a question from the host that invites the caller to tell a story or ask a question, and this turn from the host can take one of two formats. Firstly, the host can encourage the caller to talk without actually mentioning the gist of what the caller’s story or question will be about (for example, saying ‘What’s your point?’ or ‘What’s your question?’). The second way of encouraging the caller to talk involves incorporating the topic into the question, for example, ‘You
have a theory about xxx, yes?’ I have also examined two deviant cases, wherein
the callers do not wait for a question from the host but rather hold the floor and
keep speaking after their greeting. In both of these cases, the callers made a
‘setting’ comment about the show itself or a previous caller, which may account
for the caller not waiting to be asked a question.

I will now move on to discuss the callers’ first extended turns after the
greeting sequences, and what is being done in these turns. As has been briefly noted in
this section, regardless of the format of the host’s question, callers frequently give
some background information about themselves rather than orienting to the host’s
question immediately. There is a great deal of identity work being done in these first
turns after the greetings, and I now want to examine this more closely.

3.3 Identity construction in opening turns

According to principles of discursive psychology, participants’ identities
should be considered as an accomplishment in talk rather than a representation of an
actual self. Therefore cognitive notions such as attitudes, motives and identities must
be considered as part of participants’ interactional work, rather than reflections of a

Using this perspective that identities are not stable mental states but social
phenomena which are produced and managed in talk (see Antaki & Widdicombe,
1998), in this section I explore the various ways in which individuals with ‘disordered
eating’ are categorised by both themselves and those they interact with (radio hosts
and ‘expert’ guests), and explicate what kind of interactional work is being done
through making relevant these identity ascriptions. I examine the discursive resources
used to negotiate, resist or make relevant participants’ identities and memberships in

4 I use the term ‘disordered eating’ to apply to all individuals identifying as having
‘problems’ with eating or with weight; therefore when I refer to ‘disordered eating’ I
am not referring only to clinically-diagnosed conditions such as anorexia and bulimia
nervosa but to all ‘problems’ with eating – for example, over-eating, anorexia,
bulimia, comfort eating and yo-yo dieting.
various categories. Though identity construction in radio talk has already received some attention from researchers (Ferenčik, 2007; Fitzgerald & Housley, 2002; Hutchby, 2001; Thomborrow, 2001), identities in relation to eating behaviours and accountability on the radio have yet to be explored.

Having examined the greeting sequences of the radio interactions and ways in which the host encourages an account from the caller, I will now be moving on to examine what happens directly after this and how the callers respond to these questions from the host. I am particularly interested to examine the identity work which is done in the responses to these first questions.

Having examined many opening sequences in the data, it appeared that much identity construction was being done in participants' self-introductions – in introducing themselves to the radio show hosts (and effectively to the audience in general) participants tend to attribute identity categories to themselves. Self-introductions have frequently been a phenomenon of interest in discursive psychology and conversation analysis (e.g. Schegloff, 1986; Wooffitt, 1992; Zimmerman, 1992). The issue of stating one's 'identity' is particularly interesting to consider in the context of radio talk; unlike participants in one-on-one interactions with acquaintances, callers or guests on radio shows need to declare an identity or label of sorts for the benefit of the listeners. In some cases, the caller or guest does this by introducing him or herself as, for example, 'a yo-yo dieter' or 'recovering anorexic'. In other cases, the radio show host actually introduces them in terms of a 'label', for example, 'you're a yo-yo dieter, yes?'

Let us now return to Natalie's call, previously discussed as Extract 1 in section 3.2. In this fragment, we can see much more of Natalie's turn after the host's question.

(Extract 17) NAT-2
7 NAT: Good morning.
8 ((mechanical click))
9 H: What's >your< point:.
10 NAT: .hhh Um (.). >well I've< struggled with (.). with
11 food all my life >I mean that's< (.). that's a
12 basic thing I mean it's not difficult: to: to work out
that .hh (. ) to: (0.4) t- (0.3) t- you’re >going to be< overweight: if you >eat too much< the only way to lose weight (. ) is to cut down the amount you eat .hh all the diets you see .hh whether it’s high this low that .hh >when it you< cut to the chase once you’ve got (. ) o:ver the bit that makes you go and look at it (. ) it’s eat less. .hhh u:m: (. ) ↑and I’m not I- I- ↑what >I don’t< understand is I’m not an unintelligence person, I’ve worked that out:, I know that:=we all: know that. .hh but it’s just (. ) ↑doing it. .hh >I can’t< seem .hh to actually: knuckle down and ↑do that bit.

In section 3.2, I focused particularly on the host’s way of eliciting Natalie’s story. I now want to focus on the design of Natalie’s next turn, paying particular attention to the various discursive devices used within it to construct and manage Natalie’s identity as an ‘ordinary’, rational, competent person. Lines 10-11 neatly account for the reason Natalie is calling in; the phone-in is about body image and weight issues, and she is ‘struggling’ with food and has been ‘all [her] life’. Making relevant why she has called in illustrates sensitivity as to whether Natalie can legitimately give opinions on the topic at hand. This acts like a ‘headline’ framing the narrative account. She suggests that ‘it’s not difficult...to work out that...you’re going to be overweight if you eat too much’. This serves to acknowledge that she is aware that eating too much may cause one to be overweight, thus presenting herself as rational and not lacking in common sense. This is later upgraded to ‘I’ve worked that out, I know that...we all know that’. The extreme case formulation (Edwards, 2000; Pomerantz, 1986) of ‘we all’ when she talks about knowing the reasons for being overweight constructs it as ‘common sense’; everyone knows it.

As well as showing that she understands that it’s a common-sense notion, Natalie’s acknowledgement that it is not hard to understand how people become overweight shows that she herself does have common sense and some ability to think rationally, and gives the host (and the audience) some idea of what she will talk about next. She has already said she is struggling, she has asserted that it’s not difficult to work out the cause of being overweight (and if the cause is obvious, one could also
assume that the solution is obvious), so presumably she will next go on to explain why she is struggling with something that could, or should, be easy to solve.

I now want to focus on a particular fragment of Extract 1, presented again below.

(Extract 17a) NAT-3

19 NAT: ↑and I’m not I– I– ↑what >I don’t< understand is
20 I’m not an unintelligent person, I’ve worked
21 that out:, I know that.=we all: know that, .hh
22 but it’s just (0.2) ↑doing it, .hh >I can’t<
23 seem .hh to actually: knuckle down and ↑do that
24 bit. (.)

Here Natalie makes a construction of herself as being ‘not unintelligent’. I would like to consider the direct rhetorical design of this statement – rather than simply saying ‘I am an intelligent person’, Natalie chooses to counter the potential proposition that she is unintelligent. This is an interesting choice of words – she avoids the risk of sounding arrogant, by opting not to describe herself as, say, ‘an intelligent person’, instead using the much more modest ‘not unintelligent’. Also, by saying ‘not unintelligent’ instead of something rather cruder such as ‘not stupid’, she refers to the scientific, measurable concept of ‘intelligence’ instead of the harsher, less neutral idea of ‘stupidity’. The rhetorical ‘not unintelligent’ counters an alternate stance which is not made explicit; that is, that the unsympathetic outsider may see Natalie as ‘just stupid’ for not being able to change her diet and lose weight.

I now want to look at different opening turns from other callers which follow a similar pattern to Natalie’s. In the following fragment we return to Serena’s call, the opening sequence of which was presented as Extract 9 in section 3.2.

(Extract 18) SE-2

5 H: Serena you were a yo-yo dieter, ↑yes[s?]
6 SE: ↑yes,[
7 (.)
8 SE: ↑hello[;
9 (.)

84
yes I was for about seventeen years.

U:m. hh having been about two stone overweight.

and after seventeen years of yo-yo dieting I was seven stone overweight.

I suffer from depression as well so having gone to seek help for that my self esteem was very low.

A:nd: urn: I found that cognitive behavioural therapy brought up my self esteem and I think that was really crucial.

Having discussed the format of the host’s question in line 5, I now want to examine what happens after this. We see Serena responding to the host’s interrogative with a ‘yes’ – but also adding some background to this which wasn’t directly asked for – ‘I was for about seventeen years’. So rather than merely responding to a yes-no interrogative with a ‘yes’, Serena responds with ‘yes’ plus an account. A sequence of events leading up to Serena’s current situation is offered: ‘having been about two stone overweight and after seventeen years of yo-yo dieting I was seven stone overweight...I found that cognitive behavioural therapy...brought up my self esteem’.

As can be seen in the fragment, Serena’s opening sequence contains many pauses and placeholders such as ‘um’ (lines 11, 13, 16 and 17). A similar pattern has been noted in opening turns by Danby, Baker and Emmison (2005), who examined the interactional management of the openings of calls to a ‘kids help line’. They explained these pauses and placeholders as being suggestive of the caller’s uncertainty in how to describe their problem. In the extract from Serena, they may also be working as floor-holding devices; note that there are no continuers from the host. These devices may be particularly salient in radio and phone calls, where there are no visual gestures or prompts to signal whether one has finished talking or not.

As can be seen from Natalie’s and Serena’s extracts, their opening turns appear to go further than merely describing their situation; they are also used to provide an explanation for how the situation came about, referring to causes and development of the situation. It is interesting to note that hosts generally do not specifically ask how the problem came about, rather just current experiences without...
needing to look back at what caused them, while the callers themselves treat their situations as accountable.

I now want to examine a fragment of interaction between a Radio 4 host and caller Lindsay, the opening sequence of which was examined as Extract 15 in section 3.2.

(Extract 19) LIN-2
1  H: >hello Lindsay.<
2  LIN: Hi there, hi Jenni.
3  H: What’s your point.
4  LIN: Well um I’ve (.) I’m in my forties now and 
5      I’ve um over the last few years been piecing together um where my attitudes to food have 
6      come from

Here, Lindsay shows some difficulty with the host’s question as shown by her hesitation ‘um’ and micro-pause. The host asking for a specific ‘point’ positions Lindsay as having opinions to voice rather than an interesting experience to relate to the audience. It may be that with such personal narratives, participants prefer their ‘point’ to be the conclusion, or upshot, of their story rather than their starting point. Rather than going straight to her ‘point’, Lindsay begins her narrative by referring to her age ‘I’m in my forties now’. This gives the audience some background on Lindsay and puts her in the category of people ‘in [their] forties’. These age introductions feature in the majority of opening turns, and seem to function as a ‘starting point’ for a narrative or a way of framing what is to be said. Lindsay’s use of the word now – ‘I’m in my forties now’ (line 4) is logically unnecessary but works as the opening for a retrospective look at her life up to now. She gives her age as ‘in my forties’, rather than a specific age, implying she is using the age reference to relay the sense of having reached a certain stage of her life, rather than a particular birthday. This allows her to go on to talk from the perspective of a person at a certain stage of life who is able to look back at previous stages and comment on them. The ‘I now believe’ is given more credibility being positioned after Lindsay’s reference to years of ‘piecing together’ information than if she had begun her turn with ‘I believe...’. It is not just a thought plucked from nowhere; she has actually spent ‘years’ ‘piecing together’
information and come to a ‘conclusion’ from this. ‘Conclusion’ makes the whole process sound rational, implying that her thoughts are based on experience and actual evidence rather than being unfounded opinions based on prejudice, and listeners are likely to assume that Lindsay’s thoughts have credibility.

Presented now is another opening turn, this time from caller Beth who has phoned into a BBC radio show on ‘exercise for the very unfit’. We previously examined the opening sequence of this call in Extract 7 of section 3.2. This phone-in differs slightly from the previous phone-ins examined, in that this one features an ‘expert’, a professional from the British Heart Foundation, who is in a position to give advice. Callers are therefore just as likely to be phoning to ask a question and request advice as they are to be calling just to tell their story or make a point.

(Extract 20) B-2

1  H: Beth Reynolds joins us first from Exeter in Devon. Hello Beth.
2  B: Hello.
3  H: And your question please.
4  B: Er I’m-I’m seventy five, I’m reasonably fit, I walk my dog for thirty or forty minutes each day but I wonder if there-if a short regime of sort of stretching, bending would be worthwhile to do in addition to that.

After the greeting sequence in lines 1-3, the host then invites a specific ‘question’ from Beth (line 4) but, before asking a question, Beth instead sets up her situation. Like Lindsay, she introduces herself first in terms of age – ‘I’m seventy five’ (line 5). She goes on to describe herself as ‘reasonably fit’, unpacking this by explaining that she walks for thirty to forty minutes each day (lines 5-7). It isn’t until line 7 that Beth begins her question. The preamble or ‘set-up’ we get from Beth in lines 5-7 may be oriented to the possible answer she might receive to her question; her introduction functions to constrain what the host’s next turn could be to relevant matters. Stating beforehand that she walks for thirty or forty minutes a day stops the advice given to her being ‘take regular exercise’, for example.
The following fragment shows another example of a caller, Dawn, giving an
introduction including her history; in this case, she has not been prompted at all and in
fact been asked simply for her 'question'.

(Extract 21) D-2

1 H: Thank you very much for the call. We'll (..) go
2 on- (..) we have a caller in Weston Super
3 Mare, "Dawn is waiting", hello Dawn.
4 D: .hh Hello.
5 H: And (..) what's your question please.
6 D: "Hi" we'll I'm in my late fifties, I'm
diabetic .hhh and two and a half years ago I
had a triple bypass (0.3) and I was told (.)
er you know eventually I should be walking
(0.3) three miles a day. .hh Unfortunately I
started with ulcers on my feet.
12 H: .hhh is that from: [the diabetes,
13 D: [from the diabetes. .hhh
14 s:o e:r e:r which I've had throughout the last
15 (..) couple of years, (..) plus some pretty
16 nasty infections and so on. [.hhh
17 H: ["mmm"
18 D: The cardiac people are saying (..) yes but you
19 should be walking, to get your heart strong?
20 U:m: podiatry, er um like- the doctor said to
21 me the other day you should have ninety per
22 cent rest. [.hh
23 H: [a:h
24 D: So what d(h)o I [do:
25 H: [er heh heh heh
26 D: I want to get fit, I used to love walking my
27 dogs .hh but you know I can- sometimes the er
28 pain in my feet I can hardly walk a few
29 steps.

This interaction follows an identical pattern to that of Beth (extract 20). Once
again, 'hello's are exchanged before the host specifically asks for a 'question please'
(line 5). Like Beth, in spite of the invitation to go directly to her question, Dawn
avoids this and instead chooses to introduce herself, first in terms of her age — 'well
I’m in my late fifties’ (line 6) and then a condition she has – she invokes the membership category ‘diabetic’ (line 7). She then describes the development of the situation, describing the ulcers on her feet which make it difficult for her to exercise. Despite the host asking for Dawn’s question as early as line 5, it is in fact not until line 24 that a question actually gets asked – ‘so what do I do’.

Something similar happens in the following extract, featuring another caller, Ally.

(Extract 22) AL-2

1 H: Enter we go to (.) Ally Smith now, = hello Ally.
2   (.)
3 AL: Hello.
4   (0.3)
5 H: Y-you have (.) theories > about the menopause< yes:.
6   (.)
7 AL: .hhh Yeah (.) um (0.3) I’ve (.) er (.) LIKE the previous callers I’ve (0.8) hh battled with my late- with my weight (.) ALL my life: I’ve lost (.) and gained (0.7) stones:. Throughout my life. (0.3) and (0.5) it’s: (.) just exhausting * actually, just* sort of gets the- (.) the the stage . hhh where you wake up ° in the morning and you really don’t want to think about it ° ANYmore. (.) .hhh (.) BUT. (0.3) I think it’s been (0.3) um: (.) .hh made a ° lot worse (0.3) by: (0.3) er (.) the ° changes that you go through when you go through the menopause.°

Despite the direct question from the host explicitly encouraging Ally’s ‘theories on the menopause’, Ally begins her turn in a similar fashion to the previous callers we have looked at, making reference to her problem (a ‘battle...with my...weight’), when the problem started (‘all my life’), and her current status (‘the stage...where you wake up in the morning and you really don’t want to think about it anymore...I think it’s been...made a lot worse by...the changes that you go through
when you go through the menopause’). So despite the host asking a rather specific question with no mention of wanting the ‘background’, Ally’s narrative tracks her problem through her life and it is not until line 17 that she gets to the topic she was questioned about, the menopause – also, interestingly, the host shows no sign of interrupting this lengthy narrative and allows Ally to present the details of her ‘story’. The host’s turn on line 12, in particular – ‘is that the diabetes’, where she urges the caller to elaborate on their previous turn – makes it clear that such expanded contextualisation is actively encouraged.

Presented below is another extract where some category work is done in the caller’s first turn:

(Extract 23) J-2

1  H:  Okay, we'll take a walk to Lanca(h)shire, at
2 least er in cyhber space, we(h)'ll g(h)0 heh
3 to: John Thomas. hh >who is waiting for us
4 now<. tHello John and you've got a question I
5 think about a <treadmill>.
6 (.)
7  J:  Yes good after[noon.
8  H:  [fhello:£
9  J:  Hello:. S- I'm sixty years of age and
10 fourteen stone, I recently bought a
11 treadmill and er I've been on it for an hour a
12 day

Here we see the host encouraging John to ask a specific question about a treadmill (lines 4-5). In John’s opening turn however he doesn’t mention a treadmill until after he has given some background information on himself – ‘I’m sixty years of age and fourteen stone’. We can assume that, in a call-in about fitness and health, age and weight are important statistics for the caller to give. John has called in for advice and in stating his age and weight prior to asking for advice, he lessens the chance of being given advice which might not be appropriate for a sixty-year-old or for someone weighing fourteen stone.
I want to turn now to a fragment featuring Catherine, who has called a phone-in to talk about the issues she has had with her weight.

(Extract 24) CAT-2
1 H: What's your point.
2 CAT: .hhh u:m (.) listened to the points there that
3 people made, um (.) there are (.) I'm a woman
4 with see pee [CP], so I'm not as [fit
5 H: [See: pee::
6 CAT: Er cerebral palsy.
7 H: Right.
8 CAT: Not as fit as some of your other callers (.)
9 BUT it's interesting to hear the correlation
10 .hhh for instance Felicity was talking about
11 her grand(mother) who was obsessed with food.
12 (.). hhh u:m I:'m: (.) Greek. (.). so: (.) my
13 entire family was obsessed with nurturing
14 through food.

Catherine's opening turn makes the claim that 'I'm a woman with CP', which the host prompts her to clarify as cerebral palsy. Having constructed this identity of herself as a disabled woman, Catherine explains she is 'not as fit as some of your other callers'. This reference to other callers is interesting, as Catherine could just as easily have simply said, for example, 'I'm not very fit'. Instead she draws a comparison between herself and other callers, marking herself as different from them because of her disability. At the same time, she is identifying her membership to the category 'woman with CP' - she is doing categorisation work via her self-description (c.f. Schegloff, 2007). Observe lines 2-3: 'I'm a woman with [CP]...so I'm not as fit [as some other people]'. Her membership to the category 'woman with CP' is portrayed as the reason for her not being as fit as other people, by use of the word 'so'. We must also take into account the recipient design feature here - Catherine is constraining suitable next turns for the host; the fact that she has stated that she has cerebral palsy counters the potential response of 'why don't you take normal amounts of exercise?'
Catherine also presents herself as a member of the category 'Greek'. Her deployment of the word 'so' in line 10 - 'I’m Greek so my entire family was obsessed with nurturing through food' (emphasis mine) makes explicit a link between being Greek and being 'obsessed with nurturing through food'.

The opening turns I have examined from Natalie, Lindsay, Beth, Dawn, Ally and Catherine all demonstrate that regardless of how they are invited to enter the interaction - whether they are asked to make a 'point', to ask a 'question', or are invited specifically to talk about some aspect of their situation - callers tend to preface their story or question with a lengthy 'self-introduction'. The self-introductions presented here have incorporated age (either specifically, or more vaguely 'in my forties' for example) and development of their current issue; rather than simply stating what the issue itself is, participants tend to make relevant their history with the issue, how long it has been going on, or how it has developed, in a narrative fashion. The fragments presented here have all been similar in format, with minimal turns by the hosts (brief greetings and a request for a story or question) and relatively long turns by the callers, with distinct self-introductions and descriptions of the sequence of events leading up to the current situation which is the reason for the call.

These detailed self-introductions may be ways for the participants in interactions to prove their reliability as a source (see Tuchman, 1978) and display knowledge of and sensitivity to what they have rights to say and know, in relation to their co-participants in interaction (e.g. Drew, 1991). Once a participant has constructed themselves as someone in a position to know about 'yo-yo dieting', as an example, it may be difficult for a co-participant to undermine their descriptions. Therefore making explicit the reason for being a part of the particular programme and why the participant can legitimately talk about the topic, by referring to personal experience lessens the possibility of one's descriptions being undermined.
3.4 Concluding remarks

This chapter has focused on the opening sequences of radio call-ins – in particular how these opening sequences are structured and how membership category work is done in self-introductions.

I began by examining patterns of interaction within greeting sequences, and found that calls generally begin with the host providing the audience with some very brief background information about the caller, typically just their name and location – for example, ‘Beth Reynolds joins us first from Exeter in Devon’. The host then greets the caller, usually with a ‘hi’ or ‘hello’ with the caller’s name attached. Callers then reciprocate this greeting, generally with just a ‘hello’ or similar, but occasionally they will refer to the host by name. I also examined two extracts where the caller said ‘hello’ twice, possibly addressing using one greeting to address the audience and another to address the host.

Typically, after the caller’s reciprocated greeting the host will ask the caller a question. This sometimes takes the form of a ‘wh’ question, without displaying any prior knowledge about the caller’s situation – for example, ‘What’s your point’. This is not dissimilar to the typical helpline openings I discussed in section 3.1, for example, the very general ‘How can I help you?’ Other times, the host’s question will take the form of a yes-no interrogative, asking the caller to confirm (or deny, though a confirmation would be the preferred response) some specific statement – for example, ‘you’ve had surgery, yes?’. This is clearly very different from the very broad ‘How can I help you?’ which tends to occur on helplines. Why might hosts’ openings of radio calls be different? Well, firstly, radio hosts are working on the agenda of having a radio show with a time limit and an audience; secondly, the caller has already been through a switchboard which we don’t get to hear – the hosts clearly have some idea of what the problem is already, whereas with helpline calls, the call is obviously the first point of contact between caller and call-taker.

I also examined two deviant cases, where instead of the host asking a question, the caller carries on talking after giving their reciprocated greeting. In both of these cases, the callers followed their greeting with a comment about something a
previous caller had said or about the show in general, and it is likely that they did not wait for a question from the host for this very reason: because the host presumably would not say ‘what do you think about what you have heard so far?’, and so the caller has to make their comment without waiting for a question.

I then examined the turns directly after these opening sequences, and it was shown that callers tend to do identity and categorisation work in their responses to the hosts’ initial questions. Regardless of whether they get a ‘wh’ question or a yes-no interrogative from the host, callers tend to preface their point/question with a self-introduction. For example, in Extract 12, the host’s turn ‘you’ve got a question I think about a treadmill’ is responded to with ‘yes good afternoon. I’m sixty years of age and fourteen stone, I recently bought a treadmill’ – so instead of just responding with ‘yes, my question is...’ the caller gives some details about himself first. It was demonstrated that identity work is remarkably salient in self-introductions, occurring in every extract regardless of the structure of the host’s question. In these extended turns from the callers, they frequently build a ‘background’ to their story before getting to their main point. In this ‘background’, callers tend to resist, negotiate, make relevant or work up identities and memberships to certain categories. I have shown how callers build their membership to various categories such as age before talking about how their situation developed up to the current situation, which works to account for the call.

So, to briefly reiterate what this chapter has identified in terms of patterns of interaction in introductory sequences:

- Host gives brief background information about caller (typically name and location)
- Host greets caller by name
- Caller reciprocates greeting

Then, either:

- Host asks ‘wh’ question, displaying no prior knowledge about caller’s situation; or
• Host gives a yes-no interrogative, asking the caller to confirm or deny something specific; or

• Caller does not leave any interactional space for the host to ask a question, and instead carries on talking after their reciprocated greeting – this occurred in only two extracts, both of which showed the callers wanting to make a point about previous callers or the show in general.

This is followed by:

• A lengthy self-introduction from the caller, where they incorporate many extra details about themselves e.g. their age, their current situation and how their situation developed over time.

In the next chapter I will further build on the ideas of identity construction and membership categorisation, focussing particularly on ideas of ‘normality’ in identity talk.
4. Doing being ordinary... in extraordinary circumstances

4.1 Introduction

In this chapter I consider existing literature pertaining to identity construction, membership categories and ‘doing being ordinary’. In terms of my own data, I examine the discursive resources used to negotiate, resist or make relevant participants’ identities and memberships to various categories, focussing particularly on the various discursive practices functioning to construct the ‘eating-disordered’ individual as an ‘ordinary’ person with a ‘normal’ identity and relate these to issues of agency and accountability.

In this chapter I will discuss the various discursive resources participants attend to, to emphasise ‘being ordinary’, and resist some of the culturally available expectations that are potentially bound to the categories ‘eating disordered person’, ‘anorexic person’, ‘overweight person’, and so on. These include:

- Suggesting that extraordinary dieting or eating behaviour is in fact on the same continuum as ‘normal eating’.
- Suggesting that an eating disorder developed as a result of trying to do some ordinary behaviour, such as ‘being healthy’, and that intentions were actually good.
- Presenting the self as disordered, yet competent.
- Locating the causes of eating disorders as everyday pressures experienced by the majority of people.
- Generalising devices, suggesting that situations may be applicable to anyone.

I also consider existing literature pertaining to identity construction, membership categories and ‘doing being ordinary’.

The findings contribute to understandings of how individuals negotiate and manage a status of ‘normality’ and provide insight into some of the subtle yet complex rhetorical activities performed through the management of identity talk.
4.2 ‘Doing being ordinary’

Here, I want to discuss a particular form of identity construction known as ‘doing being ordinary’ (Sacks, 1984), which is considered an interactional accomplishment. If an individual fails to behave in ‘ordinary’, expected ways according to social norms, their conduct is seen as accountable (Sacks, 1984; Heritage, 1988). It is particularly interesting to examine if, and how, ‘doing being ordinary’ is deployed in talk amongst individuals with disordered eating, as ‘disorders’ are generally not ordinary behaviours; it could be suggested that those individuals suffering from disordered eating are markedly different from the general population. I will examine the ways in which participants work to resist this notion, but first I want to briefly discuss some previous literature concerning ‘doing being ordinary’ and resisting extraordinary category ascriptions.

Widdicombe and Wooffitt (1995), in a study exploring the youth subcultures known as Punks and Gothics, interviewed participants on the street and analysis revealed that respondents did not make relevant their identity as Punk or Gothic on the mere basis of the features of their outward appearance, but instead presented themselves as ‘ordinary’, ‘normal’ people. While the potential relevance of participants’ identities as members of their particular subculture was not denied, the relevance of their subcultural identity was downplayed. Participants did not present themselves solely as Punks or Gothics; being a Punk or a Gothic was presented as merely one dimension of a multi-faceted identity. Doing this enabled participants to undermine the possibility that their ‘extraordinary’ dress and appearance may be used for negative inferences.

Wooffitt (1992), examining category ascriptions in a study on people describing experiences with the paranormal, found that participants attended to the

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5 According to Garfinkel (1967) all conduct is accountable in the general sense of being reportable and describable. ‘Doing being ordinary’ may therefore in itself be seen as an account — it is an account for some action which means that no further account is needed. It is these ‘further accounts’ that I refer to here; ‘doing being ordinary’ allows for no further accountability work to be done.
credibility of their account by drawing upon the mundane circumstances in which they had their (extraordinary) experience. Wooffitt identified the discursive device ‘I was just doing x...when y’ where ‘x’ is an ordinary, mundane activity and ‘y’ is the extraordinary event. This works up the impression of being an ordinary, ‘normal’, everyday person, hence establishing the account as credible and the individual as a trustworthy witness.

Te Molder (2005) also draws reference to the concept of ‘doing being ordinary’, suggesting that by portraying oneself as an ordinary person, callers to a helpline actively undermine the potential negative inferential implications of the category ‘help seeker’. This construction of an ‘ordinary’ identity has interactional implications in that the caller’s ‘ordinariness’ deprives the counsellor of her right to shape the conversational topics.

Rapley, Kiernan and Antaki (1998) also discuss the negotiation of ‘ordinary’ identities, in their paper discussing interviews with ‘intellectually disabled’ people. Their examination of how intellectually disabled people take on the job of being ‘ordinary’, constructing the self as doing ‘normal’, mundane things, illustrates how their participants manage the ascription of a ‘toxic’ identity by ‘passing’ as ‘normal’. Rapley, Kiernan and Antaki suggest that identities and social category memberships are not static, nor immutable; rather they are contestable, and identity is something negotiated by individuals according to interactional contexts. Taking this viewpoint that social identities are locally negotiated and situationally constructed, this chapter considers constructions of ‘ordinariness’, ‘normality’ and ‘typicality’ with regard to the interactional circumstance which occasions such an identity ascription; the ways in which participants discursively construct a version of the self are considered in terms of interactional context. Therefore, it should be kept in mind that all examples of ‘doing being ordinary’, and in fact all kinds of ‘identity’ ascription, are examples of self-categorisation which is dynamic and fluid depending on the interactional context in which the categorisations are made.

‘Doing being ordinary’ has also been examined in terms of health discourse. Radley and Billig (1996) propose that “the healthy have much to say about their illness experience, while the sick are often at pains to show their ‘normality’” (p.224-
225). McHoul and Rapley (2005) in their study of the diagnosis of Attention-Deficit/Hyperactivity Disorder (ADHD) note that the young individual in their study offers extensive ‘doing being good’ and ‘doing being ordinary’ in his talk, downplaying the negative aspects of his situation. Malson, Finn, Treasure, Clarke and Anderson (2004) in a study of eating-disordered patients’ accounts of treatment experiences found multiple and often contradictory self-constructions, one of which was the construction of the self as having an eating disorder but also being ‘normal’ and even healthy.

4.2.1 Being ordinary in extraordinary circumstances

Let us now examine a fragment of narrative from Marla, who is a guest on a Radio 4 show on ‘anorexia in middle age’, talking about her experiences with developing anorexia nervosa in her forties. In the following extract, Marla talks about the reasons she decided to ‘knock...a few pounds off’ (line 7).

(Extract 1) MAR-1

1 H: .hh she was forty thre:e when: she got into
difficulties .hh >with food.=Marla how did it<
start.
2
3 (.)
4 MAR: .hhhh whe:n: I was forty three (. ) I was under a
tremendous amount of stra:in .hh with wo:rk,
fam’ly pressures, business,=money .hh ;all sorts
of things. .hh a:nd (.) I felt as if there was
nothing that I could control in my li:fe. .hhh and
. (. ) to me: (.) I thought ;if I knocked a few
pounds off,=if I looked a bit better, .hh pra’haps
I’d (0.6) be able to cope with everything

This is, interestingly, Marla’s opening turn within the conversation, so once again situation development in terms of age is made relevant first and foremost (see section 4.2). She describes feelings of being unable to control her life – ‘I felt as if there was nothing that I could control in my life’ (lines 8-9). The use of ‘I felt as if’ (emphasis mine) implies that it is not necessarily the case that she could not control anything, but she felt that she couldn’t – a confession of personal shortcomings,
perhaps. There is also an unspoken implication that these feelings were related to being under ‘tremendous...strain’ with ‘work, family pressures, business, money’. It is likely that most people have, at some point, experienced ‘strain’ with regards to work, family, business and/or money; they are everyday circumstances which most everyone has some experience with. This can be related to Wooffitt’s (1992) concept of the discursive device ‘I was just doing x... when y’. By referring to ordinary, mundane situations like work and family pressures, Marla builds up the idea that she was merely going through ordinary, ‘normal’ things, when her eating disorder started.

Note that these external causes for Marla’s feelings of being out of control are presented as a four-part list: ‘work, family pressures, business, money’. This is similar to a three-part list, a commonly-used persuasive rhetorical device (Atkinson, 1984; Jefferson, 1990; Potter, 1996). Three-part listing is often used to summarise some general class of things (Jefferson, 1990). Three items are said to be enough to indicate that we have more than individual instances on their own but instances standing for something more general (Potter, 1996). Three-part lists are frequently found to end with generalised list completers such as ‘et cetera’ or ‘that kind of thing’; indeed, this is what we get from Marla, who says ‘all sorts of things’ (line 5). The general extender (see Overstreet, 1999) ‘all sorts of things’ further suggests a general applicability; she does not even need to elaborate, it is assumed that everyone will understand what these ‘sorts of things’ are. This makes available the assumption that when finding oneself in these circumstances, anybody would feel under strain and in need of coping mechanisms. If we take the items in the four-part list to be particular examples of a category of ‘pressures’, the ‘all sorts of things’ invokes a culturally recognisable category by implying that the hearer could fill in what ‘all sorts of things’ might be.

The implication in Marla’s introductory narrative is that feeling under strain with work, family and so on led to her eating disorder developing. (The implication is that losing weight was her solution to her circumstantial problems; ‘if I knocked a few pounds off...perhaps I’d be able to cope with everything’.) The fact that the ‘triggers’ underlying Marla’s eating disorder may have been everyday circumstances such as family pressures or stresses about money makes available the assumption that anyone could find themselves in Marla’s situation; after all, anyone can have such troubles, so
surely anyone could develop an eating disorder? We must bear in mind however that *not everyone* does, so the fact that Marla in particular *did* is left unaccounted for. Presumably, in Marla’s situation, these ‘normal’ pressures were excessive – she refers to a ‘tremendous amount of strain’, perhaps suggesting that while such a strain may be normal, she was under a particularly excessive amount.

Pointing to external factors such as business and work implies that Marla’s eating disorder did not develop through any fault of her own. Eating disorders are, after all, ‘mental disorders’ which to some may suggest some sort of mental dysfunction in the brains of patients. Contrary to this, Marla points to external factors as the root of her problem – not just external factors, but circumstances *which could affect anyone*. It is interesting to note that in listing the causes of her situation, Marla points *only* to external factors, thereby countering the potential claim that her situation came about due to personal shortcomings.

I would also like to briefly draw attention to Marla’s use of the phrase ‘knocked a few pounds off’ (lines 10-11). Firstly, the ‘a few’ works to minimise the weight loss as something small. The idea of ‘knock[ing] off’ weight rather than ‘losing’ weight also seems to minimise the weight loss, lessening the implication of it being an active ploy to ‘lose’ pounds.

Let us now move on to the following fragment, transcribed from an audio recording of a BBC news segment on eating disorders featuring Grace, a recovered anorexic who has now written a book about her experiences.

(Extract 2) G-1

1 H: There are so many aspects of this but I- one thing I was gonna ask (. . . ) you about was your own personal experience (. . . ) you
2 G: mmm
3 H: lost weight, >you know< in an extraordinary way, were- were- were painfully thin
4 G: mmm
5 H: and yet you didn’t see that
6 G: mm [mm
7 H: [why: do people who suffer from an- anorexia have this
8 (. . ) very distorted body image, "why is that".
G: .hhh I think there may be a wide range of reasons
for that, I mean I definitely had a distorted perception
but (. ) it also became less and less important to me .hh
you know it wasn't at the beginning the diet was to
make myself feel better. And to look better in any way
that a normal person would go on a diet .hhhh

Firstly, note the various different ways in which the host refers to Grace’s
situation. First, it is described as ‘an extraordinary way’ to lose weight (line 5). He
refers to her being ‘painfully thin’ (line 6), a rather jarring image for the listening
audience. He then refers to ‘people who suffer from...anorexia’, turning to Grace as
the expert on this condition by asking her why ‘people who suffer from...anorexia
have this very distorted body image’. The host’s use of ‘why’ questions (lines 10-11)
function to position Grace as the expert and to encourage Grace to explain the ‘logic’
behind eating disorders to the listening audience. The host is clearly defining Grace’s
condition as something extraordinary, rather than as normal behaviour. However, his
assessments have minimal uptake from Grace – simply, ‘mmmm’, a rather non-
committal form of agreement. She does acknowledge her perception not being the
norm – ‘I definitely had a distorted perception’; this is followed with ‘but’, implying
that her next words will contradict this. Grace minimises her eating-disordered
behaviour by referring to it as a ‘diet’, saying that she dieted to ‘make myself feel
better’. She adds ‘in any way that a normal person would go on a diet’, therefore
lessening the extraordinary-ness of her behaviour.

It is important to note that the host’s presentation of Grace’s behaviour as
extraordinary or unusual may be an artefact of the radio programme. Constructing
behaviour and actions as newsworthy and interesting, and consequently calling for
guests to account for this ‘extraordinary’ behaviour, is likely to be part of the
institutional context of the interaction.

In line 2 the host asks about Grace’s ‘own personal experience’, prompting
Grace to talk personally about her own individual condition. Lines 1-9 focus only on
Grace and may appear similar in format to a counselling interaction; however, in line
10, we have a shift from Grace as an individual to ‘people who suffer
from...anorexia’. The discussion is moved from Grace’s personal experience to the
more general; Grace is now treated by the host as an instance of, and spokesperson for, a particular category – a category of which the audience may be members of. This is a particularly relevant device for a radio host to use, as it allows guests or callers to give their personal accounts whilst also making these relevant for the general audience.

The previous extracts I have examined have focused on interactions between radio show hosts and individuals with clinically diagnosed eating disorders such as anorexia nervosa. I now want to look at an extract featuring an ‘overweight’ individual who has no clinically recognised disorder but whose weight is above that which is considered ‘normal’.

(Extract 3) FAY-1

1  H:  Fay d- do you prefer to be called (.) <obese or °fatt°>.
2  FAY:  .hhh I think fatt. Because I have more fat cells than-
3        than you, and Susie .hh I am not ashamed of being called
4  fat, I mean it is the i way my body i:s, it doesn’t mean an
5        that my identity is lazy and this and that and all the
6        myths that- that people call fat people e r fat fo:¢ .hh
7        and, being fat as well, I can be healthy, I can be
8        beautiful, I can be nice, I can be productive in society

There are several constructions on identity and category membership here. Firstly, Fay accepts she is ‘fat’, but she is not just fat; she uses a four-part list to suggest she can also be ‘healthy...beautiful...nice...productive in society’ – so, right from the start of the turn, Fay herself is making ‘identity’ relevant. Fay also resists the negative stereotypes associated with the overweight; ‘it doesn’t mean that my identity is lazy’. Fay’s turn is filled with rhetorical design through denials – she is ‘not ashamed’ (emphasis mine), and this ‘doesn’t mean’ (again, emphasis mine) that her identity is ‘lazy’. The last two lines of this extract are oppositional denials to what outsiders may think of ‘fat people’ – they may think, for example, that such people are unhealthy, unattractive, or a burden on society. Fay’s turn has been designed rhetorically to deny these views by presenting the contrary; she is ‘healthy...beautiful...nice...productive in society’.

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In the following extract, recovered anorexic Penny talks about how her eating disorder developed, at the age of eight:

(Extract 4) PEN-1

1 H: And what did you actually do when you say you started to change the way you a:te. Can you remember exactly what you d[id.
2 PEN: [well initially I would eat less of- of what everybody else was eating. hh if there were diet foods available which there were around in my house .hh I- I mean I knew in- in those days you know, there was special dieting bread and it was all kind of um weight watchers stuff you know .hhhhh so I would aim to eat that, rather than the ordinary (..) packet stuff. .hh but basically it was just lessening what- what other people ate and avoiding eating as much as possible.

Penny describes how her disorder started; ‘initially I would eat less of...what everybody else was eating’ (lines 4-5). A similar notion is put forward in lines 10-11: ‘basically it was just lessening what...other people ate’. This gives the idea of Penny, as an anorexic, merely doing as other ordinary people do – simply on a different scale; Penny implies there may be quantitative, rather than qualitative, differences between the ‘anorexic’ and the ‘ordinary person’. Anorexic behaviour is not constructed as explicitly extraordinary, but as ‘ordinary’ behaviour on a lesser scale. Penny’s use of the words ‘basically’ and ‘just’ in line 10 functions to further minimise the anorexic behaviour and construct it as something small and mundane. However, the word ‘initially’ which frames Penny’s descriptions of what she was doing allows for the possibility that although her behaviour started out as only quantitatively different from normal behaviour, it may not have ended up that way. We know that at some point Penny’s behaviour became what is classified as ‘extraordinary’; she was diagnosed with anorexia nervosa. In her talk, however, Penny emphasises that her behaviour had ‘normal’ beginnings. Penny’s use of ‘you know’ in line 7 is also interesting; it orients to some level of recognisability and is packaged in such a way as to invite a potential response (e.g. it could be heard as a shortened ‘you know what I mean’, where a ‘yes’ from the host would then be sequentially relevant).
4.2.1.2 Generalising devices

Another discursive resource employed in ‘doing being ordinary’ is the use of generalising devices, such as ‘we all’, ‘they’, ‘everyone’, ‘people’ and the generalised ‘you’. Let us examine, as an example, the following extract from Carly:

(Extract 5) CA-1
1  CA: .hhh I think the issues that women have with self worth and the way that they feel about themselves when they look in the mirror I think that this is universal .hh we are all bombarded with images from the media

Carly refers to ‘the issues that women have with self worth’, presupposing the fact that members of the category ‘women’ have ‘issues...with self worth’. In this fragment we have the idea of ‘all’ being affected by the media (using the rather graphic metaphor ‘bombarded with images’), and this being ‘universal’, as well as the words ‘women’, ‘they’ and ‘we are all’. These devices imply that all women are in the same situation and therefore work to counter the potential inference that they are personally to blame for their situation; a woman can’t be held accountable for having ‘issues with self worth’ as such issues affect all women.

I will turn now to a fragment from Emma, talking on a Radio 4 programme about ‘anorexia in universities’.

(Extract 6) EM-1
1  E: I became bulimic it was er, exacerbated by the amount of alcohol that I was drinking um as a fresher does at university.

Here, Emma presents her eating disorder as exacerbated by the amount of alcohol she was drinking at the time, which in turn is presented as ordinary behaviour for a student by use of the term ‘as a fresher [freshman] does’. She is categorising herself as a ‘fresher’, which is constructed as the type of person who drinks a lot – ‘I was drinking...as a fresher does’. She implies that her drinking behaviour was nothing out of the ordinary, she was just doing what everyone else also does.
Observe the following fragment from Lynette (I have included the host's original question as well, for context).

(Extract 7) LYN-1
1 H: And how- how is your weight now that you’re moving around
2 [more
3 LYN: [U:m, I think hhhh (..) I still, of course we all would,
4 like to lose a little bit but .hh I look sli:m. No:w. Um
5 when- when I didn’t when I was young.

Lynette suggests here that losing weight is something anyone, or everyone, would naturally want to do: ‘of course we all would like to lose a little bit’. The ‘we all’ generalises her statement to anyone, and the ‘of course’ preceding it implies that it’s obvious, not something that Lynette expects anyone would argue with.

A similar kind of generalisation is made by Anna in the following extract:

(Extract 8) AN-1
1 AN: I think (..) y- y- you know< I think .hh (..) "uh::," maybe
2 I’m being a bit harsh here but women and men have (.)
3 very different i:de:as .hh you know (..) to- (..) men think
4 (.0.3) there’s a problem, −we solve it. .hhhh And with women
5 I think .hh it’s far more difficult because we <live our
6 life around fo:od,> you know (..) food is part of
7 nurr:turing .hhh um: (..) .hhh and, as somebody said
8 earlier, we use it ↓well I certainly use it (..) as a sort
9 of a .hh a comfort mechanism if I’m feeling low. .hhhh
10 U:m: (..) whereas ↑I don’t think men do that.

Whereas it is suggested that men see a problem and consequently solve it—presented very simply and matter-of-factly, and implying common sense—Anna suggests that for women ‘it’s far more difficult’. The generalisation ‘women’ implies that females in general all find it difficult—there is no ‘some women’ or even ‘many women’ it’s just ‘women’ as a whole. Anna suggests that problems with weight are something all women encounter: ‘with women... we live our life around food’. I would also like to focus on line 1, in particular the repair of ‘I think’ to ‘you know I
think'. The ‘you know’ here serves to invoke the idea that Anna’s thoughts are not unique or peculiar, but rather normatively recognisable and understandable by anyone.

I want to point out several similar fragments which will not be discussed in detail, but which show similar deployment of the term ‘you know’:

(Extract 9) - HEL-1
1 HEL: I remember just thinking you know I don’t wanna suddenly
2 wake up one day and find that I’m a teenager

(Extract 10) - HEL-2
1 HEL: then people started you know saying you wanna watch out

(Extract 11) - HEL-3
1 HEL: the more I backed away and said .hh you know please just
2 leave me alone

As has been demonstrated, participants frequently construct themselves as ‘ordinary’, either by implying their behaviour is merely ‘ordinary’ behaviour on a different scale, by downplaying extraordinary behaviours or by using generalising devices to emphasise the general applicability of what they are saying.

4.3 ‘Trying to be healthy’

I now want to consider a discursive resource used similarly to ‘doing being ordinary’; that is, presenting one’s actions as not only ‘ordinary’ but as trying to achieve something positive. As will be demonstrated in this section, participants frequently justified their disordered eating behaviours as attempts to be healthy, a notion directly rhetorically opposed to being ill, or pathological.

The following fragment comes from Helena, a nineteen year old recovering anorexic, speaking on a Radio 4’s Woman’s Hour segment on ‘anorexia in universities’, about her experiences and the book she has written about them. Here,
Helena is talking about how her eating disorder started, constructing it as a kind of ‘health kick gone wrong’ rather than an active decision to become anorexic.

(Extract 12) - HEL-4

1  H:  >And and an’< (. ) how much were you aware of what was
2      going on, with the eating disorder.
3  HEL:  I wasn’t (. ) I didn’t think I had anything wrong with me,
4      I thought I was just er all I remember doing was tryin’a
5      be healthy and >I did a~< I remember just thinking you
6      know I don’t wanna suddenly wake up one day and find that
7      I’m a teenager and I can’t keep eating packets and
8      packets of sweets like you can when you’re a child ‘n and
9      then people started you know saying you wanna watch out,
10      and Helena you’re not right, you’re not your normal self
11      and I thought everyone was just making the most enormous
12      fuss. And the more people kinda confronted me on it the
13      more I backed away and said .hh you know please just
14      leave me alone, I became er like my mum said more and
15      more withdrawn.

First, I want to focus on lines 4-5, particularly ‘all I remember doing was tryin’a be healthy’. Here Helena is suggesting that she didn’t set out to become anorexic; all she was doing was trying to be healthy, something that surely anyone would strive to be. ‘Trying to be healthy’ is something everyone likely does in their everyday lives, and Helena therefore comes across as ordinary; she is someone simply trying to achieve the ‘normal’ goal of ‘be[ing] healthy’. The suggestion that she was merely ‘tryin’a be healthy’ works to remove the responsibility of being anorexic from Helena. She cannot be held responsible for her illness, as she wasn’t deliberately choosing anorexia; she was just trying to be healthy.

Preceding the suggestion that Helena was trying to be healthy is ‘all I remember doing was...’ (line 4). This allows Helena to counter potential arguments that she wasn’t trying to be healthy; she is not stating it as fact, but is suggesting that it is ‘all [she can] remember’ about what she was doing. This makes Helena’s statement very difficult to disagree with; after all, how can anyone argue with Helena’s memory of what she was feeling at the time? Something similar is done in
line 4, with ‘I remember just thinking...’ – Helena is able to imply that there might have been more to it, that she doesn’t remember, but no one can explicitly argue with what she says, as she is talking about her own memories.

Helena justifies her decision to try to be healthy (by eating less) by saying that as a teenager she can’t ‘keep eating packets and packets of sweets like you can when you’re a child’ (lines 7-8). The repetition of ‘packets’ – which is already in the plural form, and therefore repetition is not necessary – serves to relay the idea that Helena was merely trying not to eat a huge amount of food, and therefore functions to justify her behaviour. The idea of simply cutting out ‘packets and packets of sweets’ again implies that Helena’s behaviour was ‘normal’ – she was not setting out to drastically reduce her diet, merely cut out a multitude of sweets, which again may be seen as quite a ‘normal’, healthy desire. Additionally, the notion of moving from childhood to teenage and how ‘I can’t keep eating packets and packets of sweets like you can when you’re a child’ constructs her behaviour positively and as a normal part of growing up.

Jefferson (1984b) explored the ways in which extraordinary events like shootings and hijackings were described. She found that participants frequently spoke of their experiences of such events in the following way: ‘At first I thought... but then I realised’. ‘First thought’ formulations (incorrect conclusions from an initial assessment) can also be seen in the above extract from Helena, who speaks of initially thinking that she ‘didn’t have anything wrong with me’ and that all she was doing was ‘tryin’a be healthy’.

I want to now move on to an interaction between Helena and the show’s host, which occurs slightly later in the interaction than the previous fragment. I have included the radio show host’s question to Helena along with Helena’s response.

(Extract 13) – HEL-5
1 H: What- what do you >remember of< of the strategies that you put into place to (. ) [fool people
2 3 HEL: [ .hhh (. ) I don’t remember ever making a conscious decision that I was try’n’a fool
4 5 people. (. ) that’s the scary thing I- I just remember
doing what seemed to me the natural decisions to make.

(..) it was you know I- I don’t see why I need to have .hh Flora AND a spread on my sandwich so I’m not gonna have Flora. And that wa- to me was just (..) the natural thing and I thought that was what everyone else was doin’ as well, .hh and because I was never with anyone for three- you know, three meals a day I thought .hh I must be eating much more breakfast than my friends you know than my friends have so I don’t need to eat as much lunch as they’re having. .hh and then at supper, I kind of you know used the same justifications to try and (..) get out as much you know of eating as little as I could.

Helena is put into the position where she may feel the need to defend herself by the host’s question; ‘what do you remember of the strategies that you put into place to fool people’ (lines 1-3). The question the host is directing at her has some rather negative connotations; ‘fool[ing] people’ sounds somewhat deliberate and duplicitous. The host also refers to ‘strategies...you put into place to fool people’ (lines 2-3, emphasis added). The use of ‘you put into place’ makes Helena’s behaviour sound quite deliberate, as does the use of the word ‘strategies’, which implies systematic plans being put into place by Helena with the intention of ‘fool[ing] people’.

Helena’s first response to this question is ‘I don’t remember ever making a conscious decision that I was try’n’a fool people’. This works to resist the notion implied by the host that Helena’s behaviour was a conscious effort to deceive the people around her. Helena’s response does not necessarily refute the claim that she did fool people, but challenges the notion that she was deliberately doing so. Helena goes on to say ‘I just remember doing what seemed to me the natural decisions to make’ (lines 6-8). This emphasises her claim that she wasn’t deliberately trying to fool anyone – she was merely behaving in what she claims felt normal and natural for her, rather than setting out to trick people. Helena does not say that she didn’t end up ‘fooling’ people that she didn’t have an eating disorder for a long time, but she neatly manages the issues of motive and intent implied by the host by suggesting that her behaviour was not deliberately duplicitous.
I want to now focus on Helena's comments about meals. I will present this fragment of the extract again:

(Extract 14) - HEL-6

7 HEL: (.) it was you know I- I don't see why I need to have .hh
8 Flora AND a spread on my sandwich so I'm not gonna have
9 Flora. And that wa- to me was just (.) the natural thing
10 and I thought that was what everyone else was doin' as
11 well, .hh and because I was never with anyone for three-
12 you know, three meals a day I thought .hh I must be
13 eating much more breakfast than my friends you know than
14 my friends have so I don't need to eat as much lunch as
15 they're having. .hh and then at supper, I kind of you
16 know used the same justifications to try and (.) get out
17 as much you know of eating as little as I could.

Again, 'at-the-time' thoughts are preceded by 'you know', orienting to recognisability at the point where Helena is relating what is otherwise cast as her personal thoughts. This was found to be a particularly salient feature in this data corpus – callers' personal experiences are presented for a large audience of listeners, and the relevance of those stories for anyone's lives is made clear.

Helena appears to be playing down her eating-disordered behaviour – what is generally considered to constitute an ‘eating disorder’ would presumably involve more than just not having Flora (an allegedly healthy alternative to butter) on her sandwiches. Saying that it felt ‘just the natural thing’ plays down the issue of intent, suggesting that she never realized she had a problem, just went along with what she believed everyone else was doing. The repair of ‘that wa- to me that was just the natural thing’, with the insertion ‘to me’, suggests that she may be aware that her thought patterns were not reflective of how everyone thinks. The use of the past tense also offers up the notion that she is now aware that it wasn’t natural really, just that she thought it was at the time.

Recall the study by Wooffitt (1992) which I discussed in the introduction to this chapter. Wooffitt suggested that participants attend to the credibility of their accounts by drawing upon the mundane circumstances in which they had their
paranormal experiences. Speakers regularly reported the mundane circumstances prior to extraordinary events, often using the discursive device ‘I was just doing x... when y’ where ‘x’ is an ordinary, mundane activity and ‘y’ is the extraordinary event. Helena’s account is similar to this in that we get lots of ‘I was just doing x’, but there is no explicitly stated ‘when y happened’. We as the audience know what ‘y’ is – she became anorexic – but it is not actually voiced. Instead we simply get lots of ‘I was just doing x’, where ‘x’ is ‘ordinary’ behaviour.

Helena’s entire turn here has been devoted to justifying her behaviour as what felt ‘normal’, ‘natural’, what she thought everyone else was doing, and emphasising that she was not deliberately trying to, as the host put it, ‘fool people’. Instead she displays herself as actively trying to make sense of what was going on.

4.4 Constructing ‘competence’ in talk about ‘disordered behaviour’

As well as working actively to construct ordinary identities, participants frequently work to construct themselves as competent individuals who are capable of speaking about disordered eating whilst distancing themselves from the idea of someone pathological, which an outsider may expect them to be. I now want to examine the discursive resources drawn upon to construct and negotiate ‘competence’ while talking about disordered behaviours. Orientation towards maintaining competence has been previously examined as a concern in expert-lay interaction (Heritage & Sefi, 1992). I want to consider the construction in talk of ‘competence’, in terms of building one’s identity as able to talk about a disorder. The idea of ‘talking about one’s disordered eating’ is problematic as the very fact of being seen to be disordered tends to evoke the image of someone not in a position to talk rationally. However, research has demonstrated the benefits of examining the talk of the ‘sufferers’ and emphasised the ‘competence’ and ‘ordinaryness’ that is frequently constructed in talk – for example, McHoul and Rapley (2002) illustrate the competence that so-called ‘mentally retarded’ individuals exhibit in their talk, and Harper (1996, 2004) criticises the traditional psychiatric assumption that experiences of paranoia are merely irrational signs of ‘illness’ and that individual’s own descriptions of their paranoia are meaningless and illogical. While the lay person –
perhaps many of the radio show listeners? – may not expect a ‘disordered’ person to construct themselves as rational or competent, recent research has began to highlight the salience of such ‘competence constructions’.

4.4.1 No longer disordered

One way of managing the difficulty in being able to talk about one’s disordered behaviours while also constructing a sense of personal competence is to talk about the problems one once encountered, but is now free of.

In the following extract, Catherine suggests that she does not have an ongoing struggle with her weight – her dieting struggle ‘resolve[d] itself’ (line 3) after she began suffering with allergies, and now ‘I never weigh myself’. (The grammatical structure of line 3 will be further discussed in section 6.2 of this thesis.)

(Extract 15) – CAT-3
1 CAT: when I was growing up, there was (. ) a constant (. )
2 dieting struggle going on in my life. (. ) which didn’t
3 really resolve itself until after university. And again
4 as the previous caller (. ) having had some form of
5 surgery I was suffering from allergies. (. ) and had to
6 cut various food substances out of my diet. (. ) .hh and
7 what that eventually resulted (. ) IN was (. ) I suppose
8 (. ) old fashioned (. ) balanced diet, fruit vegetables (. )
9 much more focus on protein and carbohydrates. .hhh and
10 exercise.
[5 lines omitted]
16 CAT: my WEIGHT has completely stabilised and dropped off I’ve
17 been the same weight for seven or eight years now, I’m
18 roughly sixty kilos which 1:15 (. ) I s’pose between a
19 hundred and twenty five and a hundred and thirty pounds
20 .hh I NEVER weigh myself I go by my jeans hhh
[5 lines omitted]
26 H: But when you have a disability [(.) like yo:urs
27 CAT: [mm-hmm
H: how do you regard (. ) women who don't have a disability who constantly (. ) go on about their weight.

After Catherine has constructed herself as not weight-obsessed or food-obsessed, the host can treat her as such, by referring in line 28 to ‘women who don’t have a disability who constantly go on about their weight’. Asking Catherine how she feels about members of this group implies that Catherine herself is not a member of this group. The phrase ‘constantly go on’ sounds extremely negative, implying someone who is disposed to moan or complain a lot (see Edwards, 2005). Presumably the host would not be treating the issue in this way if Catherine herself were one of those ‘weight obsessed’ people. It can therefore be assumed that Catherine’s self-identification as someone not obsessed with weight has been consequential for the host’s next turn – the question would likely have been constructed in a more delicate way had Catherine’s previous turn not had the implication that she is not one of ‘those women’ who are obsessed with weight.

Just as Catherine made reference to how she used to have a ‘dieting struggle’, the following fragment shows Serena constructing herself as someone who used to be a yo-yo dieter and who used to have low self esteem.

(Extract 16) – SE-3
1  SE: after (0.5) >seventeen years of< yo-yo dieting I was
2    seven stone overweight.
3    [12 lines omitted, talking about cognitive behavioural therapy]
15  SE: ’>hghh IT really challenged (0.3) my beliefs: (. ) about:
16    (0.5) myself and my body image an- and (0.6) general body
17    image of other people (0.7) and: (0.3) that it was
18    acceptable to be the way ↑I am: (. ) and that I'm
19    ↑beautiful: (0.4) .hh <and that I can love myself> as I
20    am. (1.1) which- which I hadn't done for years. And
21    (1.0) and once you start (0.3) to love yourself if hh (0.7)
22    then=you don't ↑feel guilty if you (0.4) you <have a
23    piece> of cake or you have a slip-up one day.

Serena suggests that she now accepts herself the way she is – ‘I can love myself as I am’. This puts her in the position to legitimately speak expertly about both
yo-yo dieting – she suffered with that for ‘seventeen years’ – and about recovering from this and learning to accept herself.

The extracts from Catherine and Serena have demonstrated that one way of managing one’s legitimacy to talk about disordered eating while still appearing competent is to present oneself as not currently suffering from a disorder which has been experienced in the past. Clearly, this cannot be deployed by those individuals still in the recovery process, and so I now want to look at another way of negotiating personal competence: externalising responsibility.

4.4.2 Externalising responsibility

I want to now consider another way of constructing and negotiating personal competence in talk about disordered eating, which involves externalising responsibility. I want to return to Marla’s interaction (see extract 7), this time focussing on a different fragment where Marla attends to her eating disorder as the consequence of external circumstances.

(Extract 17) MAR-2

1 MAR: I took a job (.) teaching adults um basic literacy. .hh
2 and that was really big mistake because I felt like a
3 square peg in a round hole. .hh and it actually (.) it
4 actually sparked the bulimia .hh a lot more. .hh as I
5 came (.) away from there and I picked my own working
6 times and .hh I’m much more (.) in control of my own
7 life and I feel a pleasure in what I do:.

Marla describes taking on a job which made her feel out of place (using the idiom ‘square peg in a round hole’ which gives the image of something – or someone – not fitting in). She says that this ‘sparked’ bulimia. In describing what caused her feelings to change, Marla highlights the importance of feeling ‘in control’ once more, this time in regard to being able to choose her own working hours. By attributing the cause of her eating disorder to something external – feeling ‘like a square peg in a round hole’, Marla can present her condition as a consequence of circumstances.
external to herself and counter the potential negative inference that her disorder is a result of some personal flaw or incompetence. Further, suggesting that she herself has made the necessary changes to improve her life — ‘I came away from there and I picked my own working times...I’m much more in control...I feel a pleasure in what I do’ works to show her competence in understanding what causes her to carry out unhealthy behaviours and what causes her to feel better.

I now want to look at a similar fragment, this time from Penny who has been questioned about the ‘root’ of her eating disorder and responds with the following:

(Extract 18) - PEN-2

1  H:  What was at the root of “that” I mean you- you said ... making yourself a smaller <target>. [...h
2  PEN: [...h o:h
3  H:  target to what?
4  PEN:  I just think I found (.). life very stressful (.). school
5  very stressful, I was very anxious and (.). as an adult
6  (.). obviously you know being involved with support groups
7  and understanding that it’s a coping mechanism ummm for
8  me it was a bit of a- a kind of tranquilising effect you
9  know that the less I’ve eaten the more numbed my feelings
10  were.

Like Marla, Penny constructs her problems as beginning with external circumstances being stressful – she refers to ‘school’ being stressful and, rather generally, ‘life very stressful’. Penny constructs her current self as being self aware – ‘as an adult...understanding that it’s a coping mechanism’ and explains her understanding of how her problems developed – ‘it was...a kind of tranquilising effect’. This kind of ‘self diagnosis’ of her problem and why it developed stresses her capability to reflect on her own condition. Penny’s turn presented above also illustrates that her eating disorder was about more than seeking thinness; it was a strategy for dealing with emotional pain.

In offering situational explanations for the development of disordered eating, participants such as Marla and Penny can present their condition as a consequence of circumstances external to themselves (Edwards & Potter, 1992). Drawing on causes
that lie outside of one’s realm of personal responsibility counters the potential impression that one’s condition is the result of some personal flaw or incompetence. This enables participants to manage the interactional difficulty of how to talk about their disordered behaviours while at the same time constructing themselves as competent.

The following fragment shows a Radio 4 caller, Lindsay, constructing herself as competent.

(Extract 19) — LIN-3

1 LIN: Hi there, hi Jenni.
2 H: What's your point.
3 LIN: Well um I:’ve (.) I'm in my forties now and I’ve um over the last few years been piecing together um where my attitudes to food have come from .hhh and um as a conclusion of that I: (.) I now believe that my mother
4
5
6 was anorexic
7

Lindsay’s use here of the idiom ‘piecing together’ is interesting, bringing to mind the image of doing some sort of puzzle, and implies that not only are there many various factors to ‘piece’ together but that she has actually done some active work to collate these and form her ‘conclusion’. Using the term ‘conclusion’ implies that her thoughts are the result of a rational process, the image of ‘piecing together’ makes her actions sound like a sort of study or experiment. Lindsay’s construction of her current stance — as someone who has been actively working to make sense of her past — may be seen as a kind of ‘life review’ (see Butler, 1963, 1974; Butler & Lewis, 1977).

Marla, Penny and Lindsay all build the impression that they have taken time to actively consider what might trigger their condition and what might help them to cope. Self ‘diagnoses’ such as these emphasise the individual’s capability to reflect on their own condition and work to construct the current self as self aware.

Extracts 17 to 19 have shown that in offering a causal explanation for their disorder, drawing upon external factors, participants can present their condition as a consequence of circumstances external to themselves. Presenting the cause for the
situation as lying outside of the realm of personal accountability works to resist the notion that their unhealthy behaviour is a result of a personal flaw and lessens the extent to which the situation can be seen as occurring due to some personal shortcoming. Instead the individual constructs themselves as both competent and legitimately able to talk about their condition.

4.5 Concluding remarks

This chapter has demonstrated the various different ways in which participants resist, negotiate, make relevant or work up identities and memberships to certain categories. Call openings were examined in order to analyse the membership category work being done in self-introductions. It was demonstrated that regardless of the vagueness or specificity of the host’s prior turn, participants’ first turns began with self-introductions, usually building their membership to various categories such as age, then talking about how their situation developed up to the current situation, working to account for the call.

It was also shown that rather than simply reporting on their lives, participants used descriptions interactionally and rhetorically to build and refute identities. Frequently participants worked discursively to present themselves as ‘ordinary’ people, through the use of downplaying extraordinary behaviours or generalising devices. It was also examined how participants might justify their behaviour as an attempt to achieve something positive, such as ‘trying to be healthy’.

Participants’ constructions of themselves as competent were then considered. Ascribing, negotiating and resisting particular membership categories were considered as discursive resources in managing issues of competence, accountability and blame.

This chapter has demonstrated several different ways of accounting for oneself and one’s behaviour by ‘doing being ordinary (in extraordinary circumstances)’.
Ways of ‘doing being ordinary’ that I have discussed include:
• Constructions of ordinariness – presenting oneself as either ‘doing what anybody in the particular situation would do’, or as doing what other people do, just to a different scale
• Using generalising devices such as ‘we all’ or ‘all women’ to imply that other people would be able to relate
• Using the term ‘you know’ to orient to recognisability
• Three- or four-part lists, frequently with general extenders to suggest applicability to other people.

I want to now consider why ‘doing being ordinary’ may be so prevalent in this data corpus. It has been suggested that respondents present themselves as ‘ordinary’ in order to counter potentially negative category bound inferences (Sacks, 1984; Wooffitt, 1992; Widdicombe and Wooffitt, 1995). There are several occasions in the data where reference is made to what these ‘potentially negative category bound inferences’ might be, both by hosts, experts, and those individuals with disordered eating. These may provide for the rhetorical design (see Billig, 1987) of what participants say about themselves.

Having explored constructions of ‘ordinariness’ and normality in this chapter, in the next chapter I move on to examine constructions of ‘illness’ and ‘pathology’. These concepts are seemingly at odds with the concept of ‘doing being ordinary’ which I discussed in this chapter; however, I argue how both ‘doing being ordinary’ and ‘doing being ill’ function in similar ways to manage accountability. In Chapter 5 I also explore talk orienting to morality, which – as I will argue in section 5.1 – is necessary to examine alongside medical talk as both medical and moral talk serve as resources for managing accountability and agency.
5. Health, illness and food: Medical versus moral talk

5.1 Introduction

While the previous chapter examined talk about eating behaviours in terms of both 'disordered' eating and what would be classified 'non-disordered', and focused on the 'normalisation' of extraordinary eating behaviour, in this chapter I focus mostly on those accounts where 'disordered eating' is topical. This is to allow me to closely analyse accounts of 'illness' and consider the function of orienting to illness and pathology in talk. Therefore this chapter explores the various ways in which the concept of 'illness' is made relevant, negotiated, or resisted in talk, and considers how behaviours are made sense of and justified through the deployment of medical terms. I focus particularly on the ways in which eating behaviours – an ordinary part of life – can be treated as medical in talk and consider 'illness talk' in relation to agency and accountability. In addition to examining medical talk, this chapter also looks at moral talk. It is appropriate to consider both medical and moral talk in the same chapter because, in talking about their conditions of problematic eating, individuals have both medical and moral trajectories available to them. In this chapter I explore the dichotomy between constructing oneself as moral (and therefore agentive) and constructing oneself as merely undergoing a medical process (and therefore passive).

Before describing the analysis, I briefly discuss why I believe it is particularly interesting and important to consider the 'accountability' of disordered eating, emphasising the difference between disordered eating and other types of 'illness'. I argue that talk about problematic eating behaviours may particularly require justifications and accounts that other 'illness' talk may not, in that disordered eating may be seen as self-inflicted and 'easily curable' to outsiders, and may consequently involve a discourse of shame and guilt.

I begin the analysis by considering why there might be this need to 'account' for behaviours, using the radio hosts' initial show introductions to demonstrate this. One feature of the radio programmes forming my data corpus is that they routinely begin with an opening, contextualising statement by the host, often dramatic in style,
to set up the programme’s topic and draw out its relevance for the audience. These initial dramatic narratives have yet to be the subject of analysis, yet they provide an ideal and ‘naturally occurring’ method for considering the practices of caller accountability. Therefore I examine the way callers manage accountability with respect to these opening ‘scene-setting’ turns and how they orient to agency in constructing their accounts.

I then focus on several excerpts where participants draw upon medical language and discuss this deployment of medical terms, considering this in terms of agency and passivity. I then move on to consider one medical term in particular – ‘addiction’ – and examine the data with consideration to existing addiction research and literature on narratives of addiction. I also examine several extracts where ‘anorexia’ and ‘bulimia’ are talked about and discuss instances where agency is given to the illnesses themselves. I consider previous conversation analytic literature on medical terms in talk, for example the use of medical terms in doctor-patient interactions and the ‘asymmetry’ in this kind of talk. I go on to explore how morality is managed in talk. Everybody has both moral and medical trajectories available in talking about problematic eating behaviours and this chapter examines how both moral and medical discourse may serve as resources for accountability. If behaviour is medicalised, there is no personal agency involved and the implication is that anyone can be vulnerable with no blame attached, as pathologising behaviour removes agency. However, if one wants to construct oneself as moral, one is required to be agentive. I end the chapter with a reflection upon the analysis of both medical and moral talk and consider how both types of talk may relate to accountability.

This chapter draws particularly on insights from discursive psychology (DP), to examine the ways in which individuals use language to construct versions of events (see Edwards & Potter, 1992; Potter & Hepburn, 2007). Using DP I examine the ‘psychologising’ done by participants (i.e., their use of ‘professional’ psychological or medical language) and its location in a sequence or narrative, and consider the function of the language in terms of identity and accountability. I examine participants’ use of medical language in terms of discursive psychology’s concerns about the ‘psychological thesaurus’ and lay people’s use of ‘expert’ psychological and medical language. I also examine participants’ use of moral language, and consider
the dichotomy between 'medical' and 'moral', by examining how people orient to and manage the ideological dilemma surrounding active and passive positioning in accounts of problematic eating behaviours.

5.1.1 A note on disordered eating and accountability

'Disordered eating may be seen as unique in comparison with other illnesses in terms of the discursive work that has to be done to manage issues of agency, choice and personal responsibility. For example, an unsympathetic outsider might see an eating disorder as something easily 'curable', i.e. something one has the power to cure by simply eating a healthier amount of food. To people without personal knowledge of what it is like to suffer from an eating disorder, anorexia nervosa and related illnesses may seem to be “bizarre, self-inflicted condition[s]” (Popham, 2007, p.1). If disordered eating is seen as 'self-inflicted', and therefore constructible as a consequence of moral choices, how do people manage this potential 'moral blame' in their talk?

Given the potential ‘lack of sympathy’ from outsiders, I was particularly interested to see if and how this was managed rhetorically by participants. I have therefore focused on how participants manage accountability, and consider whether this kind of discursive work would be likely to occur if the participant were suffering from a different kind of illness. I will consider existing literature on illness discourse (not eating disorders, but illnesses one would be unlikely to be ‘morally blamed’ for) and examine whether ‘moral discourse’ and accountability is as central a feature of talk within this as it is within my own data corpus.

Below, I have outlined several features which set eating disorders apart from other conditions, and which may mean that disordered eating is more accountable than other conditions:

1. Firstly, eating disorders such as anorexia nervosa may almost be seen as ‘desirable’ conditions – thinness is glamorised and glorified in the media (e.g. Groesz, Levine & Murnen, 2002). With the slim image being ‘sold’ as a
lifestyle by socially pervasive media ideals, it appears that disordered eating may actually be the product of seeking something desirable.

2. Sufferers of eating disorders may be unwilling to recover – many studies on eating disorders have found ambivalence in patients, who recognise the need for recovery, yet actively resist it (e.g. Garner & Bemis, 1982; Leung, Waller & Thomas, 1999; Vitousek, Watson & Wilson, 1998). The idea of being ‘ill yet resisting help’ is surely unique to a certain kind of illness – most everyday ‘diseases’ people would presumably wish to recover from. Warin (2002), examining the everyday experiences of anorexic patients at an ethnographic level, distinguishes anorexia nervosa from other conditions in terms of how it may be seen as ‘empowering’ and comments that there are very few other illnesses where one may actually desire the condition and sufferers may be unwilling to recover. Many qualitative analyses of the talk and texts of individuals diagnosed with anorexia have revealed that the condition is frequently constructed as positive, or beneficial: for example, Serpell, Treasure, Teasdale and Sullivan (1999) asked patients to write letters to their anorexia, and found that participants wrote of feeling protected by their condition, as having a sense of control, and of feeling special. Skarderud (2007) found in interviews with anorexics that symptoms of anorexia were associated with a sense of pride and that being extremely thin was constructed as a positive and extraordinary attribute. Surgenor, Plumridge and Horn (2003) found that anorexia was frequently presented in an idealised way by their participants as a state of enjoyment, a way of improving self esteem, and a way of protecting the individual from the rest of the world. This is somewhat similar to the way in which ‘symptoms’ of ‘disorders’ such schizophrenia, autism and Asberger’s Syndrome have been highly valued over time, dating from the early philosophers Aristotle and Plato who reportedly claimed that ‘insanity’ and ‘madness’ were positive features of creativity and genius (see Jamison, 1993; Neihart, 1998; Rothenberg, 1990). Other than disordered eating and the example I have given here of the ‘positive’ attributes of schizophrenia, autism and Asberger’s Syndrome, there are surely very few other conditions where symptoms are highly valued.

3. A discourse of shame and guilt may be involved. The majority of illnesses would not be considered ‘shameful’ but with this kind of ‘disorder’ there is
potential ‘moral blame’ towards the sufferer. There are arguably a small number of illness which may similarly involve moral blame – for example, smoking-related cancer, weight-related diabetes, or alcohol-related cirrhosis: in all of these cases, the sufferer could potentially be blamed for causing the illness. However, problematic eating is slightly different in that the condition itself may be considered shameful, rather than what may have ‘caused’ it.

4. Eating disorders may be seen as a lifestyle choice (see Lyons, Mehl & Pennebaker, 2006). Surrounding eating disorders are many questions relating to whether an eating disorder is an ‘illness’ or a ‘lifestyle choice’. Eating disorders are therefore unique as illnesses in that other ‘disorders’ do not raise this question of choice.

5. The ‘cure’ may seem to an outsider to be relatively straightforward: one should simply consume a healthy amount of calories to maintain a healthy weight. Sufferers must therefore work discursively to resist the notion that there is a simple cure for their illness. Agency and passivity are bound up with common sense notions of eating disorders – the solution is clearly not as easy as ‘just eat’.

5.1.2 Negative category bound inferences

In the section above, I have described why disordered eating may be more ‘accountable’ than other conditions and suggested that, to outsiders, conditions of problematic eating may be seen as self-inflicted or shameful. I now want to turn to my data corpus to illustrate some of the potential negative inferences sufferers may be countering in their everyday lives.

(Extract 1) – EM-2
1 H: and you’ve- you also found that some of the young men
2 were pretty rotten weren’t- didn’t you.
1 EM: .hhh u:m well certainly I mean when I was- I was very
2 thin, u:m I >remember< going into a nightclub and having
3 the- some boys in the hall had actually invented a chant
4 um involving the words anorexic and freak which they
proceeded to sort of chant at me in the nightclub and were and were jeering. (.) um my boyfriend also had people coming up to him and said oh oh your girlfriend’s um gonna end up in a loony bin um: you- you name it I’ve had it said really um and of course there’s er an immense misunderstanding, even people that are trying to be helpful sort of say oh well it’s cos you don’t have any hobbies or you’re bored or you’re a very selfish person, all of which are obviously completely (.) um: (.) the er you know they’re completely untrue.

Here we see some of the negative inferences that have been made about Emily as an anorexic—‘freak’, ‘jeering [at me]’, ‘gonna end up in a loony bin’, ‘you’re a very selfish person’.

Some participants suggested that they were viewed negatively not only by people in their peer group with little knowledge of eating disorders but also by people in the healthcare field. Observe the following two fragments, from Gemma and Cora respectively.

(Extract 2) - GEM-1
1 H: >Gemma what what< would you say essentially needs to be done. 
[4 lines omitted]
7 GEM: when I went to people I like found that they didn’t really even er- the counsellors didn’t really .hh know anything about eating disorders and almost had the same sort of misconceptions as (. ) everybody else .hh

(Extract 3) - COl
1 CO: she helped me for a while and then eventually er took me to the doctors um who #weren’t a lot of help anyway so(h) heh
4 H: Why- why was that:
5 CO: Well um I saw a nurse and she sort of took one look at me said yes you are thin and you need to eat more and sort of smirked and that was about it and I didn’t have any follow up appointments or anything.
Gemma suggests that the counsellors she visited ‘didn’t really know anything about eating disorders’ and that they had ‘misconceptions’ about the illness. Similarly, Cora suggests that she too sought help but her doctors ‘weren’t a lot of help’. She describes being ‘smirked [at]’ and that the advice given to her was ‘you need to eat more’. It is very likely that, given the nature of anorexia nervosa, the common-sense response by people outside of the realm of the disorder would be to ‘eat more’.

5.1.3 A note on ‘pro anorexia’

It is worth coming back to the idea of ‘pro-anorexia’ here, as this controversial subculture challenges existing theories of anorexia as pathological. As I described in section 1.2.1 in the introduction to this thesis, recent years have seen a surge of controversial websites known as ‘pro-anorexia websites’ which explicitly encourage severe thinness and extreme dieting behaviour. Within this pro-anorexia movement is a rejection of established approaches that view anorexia as a disease to be treated (Ward, 2007). Members of this subculture generally advocate anorexia nervosa not as an illness but as an alternative ‘lifestyle choice’ which anyone may choose to engage in with support and encouragement from similar individuals, and often hold an ‘anti-recovery’ perspective on the condition (Fox, Ward & O’Rourke, 2005). Members of the websites typically exchange ‘tips’ on, for example, how to lose weight, how to reduce appetite and how to hide anorexic or bulimic behaviours from others. The very idea of ‘tips’ implies that there is some choice involved in the illness – there are very few if any other illnesses where sufferers would want tips on how to become ‘worse’. Giles (2006), carrying out discourse analysis on data from pro-anorexia websites, found that anorexia was presented as the ideal, and as a representation of personal discipline and purity (in comparison with bulimia which was frequently constructed as a failure or lack of discipline). Recent research on the ‘pro-anorexia’ phenomenon suggests that members of this subculture often hold an ‘anti-recovery’ perspective on the condition and endeavour to sustain the anorexic way of life. Fox, Ward and O’Rourke (2005) carried out fieldwork in pro-anorexia communities and websites and examined how participants constructed social identities in relation to their anorexic condition. They evaluated the way in which the pro-anorexia movement resists the medical framework of the condition and found that, paradoxically, anorexia was
constructed simultaneously as a lifestyle and as a disease – or rather, not as a disease in its own right, but as a symptom of “a more deeply-seated malaise” (ibid., p. 963).

Richardson and Cherry (2006) conducted an analysis of pro-anorexia websites and argue that the users of the websites challenge the ‘medical’ model of anorexia. Firstly, by sharing information about anorexia with each other, the sites’ contributors are positioning themselves as the ‘experts’ on the condition, rather than medical professionals. Secondly, they are challenging and re-defining the nutritional requirements health professionals provide. They argue that anorexics view themselves as having control over their bodies, and therefore as active agents, and that the creators of the websites in particular are extremely agentic in that they challenge existing cultural and medical understandings of anorexia.

So, with the existence of this subculture which advocates disordered eating as a ‘choice’, the question is raised as to whether eating disorders or problematic eating behaviours in general are ‘choices’ or whether they are ‘illnesses’. In this chapter I explore the ways in which participants talk about eating behaviours as medical; do they accept, or reject, the idea of their behaviour being pathological, or do they construct their behaviours as choice? Constructions of behaviours as either pathological or personal choice will be important to look at in relation to agency and accountability.

5.2 Existing literature on illness talk

Bishop and Yardley (2004) discuss the discursive practices surrounding agency in accounts of treatment decisions about complementary and orthodox medicine in cancer. They suggest that individuals worked to avoid constructing themselves as fully accountable for their health, instead sharing responsibility with medical professionals. Increased agency available in complementary medicine is not always positive and in fact is linked to an increased burden of responsibility on patients. People worked discursively to position themselves in a variety of ways, ranging from patient to agent. Positioning oneself as a patient was found to be problematic as it violated the cultural value of agency in everyday life; positioning
oneself as an agent was also found to be problematic as it involved being morally accountable for one's health.

There have also been several qualitative studies of 'eating disorder talk’ in recent years, within which researchers have argued that participants resist medicalisation of their conditions. For example, Surgenor, Plumridge and Horn (2003) examined the discourse of a group of women diagnosed with anorexia nervosa and concluded that participants refused all implications of ‘pathology’, maintaining a sense of normalcy and constructing themselves as essentially healthy people who had ‘overdone’ it. This is similar to the ‘doing being ordinary’ concept I demonstrated in chapter 4; however, within my own data corpus there is a great amount of variability in participants’ talk with both ‘doing being ordinary’ and ‘doing being ill’ occurring frequently within the data.

Fox, Ward and O'Rourke (2005) found that overweight individuals participating in a forum for users of a particular weight loss drug constructed themselves within “dominant medical discourses” surrounding obesity. Rich (2006) explored the ways in which women manage the presentation of an anorexic identity and found that participants frequently reported that their peers and families made sense of their eating disorder through a ‘medicalised discourse’, reducing the individual to a passive, pathological position. Rich (2006) also found that participants constructed themselves not as irrational or abnormal but as embodying extraordinary strength and finding empowerment through anorexia. Rich draws attention to the following quote to illustrate the rejection of negative labels of pathology or irrationality and the construction of a ‘positive’, empowered anorexic identity:

HAYLEY: I always used to look at my friends and think that I wanted to be as good, or as pretty, or as clever as them. So I decided that not eating was a way that I could maybe achieve that.


As we can see from the example from Rich’s data above, participant Hayley treats her condition of disordered eating as something empowering, something which helps her to ‘achieve’ positive things. Rich points out that paradoxically participants reported feeling empowered yet also showed awareness that their behaviour was destructive.
Ibis paradox is illustrative of the complex relationship individuals have with eating behaviours.

Malson, Finn, Treasure, Clarke and Anderson (2004) interviewed participants who had been hospitalised at least once for either anorexia or bulimia nervosa about their experiences of treatment. A feminist post-structuralist approach to discourse analysis was used to focus on how the identity of the ‘eating disordered patient’ was constructed. An inconsistency was found within these interviews; while participants constructed themselves as ‘having an eating disorder’, they also frequently articulated constructions of themselves as normal, healthy, and as not having a problem. Participants were therefore simultaneously constructing themselves as not having a problem and yet needing to change their behaviours; their talk was found to be contradictory and ambiguous, shifting through multiple subject positions. I was interested to examine my own data for similar inconsistencies, particularly the ‘normal’ versus the ‘disordered’. I have found many instances of ‘doing being ordinary’ in my data (see chapter 4), but rather than constructing the self as ‘normal’ and healthy as Malson et al. suggest, participants tended to do this in a reflective way, taking into account their extraordinary circumstances; ‘I was just doing what anybody would do in my situation’ is the implication. While I showed in chapter 4 that participants place some emphasis on being an ‘ordinary’ person, in this chapter I demonstrate that participants also frequently use medical terms and talk about ‘illness’. So, similarly to Malson et al.’s data, I found variability in participants’ talk: frequently they were constructing themselves as ordinary in some ways and as ‘ill’ people in other ways. Despite the interesting points raised in analyses, Malson’s study can be criticised in terms of its use of interviews. Even the most loosely designed interviews run the risk of the interviewers’ interpretations and biases influencing the data in some way. Previous studies examining discourse relating to disordered eating have tended to view discourse as a way of inferring stable, internal constructs (such as ‘attitudes’), rather than examining the discourse itself for what it is. Researchers have also tended to examine talk about eating behaviours as a reflection of stable, internal ‘pathological’ illnesses, without considering that it may not be appropriate to assume disordered eating is an ‘illness’ in the conventional psychiatric way. This type of approach overlooks the shifting constructions of the self and behaviours, and does not explain why contradictions and inconsistencies may exist in people’s talk, nor what
these achieve interactionally in the contexts in which they arise. Therefore in this chapter I examine talk about health and illness using CA and DP to explicate the function of the talk, discussing what the talk may be doing and managing.

5.3 ‘Scene setting’

Before examining the ways in which radio callers and guests talk about illness, I want to consider how the topic of illness is actually introduced by the radio hosts. How is the topic of disordered eating made relevant for the listening audience? What sort of implications might these introductions have for the callers and guests, and might these provide for the rhetorical design (see Billig, 1987) of what participants go on to say about themselves?

Observe the following fragment in which a Radio 4 host, having given a brief run-down of what will be featured on the day’s show, opens a segment on eating disorders.

(Extract 4) CAS-1

1  H: But first, trivial and self inflicted. That’s the view
2  many people still have of eating disorders. And yet over
3  a million people in the you kay are affected by
4  conditions (. ) like anorexia nervosa and bulimia. And up
5  to a fifth of them may become seriously ill and even
6  die.
[several lines omitted; host explaining the set-up of the show and introducing a guest from the Eating Disorders Association]
32  H: .hhh Cassie you suffered from anorexia >for a< number of
33  years .hh what happened to yo:u.
34  CAS: Well urn it all started really I mean it’s hard to say
35  when it started but I started developing <rituals> and um
36  .hh started getting quite obsessive and even depressed
37  and everything

Here, the rhetorical stances which may be taken up by the participants are set up by the host, who describes ‘the view [that] many people’ hold - which is that eating
disorders are “trivial and self inflicted”. This is an example of the kind of negative category bound inferences which one may make about someone eating-disordered. The host’s ‘and yet’ in line 2 serves to mark that something contrastive is coming next - she goes on to contradict the idea of eating disorders being ‘trivial’ by providing statistics about the severity of the condition. These statistics state that “over a million people” in the UK being affected and ‘up to a fifth of them’ are in serious danger, with potential fatality – which surely is about as far from trivial as we can get.

It is interesting to note here that while the host does dispute the idea of eating disorders being ‘trivial’ (“up to a fifth of them may become seriously ill and even die”), the idea of eating disorders being ‘self-inflicted’ is not dealt with in the same contrastive way. It is left to the callers to potentially counter the notion of eating disorders being self-inflicted. The host’s statement that ‘many people’ see eating disorders as ‘trivial and self inflicted’ – which is stated as a fact, not a mere possibility – suggests that the individuals with these conditions might have to counter the potential layperson claim that their illness is self inflicted. Indeed, we can see the first caller, Cassie, saying that ‘it all started’ rather than ‘I started’ and referring to ‘developing rituals’ (line 35) and being ‘depressed’ (line 36) – neither of which one would presumably choose to be afflicted with.

The above fragment has been presented here to illustrate the kind of potential criticisms individuals with eating disorders may have to counter in everyday interactions. If there are, as the host suggests, ‘many people’ who view such disorders as trivial and as inflicted by the individual themselves, it may be a frequent occurrence for sufferers to have to defend their position as a sufferer.

Presented below are several other show introductions, where we can see how the hosts initially set up the concept of the show and of problematic eating behaviour:

(Extract 5) HOST-1
1 H: .hhhh now we were discussing in yesterday’s programme the extent to which young people are exposed to images of sex in the media. And of course all those images are of (.)
2 THIN: people. .hhh some new research carried out at
3 Leeds University has shown that children as young as
nine are going on diets because they've been teased (.)
about their weight. .hhh and in some cases the dieting
has led to <eating disorders>.

Consider in the above fragment the use of the term ‘disorder’, which implies
some kind of disturbance or derangement that affects the function of mind or body.

(Extract 6) MAR-3
1 H: .hhh now it’s generally assumed that anorexia and bulimia
2 only afflict the young. That it’s the teenager worried
3 about appearance and perhaps gaining control of life away
4 from parents .hh who gets into trouble with an eating
5 disorder. .hhh but there’s now evidence it can occur from
6 eight to eighty.
[5 lines omitted – introducing guest and caller]
11 H: she was forty three when: she got into difficulties .hh
12 >with food.=Marla how did it< start.
13 (.)
14 MAR: .hhhh when: I was forty three (.) I was under a
15 tremendous amount of stress .hh with work, fam’ly
16 pressures, business,=money .hh all sorts of things. .hh
17 and (.) I felt as if there was nothing that I could
18 control in my life.

In this extract we see the host starting off with the phrase ‘it’s generally
assumed that anorexia and bulimia only afflict the young’ (line 1). The use of ‘it’s
generally assumed that’ is doing ‘radio business’, and addresses the listening
audience. The host then contrasts this general assumption with the fact that ‘there’s
now evidence it can occur from eight to eighty’, thereby setting up the value of the
show. It is particularly interesting to note the host’s use of the term ‘afflict’, which
makes available the inference that eating disorders are conditions which adversely
affect individuals – i.e. not something individuals can choose to adopt or reject.

(Extract 7) HOST-2
1 H: .hhh those most at risk of developing anorexia are
2 between ten and nineteen years of age and it has one of
3 the highest mortality rates of any mental illness. .hhhhh
4 surprising then to hear that there are at least five
5 hundred pro: anorexia websites called pro ana sites .hh
not dedicated to pointing out the dangers. hh but to promoting anorexia as a lifestyle choice rather than a potentially fatal disease. hh some of these sites can glorify starvation diets and offer tips on how teenagers can starve themselves. hh in Madrid this week the authorities have acted to close down one of these sites accusing it of endangering the lives of teenage girls.

Here we can see several examples of medicalisation of disordered eating from the host—namely, by her use of the terms 'at risk' (line 1), 'mental illness' (line 3) and finally 'potentially fatal disease' (line 8).

(Extract 8) VI-1

[several lines omitted - recap of the previous day’s show]

H: So is the illness something that can be cured or once an anorexic. hh are you always an anorexic. Well lots of you responded to our discussion. Violet Carter’s daughter hh a recovered anorexic is also just starting university but Violet has no apprehensions about her daughter.

VI: I am absolutely convinced anorexia can be cured if and a big if early diagnoses are terribly important and I think you need good (.) solid (.) well cared for professional help.

In the above fragment we see the host referring to anorexia as ‘the illness’ and questioning whether there is a ‘cure’—the very terms ‘illness’ and ‘cure’ imply a pathological condition. We can see similar pathologising in the uptake from Violet, with reference to ‘cured’ (line 12), and ‘diagnoses’ (line 13).

Overall we can see that hosts’ scene-setting turns tend to have contrastive functions (for example, the host will describe what a ‘lay person’s view’ might be and then contradict this with new research or figures) which work to make the show novel and interesting for the overhearing audience. Within these scene-setting contrasts there are frequently interesting ‘medicalisations’ from the host, deploying medical terminology to talk about problematic eating behaviours. What I want to take from
looking at these extracts is that radio hosts, in their opening turns, frequently set up their shows by constructing disordered eating as something *medical*. I want to move on to look at how callers themselves construct their behaviours, and whether they accept or reject this construction of disordered eating as pathological.

5.4 Use of medical language

Within the data corpus are many examples of participants using medical terms in their talk. The use of expert language by lay persons has previously been examined in terms of how doctors and patients interact with each other, and particularly how the 'asymmetry' of knowledge between the two is managed. A wide range of studies have employed a conversation analytical or discursive psychological perspective to explore expert person-lay person interactions regarding health and illness. These have included studies examining how physicians inform patients about medical test results (e.g. Maynard, 1991; Ten Have, 1991); studies exploring counsellor-patient interaction (e.g. Peräkylä, 1995); and studies of how healthcare professionals conduct home visits with first time mothers (e.g. Heritage & Sefi, 1992). Within the institutional setting of a medical appointment or home visit from a healthcare professional, conversations generally involve an asymmetry of knowledge between the professional and the patient (see Drew, 1991; Drew & Heritage, 1992). This therefore results in unequal, or 'asymmetrical', contributions to the interaction on the part of the two co-participants. Patients may orient to medical knowledge as something 'belonging' to the professional and not to them, therefore treating the professional as having authoritative access to this type of knowledge (Pomerantz, 1980).

I consider 'medicalisation' in terms of discursive psychology's interest in the mundane use of psychological terminology. Discursive psychologists have looked at the "psychological thesaurus" in terms of memory, emotion and attitude (see Potter & Edwards, 2003; Edwards & Potter, 2005) — but there is also something to be said about the everyday situated uses of 'psychologising'.
I would like to focus on the following fragment featuring Lindsay, who claims to struggle with disordered eating and has called in to a Radio 4 phone-in show focusing broadly on 'body image'.

(Extract 9) – LIN-4

LIN: I'm very anxious around food. hhh u: m I: er I find it er particularly difficult if I'm going out (. ) to eat (. ) um you know I receive a plate that's you know covered in mountains of food. hh that just instantly makes me lose my appetite (. ) hhh u: m and er I I feel that u: m that I've got lots of rituals around food I have a phobia that's also around food

After a relatively long turn (not presented in full here) describing her anxieties with food, Lindsay upgrades 'I'm very anxious around food' to 'I have a phobia...around food'. 'Anxious' on its own is a more 'medical' term than, say, 'worried'. 'Phobia' seems an even stronger, more intense word than 'anxiety', implying an actual definite condition that explains her fear of food; while a 'phobia' is not necessarily a 'mental illness', it implies a more pathological condition than simple 'anxiety'. A phobia is a persistent fear that compels an individual to avoid the feared stimulus and there is some implication that Lindsay's feelings towards food are not her own fault, nor can she easily change them – it is a 'phobia', which compels her to behave in a certain way. The term 'phobia' also implies an actual medical condition whereas 'anxious' is a term much more available for ordinary usage; although there are anxiety 'disorders' which are recognised as actual medical conditions, the actual term 'anxious' can refer to either a very common, everyday worry (which can be expressed without using a medical term) or a medical condition. There is much less ambiguity about the word 'phobia', which needs no other word like 'disorder' tagged on to the end of it – 'phobia' instantly refers to a psychiatric term for a pathology. Lindsay's statement that she '[has] a phobia' is a way of denying agency – the common-sensical notion of phobias is that they are generally persistent, abnormal, and irrational fears of a specific thing or situation that compels one to avoid the feared stimulus. So rather than just being anxious, Lindsay has a condition that compels her to try to avoid food as much as possible. There is some implication that her feelings
towards food, then, are not her own fault – they are not rational actions that she is in intentional control of, but are merely symptoms of a pathological condition.

There is something paradoxical about medicalising behaviour in terms of a ‘phobia’; while the behaviour is constructed as pathological and therefore accountability is reduced, the pathology is still situated singularly within the individual. The word ‘phobia’ suggests Lindsay’s behaviour is not a result of rational decision-making, but it is still Lindsay’s own personal pathology which is the problem.

I would also like to briefly draw attention to, firstly, Lindsay’s reference to ‘mountains of food’ and a plate ‘covered’ in food, both of which function to make the food sound more frightening and threatening. Secondly, Lindsay’s use of the adverb ‘instantly’ on line 5 also has implications regarding accountability: the idea of ‘instantly’ losing your appetite implies an instant, automatic, bodily response which one cannot do anything about, with no thought processes involved in the reaction.

5.4.1 ‘Addiction’

The concept of addiction in talk has frequently been examined, for example, by Warhol (2002) who suggests that in Alcoholics Anonymous group discourse, being an alcohol addict is seen as a form of identity. Bailey (2005) investigated popular discourses of addiction in the media, in casual speech and in literature, in order to assess the linguistic resources used to conceptualise addiction. Bailey argued that discourse theory may be useful in re-conceptualizing the relationship between addiction and agency in addicts’ own accounts. It is interesting to consider what is meant by ‘addiction’, and how it has been conceptualised as a ‘pathology’ in recent years, as seeing addiction as pathological has implications for the concepts of agency and accountability. It has been suggested that addiction may be seen as presenting risks to the autonomous, self-governed individual (e.g. Brodie & Redfield, 2002) and as a failure of will (e.g. Sedgwick, 1993). Davies (1992, 1997) likens an addiction to a position of learned helplessness, and therefore by implication suggests that the addicted individual is ‘helpless’ and non-agentive. Bailey (2005) describes addiction
as "at its very essence, a moral concept; resting in a dualist conception of the mind-body relationship, it is conceptualized as a failure of the self in its imperative to exercise control over bodily desires and functions" (ibid., p.539). The concept of addiction has frequently been examined in relation to smoking (e.g. Johnson, Bottorff, Moffat, Ratner, Shoveller & Lovato, 2002; Laurier, 1999). For example, Johnson et al. (2002) report that participants constructed smoking as a 'comfort' as well as an 'addiction'. Gillies and Willig (1997) discuss the advantages of the lack of agency implied by 'addiction'; if one can be seen as having a condition, then one cannot be held personally accountable. However, Gillies and Willig point out that this lack of agency makes it difficult to construct the self as moral or rational.

The following fragment is the opening turn of Hannah, who has called in to a Radio 4 phone-in:

(Extract 10) - HAN-2

1  H:  Well Maggie thank you very much for that
2        (. .) historical perspective . . . and we go
3  to: Hannah Ainsworth now, hello Hannah.
4  HAN:  Hello: (. .) um I >just have< (. .) been
5        listening to the debate with interest and um
6        I've sort of thought that no one's considered
7        whether (. .) um food has become a new
8        addiction. (. .) that um rather than using
9        cigarettes or or alcohol as- as a crutch that
10       women are turning (. .) more and more to food.
11       (. .) and that maybe dieting isn't necessarily
12       the: solution (. .) but that p'raps addiction counselling
13       might be- may be something to consider.

Hannah, rather tentatively, suggests that food might be 'a new addiction'. She likens it to cigarette or alcohol addictions and refers to it as a 'crutch' - which, when taken literally, gives the image of something one can lean on for support. The idea of food being something one might 'turn to' is also interesting, subtly implying that food may be a comfort or a support, as after all we usually 'turn to' something for help or comfort. Hannah historicises the concept of addiction by referring to known addictions ('cigarettes...alcohol' on line 9) and assimilating a new one (eating): the
comparison to smoking and to alcoholism – known addictions – treats ‘food addiction’ as perhaps the next, ‘new’ addiction.

Hannah’s suggestion that ‘maybe dieting isn’t necessarily the solution’ and that, instead, ‘addiction counselling’ might be a better solution, emphasises the idea of a ‘food problem’ being an actual illness needing psychiatric care in the form of counselling to recover from, rather than the individual being able to find the solution within themselves, simply by dieting.

(Extract 11) – HAN-3
1 HAN: I think it’s not as simple as people saying oh well:
2   well if you’re overweight just simply eat less. .hh
3 because um I think that it is- it has become an addiction
4 a psychological addiction it’s not necessarily a physical
5 one [that I think maybe
6 H: [.hh Han-
7 HAN: more difficult to overcome than just through dieting.

Here, Hannah elaborates further on the concept of ‘addiction’. Losing weight is ‘not as simple’ as the common-sensical answer which would be to ‘eat less’. Interestingly, a distinction is made between physical and psychological addictions (line 4). The concept of addiction reduces accountability in that it is part of the general thesaurus that does various versions of ‘I can’t help it’ – however, suggesting psychological addiction rather than physical addiction creates a dilemma in that, as outlined in section 5.1.1, psychological conditions may invoke a kind of moral accountability that physical conditions do not. Similarly to the ‘phobia’ concept illustrated in Extract 9, the concept of ‘addiction’ reduces accountability to an extent in that it pathologises behaviour, but the pathological behaviour is still located within the individual.

I want to discuss several more extracts in which eating behaviours are constructed as addictions. In the following fragment, while not explicitly deploying the term ‘addiction’, Johnny orients to the idea of eating behaviour being something that is not necessarily within the control of the individual:
(Extract 12) – JON-1
1 JON: .hhh well I think- I think it probably is because
2 although many people (. ) know they’re oba- obese
3 they don’t necessarily know what to do about it .hh
4 I mean smokers for example know they smoke but many
5 of them need a lot of help to get them off the
6 habit .hh and what we need to do is I think is to
7 look at obesity as a much wider issue than simply
8 weight.

Here, Johnny links obesity (and, effectively, excessive consumption of food) to the ‘habit’ of smoking, suggesting that eating behaviour might not be within the individual’s own control and that instead, like smokers, overeaters might need ‘a lot of help to get them off the habit’.

In the following extract, caller Grace also discusses the concept of ‘addiction’.

(Extract 13) – G-2
1 H: I mean you were very very thin [indeed
2 G: [absolutely
3 H: but you didn’t notice that [or did you?
4 G: [..hh I think I did notice
5 that yes but by that point I’d lost (. ) all self este:em
6 and (. ) the diet had actually made me feel terrible about
7 myself ↑where I looked in the mirror, I just covered it
8 up, I didn’t think it looked nice at a:1l .hhhh but what
9 happens is you get in a cycle of addlctlon, an addlctlon
10 to um .hhh starving yourself, an addiction to watching
11 the numbers fall on the sca:le

In this fragment we see a strong negative assessment from the host - ‘you were very very thin indeed’ (line 1), an assessment which is accepted by Grace’s ‘absolutely’ in line 2. In line 3, the host asks ‘you didn’t notice that, or did you?’ – the preference is changed halfway through the question (‘or did you’), so that it becomes the preferred response to say ‘yes’. Constructing the question as ‘you didn’t notice that, or did you?’ makes it a less face-threatening question than, say, ‘did you notice?’ which would instantly make Grace accountable for noticing or not noticing her weight.
loss. The host's question in line 3 therefore subtly attends to the issue of self-infliction.

In terms of 'addiction' talk, in this extract we see Grace refer to a 'cycle of addiction', 'an addiction to...starving yourself', and 'an addiction to watching the numbers fall on the scale'. The host who is talking to Grace also refers to addiction, as can be seen in the following fragment in which the host discusses the book Grace has written about her experiences:

(Extract 14) - G-3

1  H: the first line, <if I share a secret with you> (.)
2        do you promise to tell (.) <everyone>. That I- I
3                think will sort of be a punch in the gut to anyone
4       who's ever had a problem be it with drink, with
5       food, whatever, an addiction because it is a 1-
6              thing that a lot of people keep secret.

Here, the host implies that Grace's book about recovery may be applicable to 'anyone who's ever had a problem be it with a drink, with food, whatever, an addiction'. Anorexia may therefore be seen as comparable with forms of addiction such as alcoholism and as a form of addiction itself.

In this section I have presented several extracts utilising the term 'addiction'. So, how does 'addiction' provide for accountability and solutions? What do people do with the notion of addiction? Constructing behaviour as being the result of 'addiction' medicalises what may otherwise be seen as a moral action. Constructing oneself as 'addicted' removes direct agency and consequently the individual is held less accountable for their behaviour. However, as we saw with the use of the term 'phobia' in the previous section, this medicalisation lessens agency but – since addiction is an issue affecting an individual – the problem is still located as residing within the individual and while agency is lessened, the issue of moral accountability remains.

We should also consider 'addiction' as not merely a psychological condition but as a metaphor. For example, Sarbin (1990) explores how the concept of 'mental illness' has developed over time, and argues that 'mental illness' is a metaphor derived
from bodily illness. Therefore the concepts of ‘addiction’, of ‘phobias’ and of ‘(mental) illness’ in general can be seen as metaphorical within participants’ talk: if we take the stance (as described in the introduction to this thesis) that ‘problematic’ conduct should not be viewed as ‘illness’, then references to illness by the participants themselves in their talk should be viewed as metaphorical. I will return to this idea of metaphor in Chapter 6.

5.4.2 Deviations from ‘medicalisation’

Having discussed several examples of the medicalisation of behaviour in my data corpus, I now want to examine two ‘deviant cases’. That is, rather than extracts where medical talk is used or not used, extracts where medicalisation is actively resisted. Both of these extracts come from individuals who identify as overweight but deny the ‘medicalisation’ of this.

(Extract 15) - BEL-1

BEL: I’ve been described as being clinically obese when I was about twelve and a half stone. I’m now about twelve stone and I just don’t feel obese.

Here, rather than explicitly calling herself ‘clinically obese’, Bella says ‘I’ve been described as being clinically obese’, which sounds as though it is not her own choice of self-description. The use of the word ‘clinically’ makes available the inference that perhaps the description comes from health professionals. Bella makes no mention of how she, personally, perceived herself when she was twelve and a half stone and being ‘described as clinically obese’. She does however resist the notion of being clinically obese at her current weight of ‘about twelve stone’—‘I just don’t feel obese’.

(Extract 16) - E-1

E: Medically I suppose I am [obese], yeah medically. I don’t think I am though I’m fairly fit an’ healthy (.) you know, I swim. I run. I- I do fifty lengths in the morning. I’m a really fit person. But because I weigh (.) the weight I weigh which is about fifteen
Here, we can see Emily accepting that she fits the medical classification of obesity – ‘medically I suppose I am [obese], yeah medically’ while simultaneously resisting the notion of being obese – ‘I don’t think I am though’. She makes a distinction between the ‘medical’ definition of obesity and her own, active lifestyle, emphasising her fitness levels several times – ‘I’m fairly fit an’ healthy, which is later upgraded to ‘I’m a really fit person’ (lines 3-4) and repeated in line 6. It appears that identifying as ‘fit’ means that she can’t also identify as ‘obese’ – see the words ‘though’ (line 2) and ‘but’ (line 6). Emily also contrasts this with the way other people may see her – ‘people would probably look at me and go yeah she’s definitely obese but I’m a really fit person’.

It is interesting to note that both of these deviations from medicalisation come from individuals who identify as overeaters rather than as anorexic or bulimic. Is there perhaps less need to medicalise overeating? It may be that overeating is more easily understood by lay people than other types of disordered eating; anorexia and bulimia nervosa may be more accountable, perhaps for the reasons I outlined in section 5.1.1.

5.5 Agency and control

Eating disorders are generally conceptualised as issues of “control” in psychological literature (e.g. Bordo, 1993; Katzman & Lee, 1997; Malson, 1998) Malson (1995) found a discourse of Cartesian dualism within interviews with anorexics, wherein the thin body is a signifier of a controlled identity. Anorexia nervosa is frequently suggested within eating disorder literature to be a means of controlling one’s life. However, as I have illustrated in this chapter and the two preceding it, my data corpus demonstrates a tendency to construct oneself as passive rather than agentive in talk about problematic eating behaviours. This appears to contrast with the traditional view of eating disorders as a means of ‘control’, in that being passive surely implies a lack of control. I was therefore interested to examine
excerpts where ‘control’ is made relevant by participants, to see how this fits with ideas of agency and passivity.

Marla, talking on Radio 4’s Woman’s Hour programme about her experience of developing anorexia nervosa in her forties, speaks of her disorder developing as a direct result of feeling out of control in other areas of her life.

(Extract 17) - MAR-4

1 H: .huh she was forty three when she got into
difficulties .huh >with food.=Marla how did it<
2
3 start.
4 (.)
5 MAR: .huhhh when: I was forty three (..) I was under a
tremendous amount of strain .huh with work,
family pressures, business,=money .huh >all sorts
of things. .huh and (..) I felt as if there was
nothing that I could control in my li:fe. .huhh and
(.) to me: (..) I thought :if I knocked a few
11 pounds off,=if I looked a bit better, .huh pra’haps
12 I’d (0.6) be able to cope with everything

We examined this fragment previously in section 4.2.1, in terms of how Marla constructs her problems as ‘ordinary’. I want to draw attention here to lines 8-9 of Marla’s turn – ‘I felt as if there was nothing that I could control in my life’ – and then to lines 11-12 – ‘if I looked a bit better...I’d be able to cope with everything’. The implication here is that Marla was feeling unable to control the problems with work and family in her life, and that losing weight and looking better (thereby controlling her appearance by deliberately ‘knock[ing] pounds off” would make it easier to cope with other things.

Jessica, speaking on Radio 4’s Woman’s Hour about her bulimia nervosa and shoplifting, has an opening turn very similar to that of Marla.

(Extract 18) - JES-1

1 JES: I started suffering from an eating disorder at- at about
2 the age of thirteen:n, um there were quite a lot of
variables in my life that were (.) out of control, and (.) I felt food was one thing that I could control.

It is common for participants’ opening turns to explicate what their relationship is to the topic being discussed; in radio programmes focussing on clinical eating disorders (such as those featuring Jessica and Marla) participants tend to introduce themselves by describing their personal experience of the disorder, frequently encompassing the age they were at when their disorder developed and how the disorder began.

Jessica and Marla’s situations are fairly different; Marla suffered from anorexia nervosa beginning in her forties, whereas Jessica’s disorder was bulimia nervosa and it developed at a much younger age, thirteen. Both women’s narratives, however, follow a similar pattern: they begin by naming the specific age (‘forty three’ rather than ‘in my forties’; ‘thirteen’ rather than simply ‘as a teenager’) at which age their disordered eating began. They then go on to account for why this began when it did, using circumstances and general ‘troubles of living’ as an account for feeling ‘out of control’. Marla specifically names her troubling circumstances; namely ‘work, family pressures, business, money all sorts of things’ whereas Jessica rather vaguely refers to ‘quite a lot of variables in my life’. Both women link these circumstances to feeling out of control, which in turn becomes linked to the development of the eating disorder. Jessica explicitly states that food was ‘one thing that [she] could control’, as opposed to the other unnamed ‘variables’ in her life which she felt unable to control. Marla does not explicitly make this link in her narrative. She explains her feelings of not being able to control anything in her life, and then describes her solution to this which was to ‘[knock] a few pounds off’.

Tamara, a young patient speaking of her time in an eating disorders unit, raises the same idea of control.

(Extract 19) - TAM-1
1 TAM: I think a lot of the time it’s quite common that you’re
2 not able to express yourself through things or (.)
3 especially when you feel like some things in your life
are quite out of control. hhh and I think it’s: (.) for
me really it was about finding something that I could
control and (.) unfortunately it was something very
harmful.

Here, Tamara suggests that controlling her eating was ‘something that [she]
could control’ in contrast to the unnamed other ‘some things’ in her life which she felt
she could not control.

Penny, a recovering anorexic who talks on Radio 4 about her first experiences
with anorexia nervosa at the age of eight, constructs her disorder as a coping
mechanism.

(Extract 20) - PEN-3
1 PEN: I mean for me:, hhh (.) I had feelings of safety um:
2 and it- it was my way of coping was to restrict food.

(Extract 21) - PEN-4
1 H: Penny wha- what was driving you:u to <want to make
2 yourself> (.) smaller. It- was it anything to do with the
3 images that you saw farround you or was it something else.
4 PEN: "Um ((clears throat)) I think I was aware that other
5 female members of my family were very dissatisfied with
6 er- with their bodies their- their body image and their
7 weight. Um: I think: (.) for me: I was (.) you know I
8 was aware of that. To me: I: hhh I guess I- I already
9 felt f- vulnerable, I already had those feelings, um:
10 (.) but it wasn’t- I didn’t (.) consciously go on a diet
to lose weight. To me again it was- it was to do .hohhr
11 (. ) with the coping, I felt safer, I felt calmer when I
12 didn’t eat. Um and I: hhh very quickly my feelings
13 transferred into (. ) the smaller I was, the less I ate,
14 the safer I was.

(Extract 22) - PEN-5
1 H: What was at the root of "that" I mean you- you said hhh
2 making yourself a smaller <target>. (.hh
3 PEN: [.hh c:h
4 H: target to what?
5 PEN: I just think I found (. ) life very stressful (. ) school
6 very stressful, I was very anxious and (. ) as an adult
7 (. ) obviously you know being involved with support groups
8 and understanding that it’s a coping mechanism u::m for
9 me it was a bit of a- a kind of tranquilising effect you
10 know that the less I’ve eaten the more numbed my feelings
11 were.

Penny’s references here to ‘coping’ mechanisms and to ‘safety’ (Extract 20)
may be implicative of the ‘control’ concept. In Extracts 21 and 22, again, we have
Penny referring to her way of ‘coping’, and she portrays her coping mechanism
(controlling food intake) as something which was not a conscious decision – ‘I didn’t
consciously go on a diet to lose weight’. This lessens Penny’s moral accountability for
her condition.

It is also interesting that in all three of the fragments from Penny presented
above, she uses the phrase ‘for me’ or ‘to me’: ‘for me...I had feelings of safety
(Extract 20, line 1); ‘to me again it was...to do with coping’ (Extract 21, lines 2-3);
and ‘for me it was a bit of a- a kind of tranquilising effect’ (Extract 22, lines 4-5).
There is something contrastive about saying ‘for me’ or ‘to me’ – it implies that other
people might think differently. The use of these terms by Penny works to show that
she is not generalising to all people, but focusing on her own experiences and
acknowledging that they were hers. It may be that callers need to preface talk about
the positive outcomes of food restriction by personalising their thoughts in this way –
it may be dangerous to suggest, for example, that food restriction is simply
‘tranquilising’ rather than ‘for me...it was tranquilising’ (emphasis mine) as Penny
could then be seen as advocating starvation as a method of coping.

The following extract comes from Olivia, talking about her time as a patient in
an eating disorders unit. Olivia, describing her recovery process in the unit and
contrasting her life in the clinic with her life outside, makes reference to ‘control’:

(Extract 23) - OL-1
1 OL: in the outside world you get to be living in the eating
2 disorder, trying to control everything .hhh you think
you’re very in control when you’re most out of control

hh and >being in< here you become very self aware and
you start to deal with those (. ) those issues and
problems that have actually caused the eating disorder.

Here, Olivia explicitly voices a ‘control/out of control’ dichotomy – ‘you think you’re very in control when you’re most out of control’. I am also interested in Olivia’s construction of ‘the eating disorder’ in lines 1-2, suggesting that it is something she ‘liv[es] in’. Rather than invoking the image of a person ‘who has an eating disorder’, Olivia invokes the image of a person ‘living in an eating disorder’. This locates the eating disorder as something outside of the individual. There are three mentions of control in this short fragment; ‘trying to control everything’, ‘you think you’re very in control’, and ‘you’re most out of control’. All three examples work to suggest that the individual is not in control; note the ‘trying’ (not necessarily succeeding) to ‘control everything’, the ‘you think [emphasis mine] you’re very in control’ suggesting that this ‘thought’ may well be incorrect, and finally the explicit mention of being ‘out of control’.

5.6 Moral talk

Having explored medical talk within my data corpus, and its’ relationship to the speaker’s agency, I now want to examine if, and how, morality is oriented to in talk. Previous literature on one particular type of eating behaviour suggests that talk about eating may have both a medical and a moral component: for example, Benford and Gough (2006) conducted interviews with five self-confessed ‘chocoholics’ (individuals addicted to chocolate) to examine, using discourse analysis, how the ostensibly unhealthy act of eating chocolate is defined and defended. Analysis yielded four main discourses: chocolate as dangerous; chocolate as pleasure; self-surveillance; and addiction. Chocolate consumption was generally seen as both dangerous and sinful, and linked to indulgence and greed, therefore giving the participants a dilemma in terms of how to justify their chocolate consumption whilst protecting their moral status. This was generally accomplished by recourse to the medical discourse of addiction; participants manoeuvred themselves into a position where they may be
perceived as 'sick' rather than 'sinful' (ibid., p.432). Participants also made reference to self-monitoring and to carrying out compensatory activities (such as exercise) after chocolate consumption. Positive aspects of chocolate were accentuated by participants as a means of explaining and mitigating their consumption; for example, chocolate was described as pleasurable, as comforting, and as therapeutic (c.f. Bordo, 1993, p.126). Chocolate was also frequently portrayed as a reward, or as something deserved after achievement. So, we can see from Benford and Gough’s study that in talking about chocolate consumption, individuals utilise both a medical trajectory (referring to ‘addiction’) and a moral trajectory (constructing chocolate as something only to be enjoyed when the right to do so has been earned). James (1990) also reports that excessive chocolate consumption is treated as taboo and tends to be conveyed through confessions; interviewees in James’s study referred to eating in secret and to feeling both naughty and guilty when consuming chocolate. Similar medical trajectories to that demonstrated by Benford and Gough have been illustrated in my own data in section 5.4.1, where reference to ‘addiction’ is used to position individuals as ‘ill’, and to construct the self as a victim of forces beyond individual control. According to Benford and Gough, one discursive strategy utilised in order to work up the addiction account is through analogies to other established addictions, for example, comparing chocolate to drugs, alcohol or smoking. I have also illustrated this phenomenon in my own data (see section 5.4.1). So, is there a similar moral trajectory within my data? This section explores talk about eating behaviours and, in particular, focuses on extracts where reference is made to certain foods or the physical act of eating, to examine whether morality is oriented to in talk about eating.

Far from being merely something which is essential for survival, food itself has frequently been shown to be the site of many moral conflicts (Ogden, 2003). Booth (1994) points out that the German language draws a distinction between Lebensmittel (the stuff of life, translated merely as ‘food’) and Genussmittel (literally, pleasure material, meaning a food item that is a luxury, or a treat). It has also been pointed out that food and eating behaviour may be used as a tool; hunger strikes, for example, use food as a form of political protest. Food choices are made within a wider context of social meanings (Ogden, 2003), one which requires people to account for not only their food choices but for their eating behaviour.

Studies on eating behaviours and attitudes to food have demonstrated that:
• Foods are categorised and evaluated as ‘good’, ‘bad’, ‘naughty’ or ‘sinful’ with certain foods seen as emblematic of indulgence (e.g. Germov & Williams, 1996; Lawrence, 1984);

• Food is seen as something which is needed, but also something that can induce self-loathing once consumed (Chemin, 1983; 1986; 1992);

• Talk about appetite and food consumption is pervaded by a discourse of guilt, shame and lack of control and restraint (Wetherell, 1992);

• Food induces pleasure but equally represents the source of anxiety, the main problem being that food pleasure challenges self-control (Coveney, 2000).

So, how is food constructed within my own data corpus? Many individuals give food extremely negative connotations – usually in the form of ‘guilt’, ‘shame’ or ‘failure’. Note the following extract, in which the show’s host questions caller Natalie on an earlier statement she made referring to food as a ‘treat’:

(Extract 24) - NAT-4

1 H: W-why do you s- 'you said you (. ) you a:ways think,
2 (. ) mm: .pt I'll have a (. ) tre:at:. [.hh
3 NAT: [mm:m.
4 H: W-why <is food> seen as a <tre:at:. Hh
5 (0.4)
6 ((mechanical click))
7 (0.3)
8 NAT: .hhh I- I don't know I think it's somethin:g
9 (. ) I- (. ) this i- (0.3) hhh personally
10 speaking it's something very private you can do
11 >isn't it< 'you're (. ) .hhh sitting there and
12 ↓I will, I will think my my my (. ) partner th-
13 thinks I look great. (. ) .hh ↑And he: he he (. )
14 thinks I've got a terrible um body image
15 problem. (. ) .hh But ↓I would sit there >in in
16 in< my office away from him and think .hh °ooh
17 I- >I'll just have this< and he won't know.
18 (. ) e:x and it (. ) he won't >know I'm being
19 bad<
There are several things to note about this extract. Firstly, let us look at what Natalie is actually saying: she sits in her office 'away from him [her husband]' - presumably alone but certainly where her husband can't see her - and her thought, on eating, is that 'he won't know'. She then upgrades this, from the idea that 'he won't know she is eating' to 'he won't know I'm being bad'. The whole idea of eating in secret implies that there is some sort of shame associated with the act. The fact that she refers to this secret eating as 'being bad' implies that eating is something negative, 'bad', and that there is some feeling of guilt, or at least thinking that 'this is bad behaviour', occurring. The use of 'just' when she says 'just have this' works to play down how 'bad' the behaviour is, and how it might be construed. The whole extract reads as a confession of sorts.

Secondly, let us examine the way she is actually saying this. As mentioned, the extract reads as a 'confession'. This can be seen simply by examining the actual words; the whole idea of doing something 'bad', in secret. The caller's manner of speaking is also confessional, reflecting the secrecy of the act and the guilt associated with it. Her voice goes noticeably quieter and she speaks quickly, choosing to rush through both 'I'll just have this' and 'know I'm being bad'. The very way in which she delivers this report orients to the nature of what is being said. Natalie's use of the word 'just' plays down her behaviour, making it sound opportunistic. Her deployment of 'naughty' shows a childlike discourse, through which she is able to adopt the lack of responsibility one would associate with children, to her own actions. This kind of split-subjectivity (i.e. admitting/conceding) is designed to reflect a reasonable character who is willing to accept some blame, hence increasing the authenticity of the account.

I want to look at several other extracts which have references to guilt, shame and failure when speaking of eating. The following fragment comes from Serena who has called in to a Radio 4 phone-in. She has just finished describing her experiences with cognitive behavioural therapy which she feels has taught her to 'love [her]self'.

(Extract 25) - SE-4

1 SE: A:nd: um: (.) I found that cognitive behavioural therapy brought up my self esteem >and I
think< the- (.) that was really crucial.

(0.7)

H: .hh [What-

A: [(indecipherable) able to †get (.) off the dieting.

( .)

H: What did it †actually involve hh

(0.3)

[6 lines omitted, Serena describing cognitive behavioural therapy]

SE: And (1.0) and once you start (0.3) to love yourself hh

(0.7) then=you don’t †feel guilty if you (0.4) you <Have

a piece> of cake or you have a slip-up one day. (0.7)

When you’re on a diet (0.7) and you do that: there’s

>the- there’s< great guilt that you- you’ve failed (0.5)

and then I think that sends you into a †spiral then of

eating more and more.

Serena uses the generalised ‘you’ to apply her situation to anyone and

everyone. She suggests that ‘you don’t feel guilty’ about eating a piece of cake ‘once

you start to love yourself’ (emphasis mine). The once implies some sort of change;

perhaps that if you don’t love yourself, eating a piece of cake will induce feelings of

guilt. Eating a piece of cake is equated with a ‘slip-up’.

Serena refers to a feeling of ‘great guilt’ upon eating more than a diet would

allow and refers to failure, suggesting that ‘slipping up’ might make you feel that

‘you’ve failed’. There is some agency work in line 21 where she says that the feeling

of failure ‘sends you into a spiral... of eating more and more’. The ‘spiral’ metaphor

implies something outside of Serena’s own control and the construction of the verb

phrase – i.e. that a sense of failure can send a person into a spiral – imply passivity on

Serena’s part. I will return to the grammatical structure of Serena’s talk in this extract

in section 6.3.4.

(Extract 26) - KEL-2

H: You’ve had surgery yes?

KEL: .hhhh yes um: basically I’d I’d tri:ed um: e= every:

(.) pa:th m- the <medication, the counselling:, um> (.)

er er b- every single diet and every failed diet erodes
your self esteem even more, you know you think you’re a failure. hhh um I >and in the end um once I >was sort of eight stone overweight and hhh er basically couldn’t take the dog for a walk without without sort of panting worse than the dog. hhh I wanted the choice taken away from me.

In the fragment above, caller Kelly refers to feelings of ‘failure’ and eroded self esteem—eating something perceived as ‘bad’, or ‘ruining’ a diet, is associated with guilt, shame and failure. This can be related to the moral discourse noted by Wetherell (1996), of talk reflecting the negative social identity of the “weak and wicked self”. Note that the host’s question does not explicitly orient to morality, but is simply ‘you’ve had surgery yes?’ Rather than simply answering ‘yes’, Kelly accounts for her decision to have surgery.

I want to examine another fragment which attaches some emotional meaning to food; in this case, as a ‘treat’, or a comfort:

(Extract 27) - TRI-1
1 TRI: ↑I’ve been trying to lose the weight=I’ve put on over Christmas, hhh >and so you< right, that’s it ↑I’m going to ↑settle down this week (.) I’m >not going to do this not going to do that hhh But then you just end up (0.5) treating yourself if >or you< or you get a bit down and you ↑have something to eat:. "

While it could be argued that ‘treat’ and ‘comfort’ are not dissimilar (a treat could be comforting, for example) – the caller’s use of ‘or’ treats the two as different: she eats as a treat or to comfort herself. ‘Treat’ implies that the act of eating can take someone (in fact, anyone – note the generalised ‘you’) from neutral feeling to positive feeling, while ‘comfort’ suggests that eating may take someone from a negative feeling to a neutral or positive feeling. These feelings are packaged as the kind of thing anyone would feel, which provides a further warrant for the caller’s actions, attending to her own agency in her failure of ‘self-control’. 
The above extracts have demonstrated that talk about eating behaviour is not just about health but also about morality, responsibility, agency and self control. Moral positioning is constructed and negotiated in talk about food and eating.

5.7 Concluding remarks

This chapter has discussed previous literature on problematic eating as ‘pathological’ (e.g. Malson et al., 2004) and considered the dichotomy between ‘medical’ and ‘moral’ discourse. Using DP I have explored both of these types of talk in terms of how they manage accountability.

There are implications for treating disordered eating as an ‘illness’, in terms of empowerment – if it is treated solely as a medical issue then it is medical practitioners who are empowered, as it is they who are capable of treating illnesses. Medicalising behaviour transfers agency to getting help for the ‘condition’, rather than doing it yourself. If one is pathologised, agency is effectively removed from the individual. However, morality requires one to be agentive, so in this chapter I have explored how behaviours can be given both a medical and a moral component in an unproblematic way.

I began this chapter by considering why it is important to consider issues of accountability in talk about problematic eating behaviours, comparing ‘eating disorders’ to other conditions and pointing out the many differences (for example, ‘sufferers’ may be unwilling to recover; lay opinion may be that it is a self-inflicted or easily curable condition). I also used examples from the data corpus to demonstrate some of the negative category bound inferences that come with the label ‘eating disordered’.

I looked at previous literature, with contradictory findings – some suggesting that individuals with problematic eating behaviours construct themselves as pathologised, some showing participants resisting medicalisation, and most showing complexities and inconsistencies within participants’ talk. Bearing in mind this
variability shown by previous research, I was particularly interested to explicate the function of both ‘being ill’ and ‘being ordinary’ to see what they achieve in talk.

I examined ‘scene-setting’ turns by radio hosts to see how problematic eating is topicalised by them for the audience, and demonstrated how the hosts frequently set up shows on eating behaviours using medical terminology, constructing disordered eating as a pathologised condition which needs ‘diagnosis’ and ‘treatment’. I have also shown how the callers themselves orient to their behaviours in pathologised terms, for example, constructing eating behaviour as a ‘phobia’ or an ‘addiction’. This contradicts previous literature, for example, in the study by Rich (2006) I discussed in section 5.2, it is claimed that the participants themselves rejected the ‘pathological position’ that their friends and families oriented to. However, in my data, the ‘sufferers’ themselves frequently employ a medicalised discourse, in addition to the ‘non-sufferers’ i.e. the hosts. Close examination of the talk in which this medicalisation occurs suggests that pathologising behaviour may be a way of managing accountability; if a behaviour is occurring for a medical reason, one cannot be held personally responsible for the behaviour – therefore medicalisation functions to pathologise what may otherwise be seen as a moral action. However, this raises an interesting dilemma in that a pathology is still situated within an individual, and while direct agency is removed and accountability is lessened, moral accountability is arguably still an issue.

I also examined two ‘deviant cases’, where individuals explicitly rejected medicalisation. These were the only two cases in the data corpus with such explicit rejection of the idea of their behaviour being pathological, and both came from individuals identifying as ‘overweight’ rather than, say, anorexic or bulimic. I argued that perhaps there is less need to medicalise over-eating than under-eating due to how both extremes of eating behaviour are understood by lay people (I refer you back to section 5.1.1, in which I outlined why people may have difficulties understanding conditions such as anorexia nervosa).

In the latter part of this chapter I explored morality in talk, concluding that talk about eating behaviours and food has a moral component as well as a medical component. I examined the following ways in which morality is oriented to in talk:
• Callers might orient to certain foods as a ‘treat’ or a ‘comfort’
• However, the actual act of eating might be constructed as a ‘failure’
• Eating may be talked about in a confessional tone
• References may be made to feelings of guilt and shame.

Overall, this chapter has demonstrated that both pathology and morality are embedded in talk about eating behaviours. The data corpus forming the basis of this analysis is particularly useful for demonstrating a ‘medical’ versus ‘moral’ dilemma. Billig, Condor, Edwards, Gane, Middleton and Radley (1988), in their discussion of the dilemmatic nature of ideologies, suggest that contrary or opposing themes are constructed rhetorically in talk, and that within a DP framework such dilemmas can be examined in terms of how people orient to and manage these dual or competing concerns. The variability evident in the talk we have examined in this chapter supports the idea of the existence of ‘ideological dilemmas’, with the contrary themes of pathology and morality holding competing positions. Ultimately, both of these positions focus on the individual, with moral talk focussing on individual morality and medical talk being centred around pathology residing within an individual. It would almost certainly be harmful for a sufferer to see themselves as completely morally bad and agentive or as completely medically pathologised and passive, and the use of both moral and medical talk manages this neatly by constructing the individual as morally aware while accounting for problematic behaviours by drawing upon medical reasons for such behaviours.
6. Constructions of agency and passivity: The grammatical and the metaphorical

The previous chapter of this thesis demonstrated that the duality between self-imposed choices and agency-free ‘illness’ achieves useful work in talk about problematic eating behaviours. Having explored in earlier chapters how accountability is tied up with identity construction and with both medical and moral talk, I now want to examine how accountability may be managed linguistically. It is relevant, in a thesis fundamentally focused on words, to devote a chapter purely to language and its grammatical components. The focus of this chapter is therefore on the ways in which accountability is grammatically and linguistically managed, encompassing how agency may be negotiated by the use of different grammatical devices and various metaphors for passivity. Having paid particular attention to variability within talk in previous chapters, and examined dualities between competing positions (e.g. medical versus moral talk in Chapter 5), in this chapter I also examine how metaphors for agency may be used in talk and how a strong agentive position, as well as a strongly passive position, may be negotiated through the use of grammar.

6.1 Agency and passivity in illness talk

Within this chapter I analyse several extracts in terms of who, or what, is constructed as an ‘agent’. It is therefore worth defining here what is meant by this – Karp (1986) distinguishes between an actor (a person whose actions are rule-governed) and an agent (a person with power to bring about effects on the world). I want to begin this chapter by focussing on several extracts where agency – the capacity to act (see Ahearn, 2001) – is removed from the sufferer and given instead to the ‘illness’ to provide an explanation for behaviour. In particular, I examine the grammatical constructions which allow for this displacement of agency. Therefore, in this first section, I explore the various linguistic and grammatical devices employed by participants to put causality outside of the person and onto the ‘illness’.
6.1.2 Externalising the problem

Let us first focus on an extract from Jessica, a young woman talking on Radio Four's Woman's Hour programme about her experiences with bulimia nervosa and shoplifting:

(Extract 1) - JES-2

1 JES: When I'm overtaken (.) with (.) a bulimic urge, all my morals and my values and my sense of right and wrong seem to leave me? And I feel I kind- I enter into a kind of trance like state .hhh like a horse with blinkers on, I don't see: anything except for my goal which at that time .hh is to obtain (..) lots of food, to eat it (.). .hhh to numb feelings I don't want to deal with .hhh then I have a sense of panic (.). pt and then I need to: release those feelings and that's what the vomiting does.

In the above fragment, Jessica positions herself as being passive in terms of her bulimic behaviour. She describes being 'overtaken' by a 'bulimic urge', suggesting a compulsion or drive entirely engulfing, 'overtaking', her. The 'trance like state' referred to on line 4 implies a dreamlike condition, or a daze. If we consider the general understanding of the word 'trance', we get the impression of a state of mind in which consciousness is fragile and voluntary action is poor or missing, or a state resembling deep sleep. The implication is that in a trance, one is not in control of one's own actions. Therefore, suggesting that bulimic behaviour occurs in a 'trance like state' makes available the inference that there has been a loss of conscious control and consequently lessens accountability. By indicating a loss of control, Jessica is able to distance herself from her actions.

I also want to focus on lines 2-3 of the above extract from Jessica, and particularly the grammatical construction of 'my morals and my values and my sense of right and wrong seem to leave me'. Note that Jessica chooses to make the morals, values and sense of right and wrong the objects of the verb, acting upon the subject, herself. Rather than saying, for example, 'I lose my sense of right and wrong' — which
would make Jessica the active agent – she chooses to make herself the subject, with things happening to her rather than her actively doing things.

I also want to draw attention to another fragment from Jessica, occurring shortly after the fragment presented above.

(Extract 2) - JES-3

1 JES: I’m hoping that at some point in time I will be free of this: eating disorder .hh I have to remain hopeful each day

In Extract 2 we see Jessica say that she wants to ‘be free of this eating disorder’ at some point in the future. From this we can infer that at the current time she does not feel free and, instead, is constrained or controlled or perhaps ‘trapped’.

I also want to consider Jessica’s use of the word ‘hopeful’ in line 2. To ‘hope’ for something implies that what is being hoped for is something you can’t simply do; if it were as easy as Jessica being able to free herself, she surely would not need to ‘hope’ for this to happen, she would just do it. ‘Hopeful’ implies that there is an active agent other than Jessica herself which has the power to ‘free’ her.

I now want to look at other extracts where we can see similar constructions of the self as passive. Let us observe the following fragment from Sophie, speaking on a Radio One programme about her involvement on ‘pro-anorexia’ websites (c.f. section 1.2.2):

(Extract 3) - SO-1

1 SO: We will actually turn away people (.) who come on to the sites and post messages like how do I do it how do I become anorexic >how do I become bulimic< because ninety per cent of us out there we don’t choose it. .hh (.) it’s just a way of going okay (.) this is the way our life goes. But I wouldn’t wish it on anyone. I- the- sites- people on them are my friends and they help me but .hhhh for most of us on there we just accepted it. (.) And that sounds horribly blunt but (.) I don’t (.) well I do wanna get better but I’ve just accepted that I wo:n’t. (.) and that’s a very distinctive point of view and that’s
probably why the sites can be really dangerous. (.) and most of the people I talk to, we’ve just gone okay this is it.

In this extract we see Sophie frequently deploying the pronouns ‘we’ and ‘us’, conveying a sense of identification and solidarity with other sufferers. Let us first focus on lines 5-7. Sophie says that for her (and generalises that this is also true for an estimated ‘ninety per cent of us [anorexics]’) anorexia is not a personal choice. As discussed in section 5.1 of this thesis, discourse about eating disorders may well be unique in terms of the idea of ‘choice’ which, in other illness discourse, would surely seem rather out of place. One would not ‘choose’ to get an illness such as, say, cancer and it seems unlikely that cancer patients would emphasise that they did not choose to suffer in that way. The fact that Sophie feels she needs to emphasise the point that anorexia sufferers generally do not choose their disorder suggests that outsiders may assume that it was chosen. It is interesting that there may be some ambiguity among outsiders as to whether anorexia is a disease or a lifestyle choice – surely it must be extremely rare for an illness to be potentially seen as a ‘choice’.

Sophie speaks in a very fatalistic way of merely accepting, or resigning herself, to the fact that she has this disorder. This is extremely passive – not only did she not choose to have the disorder, but she also feels that she cannot choose to change it and recover from it. In line 5 she says ‘okay...this is the way our life goes’ and similarly in line 15, ‘okay this is it’. The ‘okay’ in both incidences particularly interests me. It implies accepting, or tolerating, something – in this case, the eating disorder. Sophie is rather fatalistic about her disorder, saying that she does want to recover from it but ‘I’ve just accepted that I won’t’. The contrast between what Sophie wants and what she believes will happen (or rather, won’t happen) further illustrates the idea that she has no personal choice in the matter of recovery. She wants it, but it seems that this isn’t enough for her to believe that it will happen. Looking at the extracts from Jessica and Sophie, we can begin to see some of the subtle ways people can work discursively to construct themselves as passive, which in turn illustrates disempowerment and lack of control. This attention to one’s own agency may be a feature of recounting one’s own problematic behaviour in a public setting such as a radio show.
Something similar occurs in line 9 of the following extract from Anna:

(Extract 4) - AN-2

1 AN: you know, I still diet, every day I sort of say 'ok I'm gonna diet today.' hhhh But um (0.4) I've (0.5) I-
2 (.) you get to the point where you think I've done this: 
3 ↑so many ti:mes .hhh um- >I've been-< I've had therapy as 
4 well, (.) and (.) you know .hh (.) trying to love myself 
5 but (.) I- I (.) I haven't really got there yet. .hhh 
6 u:m: (.) .hh (.) but you get to the point where you just 
7 (0.6) HHH (.) you ↑feel guilty, because it (.) it 
8 overtakes your ↑li:fe

I should note here that Anna does not identify herself as being part of a ‘clinical’ group i.e. being anorexic or bulimic, but prior to the turn presented above she has described a problematic relationship with food and preoccupation with her weight and diet. So, Anna is talking in this extract about her difficult relationship with food and her weight and in line 9 says that ‘it overtakes your life’. The grammatical construction of this statement implies that Anna is the passive ‘object’ whose life is being overtaken, while the problematic relationship with food is active, and is the thing that is doing the action (in this case, the ‘overtaking’).

To look more closely at how agency and passivity are managed in talk, I want to focus on several extracts featuring Joanna and Helena, speaking on Radio 4 as part of a show on anorexia nervosa. Helena is nineteen years old and recovering from anorexia nervosa and obsessive compulsive disorder, and Joanna is her mother. In the following fragment, Joanna is talking about the ritualistic behaviour which was part of her daughter’s illness.

(Extract 5) - JO-1

1 JO: She’d switch the light switch on and off, she’d do a lot of checking (.) that the house was safe, the door was 
2 locked, the iron was off .hh and then it crept into her 
3 schoolwork
Joanna chooses to say ‘it crept’ (line 3), rather than ‘she started’, which functions as a denial of agency for her daughter. Rather than ‘Helena starting to develop rituals regarding her schoolwork’, the rituals ‘crept into her schoolwork’. It is ‘the rituals’ that are doing an action, rather than Helena herself. This is a transitive verb; the word that comes after the verb, ‘her schoolwork’, is the ‘object’ of the verb as it is the ‘schoolwork’ that receives the action of the verb (see Dixon, 1994). Giving agency to Helena’s behaviour implicitly removes agency from Helena and constructs her as passive. This construction of passivity may be implying that Helena’s behaviour was pathological, rather than self motivated (she has a disorder, after all) but Joanna goes one step further than simply medicalising Helena’s behaviour; not only did Helena have a disorder, but it was one capable of ‘creeping’ into other areas of her life, seemingly having a will of its own. Joanna is not only implying a pathological condition on behalf of her daughter, but an agentive pathological condition. Similar constructions of anorexia being a disorder capable of ‘creeping’ into an individual’s life have recently been noted by Dunn and Rapley (2007).

Joanna’s use of the term ‘it’ may also be a way of handling agency, as ‘it’ suggests that the disorder is something separate from Helena. The idea of the disorder being something external to the individual and yet capable of causing certain behaviours is similar to a phenomenon common on pro-anorexia websites, the externalisation of the ‘eating disorder voice’. Individuals separate their own voice from the voice which encourages their destructive behaviour, referring to anorexia or ‘Ana’ as an entity separate from themselves (see Epston, Morris & Maisel, 2004).

Before examining some examples of Helena’s talk I want to look at more examples of how Joanna talks about her daughter’s illness. The following fragment comes directly after the fragment we examined above as Extract 5.

(Extract 6) - JO-2
1  JO: Helena’s behaviour changed (.) she became very withdrawn
2        having been a very exuberant child.

In referring to Helena’s previous temperament as a child for comparison with the behaviours she displayed later when suffering from obsessive compulsive disorder
and anorexia nervosa, Joanna mentions that Helena ‘became very withdrawn’ (emphasis mine). This is a passive description, describing the ‘withdrawing’ as a process that happened to Helena rather than something that Helena agentively did (whereas, say, ‘she started behaving differently’ would construct Helena as the active agent). Helena’s ‘withdrawing’, then, is constructed as an event rather than an action; it was a process with its own momentum.

I also want to draw attention to the use of the term ‘behaviour’ in line 1. Behaviour seems to be an ‘agent-free’ concept, deleting the mind from the account (whereas an ‘action’ implies something more deliberate). The term ‘behaviour’ objectifies and makes mechanical what could alternatively be described as a person’s actions.

In the following fragment, the radio show’s host questions Helena about her awareness of her eating disorder.

(Extract 7) - HEL-7

1  H: ...and how aware were you of what was happening to yourself (.) physically. (.) that you were losing weight. That perhaps you did look different.

2  HEL: I didn’t take any not- we’ve never had a pair of scales I mean, until I was diagnosed

Right from the outset Helena is treated as passive; the host’s use of the word ‘aware’ subtly invokes a lack of accountability and implies that Helena is passively noticing something rather than actively doing something. ‘Awareness’ is arguably the most passive cognitive process available; there is no overt behaviour involved, but merely ‘recognising’ something that already exists. By asking how aware she was, the host is implying that it may be possible to be ‘not very aware’ or even completely unaware, which suggests a lack of agency. Note also what the host is asking about Helena’s awareness of: ‘what was happening to you’. This implies that the host assumes something happened to Helena, rather than Helena herself doing something. Helena is treated as the passive ‘object’ who things happened to, rather than making anything happen herself. I would also like to draw attention to Helena’s repair of ‘I didn’t take any not-‘ to ‘we’ve never had a pair of scales’ (line 4), suggesting that
rather than saying she didn’t take any notice, she in fact couldn’t take any notice, as she had no way of monitoring her weight. This again implies passivity on her part; it’s not her personal culpability for not being ‘aware’ of her weight loss. Instead, she had no way of knowing about it because she did not have the means to measure her weight.

I now want to look at another fragment (previously discussed in section 4.3), again showing the radio host asking Helena a question, which raises similar issues of ‘awareness’ as the host’s turn in the extract I have just examined:

(Extract 8) – HEL-8
1 H: >And and an’< (. ) how much were you aware of what was
2 going on, with the eating disorder.
3 HEL: I wasn’t (. ) I didn’t think I had anything wrong with me,
4 I thought I was just er all I remember doing was tryin’a
5 be healthy and >I did a-< I remember just thinking you
6 know I don’t wanna suddenly wake up one day and find that
7 I’m a teenager and I can’t keep eating packets and
8 packets of sweets like you can when you’re a child ’n and
9 then people started you know saying you wanna watch out,
10 and Helena you’re not right, you’re not your normal self
11 and I thought everyone was just making the most enormous
12 fuss. And the more people kinda confronted me on it the
13 more I backed away and said .hh you know please just
14 leave me alone, I became er like my mum said more and
15 more withdrawn.

Again, we have the host referring to awareness, asking ‘how much were you aware of what was going on’. Not only do we have the idea of passively being ‘aware’ again, but we have the image of something ‘going on’ (emphasis mine) external to Helena. We can see further externalisation of the problem on line 2 where the host refers to ‘the eating disorder’ (again, emphasis mine) – referring to the problem as ‘the disorder’ rather than ‘your disorder’ treats the disorder as a separate entity. I also want to examine Helena’s response, as it is important to assess whether this idea of ‘awareness’ (or lack of) is taken up by or rejected by Helena. Her initial response is ‘I wasn’t’ (line 3) which, looking at the previous turn by the host which she is replying
to, we might assume to mean 'I wasn’t aware’. She then goes on to say ‘I didn’t think I had anything wrong with me’, further suggesting a lack of awareness. The rest of her turn is concerned with retrospective telling of what she ‘remembers’ (line 4, line 5). So, not only do we have a rather passive and unaware self-construction from Helena, but she suggests that if there was more to it, she doesn’t remember it – and, consequently, therefore is not accountable. By talking about ‘all I remember’, Helena makes it difficult for anyone to disagree with her statements, as obviously no one else can tell her what she remembers. In lines 14-15 we also see Helena echoing her mother’s earlier formulation of ‘[becoming] withdrawn’ – this is an extremely passive description, suggesting a process that happened to her rather than something she agentively did.

Following on from the fragment in Extract 8, we have the following interaction between the host and Helena:

(Extract 9) - HEL-9

1 H: .hh th- there was a day out to the London Eye:
2 [(..) where something sig(h)nificant happened what was
3 HEL: [laughs]
4 H: that.
5 HEL: U:m, it was the first day that we were out with friends, and I (...) it was just very obvious that I wasn’t the
6 Helena of kind of al- a year ago or >less I was< .hh um I
7 used to feel you know quite confident you know, I thought
8 I was funny, I liked to joke around I hadn’t— I just
9 didn’t wanna BE there .hh I didn’t wanna go out for lunch
10 and just the prospect of having to go out for lunch, I
11 just became (...) I was absorbed by f- you know the food
12 and the >fear for once< which it was as th:ough my mind
13 was somewhere else completely distant from where I was
14 and I couldn’t really hold a conversation with anyone.

I want to focus particularly on lines 5-6, and on Helena’s reference to ‘the Helena of... a year ago’. This idea of there being two different Helenas, the newer one of which is ‘absorbed’ by ‘food and... fear’, works to distance the ‘real’ Helena from the version which is afflicted by the illness.
There comes a further denial of agency from Helena later in the interaction, who uses the same verb of ‘creeping’ that her mother used in Extract 5.

(Extract 10) - HEL-10

1 HEL: I’ve got .hh other things that I’ve worked towards and
2 that I’ve achieved which are now more important to me (.)
3 than letting that creep back into my life again

Again, we have this idea of unhealthy rituals and bad habits ‘creeping in’. This makes Helena’s disorder an object capable of ‘creeping’ into her life. ‘Creeping’ also suggests moving slowly, stealthily, and unnoticed, suggesting that Helena may not even have been aware of it happening (a fact that we actually saw confirmed in Extract 8, when Helena responds to ‘how much were you aware of what was going on, with the eating disorder’ with ‘I wasn’t’). She does accept some responsibility, however, by acknowledging that she could ‘[let] that creep back’ — her disorder may be capable of ‘creeping’ into her life, but only if she permits it to in the first place. In contrast to the idea of passively having things happen to her, which we have seen in the previous extracts 7 and 8, in the above fragment we see Helena take a more agentive position with her reference to what she has ‘worked towards’ (line 1) and ‘achieved’ (line 2). This reference to goal-oriented actions is clearly very different to the passive formulations we have seen thus far, and the contrast between agentive and passive positions is something I will discuss further in section 6.2.

I want to move away from the data featuring Helena and Joanna for a while, and turn instead to a fragment from Lara who has phoned Radio 4 for a show entitled ‘Your views: Anorexia’.

(Extract 11) LA-1

1 LA: As time has gone on, what I have discovered in my life
2 although I’m nearly fifty now, is that it hasn’t really
3 left me completely although I’m- I’m not bulimic and I’m
4 not anorexic. (.) I feel that anorexia or bulimia lie
5 dormant in your system, you feel as if you’ve recovered
6 (.) but I don’t think you really have, I think it’s like
7 a seed that’s lying deep down and I think it’s- anorexia
is sometimes triggered perhaps by adolescence. I think it also could be triggered by (.) an emotional problem, perhaps menopausally, (.) or a marriage break up, er children leaving home (.) all sorts of things like that so I think (.) you have to be watchful.

I would like to address several elements in Lara’s turn. Firstly, in lines 2-3, we see Lara saying ‘it [presumably the illness] hasn’t left me’. The grammatical structure of this claim gives agency to the illness, assuming it is capable of ‘leaving’ (or, rather, not leaving) Lara. In contrast, Lara is constructed as passive; she is the ‘object’ of the sentence, upon whom the subject – the illness – is capable of acting. This, similarly to the previous fragments demonstrating ways of giving agency to the illness itself, downplays the individual’s personal agency and works up the agency of the illness in its own right – the implication is that *it*, the illness, is doing things, not the individual. This negotiation of agency works to counter moral responsibility. Lara’s use of the word ‘it’ on line 2 rather than, for example, ‘my problem’ is also interesting, working to distance the problem from the person. I will return to this idea later in this section. Lines 4-5 also demonstrate how agency may be given to an illness; here, we see Lara suggesting that ‘anorexia or bulimia lie dormant in your system’. This, again, constructs the illness as something external to the person and also makes the illness agentive by suggesting it is *capable* of ‘lying dormant’. Following this we have the metaphor of an eating disorder being ‘like a seed’ (line 7), implying it is something alive, and something capable of growing. Next, we see Lara suggesting anorexia can be ‘triggered’ by various events – the word ‘trigger’ again reduces her own agentive position, suggesting that these events can have some sort of automatic reaction.

I now want to move on to another extract with similar features; the following fragment shows a Radio 4 host introducing a show on ‘middle-aged anorexia’.

(Extract 12) HOST-3

1 H: .hhh now it’s generally assumed that anorexia and bulimia only afflict the young. That it’s the teenager worried about appearance and perhaps gaining control of life away from parents .hh who gets into trouble with an eating disorder. .hhh but there’s now evidence it can occur from eight to eighty. And that women and some men in middle
Here, we can again see the host constructing problems with food as something which happen to a person; ‘it’s generally assumed that anorexia and bulimia only afflict the young’ (emphasis mine), ‘it’s the teenager... who gets into trouble with an eating disorder’, ‘she got into difficulties with food’. These all construct the sufferer of the problem as very passive. The host does a similar construction later in the show, as presented below:

(Extract 13) HOST-4

Again, we see the illness referred to as ‘it’ rather than as ‘your problem’, and it is the illness which is made the agentive subject of the sentence. These fragments demonstrate that the host is sensitively and subtly doing the same kind of ‘agency work’ as many of the callers, giving agency to the illness and constructing the sufferer as passive. It is also worth noting here that the host’s question itself may subtly attend to issues of agency – ‘what happened when it started to get really bad’ would seem somewhat of an odd question to ask someone with, say, cancer for example. But with an ‘illness’ such as disordered eating – which as I have pointed out is bound up with issues of intent and agency – it is not inappropriate to ask about ‘what happened’ when the condition ‘started to get really bad’.

I want to look at one more extract which illustrates what the use of the word ‘it’ might be doing:

(Extract 14) JA-1

I want to look at one more extract which illustrates what the use of the word ‘it’ might be doing:
The fragment above shows the caller, Jade, referring to her eating disorder as 'it', a phenomenon which recurs throughout Jade’s entire interaction with the host. Her disorder is constructed as this ‘it’ that is happening to her and, implicitly, is separate from her. It is interesting to consider the ontological significance of referring to an eating disorder as ‘it’ or ‘the problem’ rather than ‘my problem’; ‘my’ would suggest a sense of unity between the person and the problem, whereas ‘the’ or ‘it’ camouflages the relationship between the person and the problem. Something similar has been noted by Parry (2007), who demonstrates in her physiotherapy data that patients and physiotherapists frequently refer to body parts as, for example, ‘the arm’ (as opposed to ‘my arm’) when said body part (or action) is problematic. Nicolson (2006) also notes that the self is presented as embodied until, for example, a dispreferred event occurs – such as weight gain – which is then formulated as ‘the weight’ rather than ‘my weight’.

The fragment presented below shows part of Marla’s introductory turn, and occurs shortly after the host’s introduction in Extract 12.

(Extract 15) MAR-5
1 MAR: I thought if I knocked a few pounds off, = if I
2 looked a bit better, = hh pra’haps I’d (0.6)
3 able to cope with everything (.) so to start with
4 I: started off doing the sensible things . hh
5 changing lo- full fat to low fat grilling instead
6 of frying and I thought I’ve got this under
7 control. But it didn’t take very long . hh until
8 it had me under control instead.

I want to focus particularly on Marla’s remark that ‘it had me under control instead’ on line 8; again, we have the idea of behaviour being caused by some external force, which is capable of controlling the person it afflicts.

There are many other examples within the data corpus of radio hosts negotiating agency on behalf of the callers, which I will present here for observation of the similar grammatical features:
In Extract 16, the host constructs the question not as a simple ‘why did you...’
but as ‘what was driving you’ (emphasis mine). This raises the question of whether
there were some force compelling Penny to act in a certain way – the idea is that
Penny was ‘being driven’ by something. It is also interesting that the host doesn’t ask
‘what was driving you to make yourself smaller’ but, instead, ‘what was driving you
to want to make yourself smaller’ (again, emphasis mine). The implication is that
Penny’s feelings and desires to lose weight were driven by something, rather than her
actual behaviour. Similarly in Extract 17, the host gives agency to Emily’s illness,
assuming it ‘manifest[ed] itself’. In Extract 18, the host refers to Grace’s parents and
friends as ‘helpless’ though interestingly, he is also effectively constructing Grace as
somewhat helpless by saying, on line 2, ‘anorexia took over’ – this implies the eating
disorder had control and that Grace did not, and again gives agency to the illness.
Also, rather than Grace actively losing weight, it is her weight that ‘plummeted’. The
idea of ‘weight plummet[ing]’, again, works to deny agency on Grace’s behalf,
implying that rather than actively working to lose weight, her weight simply dropped.
‘Plummeting’, after all, is accidental; the deployment of this word suggests that
Grace’s weight was falling accidentally rather than being purposely decreased by
Grace herself. Rather than using an active verb, such as ‘I lost weight’, the host refers
to the process of weight ‘plummet[ing]’ as something Grace has undergone rather
than an experience she herself is responsible for.
I will now present two further fragments from the interaction between Grace and the host, the introduction of which can be seen in Extract 18.

(Extract 19) - G-4

1 G: we seem to >be very good< at talking about our physical
2 health at the moment you know there's all this stuff
3 about <you are what you [eat>
4
5 G: but in fact I think we're a lot more than what we eat, we
6 are what we feel really. Um and anorexia leaves you with
7 the feeling that you only feel fat: when in fact your
8 feelings are- are- are multi (.) various.

Rather than merely feeling fat, ‘anorexia leaves you’ with this feeling (lines 6-7). Describing anorexia as ‘leav[ing] you with the feeling that you only feel fat’ works up the suggestion that anorexia is an entity capable of controlling feelings.

(Extract 20) - G-5

1 H: I mean you were very very thin [indeed
2 [absolutely
3 4
5 G: but you didn’t notice that [or did you?
6 [.hh I think I did notice that
7 yes but by that point I’d lost (.) all self esteem and
8 (.) the diet had actually made me feel terrible about
9 myself [where I looked in the mirror, I just covered it
10 up, I didn’t think it looked nice at all .hhh but what
11 happens is you get in a cycle of addiction, an addiction
12 to um .hhh starving yourself, an addiction to watching
13 the numbers fall on the scale [.hh
14 [.hh

In the fragment above, the host implies that Grace's low weight was something she might not have 'notice[d]'. This is similar to the concept of 'awareness of the problem' raised by the hosts in Extracts 7 and 8 earlier in this chapter.

In contrast to Helena (see Extract 8), who claims to have been largely unaware of her problem, Grace says that she ‘did notice that [she had lost weight]’, though this is prefaced by the discourse marker ‘I think’, demonstrating only part commitment to
the statement (see Shiffrin, 1987). Grace goes on to say ‘the diet had actually made me feel terrible about myself’ (lines 6-7) which makes the diet the agent and Grace the object which has been ‘made to feel’ a certain way (emphasis mine). Further in the extract, in lines 10-11, we have the graphic image of ‘watching the numbers fall’ – an image which arguably captures the very essence of the disorder. Formulating it in this way rather than as, say, ‘losing weight’ adds to the idea of helplessness and lack of agency on Grace’s part.

I want to look at a fragment from caller Charlotte, demonstrating a similar formulation of weight being agentive. Unlike Grace, Charlotte’s weight problem involves weighing too much rather than too little, but grammatically her talk is similar:

(Extract 21) - CH-1
1 CH: the advice the doctors been giving, I’ve been hearing it now for forty years, and my weight has
2 not been going any down, it’s going going up and up and up and I’ve been trying to take their advice
3 since the age of .hhh fifteen I was er er diagnosed of dying er before fifty because my weight wasn’t
4 right for my size or for my age

In this extract we see repeated formulations from Charlotte of weight as seemingly moving of its own accord; ‘my weight has not been going any down’, ‘it’s going...up and up and up’, ‘my weight wasn’t right’. It would have been just as appropriate, grammatically, to formulate these statements as ‘I have not been losing weight’, ‘I keep gaining and gaining weight’ or ‘I weighed too much’. However, these statements would have made Charlotte the active agent and implied that she was accountable for weighing too much. The statements Charlotte actually uses, giving agency to her weight, work to resist her own accountability.

The extracts discussed in this chapter so far have shown:

• How agency is frequently removed from the sufferer (by both sufferers themselves and the radio hosts)
• How an eating disorder may be given its own source of action and effect
• How sufferers may work discursively to dissociate the self from the part that is ‘ill’
• Various words and terms which can be deployed to put causality outside of the person and onto the illness.

In summary, this section has demonstrated how individuals can work grammatically to build the notion of an eating disorder not as an inner state but as an external force that operates relatively independently, therefore constructing the individual as ‘blameless’ and lessening the chance of them being held personally responsible for their situation. It is worth considering the function that these types of constructions may have within the institutional setting of a radio show; for example, it may be that through negotiating agency in this way, callers are orienting to the fact that they are being held up for rather public scrutiny and may be being held accountable for their actions by the listening audience. This shows the value of examining this type of public interaction, as it acutely highlights a broad variety of ways that accountability and agency can be attended to in talk.

6.2 Agency/passivity contrast

From my data corpus, it became clear that a key feature of talk about eating behaviours was the management of agency through grammatical construction. The basic elements of a sentence are the subject, (indicating the person or the thing that does an action) the verb (which expresses the action) and the object. In this section, I want to examine how the subject, object and verb constructions of sentences can negotiate accountability.

The extracts discussed in this chapter so far have demonstrated how callers frequently construct themselves as passive, often giving agency to their problem itself. Being passive lessens moral accountability, whereas taking an active position would mean that one would be an autonomous and responsible individual and therefore accountable for one’s situation. In this section, I want to present extracts where an
active position is taken, and examine the context in which this is done, to explicate what function taking an agentive position might have in the talk.

Let us examine again the fragment from Helena, previously discussed as Extract 10 in section 6.1.2.

(Extract 22) - HEL-11
1 HEL: I've got .hh other things that I've worked towards and
2 that I've achieved which are now more important to me (.)
3 than letting that creep back into my life again

I have discussed in section 6.1.2 various ways in which Helena works discursively to construct herself as passive in terms of her condition, including her use of the image of an eating disorder 'creeping' into her life. In the fragment shown above, we can see this reference to her disorder 'creep[ing]' into her life, but we can also see some rather agentive statements: 'I've worked towards', and 'I've achieved'. So, why might Helena's talk in this instance be working to construct her as agentive when throughout the rest of her interaction with the host, she has portrayed herself as passive? If we look at what Helena is actually talking about when she makes these agentive statements, we can see that she is talking about other, positive things going on in her life, not her eating disorder. Helena makes it very clear that she is the one who has accomplished things and is responsible for these achievements. The fact that these agentive words such as 'worked towards' and 'achieved' occur in the same sentence as the passive 'creep[ing]' illustrates the clear contrast between agency and passivity.

So, might it be that it is in fact common to claim agency when speaking of positive things, while deny agency when problematic events or conditions are referred to? I want to look at several more fragments showing callers taking an agentive position, to see whether this always occurs when it is a positive event one is claiming responsibility for.

(Extract 23) - AND-1
1 H: Have you done anything 'about it.'
2 (0.4)
AND: Um (.) \textit{yes} um .hyyyy we- I’ve um hh (0.4) in the
eind (.) e:r because it was getting to the stage that m-
(0.5) my: (.) I couldn’t really \textit{work} properly, I was
>sort of< .hh <\textit{hiding away}> and almost becoming a
\textit{reclus}e. .hyyyy um (0.2) and I was putting this weight
on and then every day I’d get up and think \textit{OK} .hh You
can’t control this \textit{but} you can control your weight.
(0.3) Get (0.3) get on with it, \textit{do} something about it.
[10 lines omitted, talking about approaching a doctor.]
I \textit{have} to \textit{say} that um (0.7) I changed my life.

In Extract 23, we first see the host making the implication that Andrea actively
cleared her life, with the question ‘have you done anything about it’ (with ‘it’
referring to Andrea’s reported feeling of ‘invisibility’ having gained a great deal of
weight). In Andrea’s response we can see the terms ‘get on with it’, ‘do something
about it’ and then of course ‘I changed my life’ the grammatical construction of these
terms implies that Andrea’s life didn’t merely \textit{change}, for no reason; \textit{she} actively
changed it.

(Extract 24) - GEM-2
GEM: I had several hospital admissions which obviously um got
my physical health back to: how it should be um but I
think comin’ out of hospital and actually engaging in
normal life and (.) distancin’ myself from my anorexic
friends so to speak um making new friends, getting a job
and building a life for myself without anorexia included
.hh made me realis’ that (.) I don’t need to be like that
anymore, I can have a life and be happy I don’t need that
.hhh um >\textit{sort of thing}< so just rebuildin’ my life after
being anorexic for so long and after bein’ in that minds-
(.) mindset .hh is sort of creating a new mindset for
myself that doesn’t include that, was kind of the way it
helped me.

In the above extract, Gemma describes her recovery as constituting ‘engaging
in normal life’, ‘distancin’ myself from my anorexic friends’ and ‘building a new life
for myself’ – an image referred to twice in the extract, on lines 6 and 9. The agent of
these verbs is Gemma herself; \textit{she} is responsible for distancin’ herself from people
who may contribute to her problematic conduct with food, and for rebuilding her life, both of which imply some sort of conscious effort from Gemma. It is also remarkable that Gemma seems to be subtly resisting the concept of being ‘ill’ or pathologised; “I don’t need that...sort of thing” (lines 8-9) implies ownership of her own conduct, rather than being the ‘victim’ of an ‘illness’ who is incapable of changing her behaviour.

In the same way that recovering anorexics such as Gemma may construct their recovery to normal health as a very self motivated process, individuals with a different weight problem – being overweight as opposed to underweight – also speak of their weight change (i.e losing weight to become healthier as opposed to gaining weight, as in the anorexic narratives) as being self motivated.

Observe the following fragment from Kate:

(Extract 25) – KA-1
1 KA: I think I changed my life when I was about forty. I went on a diet, lost about three stone and (. .) I more or less kept it "at that weight now." Because I looked at myself in the mirror and I said this: enough is enough. (. .) So I slimmed down.

Firstly, there is the obvious ‘I changed my life’, an extremely agentive position to take. Kate speaks of her motivation to change – looking at herself and saying ‘enough is enough’. The ‘so’ preceding ‘I slimmed down’ implies that her choice to lose weight was a direct response to this moment in front of the mirror when she decided ‘enough [was] enough’. Kate makes no mention of any difficulties or struggles to do this; she merely decided enough was enough, and slimmed down. This construction of herself as wanting to personally do something about her situation casts her as a proactive, motivated individual. Both her motivation to lose weight – the fact that she was unhappy with what she saw in the mirror – and her actual weight loss – achieved by simply going ‘on a diet’ – are constructed as personal accomplishments.

Next let us examine the following extract from Mark, who has phoned in to a Radio 4 health programme entitled “Exercise For the Very Unfit”.

175
H: Mark, it's your turn.
MA: Yeah... oh yes good after[noon
H: [he:ilo
MA: H: [he:ilo
H: [he:ilo
MA: H: [he:ilo
H: [he:ilo
MA: H: [he:ilo
MA: H: [he:ilo
H: Good for you(^h) ["heh heh"
MA: [.hhhh u:m but er w- I have to say what I found in the process was unfortunately there are parts of the fitness industry which appear to be flagrantly and shamelessly <agelst>.
H: A:::h <what d'you mean by that?>
MA: U:m (.) well the:: (.) er I'm- I'm actually quite a determined and- and self-motivated individual, which was how I managed to shift most of the weight

Note that Mark says he has 'managed' to lose five stone in weight. He returns to this idea in line 17, explaining how he 'managed' to lose this weight. The verb *managing* implies that he handled, or controlled, the problem. The host's response to Mark's statement that he has lost five stone is 'good for you', suggesting she is congratulating Mark for something he has achieved. Mark's claim in lines 15-16, that he is 'quite a determined and self-motivated individual', lends some weight to the idea that he feels he has controlled his own weight loss.

Another caller, Niamh, speaks agentively in the following fragment:

(Extract 27) - NI-1
NI: Yeah, I um as soon as I realised that my mother had um inadvertently I think given me um (.) obsess(h)i(h)ons(h) u(h)m that ((indecipherable)) my own I've realised that that I was gonna have to try and do something
The *as soon as I realised* here is a way of emphasising that Niamh is trying to be responsible of her own life. Rather than simply saying 'gonna have to do something', she inserts the word 'try' implying uncertainty about whether it could be
achieved or not. 'Try' also implies a need for concerted effort (and perhaps some difficulty) in achieving this.

(Extract 28) - SE-2
1 SE: More recently: (0.6) I begin. (0.6) Began to:=think
2 "well: (0.3) long term health "this isn't good" for
3 me.=So: (1.0) ((mechanical click)) I've made hh (0.3)
4 changes to my lifestyle and my weight: (.) is going
down. But if that's (.). hhh (0.3) as a result of changing
5 my lifestyle:le=it's not my (.) main focus:.
6 (0.5)
7 H: .hhh[=SE-
8 SE: [(indecipherable) an obsession anymore.

The positive changes in Serena's life (her weight going down) she takes responsibility for, by saying 'I've made changes' (emphasis mine).

The above extracts have demonstrated that callers frequently claim agency for positive events. Do hosts, too, attribute responsibility to their callers when they are talking about something positive? Observe the following fragment from the host speaking to Grace.

(Extract 29) - G-6
H2: Well her parents and friends looked on helplessly as anorexia took over and her weight plummeted. .hhh Grace has now beaten her condition but she wants to share her experiences >in the hope< that it can help others

It is interesting to see that in the case of a positive change, Grace is given agency – she has 'beaten her condition' – even though it is not Grace doing the talking.

It appears to be common for individuals to claim agency and work discursively to deny passivity, then, when talking about a positive change they have made in their life, such as recovering from an eating disorder, or losing weight after
being unhealthily overweight. There are however two examples where a caller denies agency for something positive, which I will now discuss as ‘deviant cases’.

In the following extract, caller Catherine has already constructed herself as passive in her struggles with food, and now goes on to also construct a passive role for herself in her recovery from eating problems – a positive thing, which we might expect that an individual would want to take personal responsibility for.

(Extract 30) - CAT-4

1 CAT: I:‘m: (.) Greek. (.) so: (.) my entire family was obsessed with nurturing through food. hh u:m a:nd (.) when I was growing u:p, there was (.) a constant (.) dieting struggle going on in my life. (.) which didn’t really resolve itself until after university.

The term ‘resolve itself’ implies that Catherine herself wasn’t personally responsible for the struggle being resolved; it merely ‘resolved itself’ (emphasis mine). I am particularly interested in the formulation of a struggle ‘going on’ and the lack of agency here – there is a struggle ‘going on’ which is simply there. The words ‘resolve itself’, again, imply that there is an ‘it’ – an object outside of the individual – which can ‘go on’ and ‘resolve itself’ seemingly independently. Catherine then goes on to say that her new, healthier diet is simply a ‘result’ of having to cut various foods from her diet due to allergies – this puts the cause of her change in eating behaviour down to something situational rather than individual. It seems that Catherine is downplaying her own role in changing her diet, putting it down to something she ‘had to [do]’, without acknowledging any hard work on her part. So, in contrast to the extracts discussed previously, in this extract we get a denial of agency for positive behaviour.

There is one other case within the data corpus where a caller speaks passively of a positive change:

(Extract 31) - CAR-1

1 CAR: I do remedial pilates three times a week. (.) that’s better for posture, I don’t necessarily think it’s
Carla states that her weight ‘has completely stabilised and dropped off’. The image of weight ‘dropping off’ is a common one but seems strange positioned next to ‘stabilised’. ‘Stabilised’ and ‘dropped off’ are clearly not the same; stabilising would happen after the initial weight loss, but Carla mentions stabilising first. Again, these are passive ways of talking – the weight has undergone the process of dropping off and stabilising, rather than it being framed as an action or accomplishment on her part.

Carla also goes on to say, at the end of her call:

(Extract 32) - CAR-2
1 CAR: I’m LUCKY that I’m actually not food obsessed

I want to focus particularly on the term ‘lucky’. ‘Luck’ implies some kind of accidental good fortune, or something positive happening by chance, rather than personal virtue. ‘Lucky’ can be related to (lack of) agency, with the implication being ‘it’s not me that made things happen, just luck’. It is interesting to think about the word ‘lucky’ in comparison to, say, ‘virtuous’, which would have rather different implications.

So, there are several instances within the data corpus where individuals actively construct themselves as agents when talking about positive behaviours. There are also two instances where callers deny agency with regard to something positive. The latter may well be a way of relating their achievements or virtues without seeming to take too much credit for them. It may be that they don’t want to be seen as ‘bragging’ about their accomplishments. Again, it is important to consider here the institutional context of the talk, and note that the callers’ knowledge that they are being listened to by a potentially huge audience may make it particularly important for them that they are not seen as ‘bragging’ about themselves.
6.3 The use of metaphor in agency negotiation

The use of metaphor was startlingly pervasive in the data corpus, and it would be inappropriate to explore the linguistic devices used to negotiate agency without considering what role metaphor might play. Lakoff and Johnson (1980) suggest that metaphor is pervasive in everyday life and that human thought practices themselves are largely metaphorical. However, little research exists on the use of metaphor in talk about health and illness. One study which touches upon the use of metaphor is that of Gordon (1995), who focused particularly on how men talk about illness and concluded that they used traditional notions of masculinity in their talk; for example, they spoke of ‘fighting’ cancer. Radley (1995) also examines the use of metaphors and analogies in talk about illness and recovery and suggests that they function to convey that there is no responsibility or shame involved with having the illness. In this section I want to explore some of the metaphoric constructions which are frequently implemented in talk about problematic eating behaviours, and examine how – if at all – this deployment of metaphor may function to negotiate accountability.

It must first be noted that describing conduct as ‘illness’, as we have frequently seen participants do throughout this chapter and the previous Chapter 5, is itself metaphorical. Sarbin (1968, 1990) argues that various kinds of ‘unwanted conduct’ – of which problematic eating could be seen as a good example – are in fact metaphors, rather than illnesses; for example, the notion of schizophrenia as an ‘illness’ is based on analogy and metaphor (see Sarbin & Mancuso, 1968), as is the notion of ‘anxiety’ (see Sarbin, 1968). Sarbin’s argument suggests that such examples of unwanted conduct are medical ‘diagnoses’ only in a metaphorical way (see Chun & Sarbin, 1970; Sarbin & Mancuso, 1980). So, we should consider that any references to ‘illness’, ‘diagnosis’, ‘cure’ and the like – i.e. all the ‘medicalisations’ discussed in Chapter 5 – may themselves be metaphorical. I now want to look at other uses of metaphor in talk, beginning with the particularly pervasive metaphor of a ‘battle’ or ‘struggle’.
6.3.1 Battle/struggle

The first metaphor I want to look at is that of ‘battling’ or ‘struggling’ with a weight problem or eating problem. The following extract is the opening turn of Anna, who has phoned in to a Radio 4 show on ‘body image’.

(Extract 33) – AN-3

1 AN: I’ve er LIKE the previous callers I’ve (0.8) (hh)
2 battled with my late- (. ) with my weight (. ) ALL my li:fe
3 (.) um (. ) I’ve lost (. ) and gained (0.7) stones:
4 Throughout my life. .hhh (. ) um (0.3) and (0.5) it’s:
5 (. ) just exhausting (. ) um (0.3) and (0.5) it’s:
6 (. ) the the stage .hhh where you wake up “in the morning
7 and you really don’t want to think about it” ANYmore.

The fragment above shows Anna’s first turn after having exchanged greetings with the show’s host. Anna immediately, in line 2, constructs her weight as something to be ‘battled’ with, and something which she has battled with throughout her life. Interestingly, the use of the term ‘battling’ invokes the image of somebody fighting against something. This implies that what is being fought – in Anna’s case, ‘my weight’ – is something capable of action in its own right – otherwise there would be no struggle.

Another caller, Natalie, initially sets up her relationship with food as a ‘struggle’.

(Extract 34) – NAT-5

8 NAT: .hhh Um (. ) >well I’ve< struggled with (. ) with
9 food all my life

The word ‘struggle’ implies both strenuous effort and difficulty. Lines 8-9 neatly account for the reason she is calling in; the phone-in is about body image and weight issues, and she is ‘struggling’ with food. Compare Natalie’s image of ‘struggling’ with the image of ‘battling’ invoked by Anna in the previous extract. ‘Battling’, in particular, implies that one is contending with an adversary or opposing
force. ‘Struggling’ is a similar term which may well be implying a similar image of a ‘fight’, although unlike ‘battling’ it does not suggest that there definitely exists an opposing force. ‘Struggling’ may refer, rather, to being strenuously engaged in a task, or to progressing on a task with difficulty.

The term ‘battling’ crops up again in the following fragment from Grace:

(Extract 35) - G-7
1 G: when you’re in the middle of an eating disorder .hh
2 it seems like the most impossible thing to do:. .hh
3 and what I’ve tried to do in the book- it is about
4 finding my shape, a shape of my o:wn and that takes
5 time because as a teenager you’re growing (.)
6 mentally and emotionally .hhh and finding so-
7 feeling comfortable in your own skin can take a
8 long time to get to grips with .hhh and so of- over
9 the course of many years I’ve battled with it, and
10 fought with it .hhh and I’ve basically come to a
11 situation where (.) I: don’t want to go back into
12 that mindset and I fought very hard to do that over
13 a long period of t:me.

Here, we get Grace referring to ‘battl[ing] with it’ (where ‘it’ may arguably refer either to becoming comfortable in her own skin or to battling anorexia) in line 8. We also see the statements that she ‘fought with it’ (also in line 8) and ‘I fought very hard’ (line 10).

As I have done with the analysis throughout this chapter, I want to illustrate this point using an extract from a host as well as from callers. The following fragment shows the host introducing Joanna and Helena.

(Extract 36) - HOST-8
1 H: Well she and her mother Joanna have written a book,
2 [title removed] which charts their battle to get her well
3 again.
So, again, we get the idea of ‘battl[ing]’. The images of battling, fighting and struggling all invoke the impression that the speaker is putting in an effort to ‘fight’ their disorder. In terms of agency, these ‘battling’ metaphors give some agency to the individual, in that they are actively choosing some course of action and ‘fighting’ for it. At the same time, these metaphors are also giving agency to an eating problem, in that they are suggesting that individuals are fighting against some opposing external force.

6.3.2 Imprisonment

Another common metaphor is that of being ‘trapped’. The following fragment is from Gina, talking about pro anorexia websites:

(Extract 37) - GI-1
1 GI: to me: it- it- it’s just (. ) it’s just another a- another
2 addiction that you can get trapped into with anorexia, I
3 mean there’s enough .hhh obsessions that you get with the
4 illness anyway, the pro ana websites are just another
5 (. ) .hh another (. ) symptom if you li:ke.

In this fragment we see Gina metaphorically invoking the idea of a ‘trap’. There seems something cunning about something which is capable of trapping a person, so is the implication here that addictions are out to ‘trap’ you? The idea of being trapped also implies being ‘caught’ in somewhere difficult to get out of – this gives the impression of Gina being rather passive in her illness. Grace’s use of the term ‘symptom’ (line 5) – is also metaphorical; constructing troublesome conduct around food as an ‘illness’ with ‘symptoms’ is metaphorical in itself, taking as we have the stance that problematic eating should not be viewed in the traditional psychiatric way, as an ‘illness’.

(Extract 38) - CH-2
1 CH: when you are obese you don’t need a doctor to tell you,
you hear it everywhere you see it on every billboard, you
see it on television you see it in magazines .hh you are
insulted, you are berated, you are ridiculed, .hh what
has that got to do with health? What has it got to do
with health? Er that destroys people’s lives and
psychology, there’s a whole environment the-
It’s a life sentence to be fat.

Here we can see Charlotte’s linguistic choice of ‘it’s a life sentence to be fat’
(line 8) vividly create an image of her weight status as a prison. ‘Life sentence’, after
all, is a phrase we would likely associate with a prison term lasting for as long as the
prisoner lives. If ‘be[ing] fat’ is a life sentence, the implication is that Charlotte is the
prisoner. This type of metaphorical construction functions to construct problematic
eating as a kind of ‘prison’ in which an individual can inadvertently become trapped,
thereby implying that the condition of problematic eating is agentive and capable of
‘capturing’ a person.

6.3.3 Disappearing

Another metaphorical construction which appears frequently in the data is that
of feeling ‘invisible’ or ‘disappearing’. For example:

(Extract 39) – RU-1
1 RU: I: disappeared as a person.=I disappeared in the eyes of
2 um >er er er< in the eyes of men as a sexual person
3 apart from my h- (. ) wonderful husba(h)nd .hh um but also
4 I: I suddenly didn’t have an opinion and I >didn’t have<
5 a voice in society.=I- I felt that very very strongly

In the above fragment, Ruby invokes the image of ‘disappear[ing]’, both
explicitly (line 1) and implicitly (line 5), by suggesting she ‘didn’t have a voice in
society’ – we might assume that if one does not have a voice, that person is ‘invisible’
in society. Ruby returns to the idea of ‘disappearing’ in the following extract:

(Extract 40) – RU-2
they say "I want to disappear" like a: (0.5) (mechanical
click)) a: l- like [a
>disappearing disappear[ing was what
[y:eah
Princess Diana [said
[y:eah .hh but I- I: disappeared as a- as
an eighteen stone (0.3) person

In lines 1-2 Ruby appears to be struggling with what to say, marked by
hesitations and false starts. The host picks up on Ruby’s comment about
‘disappearing’ and gives the example that ‘disappearing’ was something Princess
Diana also spoke of in her well-documented struggle with bulimia nervosa. Ruby’s
response of ‘yeah .hh but’ implies that she already knows this (‘yeah’) and is actually
trying to make a different point (‘but’). She goes on to say ‘but I- I disappeared as a-
as an eighteen stone person’ (lines 6-7). The ‘but’ and the emphasis and elongation of
‘I:’ bring the subject back to Ruby and to the idea that being overweight made her
‘disappear’.

Related to the concept of ‘disappearing’ is that of ‘being invisible’; if one
disappears, we can assume that they have therefore ‘become invisible’.

(and I’ve heard people sa:y) before now that when you "go
through the menopause you" you .hh (0.3) you fdo actually
feel as if <you become invisible.> .hh Um .h (0.8) I- I
don’t regard "myself as being er" (.) that attractive but
nevertheless .hh (.) people don’t (.) really fLOOK at you
anymore. .hh yo:u (.) um (0.3) become this invisible
<†middle a:ged woman.>

In Extract 41 we can see Ally referring to what ‘people say’ about the
menopause which is that ‘you feel as if you become invisible’. She relates this to her
own experience, suggesting that ‘people don’t really look at you anymore’ (so, the
idea of being not seen, or ‘invisible’, again) and that ‘you... become this invisible
middle aged woman’.
Interestingly, all of the extracts I have chosen to demonstrate the 'disappearing' metaphor have been from women who identify as being overweight, rather than underweight. In fact, there are no instances within the data corpus where underweight individuals invoke the idea of disappearing, or of being invisible. This is rather surprising, as we might assume that being underweight would be more likely to be associated with 'disappearing', rather than being overweight, as *losing* weight and becoming smaller do give the impression that one might be 'disappearing'. In fact, what we see in the data is individuals relating being overweight to not being 'seen'. I want to look at one more extract using the 'invisibility' metaphor, which illustrates that not only is being overweight associated with being invisible, but that *losing* weight does the opposite and is associated with becoming *visible*.

(Extract 42) - LOU-1

1. LOU: It was— it was almost the difference between (.).
2. between being invisible and visible. It was— it was
3. like (.). you just— I popped up one— one day, all
4. of a sudden .hh I kind of went ta—ta-dah! Here I am
5. (.). and— and everybody seemed to notice (.). me: and
6. the irony is that— that I was twice the size
7. before and I was invisible.

In the above extract, Louisa is talking about her weight loss and likens it to 'the difference between being invisible and visible'. *Losing* weight is referred to as 'I popped up one...day', 'I kind of went ta-dah! Here I am' and 'everybody seemed to notice me'. So, despite *physically* becoming smaller, Louisa ironically feels that she is *more* visible; indeed, she recalls being 'invisible' (line 7) when she was 'twice the size'.

This 'invisibility/disappearing' type of metaphor subtly works to manage agency, as we could assume that one would not *choose* to become invisible or disappear, and so the implication is that the individual is not actively making choices about their condition.
6.3.4 ‘Accidental’ behaviour

A different kind of metaphor which crops up frequently throughout the data corpus, and one which vividly creates the image of the individual being passive, is that of ‘spiralling’, usually in the sense of ‘eating behaviour spirals out of control’. For example, observe the following extract from Emma, who talks on Radio 4 of her struggle with bulimia nervosa during her university years.

(Extract 43) - EM-3
1 EM: I think my problems really began before I went to
2 university, u:m certainly they just began to spiral out
3 of control once I (.) went to university.

In the above extract from Emma we have the idea of eating problems ‘spiral[ling] out of control’. This makes available the inference that Emma’s problem was something she unwittingly slipped into. This idea of eating problems being ‘accidental’ is similar to what was reported by Surgenor, Plumridge and Horn (2003), who examined the discourse obtained from a group of seven women diagnosed with severe anorexia nervosa, and suggest that the patients’ discourse refused all implication of being ‘pathological’. Their participants generally talked about their illness as ‘accidental’; they constructed themselves as essentially healthy people who had ‘overdone’ a diet, and emphasised ‘normalcy’ rather than ‘pathology’. Indeed, in Emma’s extract we get a similar idea of ‘accidental’ behaviour, as her problems ‘spiral[led] out of control’ rather than being deliberate actions.

Similarly, we have the following fragment from Serena, who struggles with ‘yo-yo dieting’:

(Extract 45) - SE-5
1 SE: once you start (0.3) to love yourself hh (0.7) then=you
2 don’t feel guilty if you (0.4) you <have a piece> of
3 cake or you have a slip-up one day. (0.7) When you’re on
4 a di:et (0.7) and you do that: there’s >the- there’s<
5 great guilt that you- you’ve fa:iled and then I think
6 that sends you into a spiral then of eating more and
In lines 2-3 we see Serena likening ‘hav[ing] a piece of cake’ to ‘hav[ing] a slip-up’. This constructs Serena as passive. Serena’s remark that ‘that sends you’ on line 6 (with ‘that’ referring to ‘feelings of guilt having binged’) implies lack of agency on her part. The metaphor ‘spiral’ used by both Serena and Emma gives the image of steady acceleration and something that, once it has started, cannot be stopped – something that keeps going. ‘Spiral’ is an intransitive verb, as there is no noun, or ‘object’, to receive the action of the word. The use of this kind of verb functions to suggest that behaviour is unintentional, and therefore managing agency. It gives the impression of something happening to people, rather than the individuals themselves making things happen. The use of words like ‘spiral’ and ‘slip’ functions to downplaying, sidestepping, or remove blame from the individual.

Interestingly, it is not only the individuals living with problems with food and weight who construct such disorders as agentive and the sufferers as passive. Radio show hosts, when posing questions to callers or introducing the show or specific guests, frequently use similar language to convey the idea of a lack of agency. In the following extract, the radio show host says (of university) that

(Extract 46) - HOST-9

1 H: it [university] can be a dangerous time when students can
2 slip into (. ) eating problems.

The host’s use of ‘slip into’ makes the eating problems sound accidental and reinforces just how worried parents should be about their children going off to university – accidents, after all, can happen to anyone!

The following fragment illustrates a similar metaphor, from a different host:

(Extract 47) - HOST-10

1 H: but when does that concern for whether you’re a little
2 bit plump or not <slip into self hatred>
The host’s use of ‘slip into’ makes the descent into ‘self hatred’ or ‘eating problems’ again sound accidental.

6.3.5 Metaphors – overview

In this section I examined the occurrences of individuals drawing on metaphors in their talk across the data corpus, and divided these into four main categories of metaphor which I will discuss using examples from the data. These were:

- ‘Fighting’ metaphors, where participants draw upon words such as ‘battling’ to convey a sense of having to work hard against some opposing force;
- ‘Trap’ metaphors, where participants invoke the image of an eating disorder being like a trap or a prison;
- ‘Disappearing’ metaphors, where participants speak of becoming ‘invisible’;
- ‘Slipping’ metaphors, where participants invoke the idea of passivity through the use of images like ‘slipping’ and ‘sliding’ accidentally into problems.

These four different types of metaphorical talk all function in some way to negotiate agency or passivity. ‘Fighting’ metaphors, for example, work to invoke individual agency (i.e. constructing the individual as actively battling something) but also invoke the idea of an eating problem having agency of its own (i.e. constructing disordered eating as an opposing force which one must battle against). ‘Trap’ metaphors again invoke the idea of an eating disorder being agentive, in this case, capable of trapping a person. ‘Disappearing’ metaphors subtly invoke the idea of passivity in that we assume that an individual does not choose to become ‘invisible’. ‘Slipping’ metaphors, again, suggest there is an ‘accidental’ quality to behaviours rather than an individual actively choosing to behave in a certain way. All of these relate to the business being done around disclaiming responsibility for one’s actions in public settings. These constructions may also be important in other institutional settings such as doctors’ surgeries and therapeutic interactions.
6.4 Depicting food as an active agent

In section 6.1.2 I examined many fragments illustrating how individuals may work linguistically and grammatically to construct ‘eating problems’ as external; as something outside of the individual. There were many instances in the data of eating problems themselves being given agency (e.g. Extracts 1 and 2, for example). I now want to turn to several extracts where we see food given agency. Observe the following fragment in which Niamh describes her mother’s attitude to food (which she feels she has ‘inherited’).

(Extract 48) – NI-2
1 NI: her attitude to food was that it was dangerous (.) and
2 very seductive

The idea of food being ‘seductive’ implies that in some way food has the active position while the individual is passive – it is food doing the act of seducing, which seems to suggest the individual is not in control. Constructing food as capable of ‘seducing’ the individual personifies food and creates the notion that it is powerful. I also want to examine Niamh’s use of the word ‘dangerous’ to describe food, which is a rather strong word to use, conveying a sense of food being threatening and unsafe. It is important to note that in this fragment Niamh is not referring to what may be considered ‘naughty food’ (see, for example, extract 45 where Anna refers to ‘cake’) as ‘dangerous’ – she is referring to ‘food’ in general, something which everyone needs in order to survive. The addition of the word ‘seductive’ immediately after the word ‘dangerous’ implies that food is seen as something bad that is also hard to resist and that effort is needed to ‘control it’.

In the following fragment, Niamh goes on to describe her relationship with food during childhood.

(Extract 49) – NI-3
1 NI: I had to constantly monitor what I was eating and .hh
2 look at my portion sizes and u:m to to: really make sure
3 that um food didn’t take over as it it obviously would if
4 you if you let it.
There seems to be something slightly ironic about having to ‘constantly
monitor’ something to make sure it doesn’t ‘take over’ – ‘constantly monitor’ implies
an obsession. There is strong agency implied here, with the idea of Niamh ‘constantly
monitor[ing]’ her own intake. The word ‘obviously’ in line four suggests that food
would certainly ‘take over’ her life if she did not monitor and limit her eating. The
fact that she says it ‘would if you... let it’ (emphasis mine) instead of ‘if I let it’
suggests she believes she is speaking generally, of something that applies to everyone
or anyone, rather than just her personally.

Niamh later gives an account of how watching her children eat at restaurants
affects her:

(Extract 50) – NI-4
1 NI: I just have to leave the table, have to go to the loo and
2 just not wa:ch

The use of ‘have to’, twice, suggests there are no ifs about this – her extreme
reaction is something she has little control over; she has to leave the table. The above
three fragments from Niamh all demonstrate different ways in which she constructs
food as an active agent; firstly, it is something capable of being ‘seductive’; secondly,
it is capable of ‘tak[ing] over’; and thirdly, it is capable of eliciting the extreme
reaction of ‘hav[ing] to leave the table’.

The following extract, from caller Alan, also demonstrates how ‘food’ might
be subtly constructed as ‘active’ in talk.

(Extract 51) – ALAN-1
1 ALAN: u:m first of all I’d like to say that .hhh I think men er
2 have also got a hard time with food,=I don’t think they
3 have as much of a hard time in the press. (.) but
4 basically I- I’ve learned a few things about food the
5 whats and the whys and the whens over the last few years
6 that I think >that’ve helped me< er (.) deal considerably
7 better with food.
It is important to note that Alan is the first male caller to appear on this particular Radio 4 phone-in. Previous callers have implied that weight struggles are predominantly women’s, and Alan counters this – and also accounts for his own call – with ‘first of all I’d like to say...men...have also got a hard time with food’. He later, in line 7, refers to food as something which must be ‘deal[t]’ with. The image of having a ‘hard time’ with food is similar in some ways to the ‘battle’ and ‘struggle’ metaphors examined in section 6.3.1. Is it possible to have a ‘hard time’ with something which is passive? It seems more likely that one would have a ‘hard time’ with something else which has its own momentum; as I remarked in section 6.3.1, you cannot ‘fight’ without fighting against something. Similarly, it is unlikely that one would have a ‘hard time’ with something unless said ‘thing’ had its own opposing force. Alan also refers to having to ‘deal... with food’, which again subtly implies that food is something that needs to be ‘dealt with’ and therefore has its own momentum.

6.5 Concluding remarks

This chapter has examined the various grammatical and metaphorical practices functioning to depict active or passive status with respect to one’s condition in talk about disordered eating. I have shown how individuals make available the impression that there is some external force at work which is responsible for their eating disordered behaviour. This enables them to talk about their problems while reducing their personal responsibility for this behaviour which may be seen as shameful to outsiders.

I have examined the various ordinary, mundane grammatical and rhetorical ways of constructing passivity. For example, I have demonstrated that verbs are descriptive resources individuals can deploy to work up or play down agency. The subject-object construction of verb phrases can also function to work up agency on behalf of something external (e.g. an eating disorder), or downplay agency on behalf of the individual. I have also shown how disordered eating may be externalised as a ‘thing’ which can be acted on or resisted, rather than constructed as an integral part of the individual.
This chapter has also examined how both callers and hosts may formulate mental processes in a passive way, referring to ‘awareness’ or ‘hoping’, for example. There are various different degrees of intentionality which may be worked up in talk, from being passive and unaware of what is happening to oneself, to being aware and actively making changes.

I have shown several examples of participants using metaphors in their talk, and illustrated how these metaphors might also function to assert or remove agency. I have also demonstrated that while many sufferers construct eating disorders as something one can ‘slip’ into almost accidentally, narratives of recovery tend to show participants taking a much stronger agentic position. So, in talk about ‘illness’ and negative behaviours, individuals tend to construct themselves as passive, illustrating disempowerment and lack of control. In talk about ‘recovery’ and positive behaviours, individuals tend to construct themselves as active agents, emphasising autonomy and personal responsibility.

To summarise, these are the key ways in which individuals may work grammatically, linguistically and metaphorically to manage agency:

- Externalising the problem, indicating a loss of conscious control
  - Suggesting that the condition of disordered eating is not a choice
  - Constructing one’s condition as agentive and capable of acting of its’ own will
  - Referring to the condition as ‘it’ rather than ‘my problem’
- Making the self the passive subject of a verb, rather than an active agent – suggesting that one is having things done to them, rather than actively doing anything
- Orienting to (lack of) ‘awareness’ of the condition – if one is unaware of their behaviour, this suggests they did not choose to act in a particular way
- Depicting food as an active agent
- Use of metaphor
  - ‘Fighting’ metaphors – these work to construct the individual as both active (in so far as they are actively fighting) but simultaneously gives agency to the condition, as they are fighting against something
- Being 'trapped' – this kind of metaphor constructs an eating disorder as capable of trapping a person
- 'Disappearing'/being invisible – being overweight is likened to being 'invisible', which subtly works to imply that the condition is not one's choice as surely one would not choose to disappear
- Metaphorically constructing behaviours as accidental by referring to 'slipping' into bad habits or 'sliding' out of control

I also examined several contrastive extracts, where participants are explicitly claiming a strong agentive position. They constructed themselves as agentive through verb construction (positioning themselves as the active agents acting upon the world) and through explicitly talking about 'making changes' and controlling behaviour. Claiming agency occurred only when participants were talking about something positive, e.g. recovering from an eating disorder. There were however several deviant cases where, in talking about positive changes, participants still rejected agency, for example saying their situation 'resolved itself' or putting their situation down to 'luck'. I argued that they may do this so as to not appear to be 'bragging'. This was linked to the institutional environment in which callers are operating – they are recounting their problems with food in a very public setting, and as we saw in earlier chapters, disordered eating is often taken to be an individual pathology over which, paradoxically, individuals have control; surely they can simply start or stop eating.

Overall, this chapter has illustrated how individuals may construct assertions of agency for their illness, and how they may downplay their own agency and construct themselves as passive, using grammar and metaphor.
7. Discussion

The aim of this thesis has been to utilise conversation analysis and discursive psychology to examine the interaction that takes place between radio hosts and callers/guests on shows devoted to the topic of problematic eating, and in particular to explore the ways issues of identity and accountability are managed in talk. This concluding chapter will accomplish the following:

- Give an overview of the four analytic chapters of the thesis and bring together the insights derived from these chapters;
- Reflect on the chosen methodology;
- Explore the contribution this thesis may make to addressing the gaps in existing literature;
- Discuss potential avenues for future research.

7.1 Overview of analysis

This thesis has explored talk on the radio from individuals with ‘problematic eating’, and in particular has focussed on the identity work embedded within narratives and how accountability and agency are constructed and negotiated through talk. Although radio programmes dealing with health and illness are becoming widespread, there is an absence within existing literature on radio talk about eating behaviours, and on what individuals appearing on these radio programmes actually do when they tell their stories in this public arena.

The study aimed to examine how individuals who participate in radio broadcasts describe experiences in relation to their problematic eating, and what kind of interactional work is accomplished in their interactions with the host (and, occasionally, with other callers or guests). This involved exploring:

- How participants construct identity
- How participants ‘do being ordinary’
- How participants use medical language to negotiate accountability
- How participants manage the dichotomy between pathology and morality
• How participants manage issues of accountability and agency using a variety of grammatical, linguistic and metaphorical devices

Assuming a discursive psychological perspective, this study approached language not as a neutral means for describing the world but as a resource for participants to accomplish interactional work in their talk (for example, minimising responsibility, negotiating agency, and constructing identities).

The first analytic chapter (3) focussed on the openings of radio calls, starting with the greeting sequences between callers and hosts, and moving on to look at the callers’ post-greeting narrative turns. I demonstrated a clear pattern of social interaction in the greeting sequences found in my data, whereby the host gives some background information about the caller for the benefit of the audience; the host then greets the caller by name; and the caller reciprocates this greeting. Other than in two deviant cases where the caller launched straight into their ‘point’ after saying hello, typically the returned greeting from the caller is followed by a question from the host which can be structured in one of two ways. The question can be open-ended and not assume any prior knowledge of the caller’s situation, or it can pick on some aspect of the caller’s situation which the host already knows about and request clarification of this from the caller.

I then examined the identity work done in the callers’ post-greeting turns, in terms of how identities were constructed and displayed. I demonstrated that regardless of whether they get an open-ended, general question of a more specific, yes/no question, callers tend to do identity and categorisation work in response. I showed how callers build a ‘background’ to their stories, usually describing their pasts and how they got to their current situations, and how membership to various categories tends to be built up and negotiated within these. This demonstrates the importance to callers of attending to how they will be perceived by the overhearing audience.

The second analytic chapter (4) continued the examination of identity construction in talk, looking at ways in which callers may categorise themselves, and the kind of interactionally sensitive business which is performed through these identity ascriptions. I showed particularly that participants frequently built up the concept of
‘doing being ordinary’, building constructions of the self as ‘ordinary’ and ‘rational’. I considered previous literature on ‘doing being ordinary’ (e.g. Jefferson, 2004a; Sacks, 1984; Wooffitt, 1992) and closely examined how ‘doing being ordinary’ was done within my own data corpus. I found that as well as emphasising behaviour as rational, ordinary, or normal, participants frequently constructed their circumstances as being extraordinary. In this chapter I also considered identity construction in relation to agency and accountability, arguing that ‘doing being ordinary’ is a discursive resource drawn upon to manage accountability. In portraying themselves as ‘ordinary’ people, callers actively undermine the potentially negative inferential implications of the category ‘eating-disordered person’, or ‘ill person’ (see section 5.1.2 for discussion of these ‘potential negative inferences’). ‘Doing being ordinary’ negates the concept of ‘illness’ and attends particularly to the potential claim that an ‘eating disorder’ is a self-inflicted ‘illness’: by emphasising that one was merely partaking in ‘ordinary’ behaviour when an eating disorder just ‘happened’, one can imply that any features of ‘illness’ they display are certainly not intentional.

I identified several different ways in which ‘doing being ordinary’ is accomplished in talk: firstly, by constructing oneself as ordinary in terms of ‘doing what anybody else would do’; by using generalising devices to suggest that anyone and everyone could relate; by using the term ‘you know’ to orient to recognisability; and by using three- or four-part lists with general extenders to suggest applicability to other people.

The third analytic chapter (5) examined participants’ talk for both medical and moral elements and analysed the discursive management of both ‘pathologised’ and ‘moral’ identities. I examined the ways in which the concept of ‘illness’ was made relevant, negotiated or resisted in talk and considered particularly participants’ usage of medical, professional, and ‘expert’ language. I related my data to existing literature on the concept of eating disorders, taking into account ideas of addiction and control. I discussed how participants’ use of medical terminology might function to lessen accountability by reducing them to a ‘pathologised’ state, and then went on to consider how moral talk tied into this, as there appears to be a dichotomy between medical and moral talk, with morality requiring one to be agentive and medicalisation rendering one passive. Chapter 5 provided examples from the data corpus which
showed that talk about eating behaviours is bound up not only with issues of pathology but also issues of morality. For example, it was demonstrated that rather than being 'neutral', certain foods were constructed as 'bad' and as something to feel guilty or ashamed about. Paradoxically, these foods were oriented to as both something to feel guilty for and as a 'treat' or a 'comfort'. Eating was frequently talked about in confessional tones, or constructed as a 'failure'. I discussed pathological talk and moral talk in terms of 'ideological dilemmas', arguing that these seemingly paradoxical concepts both ultimately centre around the individual: moral talk is concerned with individual morality and pathological talk, while lessening agency, implies a pathology that resides within an individual. I concluded this chapter by suggesting that it would be problematic for an individual to be either entirely pathologised or entirely morally responsible, and arguing that it is therefore appropriate for participants to orient to both pathology and morality in talk as this manages the dilemma of whether one is completely passive or completely responsible for one’s actions.

The final analytic chapter (6) examined how agency and passivity can be negotiated, managed and resisted through the subtle use of grammar, linguistics and metaphor. I examined the grammatical construction of agency and passivity, focusing on the subject-object verb construction of sentences and how these functioned to emphasise agency or passivity: for example, participants frequently made themselves the passive subject of a verb, suggesting that things were happening to them, rather than them actively having an influence. I also examined how agency is constructed through metaphor, looking at metaphors for passivity such as 'slipping into bad habits' or 'sliding out of control', which function to construct behaviour as accidental. I also looked at 'prison'/trap' metaphors which imply that an eating disorder is capable of 'trapping' someone; 'battle'/fight' metaphors, which construct an eating problem as an external agent against which one can fight; and 'disappearing'/invisible' metaphors, which construct the individual as passively disappearing because of their eating problem. I also examined the construction of 'food' as an active agent, capable of being 'seductive', and the construction of an 'eating disorder' as an active agent, external to the individual. This was achieved either through subject-object verb construction; through orientation to lack of awareness of the problem; through referring to the condition as 'it' and suggesting that it has its' own free will.
Overall, this thesis showed that recurrently individuals who identified as having a problematic relationship with food utilised various discursive practices that conveyed a position of passivity rather than agency in regards to their problematic eating behaviours. This idea of passivity was prominent in many accounts, regardless of the specific problem of the individual (whether a clinically diagnosed eating disorder or non-clinical, ‘mundane’ weight problems, and whether underweight or overweight) and the severity of the problem.

In Chapter 6 I presented a wide range of data extracts illustrating how individuals construct themselves as passive, work discursively to remove or lessen agency, and emphasise lack of control over behaviours. It was noted that this ‘constructing oneself as passive’ tended to occur mainly when talking about negative situations or behaviours; i.e. when talking about being eating-disordered, being too thin, or being too overweight. In contrast, I showed several extracts where participants were talking about positive situations; recovering from their condition, or reaching an appropriate weight. It was found that when positive situations and behaviours were being talked about, individuals frequently claimed a strong agentive position and emphasised personal responsibility rather than the lack of responsibility so often oriented to in talk about negative behaviours. There were, however, several deviant cases where individuals denied agency for positive behaviours, and it was argued that this ‘playing down’ of achievements may be used so that one cannot be accused of ‘bragging’.

So, overall, this thesis has used detailed case analyses to demonstrate the following:

- A clear pattern of interaction in the opening sequences of radio calls
- Participants frequently build identities and membership to categories in their first post-greeting turns
- Frequently, an ‘ordinary’ identity is emphasised, managing accountability by suggesting that an individual’s condition could happen to anyone and that the individual’s behaviour is not extraordinary
• Individuals also frequently orient to pathology, constructing themselves as being ‘ill’ – for example, having a ‘phobia’ or an ‘addiction’

• Using CA and DP I have attempted to explicate the function of both ‘doing being ordinary’ and ‘doing being ill’, and my thesis argues that these seemingly paradoxical constructions both function in some way to manage accountability, in that they suggest that one is not entirely responsible for their behaviour.

• Individuals also orient to morality in their talk, working discursively to subtly negotiate a balance between being ‘pathologised’ (passive) and being ‘moral’ (responsible).

• Individuals frequently negotiate agency through use of grammar (for example making oneself the subject of a verb).

• Individuals also negotiate agency using various rhetorical devices, including:
  • Depicting food itself as an active agent
  • Giving agency to an illness itself such as anorexia nervosa or bulimia nervosa (for example objectifying the illness as capable of controlling one’s life)
  • Using various different metaphors for passivity.

7.2 Reflections on methodology

Having provided an overview of the analytic findings of this thesis, I now want to briefly reflect upon my chosen methodology.

Overall, the choice to utilise conversation analysis and discursive psychology to examine the talk forming the data corpus enabled rich insights. The first analytic chapter (3), in particular, demonstrated how close, turn-by-turn analysis of the greetings and introductions done by the hosts and callers can reveal robust patterns for how individuals begin their ‘stories’ and construct and negotiate an ‘identity’ within these. Discursive psychology was used extensively in chapters 4, 5 and 6 (where I examined ‘doing being ordinary’, medical talk, moral talk, and the grammatical and metaphorical construction of agency respectively) and these chapters have
demonstrated how many important insights we can gain from assuming a discursive psychological perspective.

7.3 How this thesis contributes to research

My thesis makes a valuable contribution to the growing body of CA/DP research and in particular begins to address the gap in using this kind of analysis to look at radio talk about problematic eating behaviours.

This thesis contributes to, for example, conversation analytic research on ‘doing being ordinary’ and also builds on existing ‘radio talk’ literature by closely examining greeting sequences and how radio hosts do category work in bringing in new callers (c.f. Fitzgerald & Housley, 2002; Housley & Fitzgerald, 2007). This thesis will also add to the growing body of CA and DP literature on eating behaviours (c.f. Wiggins, 2001, 2004, who has used conversation analysis to explore the social nature of eating; how eating is not just about food but is bound up with social relations, and how food evaluations are oriented to actions e.g. offering food) by closely examining how talk about eating behaviours is constructed and used in interactions. Though there has been a small amount of CA/DP studies on eating in recent years, this thesis provides a unique slant by looking particularly at radio talk. So, as well as addressing the lack of CA/DP research in eating-related research, this thesis also contributes to the growing body of CA/DP research on radio talk.

In terms of topic (i.e. eating behaviours), this research fills a gap in existing literature through examining real talk occurring outside of the context of the research, rather than relying on interview responses, for example. So, what does this thesis contribute to this existing body of knowledge and literature about people’s complex relationships with food? There are several major differences between my work and previous research on problematic eating. Firstly, this thesis examines talk from a wide variety of individuals. Previous research has mostly addressed those who would be termed a clinical, ‘eating disordered’ group. More recently, researchers have begun to address ‘mundane’ dieting practices from non-pathologised individuals (e.g. Mycroft, 2007). However, this thesis explores talk from individuals who would be classed as
anorexic; individuals who would be classed as bulimic; overweight people; and those who would normally be seen as a non-pathologised group but whose eating is, in some ways, problematic. Secondly, there are relatively few qualitative studies exploring food- and weight-related discourse, and those that do tend to draw on interview data heavily influenced by the researcher's questions and produce generalisations from the interview responses. This research differs from the majority of existing eating behaviour research in that it uses fine-grained conversation analysis and discursive psychology to explore talk which is 'uncontaminated' by the researcher. I have demonstrated that talk about eating behaviours is complex and contradictory, which has been previously suggested by researchers (e.g. Malson et al., 2004), but through detailed exploration of interaction I have shown how and when this is employed by participants and explicated the function of the talk. This thesis therefore adds to our understanding of the nature of problematic eating behaviours.

So overall, my thesis makes valuable contributions to the three following fields of research:

- Conversation analysis/discursive psychology
- Radio talk
- Eating behaviours.

Chapter 5’s focus on medical and moral talk may also have important implications for therapy practices. Therapists’ foci on medical terms and on putting the source of the problem onto pathology is problematic as the individual remains the source of the problem, rather than seeing people and their accounts for their actions as socially situated. It may be useful to further investigate the negotiations between being pathological and being moral in order to benefit therapy practices, and I have argued that examination of the sort of public accountability made relevant by the institutional context of a radio show is a particularly acute venue for this type of work.
7.4 Implications for future research

This thesis has explored the discursive practices individuals employ to negotiate issues of accountability in talk about, specifically, disordered eating. It may be interesting to ask whether the findings are specific for a radio broadcast devoted to the topic of disordered eating. Would similar negotiations of agency take place, for example, in radio broadcasts focussing on different types of illness, such as the topic of depression? Or, we could ask, would we find similar discursive practices in the talk of eating-disordered individuals not on the radio, but in counselling interactions, or with peers in group therapy? I consider both of these questions as particularly interesting and relevant topics for further research. First, it would be interesting to take another ‘mental disorder’ such as clinical depression, which may have similar lay connotations to eating disorders (e.g. ‘it’s not a real illness’, ‘it’s easily curable’, ‘its self-inflicted’, and so on—see section 5.1.2) and explore whether similar accounts are made by individuals suffering from depression. Secondly, it would of course be relevant to explore whether the accountability work salient in the radio broadcasts I have analysed is also prevalent in other types of talk about eating behaviours, such as internet-based peer support groups or in face-to-face interactions, such as therapy talk. Therefore my research provides a starting point for further exploration of accountability for health-related issues within the public sphere of a radio show.

I would like to end this chapter with the consideration that future research in the area of eating behaviours would benefit strongly from taking a conversation analytical and/or discursive psychological approach, as I hope this thesis has demonstrated.
REFERENCES


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APPENDIX 1: Transcription Notations

The following transcription conventions were used throughout this study (adapted from Jefferson, 2004b).

(.) The shortest hearable pauses, less than 0.3 of a second

(1.3) (0.7) Timed pauses; in this case, 1.3 seconds and 0.7 of a second

.hhh In-breath, with more ‘h’s representing a longer breath

hhh Out-breath, with more ‘h’s representing a longer breath

heh heh Laughter syllables

The(h)y (h) denotes laughter within a word

Well Underline indicates emphasis of word, via pitch or amplitude

Un- A dash shows a sharp cut-off of a prior word

We::Il Colons show that a word is extended, with multiple colons representing longer sounds

(( )) Unclear speech where no guesses have been made by the transcriber

((click)) Provides extra-linguistic information, i.e. about mechanical clicks that can be heard.

[text] Words inserted into square brackets do not appear in the original transcripts

↑ yes An upward-pointing arrow indicates a rise in pitch
\( \downarrow \text{no} \) A downwards-pointing arrow indicates a fall in pitch

\( \bullet \text{?} \text{Know?} \) A question mark indicates a rising intonation

, A comma indicates slightly rising intonation

. A full stop indicates a 'natural' ending

# Hash symbol indicates croaky voice

YES Capital letters indicate loud speech

°quiet° Degree signs indicate quiet speech

>fast< Words spoken more quickly than surrounding talk

<slow> Words spoken more slowly than surrounding talk

.pt Representation of a slight lip-smack

Overlap [overlap] The square bracket denotes the start of overlapping talk

[...] Indicates that material has been left out of the extract

= Indicates latched words; no gap between one TCU and another

£hello£ Words between pound signs are pronounced in ‘smiley’ voice