

**THERAPEUTIC INTERACTION IN
ANOREXIA
NERVOSA TREATMENT**

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I declare that this thesis is my own account of my research and contains as its main content work which has not previously been submitted for a degree at any tertiary education institution.

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ABSTRACT

Anorexia nervosa (AN) is a chronic and complex psychosomatic condition, characterised by a primary drive to be thin and a refusal to maintain normal body weight. Only a minority of people diagnosed with AN ever become asymptomatic and more research has been called for to address high drop-out rates and lack of engagement in AN treatment services, in particular psychotherapeutic treatment. Prior studies have generally examined this problem in terms of patient mediated variables, such as attitudes and behaviours, with little focus on contextual factors. Research that has studied therapeutic engagement in the area of AN has yet to examine psychotherapeutic treatments-in-practice. Guided by this gap in the literature this thesis examines ways in which therapists engage with adolescents diagnosed with AN in naturally occurring psychotherapeutic interactions. A secondary and concurrent focus is to look at how the therapists' underlying theoretical models are reflected in *in situ* practice. The data corpus comprises twenty-four therapy sessions recorded in an eating disorders programme based in a children's hospital. In contrast to eating disorders treatment statistics reported in the literature, the programme has a low drop-out rate, zero mortality rate and good long-term patient outcomes, making it an especially suitable setting to examine engagement.

Drawing on methods from discursive psychology (DP) and conversation analysis (CA), a number of interactional practices are found which show how the key principles of engagement and neutrality are *brought off*, or achieved as such in turn-by-turn interaction. Central to the analysis, is the recurrent production of patients' bodily states and conduct as delicate items. As these topics are also the primary focus of the institutional setting, the analysis shows how practices such as perspective display series

and dispositional management allow delicately marked institutional tasks to be carried out. The analysis also examines how patients' bodies and conduct are embedded in, and constituted as problematic in the interactions. Regularities, such as agentic repositioning in accounts, demonstrate the co-production of patients as *psychologically* compliant with treatment while *physically* non-compliant.

This thesis contributes to work in applied CA concerning links between theoretical models and interactional practices by demonstrating naturally occurring regularities that describe key guiding principles of the eating disorders programme. It also builds on work in DP concerning examinations of the body and embodiment, by showing how patients' physical bodies are an integrated feature of the interactions. Finally, this thesis has implications for a clinical audience in terms of extending therapists' awareness of how engagement with patients is constituted interactionally, which also contributes to wider AN literature on 'resistance' to therapy.

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CHAPTER 1

Overview

Anorexia Nervosa (AN) is a psychiatric classification that belongs to a broader category of eating disorders (APA, 2000; WHO, 1993). With diagnostic criteria that encompass a wide range of complex psychological and physiological factors, AN presents as a chronic psychosomatic condition, with such potential negative health impacts that it has the highest mortality rate of any mental disorder. Characterised by a primary drive to be thin and a refusal to maintain normal body weight, AN is particularly prevalent in adolescent females from Western cultures. Although literature regarding the aetiology of AN is notably inconclusive, it is largely thought to be multi-factorial, incorporating biological, psychosocial and cultural influences. There is also a lack of research into ‘best practice’ treatments for AN, with most treatment programmes taking a multi-dimensional approach to eating disorder management. AN remains as a complex disorder, characterised by poor long term outcomes and high relapse and dropout rates from treatment. It is estimated that only a minority of people diagnosed with AN ever become asymptomatic. In light of this, the literature has called for more research to explicate dropout rates in order to increase engagement in AN treatment programmes, which has formed the basis for my research project (see the following chapter for associated literature review).

This thesis is primarily concerned with a discursive psychological analysis of interactions between therapists and clients diagnosed with anorexia nervosa (AN), at a hospital based eating disorders programme. The purpose of this initial chapter is to establish a brief overview of the research project itself, including its rationale, aims and methodology, as well as providing a summative framework of the ensuing chapters. To begin, I present some general information regarding the conceptual and methodological context of this thesis. I then provide a summary of the current project followed by an outline of its primary goals and potential implications.

Conceptual and methodological background

While some studies have investigated the high withdrawal rates of AN patients from therapeutic services and treatment programmes, these have generally concentrated on identifying factors relating to the patients themselves, such as individual attitudes and behaviours. In contrast, there has been limited research examining dropout predictors associated with contextual factors, such as particular treatment approaches or principles. There has also been little research in the area of AN treatment that has looked at factors that encourage engagement in therapy or which promote the actual therapeutic relationship or alliance. Additionally, there have been no studies that have focused on therapist/client interactions in therapy sessions, in order to explicate and describe the ways in which therapists and clients engage with each other.

With increasing acknowledgement of the importance of keeping patients diagnosed with AN engaged in therapy, it was evident that therapist/patient

interactions provided an important area for study. This is particularly noted in motivation theories, which state that *in situ* factors such as tone and delivery on the part of the therapist, can have a significant impact on therapeutic outcomes. These important aspects of therapeutic interaction cannot be accessed via studies that examine only broad therapeutic modalities or individual patient attributes.

The therapeutic interactions that make up the data corpus for this thesis were twenty-four individual therapy sessions between three therapists and sixteen patients, conducted at a hospital based outpatient and inpatient eating disorders programme (EDP). The sixteen patients were all females diagnosed with AN, between the ages of fourteen and sixteen, with the majority receiving treatment on an outpatient basis. The therapists comprised two clinical psychologists and one psychiatric nurse, who is also the programme director (see chapter three for further details about the setting). The therapy sessions were audio recorded and transcribed using a detailed form of notation that included prosodic speech markers such as pitch and intonation.

The EDP offers the only public hospital based inpatient treatment service for eating disorders in Perth, Western Australia. I chose this as the data collection site for the current project for two major and interrelated reasons. First, because the EDP's guiding therapeutic principles correspond to a central underpinning factor of this thesis concerning an emphasis on therapeutic engagement. Second, because the EDP had a low rate of inpatient and outpatient withdrawal from therapeutic services over their ten-year history and a good rate of long term patient outcomes. While this is yet to be verified in terms of a published

evaluation, an informal review of the EDP has identified the programme's clinicians as being particularly skilled in engaging with AN patients therapeutically.

The EDP's guiding therapeutic models are fundamentally characterised by the principles of collaboration and engagement, such that they centre their underlying position or stance on each individual patient, and the unique system of which they are part. The EDP identifies three overarching models that encapsulate their core treatment approach: systemic and motivational theories, developmental theory and a bio-psychosocial formulation of aetiology and recovery. Notably, these core models and principles are aside from the EDP's supplementary employment of a wide range of applied therapeutic modalities including cognitive behaviour therapy (CBT), interpersonal therapy, family therapy and art therapy. This thesis is primarily concerned with identifying the regular ways in which these principles are manifest in what therapists and patients diagnosed with AN 'do' *in situ* in therapy sessions.

In analysing the data from these therapeutic interactions with patients diagnosed with AN, I chose to utilise methods informing discursive psychology (DP), in particular conversation analysis (CA) (see chapters two and three for outlines of DP and CA). DP and CA provide an empirically grounded means to investigate *in situ* therapist/patient interactions in terms of explicating features in therapy sessions related to regularities in how therapists and patients interact. These practices can then be examined in terms of the extent to which they

interactionally describe the theoretical principles of the participating therapists, such as engagement and collaboration.

DP and CA have been effectively utilised in other institutional settings examining professional/client interactions, particularly in therapeutic contexts, that have yielded findings with applied implications in areas of training, policy and practice. Studies from this perspective have explored areas such as how therapists manage their questions in order to encourage a full reply from clients; how therapists solicit client questions; and how sensitive and delicate subject matter is dealt with interactionally. In regards to the current project, DP/CA made possible a way of identifying patterns of language that clinicians in the eating disorders area could more consciously take into account in their interactions with clients.

Research aims and implications

The primary goal of this thesis is to extend the AN literature by providing new analytic insights into how therapists and AN patients engage with one another in naturally occurring therapeutic interactions. It also aims to contribute to the DP/CA literature on institutional contexts, via an investigation into how interactional practices within the data are reflective of the EDP's guiding therapeutic principles. The concentration here is on how these practices describe, and/or extend, such principles. A further focus is on the sequential organisation of such practices, and how they contribute to the accomplishment of institutional tasks in the setting. This will build on recent work in applied CA, which has focused on explicating links between theoretical models and *in situ* practices.

A goal of this project is also to relate the analytic findings to the EDP's key therapeutic models, in order to contribute to therapists' understanding of how particular underlying principles or theories work in practice. I should note that this project is not designed to measure direct therapeutic outcomes, but rather seeks to explicate the function of communicative choices in fostering therapeutic relationships. In this way the thesis aims to advance theoretical knowledge by providing new information on the role of language in the therapeutic process with adolescents diagnosed with AN. This will have clinical implications by providing clinicians with a greater awareness of the effects of communicative choices in therapeutic treatment, which could subsequently impact the quality of their therapeutic relationships with AN patients. The more effective the therapeutic process, the greater the likelihood of sustained engagement in therapy.

Finally, this study will extend DP literature on the body and embodiment in regards to the diagnostic category of anorexia, in terms of the use of observable bodily states as an interactional resource. This is a recent area in DP, and is highly relevant to the current project, as anorexia nervosa is one of the few '*mental*' disorders for which *bodily* state is the primary basis for diagnosis. Hence, unlike most psychiatric conditions, AN is, to some extent, observable independently from reports (from self or others) of psychological symptoms. The current project seeks to examine how this is dealt with in therapeutic interaction, with focus on how discussions concerning patients' bodies are managed so as not

to threaten engagement and collaboration or to damage the therapeutic relationships.

Thesis structure and chapter summaries

I will briefly outline the structure of the thesis. There are eight chapters in total, including four that present different aspects of the data analysis. Chapter two provides a review of the literature that forms the basis for the current project. It begins with a general discussion of anorexia nervosa (AN), incorporating literature pertaining to its aetiology, epidemiology and treatment. This includes a review of research addressing treatment efficacy and dropout rates from eating disorder services. I also discuss literature specific to therapeutic treatment in the area of AN, particularly in regards to factors that predict withdrawal from treatment. A review is then given of research relating to the use of DP/CA methods in a range of institutional settings, including therapeutic settings, to primarily demonstrate their utility and applicability in the current context. Finally, I outline the EDP's underlying guiding therapeutic principles, and review relevant literature, particularly in regards to the overarching goals of this thesis.

Chapter three goes on to give a comprehensive account of the project's methodology, incorporating information pertaining to the EDP's formal organisational structure, history, and therapeutic approach. I describe the different phases of the research, including the data collection, transcription, and analytic stages. It also provides additional information in regards to DP and CA,

including their theoretical backgrounds and utilisation for data analysis in the current context.

Chapter four is the first of the analytic chapters, and is primarily concerned with regularities in the data relating to engagement, in terms of the delicate and highly preferred ways in which institutional tasks and topics are dealt with interactionally. This chapter draws on a significant body of research pertaining to 'delicacy' in professional/client interactions, especially in terms of Maynard's (1992) work on perspective display series (PDS). I discuss the analytic findings in relation to their particular function in the current context, as well as to the EDP's underlying therapeutic principles of engagement and collaboration.

Following on from chapter four, chapter five continues to examine the ways in which delicate tasks and topics, particularly in terms of clients' bodily state and conduct, are marked and managed in the data. This chapter extends the work in chapter four by looking particularly at how these recurrent features function in terms of the achievement of neutrality, and how this relates to the theoretical model of therapists maintaining a neutral stance in relation to patient change, in turn making links between neutrality and engagement. Bergmann's (1992) work on information-eliciting tellings is particularly drawn on to elucidate regularities in the data that allow therapists to delicately 'check-up' on patients' conduct relating to their AN diagnosis. This chapter will also examine client disclosures regarding their conduct that relate to areas of physical safety, especially in regards to how therapists maintain a collaborative and neutral position in such interactions.

The focus of the analysis in chapter six shifts to include how *clients* manage activities regarding the delicate items and tasks, as examined in relation to the therapists in the previous two chapters. A particular concern here is with the use of agency in terms of clients' accounts for their conduct and bodily states, and therapists' requests of such accounts. This chapter also draws on work by Wiggins and colleagues (e.g. Hepburn and Wiggins, 2005; Wiggins, 2002) on embodiment in interactions, to look at how accounts for bodily conduct and state are constructed for, and embedded in the data, as well as how patients' bodies themselves relate to accounts and account requests. Finally, the chapter examines how recurrent uses of the term 'anorexia' function in terms of the accomplishment of interactional tasks.

Chapter seven contextualises the prior three analytic chapters by concentrating on how the therapists and clients orient to institutional identities in the data; or how it is that the interactions are recognisable as 'therapy talk'. This chapter draws on, and discusses literature that concerns the DP and CA understandings of contextual factors in institutional interactions, including asymmetry and its links to engaging with patients *in situ*.

The concluding chapter of this thesis begins by summarising and integrating the findings of the four analytic chapters, with particular reference to the overall aims of the research. It also discusses the limitations of the current project, after which it presents implications relevant to different academic and clinical audiences. Finally, it discusses recommendations for potential future research.

CHAPTER 2

Literature Review

Introduction

As outlined previously, this chapter provides a more detailed description of the rationale for this study and the supporting literature. It will begin by giving an overview into anorexia nervosa (AN) research, before focusing on literature defining treatment for AN. Specifically, research on difficulties in treating patients diagnosed with AN therapeutically, including significant drop-out rates, patient ‘resistance’, and other issues central to this area will be addressed.

Current AN literature that has endeavoured to address these difficulties such as treatment based on motivational theories will be also reviewed. Based on this, and other relevant AN literature, it will be argued that more research is needed to further explore and explicate the therapeutic relationship in AN treatment.

The focus of this chapter will then shift to provide some theoretical grounds regarding the methodologies to be used in the current study, discursive psychology (DP) and conversation analysis (CA). It will review key literature that has employed DP/CA to investigate patterns and structures of talk in different institutional settings. This research will be recruited to support the current study’s use of DP/CA to analyse therapeutic talk in a population of adolescent patients diagnosed with AN. In relation to the area of AN, DP/CA literature that has focused on examination of the ‘body’ and ‘embodiment’ in talk-in-interaction will be reviewed. This will be contrasted to psychology’s

typical methods of studying the ‘body’, specifically in the area of ED literature. I should note that relevant DP/CA literature will be employed throughout the subsequent analysis chapters, and is discussed in this chapter primarily to outline a basis for its use with the current data corpus. I then describe the overarching treatment models of the Princess Margaret Hospital for Children Eating Disorders Programme (EDP) where my research was carried out, including supporting literature, with a particular focus on the team’s key guiding therapeutic principles. This chapter then highlights the relevance of these principles to the current thesis, via recent CA work that has focused on linking theoretical models with *in situ* interactions. Finally, I discuss the primary goals of the current project, and the potential for it to contribute theoretical and applied areas.

Overview of Anorexia Nervosa

Eating disorders encompass a number of disorders that are broadly associated with an excessive preoccupation with food, weight and shape. The two most formally researched and prevailing of these are anorexia nervosa (AN) and bulimia nervosa (BN). AN has been medically recognised since the late 19th century, while BN did not gain official status as a clinical diagnosis until 1979 (Herzog, Eddy & Beresin, 2006). AN is most frequently observed in adolescent and young adult females (Herzog, Eddy & Bersein, 2006), and is the third most common chronic illness in adolescent females, surpassed only by asthma and obesity (Fisher et al, 1995; Steiner & Lock, 1998). With prevalence rates for AN in young females between one and four percent (Beumont, Russell & Touyz, 1993; Hoek, 2006), and reported mortality rates ranging from eight to twenty

percent, AN presents as the most serious of the eating disorders, and is widely cited as having the highest mortality rate of all mental disorders (Birmingham, Su, Hlynsky, Goldner & Gao, 2005; Fisher et al., 1995; Steiner & Lock, 1998).

Although AN primarily affects young women living in western societies, prevalence rates of AN are steadily increasing in males, as well as cross-culturally (Katzman, Hermans, Van Hoeken & Hoek, 2004). For instance, one Iranian study found that prevalence rates for AN and BN in adolescent females were comparable to those cited in ED research from Western countries (Nobakht & Dezhkam, 2000). The specific aetiology of AN is unknown, but frequently presented as being multi-factorial, with biological, psychosocial and cultural influences presenting as major contributory factors. However, it is acknowledged that there is insufficient empirical evidence for any specific aetiological model for AN (Haliburn, 2005).

Diagnosis and presentation of AN

As a chronic psychosomatic condition, AN features both psychological and physiological elements (McDermott, Harris & Gibbon, 2002) that combine to impact significantly on a range of physiological processes (Heebink, Sunday & Halmi, 1995). Patients diagnosed with AN can present with multiple physiological symptoms associated with malnourishment such as extreme weight loss, cardiac, electrolyte, renal, gastro-intestinal, and haematological problems (Haliburn, 2005).

Specific diagnostic criteria of AN in the International Classification of Diseases and Related Health Problems (ICD-10: WHO, 1993) and the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR: APA, 2000) are; 1) not maintaining minimally normal body weight (e.g., 85% of normal body weight for age or body-mass index is 17.5 or less) or failure to make expected developmental gains; 2) intense fear of gaining weight despite being underweight; 3) denial of a problem with body weight or disturbance in their experience of their body weight or shape; and 4) amenorrhea in post-menarchal females. The DSM-IV-TR also identifies two subtypes of AN; the ‘restricting type’ in which there is an absence of bingeing and purging behaviours, and the ‘binge-eating/purging type’ where such behaviours *are* present, for example excessive eating followed by episodes of purging, such as self induced vomiting, excessive exercise and or abuse of laxatives or diuretics. The ICD-10 also specifies a subtype of AN it calls ‘atypical anorexia nervosa’, where all diagnostic criteria are met for an AN diagnosis except one key feature, or else all key features are met but only mildly. This is specified in the DSM-IV-TR as ‘eating disorder not otherwise specified’ (EDNOS).

Issues of comorbidity

There is common comorbidity of other psychological diagnoses observed in patients diagnosed with AN (Blinder, Cumella & Sanathara, 2006). The most frequent of these encompass mood disorders, mainly depressive, followed by anxiety disorders. Psychotic disorders are also significant in acute cases of AN, as severe malnutrition can exacerbate related symptomatology, such as delusions and hallucinations. While there is evidence associating malnutrition with mood

and anxiety disorders, dating back to Keys and colleagues' (1946) classic Minnesota starvation-rehabilitation experiment, studies have also found such disorders present before the onset of AN (Godart, Flament, Lecrubier & Jeammet, 2000). Suicidality, as well as self-harm behaviours, are also prevalent in AN patients. Suicide attempts are as high as 20% (Franko & Keel, 2006), and suicide accounts for approximately 30% of the AN mortality rate (Sullivan, 1995). Axis II personality disorders (PDs), specifically obsessive-compulsive PDs are also common in AN patients, with addressing traits such as perfectionism and rigidity being a recommended focus in treatment guidelines for AN (Bruce & Howard, 2005).

Treatment of AN

Hospitalisation for AN occurs in extreme cases of weight loss, generally when weight falls below 70%, with the major aim being weight restoration, in conjunction with multidimensional strategies aimed at addressing issues such as fear of weight gain, comorbid psychiatric disorders, malnutrition and physiological complications (Anderson, Bowers & Evans, 1997). It is widely accepted that AN is a difficult disorder to treat, predominantly because patients diagnosed with AN are often considered to be ambivalent or 'resistant' to treatment, and are frequently in denial about the existence of problems, or of the disorder itself (Treasure, 1999). Specialised cognitive behaviour therapy (CBT) programmes have been developed in response to the multifactorial nature of AN, most notably Fairburn and colleagues' (2003) transdiagnostic approach, or the 'Oxford model', which targets a wider range of maintaining mechanisms than standard CBT approaches. The capacity of Fairburn's model to treat AN

patients in different settings, such as inpatient or outpatient, has also been extended by Grave (2005) whose CBT-Multi-Step approach is designed for delivery by a multidisciplinary team and also includes a CBT family module for adolescents diagnosed with AN.

CBT and interpersonal psychotherapy (ITP) are the most common approaches for treating AN psychotherapeutically (Haliburn, 2005), however no one specific psychotherapy has been found to be more effective in adult populations (le Grange & Lock, 2005). A recent review of studies on psychotherapeutic treatments, only identified the use of family therapy in children and adolescents diagnosed with AN as 'best practice' (le Grange & Lock, 2005). Due to the lack of randomised controlled trials (RCT's) into treatment for AN 'best practice' guidelines have been largely established based upon uncontrolled trials and expert opinion (Haliburn, 2005), and currently there is not a uniform approach for the psychological, as well as general management of AN, especially in adults (Wilson & Fairburn, 2002).

The multidisciplinary teams that treat patients diagnosed with AN are generally comprised of a variety of health professionals including clinical psychologists, psychiatric nurses, dieticians, psychiatrists, gastroenterologists, and occupational therapists. The diversity of treating specialists highlights the complexity of AN, a position commonly reflected on in the literature, with authors suggesting that the treatment of patients diagnosed with AN is inherently difficult, and frequently met with 'resistance' (Eivors, Button, Warner & Turner, 2003; Kahn & Pike, 2001; Mahon, 2000; Pike, 1998; Wilson, 1998; Waller, 1997). Though empirical

research is lacking, it is approximated that up to 50 percent of patients with AN prematurely withdraw from treatment services, and that long term relapse rates, poor health and psychosocial outcomes are considerable (Halmi, Agras, Crow, Mitchell, Wilson, Bryson & Kraemer, 2005; Carter, Blackmore, Sutandar-Pinnock & Woodside, 2004; Button, Marshall, Shinkwin, Black & Palmer, 1997; Fichter & Quadflieg, 1999; Herzog, Dorer, Keel, Selwyn, Ekeblad, Flores, Greenwood, Burwell & Keller, 1999; Eckert, Halmi, Marchi, Grove & Crosby, 1995). 'Chronic-relapsing' courses of AN have been associated with late onset of the disorder (Deter & Herzog, 1994), disturbances in family relationships and premorbid asociality (Strober, Freeman & Morrell, 1997). One preliminary AN study also suggested that being underweight at hospital discharge is a risk factor for relapse (Baran, Welzin & Kaye, 1995), while another found that significant weight-loss in the first year post-discharge predicted a more chronic and severe course of illness (Strober, Freeman and Morrell, 1997).

In studying the long term course of AN and BN in a twin cohort, a recent Australian study (Wade, Bergin, Tiggemann, Bulik & Fairburn, 2006) found that while ED pathology decreases significantly over time, only a minority of ED participants ever become asymptomatic. Research has suggested that patients diagnosed with AN have better health outcomes when they receive therapeutic treatment versus no treatment (Crisp, Norton, Gowers, Halek, Bowers, Yeldman, Levelt & Bhat, 1991), and the literature concludes that adolescents who receive treatment for AN have better long term recovery rates than adults (le Grange & Lock, 2005). This highlights the importance of keeping patients engaged in treatment services.

A limited number of studies (mostly naturalistic) have investigated factors predicting dropout from therapeutic treatment in AN patients, including problematic family behaviours, co-morbid psychiatric disorders (Lock, Couturier, Bryson & Agras, 2006) and low cooperativeness (Bandini, Antonelli, Moretti, Pampanelli, Quartesan & Perriello, 2006). The majority of studies investigating treatment cessation rates have focused on inpatient treatment programmes, and have found that high levels of motivation to change, and a higher body mass index at admission to hospital, is predictive of weight maintenance at a nine month follow-up (Castro-Fornieles, Casula, Saura, Martinez, Lazaro, Vila, Plana & Toro, 2007). Halmi et al's (2005) results indicated an association between treatment completion of CBT and high self-esteem in patients with AN, while Vandereycken and Pierloot's (1983) study associated premature drop-out from inpatient treatment with higher age at admission, lower levels of socioeconomic status and education. These studies, however, have generally measured *patient* situated predictors of treatment dropout, such as attitudes and behaviours, rather than predictors associated with treatment settings such as different therapeutic principles or approaches. One study investigating ED patient dropout, which included the influence of the patient-therapist relationship (Clinton, 1996), suggested that a misalignment between patients and therapists' treatment expectations was associated with premature withdrawal from treatment.

I should note that the current thesis has not distinguished between inpatient and outpatient populations in the studies reviewed, and in turn the 'extra' treatment

components in inpatient programmes, with outpatient programmes consisting primarily of therapeutic services (Thornton, George & Touyz, 2005). As noted in the literature though (Meads, Gold & Burls, 2000), disparity between treatment outcomes for both groups is under researched and studies to date have suggested that any apparent differences are negligible.

Motivational treatment approaches

“I do not suffer, therefore I must be well.” (Charles Lasègue, 1873/1964)

In exploring the difficulty of engaging patients with AN in treatment services, many researchers in recent years have proposed that it is useful to focus on ambivalence and resistance to change as the key symptoms to address with anorexic patients (Kaplan, 2002; Treasure, 1999). This reconceptualisation shifts away from the targeting in treatment of traditional behaviours related to anorexic patients’ primary drive to be thin (i.e. weight loss causing behaviours such as caloric restriction). Such behaviours are depicted as hard to contend with due to AN patients’ basic denial of their illness, and apparent ‘resistance’ to changing associated behaviours. There is evidence that the majority of patients diagnosed with AN do not seek treatment voluntarily, do not want to change AN symptomatology, such as low body weight (Vitousek, Watson & Wilson, 1998), and initially deny that they have a problem at all (Noordenbos, 1992).

Impacts relating to self-identity and self-concept are not necessarily perceived as negative by persons medically categorised as ‘anorexic’; indeed patients with AN often view their disorder as both an achievement and a central functional

identity (Casper, 1982). This was recently demonstrated by the rise of ‘pro-ana’ websites that ostensibly provide a supportive AN community, but one that promotes and endorses AN (Norris, Boydell, Pinhas & Katzman, 2006). For instance, research analysing chat-room data from pro-ana websites described a community that views AN as a ‘disciplined’ and ‘pure’ ‘lifestyle choice’ rather than an imposed medical diagnosis with negative consequences. The chat-room talk chastised and excluded apparent ‘fakers’ and ‘wannabes’, who failed to produce themselves as being authentic ‘anorexics’ (Giles, 2005). In fact, the prospect of ‘losing’ their AN identity and its functions is for many patients on the scale of the death of a parent or child, a point that Vitousek and colleagues (1998) noted is often misunderstood by treating therapists.

Such lack of motivation for change in patients diagnosed with AN, has been recognised in the literature as a major problem for AN treatment services (Geller, 2002a; Touyz, Thornton, Rieger, George & Beumont, 2003), prompting the widespread move since the 1990’s to concentrate on resistance and denial, before focusing on behavioural change in therapeutic treatment settings. This has generally taken the form of adaptations of motivational approaches, such as motivational interviewing (MI; Millier & Rollnick, 1991) and the transtheoretical model of change (TMC; Prochaska & DiClemente, 1982). The TMC has three dimensions characterised by five stages of change: pre-contemplative, contemplative, preparation/determination, action and maintenance, as well as five levels of change, and ten processes of change. It works on the assumption that people go through a number of stages to change behaviour and that the right emphasis on particular processes of change, in accord with different stages of

change, can encourage progression through the stages (Sutton, 1996). Based on promising preliminary results applying the TMC to ED patients (Blake, Turnbull & Treasure, 1997; Ward, Troop, Todd & Treasure, 1996), a number of models of change have been developed for the area of eating disorders. Treasure and Ward (1997), for instance, combined the TMC with MI principles to develop motivation enhancement therapy (MET), specifically for use in AN treatment. However, most research to date has focused on the development of instruments designed to assess motivation in patients diagnosed with ED's (Gowers & Smyth, 2004; Gusella, Butler, Nichols & Bird, 2003; Geller, Cockell & Drab, 2001; Geller, 2002b; Rieger, Touyz, Schotte, Beumont, Russell, Clarke, Kohn & Griffiths, 2000; Geller & Drab, 1999; Treasure et. al., 1999; Killick & Allen, 1997).

In MET, for example, if a patient is assessed as not wanting to change (i.e. in a pre-contemplative stage of change), then the therapeutic approach would focus on relational aspects such as building and maintaining engagement, as well as assistance with problem recognition. In the next contemplation stage, where the client is considering change, techniques would be employed by the therapist to aid the patient in how they view particular 'pros and cons' of change. Patients in the following preparation and action stages, where they are committed to change, are assisted by the therapist in terms of their provision of techniques that highlight the skills needed to change. Then in the subsequent maintenance stage the therapist largely works with the patient to prevent relapse (Thornton et. al., 2005), though patients may recycle through the prior stages a number of times before stable and long term maintenance is achieved (Prochaska & DiClemente, 1992).

Geller (2006) also proposed an alternative ‘theory of change’, combining cognitive behaviour therapy and motivational principles, based on the premise that patients’ beliefs maintain a self-perpetuating cycle of maladaptive behaviours. These beliefs can be reformulated in therapy via development of a cohesive set of higher values in a non-directive and trusting therapeutic environment. This higher value system then allows patients to make their own autonomous decisions for long term change.

Overall, the focus of motivational approaches is on therapists validating and accepting whichever stage patients are at, by continually maintaining a non-directive or neutral stance in relation to patient change, being curious, and on the same side as the patients (Geller, Williams & Srikameswaran, 2001). It is important to note that motivational approaches are generally conceptualised as a ‘stance’, rather than a specific treatment, and the principles are then utilised in conjunction with other therapeutic paradigms (Geller, 2002a). The efficacy of motivational principles have been supported by research that has demonstrated that putting pressure on ED patients to change behaviours induces psychological stress, which is associated with a reduced amount of behaviour change (Geller, Drab-Hudson, Whisenhunt & Srikameswaran, 2004). Furthermore, research suggests that motivational approaches are of particular relevance to inpatient settings, due to low level of motivation in adolescent patients with AN being associated with higher hospital admission rates (Ametller, Castro, Serrano, Martinez & Toro, 2005). While the efficacy of motivational approaches in AN treatment have been researched in a few studies (Treasure et. al., 1999; Feld, Woodside, Kaplan, Olmsted & Carter, 2001), and motivational principles have

been purported in the literature as greatly assisting therapeutic engagement with patients diagnosed with AN (Vitousek et. al., 1998), they have yet to be evaluated through major randomised controlled trials.

The current project

While lacking in empirical studies, the literature suggests that a significant subset of patients diagnosed with AN do not want to change related ED behaviour, resulting in long term duration of symptoms and low collaboration with ‘recovery’ goals. Some patients even view anorexia as a positive and functional identity, and actively seek to impede treatment directives. Consequently, keeping AN patients engaged in therapy continues to be recognised as a major challenge, and more research has been called for into the high rates of treatment dropout, refusal, and significant ‘resistance’ to engagement in therapeutic services (Button et. al., 1997). It has also been suggested that focusing on factors that keep patients diagnosed with AN engaged in treatment, may provide important information to assist patients that withdraw from treatment prematurely (Eivors et. al., 2003).

Research that has studied therapeutic engagement in psychotherapeutic treatment in AN has yet to examine actual treatments-in-practice. That is, it has not looked directly at therapeutic interactions between therapists and clients diagnosed with AN. Naturally occurring psychotherapeutic interactions also offer up an important site for study, on the grounds that research studying experiences of AN patients has suggested that individual psychotherapy is the most consistently important factor cited in recovery from AN. This includes the ‘quality’ of

therapeutic relationships (Button & Warren, 2001), as well as general relationships with friends and family members (Nilsson & Högglöf, 2006).

These gaps in the literature formed the basis for the current project, which aims to address them, predominantly by exploring ways in which therapists engage with patients diagnosed with AN, in naturally occurring psychotherapeutic interactions. A secondary and concurrent focus is looking at how the therapists' theoretical models of engagement reflect in actual practice. As outlined below, the central guiding therapeutic principle of the participating therapists is engagement, based on systems and motivational models. *In situ* interactions are particularly relevant to motivational approaches as they characterise 'resistance' to change as being 'a function of the interaction with the social environment' (Vansteenkiste, Soenens & Vandereycken, 2004), such that it is mediated via the interactions between therapist and patient (Geller et. al., 2001). The fact that the therapeutic alliance, or strength of engagement, with patients is a central aspect of motivational approaches, allows the current project to look at reciprocal links between engagement in theory and actual practice. In the literature, motivational principles are also connected with the manner with which therapists interact with patients diagnosed with AN, with emphasis placed on therapists' 'responsiveness' to patients (Geller, 2002a). As outlined below, the current project utilises methods that allow for investigation into how therapists accomplish this, in naturally occurring interactions.

Discursive psychology and conversation analysis

To explore ways in which therapists engage with patients diagnosed with AN in *in situ* therapeutic sessions, and how links might be made between such practices and theoretical models of engagement, I employ the methods of discursive psychology (DP) and conversation analysis (CA). These approaches offer rigorous and empirical methods for analysing therapeutic interactions, in fine-grained detail. DP (Edwards, 1997; Edwards & Potter, 1992; Potter, 1997) is a recently developed method in psychology, which is primarily concerned with respecifying psychological topics as discourse practices. For instance, DP focuses on *how* psychological topics, such as emotions or thoughts are managed and constructed in talk and text, or how it is they are achieved as such in the discourse, rather than as reflections of inner, cognitive states.

In practice, DP draws heavily on the method of CA, which is a fine-grained, linguistic based form of analysis originating from ethnomethodology. CA focuses on the sequential organisation of interaction so as to examine how participants orient to, and respond to each other's interactional actions, and to identify the resources on which they rely, in the accomplishment of social actions and activities, such as in a therapy session (Drew & Heritage, 1992; Atkinson & Heritage, 1984) (DP and CA are further explicated in chapter three). In analysing transcripts of therapy sessions, DP and CA allow for investigation beyond theoretical or idealised descriptions of therapeutic techniques or principles, providing a way of examining practical working methods of therapists and patients in their actual interactions (Drew & Heritage, 1992).

Researchers have employed these methods to analyse interactions with patients in various institutional settings, ranging from medical interviews to therapy sessions. This work has not only contributed to the corpus of CA findings regarding how actions are designed, and tasks are accomplished in interactions, and more recently to DP in terms of how psychological topics function in institutional practices, it has also provided institutions with feedback that has informed organisational changes, such as in policy, training and practice. As mentioned above, the following sections provide some perspicuous instances of how DP/CA research has been utilised in institutional settings, while the subsequent chapters draw and expand on DP/CA research in more detail, as relevant to the analysis.

As noted by Wiggins and Hepburn (2005), only recently has there been a greater focus in DP on examining interactions in institutional settings, which have included both medical and therapeutic locations. For instance, Hepburn and Potter's analysis of calls to a child protection helpline (Hepburn and Potter, 2004; Potter and Hepburn, 2003; Hepburn, 2004), highlighted some structural features of the call openings, and explicated what these accomplished in the call sequences (there is also a growing body of CA work pertaining to call openings, see Danby, Baker & Emmison, 2005; Baker, Emmison & Firth, 2001; Schegloff, 1979). The data comprised 50 calls that were made to the National Society for the Prevention of Cruelty to Children Child Protection Helpline (NSPCC Helpline), staffed by social workers known as Child Protection Officers (CPOs). The primary purpose of the call centre was to receive calls from people reporting possible cases of abuse of children. The CPOs assessed the calls to decide

whether or not to refer the information on to a relevant authority, such as the police. The analysis found that the majority of callers began calls using a concern construction formulation, whereby they referred to themselves as being concerned (i.e. "I'm concerned about x"). These concern constructions were demonstrated to work in a number of ways in the call sequences, such as allowing CPO's to construct themselves as taking the caller's claims seriously, but safeguarding them against having to express actual belief in the claims. The researchers suggested the potential for several practical applications of their research within the NSPCC Helpline, including the provision of resources for training and practice, as well as for staff on an individual level. As pointed out by Hepburn and Potter (2004), training in this area is built on assumptions about how interaction works, whereas analysis of *in situ* talk can often contradict such suppositions.

This was demonstrated in a recent study, which analysed interactions between staff and clients in a residential home for people with intellectual disabilities, and established discrepancies between a particular institutional task description and the corresponding interaction (Antaki, Finlay, Jingree & Walton, 2007). Rather than solicit residents' views in a bid to extend their rights and promote greater independence, in line with government policy, the analysis found that residents were actually ascribed a disempowered identity in the talk. Another DP study of institutional talk analysed transcripts from a prison-based sex offender treatment programme (Auburn & Lea, 2003), and demonstrated that regularities in how participants constructed descriptions to manage blame and responsibility for their

crime, had implications for training of treatment facilitators, and potential for reworking the overall treatment model.

There has been no research specific to the area of AN that has utilised DP/CA to analyse naturally occurring therapist and patient interactions, though some recent qualitative work has employed *discourse* analytic approaches to examine interview transcripts with ED patients and healthcare workers (Malson, Finn, Treasure, Clarke & Anderson, 2004; Hepworth, 1999). The aims of the current project differ from this previous research, which is more aligned with using discourse analytic methods to ‘critique’ institutional contexts on moral grounds, as opposed to examining ways in which institutional practices are ‘functional’ (ten Have, 1999). However, there *are* parallels drawn on in the current thesis, such as common assumptions regarding how actions, identities, experiences or events are constituted through discourse, which do not reflect or access an underlying cognitive or ‘real world’ reality (Potter & Wetherell, 1987).

Hepworth’s (1999) analysis of transcripts from interviews with AN healthcare workers emphasised, for instance, the importance of understanding the functions and effects of language when interacting with patients diagnosed with AN, with respect to unduly pathologising patients. Correspondingly, Malson and colleagues’ (2004) study of ED patients’ accounts of treatment suggested that patients were constituted as pathologised and ‘resistant’ to treatment via interactions with healthcare workers. The current project builds on these studies by its focus on naturally occurring therapeutic interactions in an AN treatment

programme, allowing for analysis of *in situ* institutional practices, rather than *accounts* of such practices elicited by an interviewer.

Qualitative research has been recognised as being important for identifying reasons for ‘resistance’ to therapy for AN, specifically in explicating high dropout rates in treatment services (e.g. Mahon, 2000). The growing number of qualitative studies in the AN literature have utilised methodological approaches such as grounded theory (Serpell, Treasure, Teasdale & Sullivan, 1999; Eivors et. al., 2003), interpretative phenomenological analysis (Colton & Pistrang, 2004; Jarman, Smith & Walsh, 1997), deconstructive approaches (Rich, 2006; Surgenor, Plumridge & Horn, 2002; Guilfoyle, 2001) and content analysis (Chan & Ma, 2002). In contrast to the current project, these studies have generally relied on accessing patient ‘experiences’ via interviews or surveys, and have not looked at detailed *in situ* therapeutic interactions.

Embodiment and bodies in discursive psychology

Other recent work in DP has studied how embodiment, bodily conduct and accounts are constructed for, and embedded in, interactional activities (Hepburn & Wiggins, 2005; Wiggins, 2002; Wiggins & Potter, 2003; Wiggins, Potter & Wildsmith, 2001). Embodiment is a key factor in the current institutional context, as patients’ bodily state is both the basis of AN diagnosis *and* the primary measure of associated treatment efficacy. AN is one of the only mental disorders where this is the case, which distinguishes the current data from other institutionally based CA/DP studies in terms of patients’ bodies being both an observable and central factor of the context.

DP research on embodiment is a departure from how psychology has traditionally studied the body, which has predominantly been in terms of an individual's perceptions and cognitions of their body as a physical entity. Similarly, AN literature has also examined the 'body' in terms of perceptions and cognitions regarding body size, and attitudes towards the body (Skrzypek, Wehmeier & Remschmidt, 2001), as well as a physical site to provide information to indicate the presence or absence of eating disorder pathology. Negative attitudes regarding body image, for instance, have been studied as a predictor of duration of ED symptomatology (Ruuska, Kaltiala-Heino, Rantanen & Koivisto, 2005), while changes in perceptual body size distortion have been researched in relation to effectiveness measures of treatment regimes (Benninghoven, Jürgens, Mohr, Heberlein, Kunzendorf & Jantschek, 2006). An example of an ED treatment component that has gained recent attention in the literature is a technique called 'mirror exposure', whereby ED patients' cognitions and emotions while looking at their bodies are measured periodically over an extended period of time (Vocks, Legenbauer, Wächter, Wucherer & Kosfelder, 2007).

These studies are illustrative of Hepburn and Wiggins' (2005) argument that perceptions regarding size or weight tend to be focused on as discrete and quantifiable cognitions, such that there is a separation between mind and body. In contrast, a discursive psychological approach investigates the 'body' as constituted and constructed through everyday talk, as well as how it is utilised as a resource that accomplishes particular actions in interactions. It has also been

noted (Hepburn & Wiggins, 2005) that recent DP research focusing on the 'body' has built on previous CA literature on this topic (e.g. Beach & LeBaron, 2002; Heath, 1986), extending it to examine how bodies '*themselves* are constructed'. This is opposed to primarily looking at how bodies are utilised '*alongside* talk to structure interaction', and how they have been downplayed as 'extra discursive' features (Wiggins, 2002).

Wiggins (2002) addressed this by examining embodiment, specifically gustatory pleasure, in mealtime interactions. The study found that embodiment was constructed in and for interactional activities, such as displaying agreement, and was inseparable from the talk itself. An important feature of this area of DP research is that it reduces the differentiation between individual bodily experience and discourse, so that even bodily practices such as eating are shown to be intrinsically embedded in the sequential organisation of interaction. Mycroft's (2004) analysis showed, for example, how the bodily activity of being weighed at a weight management group was situated in interaction via accountability and news delivery practices. Another paper by Wiggins (2004a) focused on accountability in terms of food evaluations in everyday mealtime conversations. The findings of this study detailed how speakers were held accountable for their consumption and evaluation of food in interaction. This not only contributed to DP research on embodiment, but also on an applied level to literature addressing food practices in terms of early intervention for obesity and eating disorders in children and adolescents (see also Wiggins, 2004b).

There have been few DP studies on the body in institutional settings, with a notable exception being Hepburn and Wiggins' (2005) analysis of calls to a national child protection helpline (using the same NSPCC Helpline data as mentioned above). It looked at how constructions of individual body size were used to imply potentially problematic behaviours, which could in turn warrant further investigative action to be taken by the organisation. Another institutional study was Parry's (2007) analysis of embodiment in physiotherapy treatment consultations, which found that referencing practices prefaced with the word 'the' were associated with delicate or troubled matters concerning client body parts, in contrast to references to body parts prefaced by personal pronouns (e.g. "the knee" versus "your knee"). These institutional studies highlight the practical and consequential effects of bodily accounts in interactions, which is at odds with a cognitivist view of discourse being primarily a by-product of thought.

The analysis in chapter six of this thesis draws on and extends the DP embodiment literature by examining how patients' bodies are embedded in the interactions, in terms of functioning as an interactional resource, as well as examining how patients' physicality relates to practices of account requests, and subsequent accounts by therapists and patients.

Conversation analytic research in institutional settings

Reviews of the literature have revealed no conversation analytic studies that have been conducted in institutional settings related to the area of AN, although there is a solid body of work in other institutional settings that have had both theoretical and practical relevance, predominantly in the area of medical

consultations (see Heritage & Maynard, 2006; Peräkylä, 2002; Heath, 1992). As noted by Drew, Chatwin and Collins (2001) CA methodology has for the first time permitted investigation into actual interactions between health-care professionals, such that it can explicate the impact of communicative choices of the speakers *in situ* on factors such as patient participation. This is different from *content* analysis, which codes and statistically aggregates specific features such as explanatory style (Colligan, Offord, Malinchoc, Schulman & Seligman, 1994; Schulman, Castellon & Seligman, 1989) or emotional variables (Lee & Peterson, 1997), as CA does not use a coding system that is based on assumptions about individual psychological factors or the like. The most consistent focus of CA studies of institutional interactions has been turn-taking systems, in particular the formal and informal pre-allocation of question and answer tasks, though there is some caution in CA literature regarding the need of a balance between ‘a focus on social structure’ and a ‘focus on conversational structure’ (Schegloff, 1991). As ten Have (1999) noted, it is important in many institutional settings, to focus primarily on the ‘sequential-organisational *effect* of an institutional *activity allocation*’ (p. 167), instead of looking at questioning in terms of *pre-allocated turn-types*.

An example of CA being utilised in a general area of mental health is McCabe et al.’s (2002) analysis of consultations between psychiatrists and patients at two psychiatric outpatient clinics. The analysis found that patients repeatedly and unsuccessfully attempted to discuss the content of their psychotic symptoms with the treating psychiatrists, which produced noticeable tension in the talk. Such tension was evidenced by a number of interactional patterns found in the

transcripts, such as the psychiatrists' frequent use of delay devices marked by talk characterising hesitation (e.g. "well", "eh", and "ehm"), and minimum response tokens (such as "mm"), when patients would attempt to speak about the nature of their psychotic symptoms. The researchers concluded that interactional engagement may be strengthened via patients' concerns about their troubles being directly addressed by psychiatrists.

In contrast, Parry's (2004) study of physiotherapy treatment sessions found that therapists' avoidance of talking about patients' problems was actually linked to their sensitivity regarding potential negative implications of explicit focus on patients' physical incompetencies. This formed part of the collaborative and active management of patients' physical incompetencies, found to be central in the interactions, which worked to emphasise patients' *personal* competency and alignment with treatment goals. The recurrent practices via which this was achieved not only provided a greater understanding of how physical incompetencies were dealt with in the interactions, but also challenged notions regarding the perceived negative impact of relational asymmetries. Similarly, Pudlinski (2005) found that methods for 'doing' empathy in interactions from a peer-support call centre were not dependent on how the call takers formulated empathic responses, but were co-produced by both the call taker and the caller, such that empathy was constituted or 'created' via sequential turns in the interactions.

Another study by Maynard (1992) focused on consultations at two clinics for developmental disabilities. The purpose of the consultations was for doctors to

inform parents of the results from evaluations of their children, which could include informing them of specific diagnoses such as autism, or language and learning disabilities. The analysis found that the process of delivering an unfavourable diagnostic assessment to parents of their child's condition, represented a delicate interactional task, and that the risks of conflict or tension could be minimised via the implementation of specific interactional devices such as perspective-display devices (see chapter four for further elaboration on this study). Such studies illustrate the practical relevance of CA in institutional settings, by allowing health-care professionals a unique insight into the underlying linguistic mechanics of their interviews, such as being shown regularities in how doctors co-implicate parents into their final diagnosis, thus working it up to be collaborative and reducing potential for resistance and complaint.

Research by Peräkylä (1993) also highlighted a recurrent discursive feature in AIDS counsellors' talk with patients, whereby the counsellor introduced a *hypothetical* future scenario followed by questions centering on the patient's fears concerning this scenario. The patient's collaboration with this hypothetical future was posited as particularly important in AIDS counseling, as a central objective of the counsellor was to assist the patient in accepting the prospect of an uncertain future, due to their illness. The analysis revealed that the patients were more likely to collaborate with the hypothetical future when the AIDS counsellors attended to a positive conversational environment, and management of the epistemological framework of the discourse.

CA findings have been successfully applied in other general workplace settings as well. One such case incorporated the results of a CA study into an iterative design process (Woodruff, Szymanski, Grinter & Aoki, 2002). The findings identified several key factors, which significantly influenced the development of the electronic guidebook, based on video recordings of how people interacted with the device. Notably, the design team reported that these findings could *not* have been obtained using alternative methods.

Connecting conversational practices to therapeutic models

Another recent focus in applied CA has been using CA findings to describe theoretical models in psychotherapeutic contexts. For instance, via analysis of psychoanalytic sessions, Peräkylä (2004) demonstrated some interactional practices through which psychoanalysts shape and reshape their patients' experiences, in order to make links between them. This provided participating professionals with additional understanding of the psychoanalytic technique regarding interpretations. What studies such as this one achieve is to highlight the ability of CA research to look at theoretical therapeutic techniques and models in practice, an area that has gained specific focus in CA work (Peräkylä, 2005; Vehviläinen, 2003; Buttny, 1996). Peräkylä and Vehviläinen (2003) termed these theories and models 'stocks of interactional knowledge' (SIK) and reviewed how CA literature has explored the relationship between SIK and findings elicited by CA studies.

In particular, Peräkylä and Vehviläinen noted how CA can 'falsify and correct' theoretical elements of SIK, provide greater insight into practices outlined in

SIK, or increase understanding of relevant psychotherapeutic ‘constructs’ (Madill et. al., 2001); and ‘expand’ on the description of these practices. For instance, Ruusuvuori’s (2000) analysis of medical consultations challenged the widely endorsed recommendation that a ‘patient-centred’ approach can be advanced by the use of open-ended questions, demonstrating that the patients’ answers were not found to be inhibited by the question form of the doctor. Further work has provided analytic insights that both extended and clarified guiding principles in educational counselling (Vehviläinen, 1999, 2001).

Hutchby’s (2005) study of therapeutic interactions between counsellors and children, for the purpose of assisting the children to adjust to the divorce or separation of their parents, focused on the conversational practice of formulation and its relation to the standard therapeutic technique of active listening.

Formulations, or ‘candidate re-representations’, that developed or highlighted therapeutically relevant factors from the children’s responses, were used by the counsellors to attempt to elicit ‘feelings-talk’ from the children. Hutchby’s analysis also revealed how ‘loosely’ the theoretical models of counsellors were reflected in the actual interactions, again highlighting the usefulness of CA in clarifying and correcting aspects of overarching SIK. Buttney (1996) also examined formulations in terms of the therapeutic technique of ‘reframing’ in couple and family talk. The analysis found that ‘reframing’ was interactionally achieved via reformulation practices, such as assessments and third-turn evaluations, that primarily worked to draw on elements of client talk to formulate therapeutically relevant interpretations and to infer different implications. Such

studies have in turn been applied to inform training and policy in various institutional settings.

Throughout the current analysis, I make links between regular interactional activities and theoretical models of the EDP therapists. In particular, the principles of engagement, collaboration and neutrality in relation to change are focused on, which are also common to the area of AN on a whole. While these principles have not been studied before in the area of AN, Madill and colleagues (2001) did describe specific practices, or 'sets of actions', in psychotherapeutic interactions that they termed 'resistance', which could be representative of the *opposite* of practices the principle of 'engagement' might describe. These practices included non-uptake by patients of therapist directives, and the management and rejection of topic changes.

Site of data collection

With my aim to examine therapeutic activities in patient/therapist interactions, I conducted my research at the only public hospital inpatient/outpatient programme for eating disorders in Western Australia, situated in the Princess Margaret Hospital for Children's Psychological Medicine department in Perth (see chapter three for a more detailed description of the Eating Disorders Programme (EDP) and the data collection process and methods). In terms of investigating how the therapeutic models of the EDP therapists are reflected in therapeutic interactions with patients, it was critical for me to gain an understanding of these approaches that closely matched those of the EDP clinicians. This was in line with recommendations and practices in DP/CA,

which highlight the importance of gaining comprehension of specialised tasks and procedures in institutional settings, to the level of study participants (ten Have, 1999; Peräkylä & Vehviläinen, 2003).

Based on fieldwork prior to my study's analysis, which included a number of meetings and focus groups with the EDP clinicians participating in the project and other team members, as well as studying the programme's Clinical Practice Guidelines document, I endeavoured to attain at least a working understanding of the team's key therapeutic treatment approach. Ostensibly, it is based on three overarching models, namely systemic and motivation theories, developmental theory and a bio-psychosocial formulation of aetiology and recovery. A wide range of therapeutic techniques are employed by clinicians in individual and family settings that fit within these three models, but their application is tailored to each patient's individual needs and readiness for change. This is aligned with key principles from motivational approaches (as mentioned above), that work within a framework guided by clients' stage of change. Being adapted from motivational interventions in the field of addictions, motivational approaches have only been prominent in ED literature in the last decade, as stated above. Primarily, they work on the premise that treatment will be more successful if it is matched to the patient's level of motivation to change (Thornton et. al., 2005; Gowers & Smyth, 2004; Geller, Cockell & Drab, 2001; Geller, 2002b). I should note, that while aspects of the EDP's approach now employ, or are similar to, motivational principles, the team's original treatment model was developed alongside its rise in the ED area.

Although the EDP does not use structured motivational instruments to measure patients' stage of change, it does assess readiness for change based on clinical judgement. Parallel tenets to motivational theories can also be found within systems theory and even the Socratic method (Vitousek et. al., 1998), such that a therapist's explicit assumptions or statements that a client's family, for example, must change certain ways of functioning can work to actually *impede* potential for change (Tomm, 1984). A key principle of maintenance of a *neutral* stance in motivational approaches is also similar to a core feature of systems theory, whereby therapists are both observers of the therapeutic process, and participants in it (Tomm, 1984). Furthermore, motivational approaches and systems theory both place importance on these areas in terms of how therapists communicate them, for instance, in the utilisation of different question formats (Tomm, 1988).

Overall, the key guiding therapeutic principles of the EDP are collaboration and engagement, where regardless of the particular therapeutic technique employed, be it cognitive behaviour therapy, interpersonal therapy or art therapy, their underlying position or stance is one that is focused on the individual and the unique system of which they are part. From the team's perspective, this focus exemplifies their treatment approach. While in therapy this is partly expressed by building and maintaining engagement and relationship with each client and their family, it is also the fundamental basis of the EDP's entire programme. This interest in the individual can be seen both formally in the team's structure, for instance psychological assessment instruments for outcome measures are not employed in therapy past initial intake assessments, as well as informally via the

long term contact maintained between the EDP and past clients and their families.

Project aims and summary

The literature I have reviewed in this chapter was employed to facilitate a scholarly foundation for the current project. The brief summary of literature pertaining to the aetiology, epidemiology and treatment of AN revealed poor long term outcomes for patients diagnosed with AN, lack of research into efficacious treatments and high rates of premature withdrawal from treatment services. The limited research that had investigated reasons for AN patients' resistance to treatment was found to have predominantly relied on patient mediated variables that included measures of motivation, self-esteem and body mass index. Based on a call for more research into ED dropout rates, specifically in regards to therapeutic engagement, the current project was formulated whereby therapy sessions with female patients diagnosed with AN, from the EDP would be analysed using DA and CA approaches. As mentioned, these methods have not been utilised before in this particular institutional setting, however, their use in other medical and therapeutic contexts have yielded findings that have had applied implications for the institutions involved.

To return to the 'project goals' outlined in chapter one, my study will contribute to AN literature by providing new analytic insights into how the theoretical principle of engagement can be linked to practices in naturally occurring therapeutic interactions. Furthermore, this will extend the DP/CA literature in institutional contexts, via focus on the sequential organisation of such practices,

and how they contribute to the accomplishment of associated tasks in the institutional setting. Relating analytic findings to therapeutic principles, or ‘stocks of interactional knowledge’ (Peräkylä and Vehviläinen, 2003), will potentially improve therapists’ understanding regarding how these models or theories operate *in situ*, as well as providing a means with which to communicate to therapists the significance of analytic findings to their clinical practice. This will in turn contribute to recent work in applied CA that has focused on making links between theoretical models and interactional practices.

Finally, this thesis aims to extend DP literature, particularly on recent examinations of the body and embodiment, as embedded and constructed in interaction. This is highly significant to the current context, as it is a forum where the speakers’ bodies and associated conduct constitute the central purpose of the institutional setting (i.e. they have been diagnosed as anorexic), as well as being a ‘physical’ dimension of the context. In particular, chapter six of my analysis explores how this physical aspect is not only embedded in the data, but how it is relevant to and affects account requests and corresponding accounts by therapists and patients. This chapter also focuses on embodiment in regards to how therapists and clients use agency in terms of clients’ bodily states as an interactional resource.

In addition to the scholarly basis of my study as presented in the current chapter, the following chapter will outline the methodological history of my project in terms of the data collection process and provide further explication of the

analytic tools employed in the subsequent data analysis chapters (four through to seven).

CHAPTER 3

Methods and methodology

He begins by taking note of an interactional effect actually achieved in a singular, real episode of interaction...And he asks, was this outcome accomplished methodically. Can we describe it as the product of a method of conduct, a *situated* method of conduct, such that we can find other exercises or enactments of that method or practice, in that situation or context or in others, which will yield the accomplishment, the recognisable accomplishment (recognisable both to co-participants and to professional analysts) of the same outcome – the same recognisable action or activity or effect. (Schegloff on Sacks, 1992: xxviii)

Introduction

The primary focus of this chapter is to provide a thorough description of the project's methods and methodology. I begin by detailing background information regarding the hospital EDP including its history, admission procedures and therapeutic approach. I then summarise the data collection and transcription process of the study, which includes information regarding participants, and the ethics approval process. Following this, I will describe the analytic phase of the project, in addition to further outlines of DP and CA approaches.

Information I detail in this chapter regarding the institutional setting, is based on several months of field observations, meetings with the staff from the EDP, three focus group sessions with clinicians and the EDP's clinical guidelines document (included in Appendix E).

Institutional background information

The institutional setting for my project was the only public hospital programme for eating disorders in Western Australia, situated in the Princess Margaret Hospital for Children's Department of Psychological Medicine. The EDP has been in operation for ten years, treating children and adolescents with eating disorders, up to sixteen years of age, in an inpatient and outpatient setting. The EDP encompasses acute and chronic stages of care, via the integration of multiple disciplines including psychological medicine, paediatric medicine, allied health and hospital school services.

The treatment programme provided by the EDP is aligned with the current evidence base for assessment and therapeutic interventions, consumer participation principles and the Australasian and international clinical practice guidelines. As noted in the EDP's clinical guidelines document (see Appendix E), their overarching philosophy to treatment is:

to provide a collaborative, continuum of care with treatment delivered in least restrictive, community environments where possible and more intensive hospital admissions considered when appropriate for physical safety. Close collaboration with families, primary and secondary health providers and education professionals (including those in rural and remote regions) is central to our approach. (p. 4)

EDP Admission/Assessment Process

The EDP conducts between 60 and 80 assessments of adolescents per year, via referrals by doctors, psychologists and other mental health units. It carries out the assessment process for new patients over two mornings, consisting of a multi-dimensional evaluation process taking into account mental and physical factors. EDP specialists from medical, psychological, educational and nutritional professions conduct the assessments (see Appendix E, p. 8 for further information regarding specific assessment instruments), with approximately 40 percent of assessments resulting in hospitalisation. The typical stay for inpatients is 70 days, over an average of two admissions. The EDP treats patients that do not require hospitalisation on an outpatient basis, or refers them to alternative options for eating disorder treatment.

The EDP views their service as being predominantly focused on outpatient care, with decisions for hospitalisation made primarily on medical grounds, by a gastroenterologist, for instance, if a patient requires immediate nutritional therapy. Patients can also be admitted to hospital involuntarily, although this has only been invoked in a small number of cases over the EDP's history, and is an extremely rare occurrence. The fundamental goal of the inpatient programme is to stabilise patients physically and medically, through intensive nutritional therapy, which can include nasogastric feeds in cases of severe malnourishment. The EDP endeavours to manage psychological problems in the outpatient programme, which includes one to two sessions a week of individual therapy and approximately one session a fortnight of family therapy. This separation allows for consistency in the outpatient setting, where psychological issues are

addressed long term, whereas the inpatient setting is viewed in terms of dealing with acute physical problems associated with AN in the short term.

EDP Therapeutic Treatment Approach

As discussed in chapter two, the EDP's therapeutic treatment approach is informed by systemic and motivational theories, developmental theory and a bio-psychosocial formulation of aetiology and recovery. The overarching guiding therapeutic principles employed are engagement and collaboration (see p. 10-12 of Appendix E). The EDP view engaging with clients via an empathic, collaborative and supportive relationship as an ongoing process that is essential for successful psychological treatment. This is partly because EDP patients diagnosed with AN are generally ambivalent about the process of change, so engagement in therapy is a vital prerequisite for ensuring consistent long term treatment. The EDP's therapeutic focus on individual patients also reflects in its initial consideration to therapist-client suitability or 'match'.

The overall aim for each therapeutic relationship is to provide a safe and supportive setting for patients, which promotes optimal functioning on psychological, emotional, social, spiritual and physical levels. The EDP view this goal as primarily mediated via the therapeutic relationship, rather than the *type* of psychotherapy employed. However, a number of psychotherapies *are* utilised, including cognitive behavioural therapy (CBT), dialectic behaviour therapy (DBT), interpersonal therapy, schema focused therapy, narrative therapies, creative therapy and gestalt therapy.

Data collection and transcription

The data for the project consisted of individual therapy sessions between EDP therapists and patients. Twenty-four therapy sessions between 30 and 60 minutes comprised the final data corpus, which were audio taped via digital recorders operated by the participating EDP clinicians (see Appendix B for session numbers and corresponding extracts and times). The reason for the number of sessions taped was predominantly informed by pragmatic considerations. Given my project's overall timeline, the data collection period was scheduled to occur over a six-month period. However, after experiencing some initial technical obstacles, this eventually exceeded twelve months. The total quantity of taped sessions was 34, however ten of the early sessions were unusable due to inaudible and corrupted sound files. This was mainly due to the external microphone not being switched on, or the incorrect activation of the 'record' function of the taping device. These problems were resolved by employing more 'user friendly' recording equipment and providing additional operational training for participating clinicians.

There were no criteria regarding patients' number of previous therapy sessions, or number of hospital admissions that excluded participation, nor were there requirements in the study regarding the sequence of session recordings in terms of taping a certain trajectory, or order of sessions with the same patients. This decision was again based on pragmatic grounds, in order to expedite the data collection period. Therefore, the clinicians were instructed to record a range of sessions with different patients, at varying stages of treatment. Prior to sessions being audio taped, patients and their parents were given information sheets (see

Appendix D) that contained plain language statements, and parental and patient consent forms (see Appendix C). Once both consent forms had been signed and returned to the EDP, further verbal consent was gained from participating patients prior to therapy sessions being recorded. The session recordings were transcribed verbatim, after which data fragments relevant to the analysis were transcribed using Jeffersonian notation (see Appendix A for notation glossary). The digital program Audacity was utilised to assist in the accuracy of transcription, such as in the measurement of pause timings in the data.

Participating EDP clinicians

Three out of the four EDP therapists volunteered to take part in the current study. Two of them are psychologists, one being a clinical psychologist, the other a clinical psychologist registrar. In Australia, eligibility for registration as a clinical psychologist requires six years of accredited study, which includes a four-year undergraduate degree in psychology followed by a two-year master's degree in applied psychology. After completion of the master's degree, there is a two year supervised period as a registrar before the full title of clinical psychologist may be employed.

The other therapist, who is also the EDP team leader, is a registered psychiatric nurse. This requires additional training in the area of mental health beyond a standard nursing qualification, which in Australia is obtained via a four-year university degree. All three clinicians have at least ten years experience in the eating disorders field as therapists, both in Australia and internationally.

Participants

The EDP patients who participated in the study were sixteen female adolescents aged fourteen to sixteen years who met the ICD-10 (WHO, 1993) diagnostic criteria for AN. All participants had prior EDP hospital admissions, though the majority of cases were outpatients at the time therapy sessions were recorded, with only three participants being current inpatients.

Process of EDP and hospital ethics approval

The early stages of my project were significantly prolonged. I conducted a number of preliminary meetings with EDP staff in order to obtain approval of my research proposal. Initially, it was necessary to convince the staff that my study would be helpful to both their clinical practices, and to the discipline of psychology on a whole. After two meetings, some EDP members considered the project to fulfil these criteria, while others had reservations about the qualitative nature of the methodology. These included questions raised regarding the relevance and potential helpfulness of the proposed methodologies. None of the team had prior experience or familiarity with approaches that analysed *in situ* interactions, and subsequently a considerable amount of time was spent explaining the principles of DA and CA.

In the subsequent meetings, I discussed the potential benefits of the study. The EDP identified key factors they viewed as particularly relevant, which included having a better understanding of what went on in each other's therapy sessions, from the perspective of developing a more collaborative and collective team approach. This was identified as being helpful for producing a more efficacious

working environment and improving the standard of therapeutic care provided by the EDP, specifically for patients diagnosed with AN. The clinicians also anticipated that having an increased understanding of how they conducted therapy would provide valuable information for their contributions to national and international conferences and workshops.

It was further reported that some EDP clinicians were interested in what a fine-grained descriptive analysis would reveal about the content of their *own* therapeutic sessions. As stated above, three out of four of the EDP therapists volunteered to participate in recording their individual therapy sessions for the project, after which a formal application to the hospital ethics committee was made. This took several months to acquire final approval from the committee, which was largely because the hospital scientific sub-advisory committee had only recently begun to approve studies employing qualitative research methodologies. Another delaying factor was the limited number of studies allowed each year in the EDP, to ensure that the child and adolescent demographic treated at the clinic was not 'overstudied'. This meant that in order to gain final approval, my project had to be perceived to have greater potential benefit for the EDP, and the area of eating disorders in general, in comparison to other research applications.

Hospital ethics committee provisions

In the course of the ethics approval process, a number of stipulations were made by the committee concerning data collection protocols. To minimise any effect the taping of the therapy sessions might have on patients, or the therapeutic

process, the participating EDP clinicians made an informed clinical decision as to which patients to approach for consent. This potentially produced bias in which sessions were ultimately recorded, as clinicians could exclude certain patients. To minimise this, the clinicians were instructed to record a representative sample of therapeutic interactions. Patients were advised on the patient information sheet and verbally before recording commenced that they were able to withdraw their consent before, during or after the therapy sessions. Patients were also informed that withdrawal or non-participation in the study would not affect the care they received with the EDP. Patients were further advised that no identifying details would be made public in the study and that the audio tapings of therapy sessions would not be played publicly. In addition, the hospital ethics committee required a final amendment to the application, which stipulated that all original recordings and sound file copies be destroyed subsequent to the analysis phase of the study.

Analysis and methods

As outlined in chapter two, my decision to utilise DP and CA approaches originated from their provision of a practical methodological key to examine details of social action, specifically in institutional settings. By employing analytic tools informing DP/CA, and relying on the already large body of CA findings, I had the means to explicate some features of the therapy talk that were relevant to my study. In practice, these tools were applied via listening repeatedly to sound files of the therapy sessions and reading of session transcripts. Some of the recordings and transcripts were also presented throughout the analytic phase of the study at a data session at relevant

conferences, as well as two discourse and rhetoric groups. These opportunities not only gave me alternative and invaluable perspectives for data analysis, but they also represented forums where specialist academics in my area of study could listen to audio recordings of my data (given that the ethics stipulations precluded post analytic playing of sound files). Before providing some further descriptions of DP and CA, I should note that I have not included an extended account of the procedures, principles and the analytic opportunities afforded by these methods, as these have been cogently described elsewhere (for DP see Edwards, 1997; Edwards and Potter, 1992. For CA see ten Have, 1999; Psathas, 1995). However, where various specific features of DP and CA are introduced in the following analytic chapters more detailed descriptions will be given.

Discursive psychology

DP uses discourse analytic concepts to redefine psychological topics as discourse practices (Edwards & Potter, 2001). This means that instead of attempting to determine the motivation behind a particular piece of talk, or the underlying cognitive processes driving it, discursive psychology concerns itself with the work done by the discourse, or in other words its construction and what that produces (Edwards, 1997; Potter, 1996). This is illustrated by DP's interest in both the action (rhetorical or otherwise) produced in discourse by psychological vocabulary, as well as the management of more implicit or 'indirect' psychological themes such as 'identity' and 'prejudice' (Edwards, 1997).

DP began largely in the domain of social psychology, however in recent years has gained prominence in general areas of psychology and social science via its

increasingly applied focus in institutional settings. In regards to social psychology, DP does not share the same mainstream approach to identity and categorisation, such as self-categorisation theory (SCT) or social identity theory (SIT). Such theories for the most part depict people as ‘passive vehicles’ whose cognitive machinery is ‘activated’ by external situational features (Rapley, McCarthy and McHoul, 2003). In contrast, DP suggests that identity can be more usefully explicated as something that is produced in talk for local purposes, with categories of identity being used to do moral and rhetorical work (Edwards and Potter, 2001; Edwards, 1998; Potter and Wetherell, 1987). This view, inspired by Garfinkel, regards people not as ‘cultural dopes’, but as active participants utilising norms to bring order to their surroundings (McHoul and Rapley, 2001; Silverman, 2001).

As summarised by Potter (2005), this deviates from the general view in psychology that prizes access to people’s inner states and processes as the primary avenue for understanding and studying human action. On the other hand, DP’s focus is on the practical representations of such processes, which they treat as resources that do particular work in interaction. In light of this, DP examines how psychological categories, classifications and orientations are drawn on and made relevant by people in interactions, which in institutional settings, for instance therapy, are studied in terms of how such resources constitute not only key institutional tasks, but also the institutional context itself. Potter (2005) makes an important note that DP’s perspective on psychological phenomena does not dispute the existence of internal cognitive states or processes, but instead posits that they can be usefully studied via detailed focus on the types of

discursive practices people are involved in, which is not dependent on analysis or understanding of corresponding ‘cognitive phenomena’.

Conversation analysis

As mentioned in chapter two, DP draws heavily on the method of CA, which emerged from California in the 1960’s. CA was broadly developed by Harvey Sacks, Emmanuel Schegloff and colleagues, who were strongly influenced by Erving Goffman and Harold Garfinkel (ten Have, 1999). From the work of Sacks in particular (see Sacks, 1992), which provided a fundamental framework, CA has become a distinct, established perspective and method for analysis of talk-in-interaction (Heritage, 1999). CA can be described as a fundamentally inductive method that predominantly involves working with naturally occurring data, which are transcribed using detailed notation and then analysed. CA is centrally concerned with the sequential organisation of interaction, as a way to look at how people orient to each other’s conduct, and to help identify the resources that they rely upon in the accomplishment of social actions and activities (Drew & Heritage, 1992; Atkinson & Heritage, 1984). The basic underlying assumptions of CA have been neatly organised by Psathas (1995) in the following list:

1. Order is a produced orderliness.
2. Order is produced by the parties *in situ*; that is, it is situated and occasioned.
3. The parties orient to that order themselves; that is, this order is not an analyst’s conception, not the result of the use of some preformed or preformulated theoretical conceptions concerning what action

should/must/ought to be, or based on generalising or summarising statements about what action generally/frequently/often is.

4. Order is repeatable and recurrent.
5. The discovery, description, and analysis of that produced orderliness is the task of the analyst.
6. Issues of how frequently, how widely, or how often particular phenomena occur are to be set aside in the interest of discovering, describing, and analysing the structures, the machinery, the organised practices, the formal procedures, the ways in which order is produced.
7. Structures of social action, once so discerned, can be described in formal, that is, structural, organisational, logical, atopically contentless, consistent, and abstract, terms. (Psathas, 1995: 2)

Psathas' above summary is underpinned by Sacks' (1992) position that there is 'order at all points'. Rather than understanding order to exist at an aggregate level, such that cultural phenomenon can only be understood by the proper sampling and adding of cases (Rapley et. al., 2003), it is observed to exist:

...in detail on a case by case, environment by environment basis. A culture is not then to be found only by aggregating all of its venues; it is substantially present in each of its venues. (Schegloff in Sacks, 1992:xlvi)

In contrast to the dominant 'positivist' methods in psychology, which are based on an aggregationist model, Sacks' 'order at all points' view dictates that such

approaches overlook essential 'cultural (and therefore non-aggregable) grounds of human action' (Rapley et. al., 2003, pp. 6).

Forty years of CA research has yielded extensive findings that have rendered 'observable-reportable' or 'storyable' (Sacks, 1992) a large body of communicative practices that can, and have been applied, in institutional settings (ten Have, 1999). These settings have frequently been sites for professional-client talk, and as demonstrated in chapter two, their analyses have provided many useful insights and implications on applied levels in these institutions and relevant wider disciplines. Such studies are identified as representative of what has been termed '*applied CA*' (ten Have, 1999), which is essentially concerned with studying the 'management of social institutions in interaction' (Heritage, 1997:162). Applied CA involves applying the accrued knowledge in CA regarding conversation organisation ('*pure CA*') to institutional interactions, in order to explicate participants' orientation to institutional practices (ten Have, 1999), or how these institutions are 'talked into being' (Heritage, 1984: 290). While '*applied CA*' is often described as a more recent area of CA, as Schegloff (in Sacks, 1992) noted, Sacks' shift to sociology was provoked by an original concern with how the law works as an institution.

CHAPTER 4

“Muscly and tall and normal” versus “Too thin”: Practices in the Management of Delicate Items

Introduction

This chapter centres on some of the recurrent interactional activities or practices that can describe how therapists engage with patients, with a particular focus on the ‘delicate’ management of items relevant to the context. The delicate nature of many institutional interactions has been widely attested to in the DP/CA literature, particularly in studies employing CA approaches. There is a growing body of research that has focused on the local organisation of ‘delicacy’ in institutional settings (Silverman, 1997; Maynard, 1992; Bergmann, 1992; Silverman & Bor, 1991; Silverman & Peräkylä, 1990). Bergmann (1992) noted, a delicate item is ‘constituted by the very act of talking about it cautiously and discreetly’ (p. 154), while Silverman (1997) described the ‘production’ of delicate matters as something that is locally achieved and dealt with, as speakers themselves construct or assemble some context for their talk.

Research on delicate topics in institutional talk has been demonstrated to have significant applied and theoretical relevance in different contexts. An analysis of gynaecological consultations for instance, demonstrated that both speakers in the interactions jointly marked matters concerning sexuality as delicate, via delay,

avoidance and depersonalisation (Weijts, Hanneke, Houtkoop & Mullen, 1993). Silverman and Peräkylä's (1990) study of AIDS counselling data also found that delicate topics such as 'contraceptives' and 'sexual intercourse' were marked as such by regular preceding delays, or 'pre-delicate perturbation', and had no alternative sequential function, other than to delay reference to delicate items. As Silverman (1994) demonstrated, such markers, in part, form a locally produced and managed 'solution' to the problem of delicacy, highlighting Sacks' (1992) observation that speakers skillfully orient to the implications of their accounts.

This chapter begins by utilising the literature on delicacy to demonstrate some ways in which topics and tasks relating to patients' bodily state and conduct, in the present data, are marked as delicate, as demonstrated throughout the analysis. I then draw on Maynard's (see 1992, 2003) work on perspective display series (PDS) in relation to the delicate management of institutional tasks in the current context. This chapter also discusses organisation of such delicate matters and tasks, in regards to the EDP's keys theoretical models of collaboration and engagement.

'Bodily state' and 'conduct' as delicate matters

Similar to other institutionally based DP/CA work on delicacy (Silverman & Peräkylä, 1990; Weijts et. al., 1993), there are topics specific to the current context that are recurrently marked and managed as delicate items; namely patients' bodily state and related conduct. As mentioned previously, these matters are extremely significant in the present setting, because AN is one of the only mental disorders where the diagnostic criteria centres on bodily state, and

associated conduct (WHO, 1993; APA, 2000). Analysis of the current data, demonstrated these topics to be regularly co-produced as delicate matters, via ‘perturbed’ sequences of talk preceding the initiation of these topics, for example:

Extract 4.1

1 **THER:** So- so u::m (.) that (0.3) w-was
2 something (0.2) that was different
3 about you (0.2) u:m y- your (0.3) .hh
4 >your weight?<
5 (0.8)
6 **PAT:** °M::m° (0.5) yeah. (0.2) I spo:se.

Here, the topic of the patient’s bodily state in the form of her ‘weight’ (4) is packaged as delicate by the succession of prior delays or ‘expressive caution’ (Silverman, 1994), characterised by a number of pauses and hesitations (1-3). The topic of weight is then co-produced as delicate by the patient’s corresponding response (6), which is also delayed by the sizeable pauses (5-6) and minimal acknowledgement token of ‘mm’ (Jefferson, 1985) on line six. The consistency across all the therapeutic interactions of such features when topics related to patients’ bodily state and conduct are initiated, coupled with there being no other sequentially relevant account available (Silverman & Peräkylä, 1990), marks these items as recurrently delicate. The ‘I sponse’ (6) also works to downgrade the preceding agreement token of ‘yeah’, with the low intonation reinforcing the turn completion point. The following extract is an instance of another recurrent topic marked as delicate throughout the data relating to patients’ bodily conduct:

Extract 4.2

1 **THER:** Ok (0.3) u::m s- so (.) what happened
2 before that (.) u:m were you:: (0.3)
3 were you (.) ea↑ting (0.2) or >not
4 eating before ↓that<
5 (0.9)
6 **PAT:** I:: (0.3) w- wasn't (0.2) °eating° u::m
7 (0.3) unti:l (.) u:m Monday (4.5) I try
8 and avoid people who eat at school
9 (0.2) >they always eat<

In this extract, the bodily conduct of 'eating' is marked as delicate via the expressive caution demonstrated by the lengthy hesitations and pauses (1-3), prior to the topic initiation. The mention of 'what happened before that' (1-2) also provides a way of introducing the matter of 'eating' in connection with a prior interactional topic. The patient's subsequent turn marks the conduct of eating as jointly constituted as delicate, as well as by the prolonged pause on line five, followed by the hesitations and pauses preceding the patient's mention of 'eating' (6), which is also underlined as a delicate item via the lowered volume of its delivery. Note that the following sequence of the patient's talk (8-9) concerning the same conduct of eating ('people who eat at school'), though in terms of other people's eating, is markedly unperturbed. This part of the interaction works as a deviant case (ten Have, 1999) to highlight the topic as only marked as delicate when deployed in relation to the patient's own conduct. Another way patients' bodily state and related conduct are produced as delicate in the current data, by therapists, is by downplaying their significance, via offhandedly connecting them with non-delicate therapeutically relevant matters, as in the following extract:

Extract 4.3

1 **THER:** Ok (0.6) so your:: (0.4) u:m (1.4) °um°
2 (0.9) cause with with with (0.2) with
3 (0.4) with the motivation (0.2) u:m
4 (0.5) now the recovery mountain (0.4)
5 sort of stuff (0.6) so when when you
6 leave as part of that recovery (0.4)
7 process is um: (0.2) maintaining .hhh
8 (.) u:m your weight an:d (0.5) or um
9 (.) increasing (0.3) your weight .hh
10 (0.4) um (.) as well as all the other
11 **PAT:** Yep.=
12 **THER:** =The other things (0.2) which I'm gonna
13 (.) check out about but um .hh (0.5) ah
14 (0.4) so so when you leave sort of on
15 that recovery mountain .hh (0.5) in
16 terms of motivation (.) um and to eat
17 and .hh sort of weight wi:se (0.4) do
18 you think (0.5) you want to be
19 somewhere below (0.2) what you
20 discharged at?
21 (0.7)
22 **PAT:** I don't (.) I want to stay where I was
23 sort of discharged and of move up from
24 ↑it.
25 (.)
26 **THER:** Ok.
27 (0.6)
28 **PAT:** Yeah.
29 **THER:** Ok that sounds (0.2) sounds a good
30 (0.2) [good]=
31 **PAT:** [Mm.]
32 **THER:** =Position to be in.
33 (1.2)

34 **PAT:** Yeah.
35 (0.2)
36 **THER:** U:m um .hh (.) is (.) is it working?

In this extract, the therapist introduces the matter of the patient's weight by tying it to topics of 'motivation' and the 'recovery mountain'. Similar to extract 4.3, this provides both a means for initiating the matter of weight in a non-directive way, as well as a way to delay its initiation considerably. This, combined with the notable expressive caution evident throughout the therapist's turns, again produces the topic of the patients' weight as delicate. Parallel to Weijts and colleagues (1993) study, this is also demonstrated by the therapists' avoidance of the term 'weight' when using a direct question format. Instead, it is formulated by asking if the patient wants to be 'somewhere below' (19) what she was 'discharged at', which evades any specific reference to weight. The patient's affiliation to this is evident in her following turn, where she also avoids direct mention of weight, adopting the same terminology as the therapist.

This avoidance is continued by the therapist in the remainder of the extract, with the patient's account of wanting to increase her weight termed as 'a good position to be in' (30, 32), and the process of such referred to as 'it' (36). This final question in the extract that the therapist formulates as 'is it working' (36), demonstrates the extent to which questions regarding delicate topics are delayed in the data. While the therapist's overall directive in this sequence of talk has been in regards to the patient's weight since being discharged from hospital, it is cautiously produced over several turns in the interaction. Alternatively, the therapist could have produced a direct question in regards to this in the first turn

of this sequence, but instead her tentative initiation of the topic of weight works to ‘test-the-waters’, in order to gauge the patient’s uptake of the matter. This has been demonstrated in analysis of a primary care visit (Gill, Halkowski & Roberts, 2001), where it was found that the patient produced opportunities for the doctor to ‘formulate’ the ‘upshot’ of the matter they were reporting prior to its completion, which also marked it as a delicate activity. As noted by Drew (1984):

Reporting can enable speakers to test recipients’ likely reactions, by finding what they do in response to a position implied through the reporting. But because they thereby avoid taking an official position, speakers leave themselves the option of subsequently revisiting their position in the light of the other’s initial reaction, though any such revision may itself be done implicitly through further reporting. Thus participants may negotiate positions, make concessions, stand firm or hold out on some matter, but without any of these activities being done officially. (Drew, 1984, p. 147)

This is evidenced in the current extract by the number of transition-relevant points following instances where the therapist mentions weight (8, 9, 17, 18). When these are consistently passed over by the patient, although not taken up to produce disagreement, the therapist produces an indirect and carefully constructed question regarding the patient’s weight, such that it asks whether the patient wants to be ‘below’ (19) what she was ‘discharged at’ (20). Not only is this question softened by the omission of the term ‘weight’, the inclusion of ‘do you think’ (17-18) packages the inquiry as being separate from the previously

mentioned conduct of ‘maintaining’ (7) weight, which received no uptake from the patient. The therapist’s use of the term ‘below’ (19) also downgrades the question, as it is in direct contrast to the previously stated activity of the patient ‘increasing’ her weight, which is a contextually established delicate matter. After the patient’s subsequent turn (22-24) indicating her *psychological* compliance with the matter of weight increase, the therapist produces a formulation of the patient’s prior turn, in terms of sounding like a good ‘position to be in’ (29-32). This is in line with Hutchby’s (2005) demonstration that formulations can ‘stretch’ talk to develop or topicalise matters that are ‘therapy-relevant’. In this case, the therapist’s formulation operationalises the patient’s preceding turn, such that her ‘want’ (22) to maintain and increase her weight is converted into a more substantial ‘position’ (32). The therapist’s formulation is also structured via the preface of ‘okay’ (29), which as Hutchby (2005) noted, orients to the patient’s turn as if it were directly referencing her subsequent formulation. The inclusion of ‘sounds a good’ (29) also structures the formulation so that it invites next turn agreement by the patient (Pomerantz, 1984), which is achieved via the patient’s delayed agreement token of ‘yeah’ (34). It is only then that the therapist produces her question ‘is it working’ (36), which is the first time in the sequence she directly refer to the patient’s weight related conduct in a question format.

Perspective display series

Such tentative ‘check-ups’ that function to gauge patients’ responses to prospective questions regarding delicate topics, are also apparent in the data in regards to the therapists’ delivery of delicate assessments or formulations. This has been researched in Maynard’s (2006, 2003, 1997, 1992, 1991, 1989)

extensive work on the delivery of good news and bad news in medical institutional settings. This work has its basis in a paper by Schegloff, which noted that the delivery of bad news in ordinary conversation is regularly organised via practices of ‘clueing, guessing and confirming’ that result in the recipient of the bad news actually being the one that pronounces it (Schegloff, 1988). Maynard’s (1992) study for instance, found that the process of delivering to parents a diagnostic assessment of their child’s condition represented a delicate interactional task and that the risks of conflict or tension could be minimised via the implementation of specific interactional devices. The use of perspective-display series (PDS) for instance worked to present the doctor as technically confirming the parent’s view of what difficulties their child has. Maynard outlined a basic three turn schematic design of the PDS device as follows:

1. Clinician’s opinion-query, or perspective-display invitation.
2. Recipient’s reply or assessment.
3. Clinician’s report and assessment.

While the doctor would deliver a more technically labelled and complex diagnosis, it was generally a confirmation of the parent’s lay opinion regarding their child’s state of functionality in regards to the diagnostic assessment testing they had undergone at the clinic. The emerging pattern throughout the various interviews was that doctors managed interactionally to deliver their diagnoses as being a confirmation of the parents’ previously stated account of their child, and that this produced minimal ensuing complaint or query on the part of the parents.

This was characterised in the interviews by the doctors initially requesting the parent's viewpoint of their child's diagnosis. The doctor would then reformulate aspects of the parent's view that were compatible with the doctor's diagnosis, such that the final diagnosis delivery would be produced as a confirmation of what the parent previously stated. While a number of points raised by the parents might be ignored by the doctor and or indeed contradicted, this co-implication worked up by the doctor reduced the likelihood of the parent querying what the doctor had not addressed. The data demonstrated that confirmation, elaboration and reformulation on the part of the doctor worked to provide the basis of mutual engagement between the doctor and parent in relation to the delivery of the ultimate diagnosis by the doctor.

For example, the doctor in one interview employed a marked invitation to ask a parent what they thought her child's problem was, to which she replied 'speech'. The doctor agreed with the parent but then reformulated 'speech' into 'language', which was more related to the final diagnosis. The doctors also upgraded, rather than just reformulated, parental opinions into more technical diagnostic language. This was not always successful though, and when via prolonged pauses or verbal means the parent resisted the doctor's upgrade of the diagnosis, the doctor would, in many cases, retreat from persisting with the upgraded diagnosis, and adopt more informal language to address the parent's reluctance to accept the upgrade. The doctors demonstrated acute orientation to the type of response tokens offered by parents when presented with different terminology in relation to their child's condition. For example, if neutral

continuers were offered by parents instead of agreement tokens they would be received by doctors as withheld disagreement, illustrated by the doctors' responses of backing down from the previously offered upgraded diagnosis.

Maynard's perspective display series (PDS) have been shown to function as practices relating to institutional situations or contexts requiring caution, or as a way that speakers package their actions as cautious. Silverman (1997) suggested that this might explain why PDS occur most commonly in ordinary conversations between strangers or acquaintances when the speaker who is about to present an opinion has had little or no previous access to the other's views regarding said opinion. In Maynard's paediatric setting, the functions of PDS' are described as follows:

By adducing a display of their recipients' knowledge or beliefs, clinicians can potentially deliver the news in a hospitable conversational environment, confirm the parents' understanding, co-implicate their perspective in the news delivery, and thereby present assessments in a publicly affirmative and non-conflicting manner. (Maynard, 1992, p. 484)

PDS in the current setting

In the current data, while completed PDS are not technically present, elements are apparent which are interesting in how they *differ* from PDS observed in medical consultations. In terms of their function in the current setting they are part of a number of practices that allow the therapists to achieve neutral footing

in carrying out institutional tasks, while concurrently marking the tasks as delicate activities:

1. Challenges to the client's position on a current topic; and
2. Attempts to deliver assessments or formulations to the client about such topics.

Institutionally, the first task relates to a common goal in many therapeutic paradigms, which is to challenge clients' views about themselves that are deemed irrational and or negative, especially in relation to a psychiatric diagnosis. This is apparent in the current setting where, unlike most psychiatric disorders, the participants' diagnoses of AN is largely based on a physical characteristic: their bodies being severely underweight (a point which is further addressed in chapter six). If a patient espouses a view that contradicts this, such as producing a description of their bodily state as 'obese', it would be a common therapeutic practice to endeavour to realign their view with the 'rational' institutional one, that she is in fact significantly underweight. In contrast, the governing theoretical models of the current setting, such as motivational and systems theories, advocate a neutral or non-directive stance, and low or matched investment in relation to patient change (Geller, et. al., 2001). While they employ tools such as 'curiosity' (Vitousek, et. al., 1998) to maintain such positions while exploring client views, they ultimately see change as residing with the client.

Whereas a primary purpose of a PDS in Maynard's institutional settings was for a diagnosis or assessment to be delivered to the recipient(s) (such as 'informing interviews', 1992), which accounted for the 'fixed' completion of all three turns

in PDS (as outlined above), the current setting's primary purposes allow for no such rigidity. This was also seen in Buttny's (1996) analysis of therapeutic interactions. While elements of PDS were found, such as formulations of client accounts that worked to align them with a 'therapeutic version', the formal structure as detailed by Maynard was not observed. This is apparent in the current data, where non-achievement of third perspective display turns, with repeated first and second turns, are observed. In extract 4.4 below, for example, we see the therapist repeat several different versions of the same perspective display invitation, which they eventually abandon and initiate a topic change.

Lengthy perspective display turn one and two sequences, are also featured regularly in therapists' attempts to gain patients' affiliation with the therapists' views concerning their bodily state or conduct. The drawn out nature of such sequences could arguably be related to the delicate items the perspective display invitations concern, so that the high prevalence of expressive caution marking such items as delicate, and the strong emphasis on preference organisation, contribute to it taking longer to establish collaboration on matters integral to a favourable environment for the third turn to occur.

The following extract is a typical example of similar instances throughout the data, whereby the first two turns of a PDS are repeated but the third turn not achieved, after which the therapist abandons further perspective display invitations and pursues another topic. Prior to extract one, the patient has just told therapist that she must exercise 'a lot' to avoid becoming 'overweight':

Extract 4.4

1 **THER:** And exercising a lot (.) or else I'm
2 just going to end up this overweight
3 (.) TV watching person
4 (.)
5 **PAT:** Yeah.
6 (0.6)
7 **THER:** .Hhh (.) is there (.) somewhere in-
8 be↑tween
9 (0.3)
10 **PAT:** Ye:ah (0.4) yeah well (.) I see myself
11 as like (0.6) sort of like (0.3) muscly
12 and (.) tall and normal.
13 (0.4)
14 **THER:** .Hhh (.) m:m
15 (.)
16 **PAT:** Yeah (.) >that's how I see myself<
17 (0.6)
18 **THER:** Do you feel muscly now?
19 (.)
20 **PAT:** M:m (1.0) ye:ah.
21 (0.4)
22 **THER:** ↑Do you think you look muscly (.) or do
23 you think you look (.) thin?
24 (0.6)
25 **PAT:** N:o (.) I probably (0.3) would be more
26 muscly I rec↑kon (0.4) ye:ah.
27 (1.2)
28 **THER:** .Hhh (.) do:es that mean you think you
29 look ↑thin (0.3) or would that
30 be something difficult (.) for=

31 **PAT:** =M:m (0.2) nah (.) it's probably >just
32 too difficult<(.)yeah.
33 (.)
34 **THER:** .Hh so if somebody else says that (.)
35 hh (0.3) u:m if ↑I say (.) you look too
36 thin heh .hh (0.3) u:m
37 (.)
38 **PAT:** >Well I just think it's wrong< (.)
39 cause mum's always like (.) >↑oh you
40 look good now< (.) >OH you look good
41 in those clothes< (.) and heh I'm like
42 (.) o:kay then .hh
43 (0.8)
44 **THER:** So would your mum say that to you n↑o:w
45 (.)
46 **PAT:** Ye[a:h no]
47 **THER:** [or or] was she saying that to you
48 when y[ou]
49 **PAT:** [she-] she's saying that to me
50 no:w (0.3) she wouldn't say that I'm
51 thin (.) so when you sa(h)y it I'm like
52 (.) heh (0.2) she would know better

In lines 1-3, the therapist provides a summary formulation of this, which elicits agreement from the patient on line five. Lines seven to eight then see the therapist offer an invitation to an alternative characterisation. The therapist also marks the invitation as 'delicate' (Silverman, 1994), via the 'expressive caution' noted by the pause on line six, the in-breath, and two pauses on line seven. This also marks the utterance as indicative of a perspective display invitation, whereby the therapist's utterance can be heard as an endeavour to 'co-implicate' the patient in a subsequent assessment delivery. We see in this extract though, that while the 'co-implication' is not achieved, it is at the same time marked by

much expressive caution. The patient's response in line 10 is also packaged as cautious with the pauses on lines 9 and 10, and the 'yeah' followed by 'yeah well' (10), hearable as, and functioning like, preference organisation (PO) delays (Pomerantz, 1984). While her use of the first person (10) follows the same form as the therapist in line one, it also accomplishes some preference work, in that it positions the patient as merely stating her own opinion, as opposed to directly disagreeing with the therapist. As Silverman (1997) has noted, the construction of delicate items are co-produced by both speakers, which is also evidenced here.

We then see displays of thoughtfulness from the patient via the pause on line 11, followed by 'sort of like', and another pause. This again adds to the construction of the sequence as preferenced for agreement, and demonstrates the patient orienting to her answer as not being what the therapist is 'fishing' or 'clueing' for (Pomerantz, 1984, 1980). This is confirmed by the therapist's non-affiliation marked by the (0.4) pause on line 13, the in-breath and following pause on line 14 that precede the neutral continuer, mm (Schegloff, 1982). The patient then restates her previous turn via a summary on line 16, which after a 0.6 second pause the therapist asks 'do you feel muscly now' (18). This formulation of the patient's previous reference to 'muscly' (11) into a structure of tense by the use of the adverb 'now' works to indirectly challenge the patient's view. This demonstrates Heritage's (1985) point that formulations can build on a topic from a prior turn in a non-explicit way.

This becomes clearer in the therapist's next turn after the patient's agreement tokens of 'mm, yeah' (20). The therapist, in line 22, uses the patient's

formulation (muscly) to build up an item referring to the patient's bodily state indirectly, which is continually marked as delicate in the data, 'thin' (27). This is apparent in this instance via the pre-delicate hesitation on line 23. Note also that the therapist uses the same emphasis on 'muscly' as did the patient previously (22), which marks affiliation (Sacks, 1992) with this prior turn. The patient resists the therapist's formulation, but the strong preference organisation is apparent by the pause on line 24, the continued emphasis on the first syllable of 'muscly', as well as the fact that she accepts that the therapist's formulation is possible, via the use of 'more' (25). As noted by Maynard (1992), a way collaboration can be achieved is by incorporation of prior statements from a PDS second turn response. Thus, the therapist's use of the patient's term of 'muscly' also works to build mutuality on the current topic.

The therapist's subsequent formulation on line 28 is delayed by a 1.2-second pause (27), an in-breath and a further pause on line 28, which could be particularly suggestive of two things. Firstly, of PO like delays, especially extensive given the perspective-display invitations in the therapist's previous turns which did not elicit affiliated responses from the patient. Secondly, as pre-delicate markers foreshadowing mentioning of a delicate item. These are both confirmed by the therapist's formulation (28) which is only weakly grounded in the patient's prior statement, via the patient's use of 'more' (25), and again the therapist's reference to the delicate item of 'thin'. 'Thin' is also marked as delicate by the brief transition point (0.3 seconds) on line 29, directly preceding the non-affiliation downgrade of 'or would that be something difficult for'. Similar to her previous turn, we see that although the patient subsequently

disaffiliates with the therapist's initial question ('does that mean you think you look thin', 28-29) on line 31, there is still clear organisation for preference in her utterance via the 0.2 second display of thoughtfulness (31), the micro second PO like delay (31), and following downgrade ('probably'). This precedes her verbatim use of 'difficult' (31) and agreement token ('yeah', 32) marking affiliation with the therapist's 'escape clause' ('or would that be something difficult', 29-30).

The therapist, in line 28, then initiates another question by using an alternative way of grounding her description. This begins with a move from 'you' in the previous invitations to 'somebody else' on line 34. 'Somebody else' is then repaired (35-36) with heavy expressive caution via the pauses, in-breath and hesitation, converting 'somebody else' to 'I'. The level of expressive caution and the prior downgrade of 'if' (35) packages 'I' and the subsequent statement as an especially delicate matter. In relation to the institutional setting, this is particularly relevant, given the emphasis placed on communicating 'neutrality' and 'low investment' to patients regarding their bodily states and conduct, in connection with their diagnosis. On one level that the therapist is subjectifying a statement (35-36), while referring to the patient's bodily state ('too thin') in terms of a relapsing category, is a deviant case in the data. There are no other instances of therapists making subjective statements in relation to a patient's bodily state or conduct in the transcripts (this is further dealt with in chapter five, which is concerned with how therapists *do* communicate with patients regarding these matters). However, the therapist's utterance is not explicitly subjective as it is also couched as a hypothetical statement and could be viewed in terms of

working to elicit further information from the patient in a delicate way, as noted in Silverman and Peräkylä's analysis of HIV counseling (Silverman, 1997).

While the therapist upgrades her previous mention of 'thin' (29) to 'too thin', her statement is immediately downplayed, via the laugh particle (36), which added to the initial downgrade 'if' (35), and continues to mark the utterance as delicately produced. The increase in pitch on 'I' (35) also downplays the statement, as it makes the 'I' hearable as more 'offhand', questioning, and far removed from any seriously thought-out opinion. The therapist further continues to orient to her previous statement as delicate via the in-breath, short pause and hesitation on line 36, which perhaps would have preceded another downgrade had the patient not begun her turn after the 0.1 second pause on line 37. The patient's response (38) marked by the PO like delay 'well' disaffiliates again with the therapist, though it is softened by the inclusion of 'just' and 'it's' instead of a direct reference to the therapist, which would have followed her previous turn (34-36). The patient further resists the therapist's prior formulation by providing grounds for her disaffiliation, via direct speech from her mother ('oh you look good now, oh you look good in those clothes', 39-41).

The patient's following laugh particle (41) follows the form of the therapist's laugh particle (36) marking agreement with it. When, combined with the following 'I'm like okay then', works to downplay the patient's prior disaffiliation, in that it produces the patient as not disagreeing with the therapist, but merely agreeing with her mother. Laughter is also a device used to mark and manage delicate matters in institutional settings, such as when patients

'problematise' doctor formulations (Haakana, 2001). The patient's invocation of her mother's opinion then places the therapist in the position of potentially disagreeing with the parent if she is to continue with her same line of questioning. This is a particularly delicate matter given the EDP's emphasis on the importance of 'teamwork', and 'good communication' concerning patients' families, with family therapy seen as an essential and integral component of the hospital's treatment approach. There were no cases in the data where a therapist directly disagreed with a patient's reference to her parent(s); rather it was recurrent that the therapists would make specification or clarification requests, or significant reformulations to disaffiliate with such reports indirectly. This is evident in line 44, where the therapist asks a tense related clarification question. The indirect disagreement with the patient's report is evident from the sizeable 0.8-second PO like delay (43), and strong emphasis on the adverb 'now'. The patient's response to the therapist's challenge relies explicitly on the outside authority of her mother as continued grounds for resistance. The patient's utterance of 'she wouldn't say that I'm thin' directly disaffiliates with the therapist's prior questioning sequence, while her final comment of 'she would know better' clearly construes her mother's opinion as outweighing the therapist's. Following this extract, in talk not reproduced here, the therapist retreats from her attempts to gain affiliation from the patient (that her bodily state is 'too thin') via an initiated topic change.

In extract two below, we see elements of the PDS structure that also involve the therapist having to disagree with a patient's report of her parent's views implicitly, although the therapist in this data fragment is successful in co-

implicating the patient in an alternative position. This extract is also an example of several instances in the data, where the patient ends up pronouncing a co-implicated viewpoint contrary to her parents. The disagreement with the patient-reported parental viewpoint in this extract is far less problematic than in extract one, where the patient cited their mother's opinion to warrant her own and contradict the therapist's. The current extract, instead depicts an instance where the patient is not directly in agreement with what her parents have reportedly said:

Extract 4.5

1 **PAT:** Mum and dad have said (.) that (0.2)
2 I've (0.5) wrecked the family and I've
3 split them up↑ a:nd (1.1) that I don't
4 want the family to be together and
5 (0.4) m:m
6 (1.7)
7 **THER:** That's a pretty (0.3) POWerful thing to
8 say or (.) .hh or
9 **PAT:** Mm.
10 **THER:** W-what was your response?
11 (0.4)
12 **PAT:** I said it's not true mum I don't want a
13 that (0.5) I said I just want us to be
14 happy family
15 (0.6)
16 **THER:** I wonder what they me:an (1.9) wreck
17 this family.
18 (0.4)
19 **PAT:** They reckon I've-j- (.) I've torn this
20 family apart and I've wrecked it.
21 (0.5)
22 **THER:** °.Hh° (0.5) U:m (1.3) a:h .hh but ↑what

23 things (1.0) are y- (.) your parents
24 talking abo:ut (.) when they sa:y (0.8)
25 you've (0.4) wrecked the fam:ily (0.7)
26 cause

27 **PAT:** I don't know (0.2) I honestly don't
28 know if (.) I don't know (2.7) °so°
29 (2.0)

30 **THER:** .Hhh (.)oka:y↓ .hh cause-cause (0.4)
31 u:m (2.7) I'm wondering if there's
32 different wa:ys (1.0) to describe it
33 rather than (0.2) wrec-wrecking the
34 family (0.2) u:m .hhh (0.2) cause you
35 would agree: (0.4) having anorexia
36 (0.5) has (0.3) had an ↑impact on your
37 family.

38 **PAT:** Ye:ah.
39 (1.2)

40 **THER:** It's (0.2) had an impact on all
41 families (0.5) u:m that-that's (0.3)
42 not about you (.) .hh (0.4) it has
43 probably more of an impact (.) or a
44 different impact (0.9) for your family
45 cause you live in Pemberton.

46 **PAT:** Yeah.
47 (0.8)

48 **THER:** So coming up and sort of staying up
49 (.) .hh (0.3) u:m: (2.2) the notion of
50 whether or not (.) that constitutes:
51 (0.6) wrecking (0.7) u::m-a family
52 (1.0) u:m .hhh (0.6) would you like it
53 to have less of an impact on your
54 family.
55 (0.5)

56 **PAT:** Yeah I would (0.5) I wish that I didn't
57 like impact on them so things could be
58 the way it was and stuff.

59 (0.3)

60 **THER:** I don't↓ (.) does-does that (0.5) cause

61 if-if (2.4) °u:m° (0.5) what would ↑you

62 like to replace the word wrecked with?

63 (2.3)

64 **PAT:** U↑:m.

65 (1.8)

66 **THER:** Or how-how would you: (0.2) how would

67 you descri:be it (0.8) like how this

68 (0.6) anorexia has an impact on your

69 fa:mily rather than

70 (0.2)

71 **PAT:** It's changed ↑it (.) not wrecked it

72 it's changed ↑it.

73 **THER:** O↑k (0.2) ye:ah (1.8) it's changed it.

This extract begins with the patient citing her parents as having said she has 'wrecked the family' (2). The therapist's response on lines seven and eight again depicts the delicacy with which such parental reports are managed in the data. Note the large pause on line six, characteristic of a PO like delay and perhaps withheld disagreement from the therapist. The 0.3 second pause on line seven also functions as a pre-delicate marker to the therapist's formulation of 'powerful' (7), which although overtly neutral, has overtones of disaffiliation via the emphasis on the first syllable. The further dispreference markers on line eight are also indicative of the trouble the therapist has with trying to manage a response to the patient's description that is both unbiased and non-aligned. This continues to be marked as a problematic matter for the therapist in this extract, and is dealt with in her next few turns, via repeated specification requests (e.g. 'I wonder what they mean wreck this family', 16-17) that attempt to find grounds

in the patient's answers to build collaboration with an alternative view to her parent's. As Maynard (1992) noted, working towards a co-implicated assessment is less problematic when the practices of confirmation and reformulation are possible. The patient's failure to provide grounds for such practices becomes explicit in lines 27-28, where she repetitively reports that she does not 'know' why her parent's say she has 'wrecked the family'.

The therapist's next turn is indicative of highly perturbed speech, evident by the underlined expressive caution. These repeated hesitations and delays including a number of considerably large pauses (29-32), demonstrate how delicate it is to counter a parental view. After significant struggle the therapist finally asks the patient whether she would 'agree having anorexia has had an impact' (35-36) on her family. The patient's affiliation with this on line 46, via her acknowledgement token (Jefferson, 1985; Schegloff, 1982) of 'yeah', then gives the therapist grounds to continue to build a formulation that demonstrates an alternative view. This succeeds in avoiding disagreement that the family has been 'wrecked', yet transfers agency to the 'impact' of the patient 'having anorexia' (35), and the remoteness of her residence in relation to the hospital ('cause you live in Pemberton', 44-45). The patient's continued 'yeah' tokens on lines 38, 46 and 56 finally provide sufficient grounds for the therapist to endeavour to formulate an alternative to 'wrecked' via her asking the patient what she would 'like to replace the word wrecked with' (62). This question is produced as being particularly cautious by the significant delays, hesitations and repairs preceding it (59-61). After the patient's ensuing and largely delayed hesitation ('um', 64), the therapist reformulates her previous question to 'how

would you describe it'. Following no response by the patient to the subsequent 0.8 second transition point, the therapist again reformulates the question to further 'clue' the patient to a suitable response. This is finally achieved by the patient in line 71, with 'it's changed it, not wrecked it, it's changed it'. The therapist's highly affiliated response via the emphasised agreement tokens and following repetition of 'it's changed it', demonstrates her recognition that a collaborative and alternative version of 'wrecked' has finally been accomplished.

Extract three is reflective of another regular pattern in the data whereby the therapist delivers an assessment that is similar to a PDS third turn completion, though it is formulated as a question. While the patient's responses to the therapist's PDS invitations provide enough grounds for the therapist to construct formulations and make subsequent specification requests to build up co-implication for a third turn attempt, it is subsequently resisted by the patient. The therapist then re-attempts to establish collaboration on the topic, but after further resistance by the patient, she eventually initiates a topic change.

This extract is part of a long sequence, which commenced with the patient telling the therapist that she views staying in the hospital's ED ward as akin to being in a 'prison'. The therapist then initiated a long question-answer sequence, in a bid to co-implicate the patient in aligning her perspective with the assessment of her 'eating disorder' being similarly a 'prison', a view the patient initially resisted. Just prior to the extract's beginning, the patient has told the therapist that she does not want to gain weight:

Extract 4.6

74 **THER:** .hh u:m and if you gain (.) weight?
75 (1.5)
76 **PAT:** Well (.) then I always think if I gain
77 weight and then Dr. Jones weighs me um
78 (.) then he'll think .hh (.) m:m
79 (0.5) well I guess yeah (.) I'd be
80 (.)embarrassed
81 (0.3)
82 **THER:** .hh s- so you'd be e- e- embarrassed if
83 you gained (.) w[eight]
84 **PAT:** [Yeah.]
85 (0.2)
86 **THER:** What what what what would embarrass you
87 about (.) gaining weight?
88 (0.4)
89 **PAT:** We:ll he'd think that (.) oh well she
90 must not be (.) doing (.) any
91 exerci(h)se or (0.3) .hh or (.) eating
92 a lot or .hhh °yeah°.
93 **THER:** O:kay (.) and then what might people
94 think of you if you weren't exerci:sing
95 o:r
96 (.)
97 **PAT:** That maybe (.) oh (.) she'll keep
98 gaining weight hhh
99 (1.0)
100 **THER:** A- and if you were (.) to keep
101 gaining weight what views would people
102 have of you
103 (0.2)
104 **PAT:** Of that she'll be obese
105 (.)
106 **THER:** A:::hh .hhh (.) m:m (.) so you have to
107 follow these routines and boundaries(.)
108 have to follow these rules (.) have to

109 do this exercise so you don't become
 110 obese
 111 (.)
 112 **PAT:** Mm.
 113 (0.3)
 114 **THER:** .hh o↓k (0.2) a bit different to a
 115 prison?
 116 **PAT:** Oh >it's different to hospital.<
 117 (.)
 118 **THER:** Different to hospital?
 119 (0.3)
 120 **PAT:** We:ll .hh (.) yeah
 121 **THER:** U:m (.) cause hospital has some
 122 boundaries?
 123 **PAT:** Ye:ah
 124 (.)
 125 **THER:** Rules and routines?
 126 (0.2)
 127 **PAT:** But (.) I wouldn't say (.) that
 128 they're the same
 129 (0.2)
 130 **THER:** .hh m:m (3.8) do you see Dr. Jones
 131 today?
 132 **PAT:** Yeah.

On line one, the therapist asks a question about what would happen if the patient gained 'weight', which is directly formulated from the patient's previous turn. 'Weight' is produced as a delicate item via the in-breath, hesitation and pre-delicate micro pause just before the item is mentioned (1). The emphasis on 'weight', in contrast to these other markers of expressive caution, is also heard as the therapist attempting to produce it as an ordinary topic, like a mundane checklist item to which the patient may have no difficulty responding to. In contrast, the data demonstrate that broaching the topic of 'weight' directly is in fact an

extraordinary topic, consistently marked as delicate through the data, but especially so when a therapist requests information from the patient about it.

This is apparent in the patient's answer (3), which is produced as non-affiliated via the lengthy pause on line two and PO like delays of 'well' and the following micropause (3). This is confirmed by the patient's following delayed and evasive response to the therapist's previous question. It begins with reference to what Dr. Jones would 'think' when weighing the patient if she had gained weight, but is then repaired on line five to refer to how the patient would feel in such a situation ('embarrassed', 7). Patient-reported feelings marked as negative are recurrently produced with underlined expressive caution in the data, as in this case where the feeling-description is significantly delayed via the repair, in-breath, pauses (5, 6) and hesitation (mm). This marks the description as dispreferred or problematic, which is also emphasised by the PO like delay and downgrade (well, I guess, 6), and produced as delicate via the pre-delicate marker on line seven.

The therapist's response on line nine neatly avoids any association in the patient's previous turn regarding what Dr. Jones might 'think' (5) with the reported feeling of being 'embarrassed'. Instead it is formulated to include only the feeling 'embarrassed', while keeping approximately the same form as her prior turn, except for a tense change from 'gain' (1) to 'gained' (10). While the delays prior to 'so' and 'embarrassed' also mark the turn as dispreferred or problematic, and produces the therapist's utterance as surprised and incredulous, the same emphasis on the second syllable of 'embarrassed' marks agreement

(Sacks, 1992). After the patient's subsequent and preferred agreement token of yeah on line 11, the therapist makes a further specification request, again marked as dispreferred via the repetitions of 'what' (13) and emphasis on 'embarrass' (13). We see the familiar underlined expressive caution in the patient's response via the pauses, preference delays (well) and laughter particle downplay in 'exercise' (16-19), packaging and marking the items of 'exercise' and 'eating a lot' as particularly delicate. These items are clearly collaborative, however, with the therapist's overall assessment of the patient's eating disorder being like a prison. This is apparent by her newsworthy token of 'okay' on line 20, followed by a formulation that converts her reference to Dr. Jones ('he'd', 16) to the collective noun of 'people' on line 20.

The patient's response utilises the transition point on line 23 and again demonstrates expressive caution via the downgrade of 'maybe' and micro-pauses (24), which maintain the topic as delicately produced (see chapter 6 for further explication of the work that is achieved via the pronoun 'she' and other such third person references throughout this extract in relation to the production and management of delicate items). It is evident from the therapist's next turn (27), that this reply from the patient provides continued grounds for collaboration, as she makes a further specification request that again is a formulation around 'gaining weight'. Note that this formulation, and subsequent patient reply, lack the downgrades present in the previous two turns ('might', 20 and 'maybe', 24). This would confirm that sufficient agreement was established, such that further downgrades were not warranted, and indicate that the therapist is 'on-track' with getting the responses for which she is 'fishing' (Pomerantz, 1980).

The therapist's next utterance on line 33 is a highly preferred uptake of the item of 'obese' in the patient's previous turn (31). The emphasis on the newsworthy token 'ah' (33), and its drawn out first syllable, denotes 'obese' (31) as being particularly significant. This is confirmed by the therapist's following formulation, whose 'so' preface also indicates that there is something newsworthy in the patient's previous turn (Hutchby, 2005). The formulation (33-37), and patient's responding agreement token (39), demonstrates a level of alignment between the therapist's and patient's views for the therapist to subsequently seek to co-implicate the patient in her original assessment that the eating disorder is just as much of a prison as hospital. This assessment delivery on line 43 is still marked as cautious however, via the pauses (40-41), downgrade ('bit', 41), question format and informal phrasing ('a bit different to a prison?'). The question format is how assessments or advice are regularly delivered in the data, and allow the therapists to retain their neutral footing while doing the subjective work of giving an opinion. The initial 'okay' (41) in the therapist's turn works to formulate agreement about the similarities between hospital and the patient's 'eating disorder' that have been established via the previous question/ answer sequence. This is also confirmed by the way in which the subsequent question is posed by the therapist, in that it implies that the only rational answer to it, given the sequence that has transpired previously, is to endorse the assessment that the eating disorder does reflect a prison.

The patient's response on line 43 shows demonstrates sensitivity to the potential contradictory nature of a direct disagreement, and neatly avoids this by instead

making the implied distinction that the eating disorder is a 'different' kind of prison to hospital' (43). Observably, the implicit incongruency in the patient's response is confirmed via the therapist's resulting query on line 45 of 'different to hospital'. This query nonetheless takes the form of a preferenced action via the repetition of the patient's prior turn, with the emphasis on the first syllable of 'different' marking agreement (Sacks, 1992). The patient's next turn shows strong preference organisation characterised by the 0.3 second pause on line 46, and the following 'well' and in-breath on line 47. These also downgrade the patient's subsequent and continued resistance to the therapist's assessment via the 'yeah' token. It is this downgrade that gives the therapist grounds for her next turn, which refers to similarities between the hospital and eating disorder that the patient has agreed to previously. The initial 'um' (48) functions as a PO like delay but also does some work to position the therapist's following question as merely curious and not in direct disagreement with the patient. After the patient's 'yeah' agreement token on line 50, the therapist continues with another question to rebuild co-implication with her assessment. The patient though, continues to resist ('I wouldn't say that they're the same', 54-55), after which the therapist initially responds with a neutral continuer ('mm') on line 57, which together with the large ensuing pause of 3.8 seconds, provides the patient with an explicitly underlined transition point. Her non-uptake demonstrates withheld disagreement with the therapist's assessment, after which the therapist gives up on trying for any further collaboration with the patient, and initiates a topic change ('do you see Dr. Jones today') on line 57, to which the patient immediately confirms with an agreement token ('yeah', 59).

In the following extract, the therapist is working to gain collaboration with the patient regarding the assessment or formulation that her level of exercise is excessive. While this extract again works to demonstrate the formulation as being a rational ‘fact’ in the world rather than a subjective opinion of the therapist, it differs in that it is not resisted by the patient. Prior to the sequence in this extract, the patient has been talking about how her parents do not do any exercise, and still ‘stay the same’ in terms of their weight.

Extract 4.7

1 **THER:** Are you ↑doing other things (.) so
2 apart from the ↓exercise .hhh (.) u:m
3 (0.2) see hhh (.) is the exercise just
4 running at the moment?
5 (0.2)
6 **PAT:** N:o (0.2) I usually do walking and
7 (.)
8 **THER:** So w:alking (.) >any other exercise<
9 (.)
10 **PAT:** I do aerobics
11 (.)
12 **THER:** Aer:obics (.) and how (.) how often
13 (0.5)
14 **PAT:** I try and do it everyda:y (.) except
15 when I go out like today I wouldn't do
16 it (0.2) °I didn't do anything else
17 toda:y°
18 (.)
19 **THER:** Anything ↑else (.) >swimming<
20 (0.2)
21 **PAT:** Ye:ah (.) when it gets hotter
22 (0.6)
23 **THER:** >Any other exer↑cises<

24 (0.6)
 25 **PAT:** A::h (0.4) I kick the footy ar:ound
 26 (.) and like (0.5) shoot a few
 27 baskets (0.9) when I feel like it
 28 **THER:** Hh(h)h (.) well you're just (.)
 29 quite active (.) all the [time]
 30 **PAT:** [yeah]
 31 (.)
 32 **THER:** All the ↓time
 33 **PAT:** Ye:ah.

The repetitive, 'checklist' format of questioning employed by the therapist in this extract is reflective of a three part list, in that it places emphasis on the patient's level of activity as excessive in a coherent and complete way (Atkinson, 1984). The therapist accomplishes this via keeping on topic over several turns, without orienting to attempts at direction by the patient. This is seen in line six, where the therapist self selects her turn at the first available transition point, repeating the patient's previously stated activity of 'walking', which is so-prefaced, marking it as newsworthy and therapeutically relevant (Hutchby, 2005). The therapist also uses the same emphasis as the patient on the first syllable of the verb, which marks agreement (Sacks, 1992), and then rapidly asks whether she has done 'any other exercise' (8).

This is evidence of the therapist's talk constructing the exercise in the form of a list, as seen at the end of the patient's prior turn on line six, she may have been going to disclose further activities, but were interrupted by the therapist. This 'checklist' format apparent in the therapist's talk, also works to produce the patient as reluctant to disclose information about her level of exercise. This is

accomplished via an interrogational style of questioning, whereby the interrogator asks a rapid succession of questions to elicit information from the patient. This in turn works to normatively construct the list of patient activities as indicative of abnormal behaviours, whereby information that is constructed as reluctantly produced, may normatively indicate that the patient had something to hide, and in the context of the current therapeutic setting this may be constructed as predicated to a relapsing state of being.

This 'checklist' style of questioning also works to allow the therapist to deliver her third turn formulation at the end of the list. As Sacks (1992) noted, the person asking the questions has the right to sum what has been said, although as demonstrated by Peräkylä and Silverman (1991), long question/answer sequences are reliant on both parties to produce them. On line 29 the therapist concludes that the patient is active 'all the time', a formulation of the previous list of exercises as excessive. This style of checklist questions also attends to potential non-uptake of the subsequent formulation by the therapist (Pomerantz, 1984). If the therapist had merely asked the patient 'do you think you are exercising too much?', for instance, there is far more room for the patient to simply say no, leaving the therapist then in a position where she must contradict the patient if she wants to establish the patient's level of exercise as excessive. The checklist style of questioning, on the other hand, effectively demonstrates to the patient that this is the case. By the time the therapist delivers her formulation on line 32, the patient (after her consistent displays of agreement) is left with few other rational alternatives, except producing another agreement token, which is

clearly apparent with her overlapping “yeah” on line 30 and immediate “yeah” on line 33.

This is oriented to by the therapist as being a delicate matter via the laughter token downplay on line 28, and the further downgrade of ‘just quite’. The pauses prior to ‘quite active’ and ‘all the time’ also function as pre-delicate markers and are indicative of expressive caution. It is only after the patient’s preferred response on line 30 that the therapist repeats part of her formulation ‘all the time’ (32), which again receives a ‘yeah’ agreement token from the patient on line 33. Note the term ‘active’ (29) does not in itself pronounce the patient’s level of exercise as excessive, but rather the following addition of ‘all the time’, which converts the statement into an extreme case formulation (ECF: Pomerantz, 1986; Edwards, 2000), neatly formulating the exercise as being abnormal.

Conclusion

This chapter has focused on ways in which matters concerning patients’ bodily states and associated conduct were co-produced, by therapists and patients, as delicate items in the data. By drawing on relevant work in DP/CA, particularly by Silverman (1997), it was demonstrated that a number of regular practices packaged these matters as delicate. This was predominantly accomplished via the use of ‘expressive caution’, characterised by significant hesitations and delays prior to topic initiations, as well as topic avoidance and sequential delay of direct topic questions, until prospective patient uptake was gauged.

This chapter also looked at how institutional tasks relating to delicate items were recurrently carried out in the interactions; primarily drawing on Maynard's (1992, 2003) work on PDS in institutional data. PDS were observed to function in the current setting as part of a number of practices that allowed the therapists to achieve neutral and non-directive stances, in line with the EDP's underlying theoretical models of collaboration and engagement, while carrying out potentially paradoxical institutional tasks, such as challenging patient's views and delivering assessments. This conflict of interest was strongly evident in the data, with these tasks being produced and managed as delicate items via the lengthy turn one and two PDS, in addition to high prevalence of other 'delicate' markers, such as expressive caution and the strong emphasis on preference organisation.

The interactional management of delicate items was accomplished in two predominant ways. Firstly, as outlined above, certain tasks are marked as delicate matters for the therapist, in that her neutral and non-directive stance is jeopardised. Secondly, the actual topics posed in the PDS, the patients' bodily states and conduct, are produced and marked as delicate items in themselves, as consistently observed in the data. These two layers of delicacy may account for the lack of, or delayed completion of PDS third turns, and the prolonged turn one and two sequences. The analysis clearly demonstrated that while therapists would consistently make PDS type queries and requests, they would inevitably retreat if patients' responses proved resistant. Therapists were especially sensitive to continuers and agreement tokens from patients and, in their absence, would quickly reformulate or abandon their prior topic.

In cases where all three turns in a PDS were completed, the analysis revealed these were concerned with topics relating to patient conduct, versus views regarding their bodily state. This is because practical activities concerning the body may be less complicated to achieve alignment on interactionally, and strong collaboration allows for the smooth delivery of the therapist's assessment regarding such activities. In extract four, we saw the PDS turn one and two sequence 'talk' the subsequent assessment into being, as it demonstrated turn by turn that the activities of the patient were excessive and abnormal.

Some of the activities involved in the production of PDS noted by Maynard in medical settings were also found in the present context, although in a less consistent and differently weighted form. This is most rationally connected with individually relevant purposes, such as in the case of Maynard's (1992) study where the primary aim of the medical interview was to deliver an assessment or diagnosis to parents regarding their child. This formal structure allowed a more consistent PDS 'apparatuses' to be constructed, for example:

Delivery of diagnosis = confirmation + reformulation + elaboration

In the current setting, practices of reformulation and clarification were far more common than confirmation and elaboration.

Rather than working as a device to cautiously and progressively pave the way for a co-implicated diagnostic assessment, PDS functioned in the setting as a way

for therapists to challenge patients and deliver assessments about the delicate matters of patients' bodily state and conduct. A feature of several of the extracts was that the question/answer sequences incorporated in the PDS, served as a way for the therapist to *demonstrate* to the patient that her views or conduct were irrational or abnormal.

Another relevant aspect of the analysis was the asymmetrical distribution of questions in the data, in regards to the management of delicate items and theoretical models of the EDP (see chapter seven for focus on such asymmetries in terms of their overall contextual relevance). Asking questions is particularly linked to the key principle of 'curiosity' in motivational and systems theory. According to these theories questioning prevents 'power struggles' and thus reduces the potential for the therapist to make statements that the patient could oppose (Vitousek et. al., 1998). This was recurrently apparent in the analysis where apart from neutral continuers, the organisation of therapists' turns was almost exclusively in question format. As noted by Silverman (1997) "patients produce a minimal amount of potentially delicate items at a first turn after a question, leaving it up to the recipient to decide whether to treat it as a gloss which needs unpacking" (p. 76). This was actively demonstrated in patients' turns in the current data, where they would regularly orient to questions regarding their bodily state and conduct as delicate matters via their 'minimal' responses, which in turn elicited further questions from the therapists. Sacks' (1992) point that "the person who is asking the questions seems to have first rights to perform an operation on the set of answers. You can call it 'draw a conclusion'" (p. 54), also accounts for the regularity of formulations exclusively

by therapists in third turn positions, a finding also common in other therapeutic settings, and has been termed as a question-answer-formulation (QAF) structure (Hutchby, 2005).

In conclusion, the practices observed in the analysis, regarding how the delicate items of patients' bodily state and conduct were regularly dealt with and produced as such in the data, are directly relevant to the EDP's theoretical models of engagement and collaboration. The way these interactional activities demonstrated the therapists' orientation to patient uptake of delicate items and related institutional tasks, can be viewed as a set of practices that describe the theoretical model of engagement in terms of how therapists engage with patients in practice. The analysis also provides important analytic insights into how the therapists' theoretical stance of a non-directive and neutral stance were related to *in situ* practices in the data. This is a central focus in the following chapter, which continues to look at how 'delicate' institutional tasks are carried out in the data, with particular focus on the therapists' maintenance of neutrality.

CHAPTER 5

Neutral practices in conduct ‘check-ups’ and ‘safety non-negotiables’

Introduction

The previous chapter focused on how topics concerning patients’ bodily states and conduct are consistently marked and managed as delicate items in the data by both the therapists and patients. It then examined some practices involved in carrying out interactional tasks regarding such topics, particularly in terms of perspective display series (PDS). The PDS functioned to allow therapists to indirectly contradict a patient’s perspective and demonstrate an alternative view in a collaborative and objective manner, without compromising the therapists’ position of neutrality. As Drew and Heritage (1992) noted, delicate items are often packaged via talk that is indirect and dispassionate, and are organised to maintain the speaker’s position of ‘neutrality’.

This chapter will continue to examine how therapists perform institutional tasks concerning the delicate topics of patients’ bodily states and conduct, while maintaining an engaged and neutral stance; however, it will place greater emphasis on the interactional achievement of neutrality. To begin with, this chapter draws primarily on Bergmann’s (1992) work on information-eliciting tellings as a recurrent interactional resource used by therapists to ‘check-up’ on patient’s conduct around delicate topics, in a cautious manner. It then focuses on the therapists’ position of neutrality in more detail, in particular on regular ways

in which the therapists maintain a neutral footing, and how it is *brought off* as such, in the interactions. This chapter will also look at how therapists manage their neutrality when patients disclose conduct that potentially jeopardises their physical ‘safety’. The links between these *in situ* practices and the therapists’ overarching theoretical model of neutrality as a stance are also discussed.

Information-eliciting tellings

A major task facing therapists in the current setting is eliciting details regarding patients’ conduct and bodily states. This is particularly challenging because while these topics are central to the context, they are also demonstrated in the data to be delicate items, which patients may be reluctant to discuss, or give accurate information about. Indeed, the EDP staff reported that AN patients’ frequently provide *false* information regarding these topics. Therefore, therapists need ways in which to ‘check-up’ on patient conduct that maintains continuation of the turn-by-turn therapeutic interactions (i.e. engagement), while at the same time eliciting truthful information from patients, which they may be hesitant to provide. While not in the current context, this was addressed in a classic paper by Bergmann (1992). His study analysed psychiatric interviews, where the psychiatrists’ predominant activity was to evaluate patients for the purpose of deciding for or against their hospital admission to a psychiatric facility. Bergmann observed regularity in the data, whereby the patient would offer an answer to a question that was not directly asked for by the psychiatrist. Instead of posing a question the psychiatrist would offer up a statement containing information about the patient that in turn elicited a response from the patient constituting an answer in terms of a direct question/answer format (see

Pomerantz, 1980 for a non-institutional analysis in this regard, who called such a phenomenon ‘fishing’). These ‘information-eliciting tellings’ (or ‘fishings’) operated on the premise that the teller, in this case the psychiatrists, makes a personal statement or observation about the interviewee (patient) but in a way that acknowledges the teller’s limited and restricted view of the interviewee. This then indirectly classifies the interviewee as the expert regarding all that relates to themselves and invites them to provide information in their authoritative capacity without needing a direct inquiry.

In the psychiatrists’ utterances, Bergmann found that they employed a number of methods to formulate their information-eliciting statements as originating from an impartial or third party perspective, with the effect of putting the patient in the position as the authority on the said subject of themselves. Such techniques included attributing their source of knowledge to a third person (“I just got the information...”) or formulating statements as external observations or impressions regarding the patient’s internal state (“I mean I can see from your face that the mood...”), or formulating the statement so that its factuality is left in question for the patient to confirm or deny. In effect, the patient again was cast into the authoritative position of providing the complete, first hand version of the psychiatrist’s preceding statement.

The study attributed the frequency with which information-eliciting tellings appeared in this particular category of institutional talk to two major reasons. Firstly, it gave doctors an avenue to speed up the process of information retrieval from patients in relation to prior information they had access to from other

sources. Secondly, information-eliciting tellings were considered useful devices for the psychiatrists to catch the patients out in lying. By positioning the patient as having ‘unrestricted access’ to a personal topic in contrast to the psychiatrist’s seemingly limited knowledge base, the patient was produced as the authority on said topic and could thus be ensnared into utilising their superior status to engage in an advantageous deception in terms of the overall context of the interview.

The data showed that if the psychiatrist was indeed withholding knowledge regarding the patient (‘playing dumb’), they were then able to immediately confront the interviewee based on their contradictory information. In such sequences, it was observed that patients were then likely to confess their falsification rather than continue with the deception. Such readiness to confess confirmed the effectiveness of the doctor’s initial information-eliciting telling as a means of alerting the patient to their apparent lack of knowledge concerning the stated topic. Bergmann’s paper also examined features of the talk that denoted it as ‘psychiatric talk’ via the interactants’ orientation to the context as such (see chapter seven for further discussion on this).

Some analogous features are characteristic in the current data, with some distinct contextually based variations and functions. These are logical, given the obvious disparities between the two contexts including demographic, diagnostic, professional, and institutional differences. For example, in the current context the primary purpose is for therapy to be conducted, whereas in Bergmann’s study it was for a psychiatric assessment interview to be carried out, for determining inpatient or outpatient status. Extract 5.1 below is an example of an information-elicited telling in the present setting. Prior to this extract, there was a therapist

initiated question/answer sequence regarding general activities engaged in by the patient.

Extract 5.1

- 1 **THER:** U::m (.) so your mum says o:h (0.2)
2 whether or not there's some beha:viours
3 and some things that (.) that (.)
4 you're doing (.) that you might not
5 have done for a ↓while (0.3)and some of
6 those things (0.2) I don't [↓know]
7 **PAT:** [M:m] yeah
8 **THER:** U::m .hh=
9 **PAT:** =Cause I try and ask mum but she never
10 s- says anything (.) they don't say
11 anything to ↑me.
12 (.)
13 **THER:** .hhh u- um (.) th- the biggest worry's
14 around your flu↑id
15 (.)
16 **PAT:** Ye:ah?
17 (.)
18 **THER:** And your mum thinks that (.) you're
19 probably (.) .hhh u:m (.) very afraid of
20 having flu↑id
21 (0.5)
22 **PAT:** No:t as much as I used to (.) I used to
23 be really afraid of it but I've been
24 (.) having a lot more and stuff (.)
25 °so° .hh
26 (0.3)
27 **THER:** Would you (.) would you have mo:re than
28 a litre and a half a day of water?
29 **PAT:** Probably not.
30 **THER:** How (.) how much would you (.) ha(h)ve

31 .hhh
32 (.)
33 **PAT:** Probably (1.2) o::h (0.5) probably (.)
34 about four glasses (.) >so about half of
35 what I'm meant ↑to<.
36 (.)
37 **THER:** W- would you have four four glasses (.)
38 cause I checked with your mu:m (.)and
39 your mum probably would reckon that you
40 wouldn't have that much water (.) or
41 that much fluid in a day (.)
42 **PAT:** Na:h (.) cause I've been buying myself
43 juices and things and (.) like that so
44 (.) and they're two hundred and fifty
45 mills each (.) °so°
46 **THER:** So that that (.) that's that's=
47 **PAT:** =It's not (.) it's hard because (.)
48 like (.) I don't do it in front of them
49 a lot (.) l:ike (.) I don't drink a lot
50 in front of them (.) but so then
51 therefore they say that I don't do it
52 cause they hardly see me (.)I don't do
53 it deliberately (.) it just happens to
54 be when I go to the fridge they're just
55 not there (0.2) like they're doing
56 things up in the bedroom or dad's away
57 or whatever (.) so I (.) I wouldn't
58 deliberately not do it (0.2) so they
59 think I don't drink cause I don't do it
60 in front of them (.) I've got to do it
61 in front of them (0.2) but otherwise I
62 do it at work I buy myself drinks at
63 work and things (.) °so° >and I've
64 always been told at work how important
65 it is to< (.) keep your fluids up and
66 everything °so°

67 (.)
68 **THER:** U::m .hh so then related to that is
69 probably (0.2) concern around some of
70 your concerns around (.) weight (.) and
71 (.) eating has got harder for you
72 (.)
73 **PAT:** It has been (.) like at times it has
74 been ye:ah (.) I admit that ye:ah it
75 has been like (.) much harder °and
76 stuff°

In her first turn, the therapist employs the technique described by Bergmann (1992) of ascribing her source of information to a third person, the patient's mother. This is a delicately produced utterance, evident from the vague and indirect references to 'some behaviours' (2) and 'some things' (3) that work in a similar way to the 'litotes' device Bergmann noted in his data, which allows the speaker to talk about a topic without actually naming it. The therapist's statement is also produced cautiously via the frequent preference organisation (PO) delays, downgrades and softeners. Such markers as 'whether or not' in line two, and the inclusion of 'might' in line four, construct the therapist as having no personal knowledge or opinion regarding the matter her statement is referring to, and sets up the patient as having sole knowledge to confirm or deny her mother's reports about her behaviour. This is explicitly underlined by her utterance of 'I don't know' on line six, which elicits an overlapping affiliation from the patient on line seven. Previous to the therapist's statement of 'I don't know', there are two transition points subsequent to 'while' on line five and 'things' on line six, which the patient fails to reply to, and when she does finally respond, it is not an elaboration on the therapist's reference to her supposed 'behaviours' (2). Rather,

the patient's response centres on the therapist's last comment of 'I don't know' (6), which she produces in her following turns as a complaint regarding her mother. The patient affiliates with this on line seven, and then elaborates on it in lines 9-12, constructing her 'mum', and then both of her parents, via the term 'they', as 'never' saying 'anything' to her.

From the therapist's lack of uptake of the patient's complaint, and dispreferred turns on lines eight and 13, it is clear that this was not the response she was 'fishing' for from the patient. This is then apparent from her immediate return to her original topic of the patient's 'behaviours', although in this utterance the therapist makes more direct reference to the 'biggest' (13) concern being about the patient's 'fluid' (14). The patient's subsequent failure to elaborate on this statement results in the therapist citing her third party knowledge in yet more explicit detail, however, note that her turn is still constructed as a statement rather than a question. This description of the patient as being 'very afraid of having fluid' (19-20) finally elicits an on-topic response, where while organised for preference via the patient's initial affiliation with the therapist's statement in *past* tense via 'I used to be really afraid of it' (22-23), she then says she has been having 'a lot more and stuff' (24). After some subsequent specification questions by the therapist, regarding how much fluid the patient is drinking, to which she eventually answers 'probably about four glasses' (33-34), the therapist then reveals that she has contradictory knowledge from the patient's 'mum'. This is strenuously resisted by the patient in lines 42 to 45, who claims access to the topic of her fluid intake outside that of her mother, and after the therapist's formulation attempt on line 46, suggested by the 'so' preface, the patient makes a

lengthy elaboration to support her position (47-67), which is not subsequently challenged by the therapist.

So corresponding to the organisation of information-eliciting tellings in Bergmann's study, the therapist in extract 5.1 progressively reveals information from her third party source. This in turn gives the patient authority over the topic of her fluid intake, evident via her hesitant disclosure of topic related knowledge, which increases incrementally with the therapist's own disclosures. In contrast to Bergmann's data, where patients' promptly made confessions when caught out in a lie, extract 5.1 shows that while the patient makes some admission that she is not drinking enough fluid, she ultimately resists the therapist's third party information on this topic. The patient is, however, not resistant to the therapist's information-eliciting statement on line 68, where the therapist again uses third party information, this time regarding the patient's 'concerns around weight' (70). Note, that as opposed to the therapist's previous turns on the topic of fluid, we now see pre-delicate markers before the items of 'weight' (70) and 'eating' (71), which is again consistent with the packaging of these matters as delicate throughout the data corpus. The statement topic is also delicate, in that it is delayed in the sequence, following the less delicate matter of the patient's fluid intake.

I would argue that the patient's almost immediate admission on lines 73 to 76, that she has been finding eating 'much harder', is linked to the patient's associated bodily state being accessible to the therapist through multiple sources, not least of all via *in situ* observation. The topic of the patient's fluid intake, on

the other hand, is only attributable to one other source, the patient's mother. This gives the patient significantly more scope for working up an alternative account for her actions, or normative self-assessment (Edwards, 2006), which was not explicitly evident via her physical state. This is further addressed in the following chapter, where ways in which patients produce themselves as compliant with treatment and recovery from AN are examined, despite contradictory bodily states.

In the following extract, we see a variation of an information-eliciting telling, though the topic still regards weight related conduct of the patient. Before this interaction, the therapist has been talking to the patient about the implementation of recovery strategies.

Extract 5.2

- 1 **THER:** .hhh okay (.) so with that at (.)
2 cause with the reassu:ring (.) just
3 before you went ho:me there was a few
4 things that we thought might represe:nt
5 (0.6) a:h- the anorexia being there
6 less (.) .hh (.) one was you gu:ys
7 (0.3) eating together at the table
8 (1.2) how's that going
9 (0.2)
- 10 **PAT:** ↑Good (.) yeah we always kept that
11 ↑up.
12 (0.3)
- 13 **THER:** Kept that up (.) .hh a:h (.) are you
14 eating what your mum cooked?
- 15 **PAT:** Hh °no° (0.6) one ↑night
16 (0.3)

17 **THER:** °Heh° (0.4) okay=
18 **PAT:** =Shutup I did it once (.) but (0.6)
19 I'm (.) go:nna try when I go back
20 (0.5)[this] time to try
21 **THER:** [.Hhh]
22 **PAT:** And do that (.) I'm really gonna
23 (.) like
24 (1.7)
25 **THER:** Ok (0.7) .hh heh heh heh (.) .hhh
26 °heh° (.) u(h)m .hhh (0.4) um o:h
27 (0.7) cause before you went cause we
28 thou:ght (.) not doing tha:t (0.6)
29 wa:s (.) was probably abo:ut the
30 anorexia being (0.4) a bit (0.3)
31 stronger.
32 (0.2)
33 **PAT:** :Yep.
34 (.)
35 **THER:** And the anorexia sort of creeping in
36 again (.) .hh (.) u:m (.) .hhh so
37 the not eating what your mum's (.)
38 cooking (0.7) would (.) might suggest
39 (0.5) how the anorexia's
40 (0.2)
41 **PAT:** °Mm°
42 (0.7)
43 **THER:** That's a way for it to get a ho:ld
44 (0.2)

While the therapist's turn beginning on line one ostensibly differs from an information-eliciting statement, given the question format of line eight, the one-second pause prior to the question, denotes a slot or turn completion point (Sacks, Schegloff & Jefferson, 1974), whereby the therapist's previous statement on lines two to seven could have elicited information from the patient regarding

this statement. Therefore, I argue that it is a failed information-eliciting statement, such that the therapist is then forced to ask a question on line eight, after the one-second pause. The question though is still delicately packaged, in that it is neutral and informal in structure. This is evident by the fact that the question “how’s that going” does not portray the therapist as being invested in the answer to the question. It is almost a casual add-on, which does not refer directly to the subject the question is referring to, and makes no inferences to potential indexes of success such as “is that going well” or “how often are you all eating together”.

The therapist’s question *is* similar to an information-elicited telling, in that it locates the patient as having exclusive knowledge regarding the topic of the regularity of her family eating together. This in turn, as in Bergmann’s research, puts the patient in the position where she seemingly has unrestricted latitude over the accuracy of her answer. This is apparent in line 10, where the patient’s answer of “good yeah we always kept that up” uses an extreme case formulation (Pomerantz, 1986; Edwards, 2000), combined with the general and idiomatic phrase of ‘kept that up’, which formulates the activity as routine. As Edwards (1995) concluded, formulating events as routine can be rhetorically useful when the speaker’s disposition as credible is in question. The use of the extreme case formulation produces a stronger account, which may be indicative of the exclusive latitude on the topic set up in the therapist’s previous turn. In line with information-eliciting tellings, it is at this point in the interaction that the therapist changes her previous position of having limited knowledge on the subject of

meal-time regularity, and directly challenges the patient on whether she is actually 'eating' what her mother is cooking (13-14).

This form of interactional ambush, again synonymous with Bergmann's research, is met with a concession by the patient on line 10 that "no" it has, in fact, only been "one night". The therapist's response on line 17 is indicative of the delicate way in which she handles the interaction. The muted laughter particle acts as a softener and downgrades her following response of "ok" (17) to 'good natured' teasing as opposed to a serious accusation. This is confirmed by the immediate and affiliated uptake by the patient on line 18, via her response of "shutup I did it once". Moreover, the "shutup" combined with the following "this time", on line 20, indicates that this is a reoccurring pattern, and marks the therapist's previous laugh on line 17 as being in recognition of this. This is also demonstrated on lines 25 and 26, where the therapist's laughter works to do indirect and delicate disagreement or non-affiliation with the patient's previous turn.

After first part of the extract (lines 1-23), concerned with the information-eliciting telling or 'fishing' device, the therapist then delivers an assessment of the patient's conduct as constituting a relapse with her 'diagnosis' of anorexia. This demonstrates some of the common ways in the data of how therapists make assessments of patient's conduct on a neutral footing. That is, how their formulations are produced as being merely obvious and objective remarks, such as one might observe in a conversation about the current state of the weather, and

separate from any personal opinion of their own; as has been termed stake inoculation (Potter, 1996).

The inclusive pronoun 'we' on line 27 works to distance the assessment from being a subjective one from the therapist, and marks the assessment as co-produced with the patient. This again sets up the interaction for agreement, managing possible disagreement from the patient. The therapist's use of "probably" on line 29, and "a bit" on line 30, also act as softeners and downgrade the therapist's assessment of the patient's conduct, again prefacing the interaction for agreement. Confirmation of this is seen on line 33, where the patient's turn is an affiliative "yep". The use of "the anorexia" on lines 30, 35 and 39 also does some work here, which will be addressed in detail in chapter six. Again, the therapist's assessment is downgraded on lines 35 and 38, via her use of "sort of" and "might suggest", to which the patient responds with "mm" (40). This is sequentially confirmed as a neutral continuer (Schegloff, 1982), by the therapist staying on topic in line 42. So as in extract 5.1, variations on the information-eliciting telling in the current institutional setting permit the therapists to 'check up' on patients' conduct cautiously, without it being a direct inquiry.

Neutrality as an interactional achievement

Techniques apparent in the organisation of information-eliciting tellings, such as the knowledge accredited to third parties in extract 5.2, allow the therapists to access delicate topics interactionally, while minimising potential inferences of subjective moral value. As mentioned previously, this is complicit with the

institutionally neutral position of the therapists. In this section, I address this in more depth, given that it is a highly relevant and central aspect of the institutional context. The therapists' theoretical models concerning neutrality stem mainly from motivational and systemic theories. Motivational theory describes neutrality in terms of a non-directive therapeutic stance in relation to patient change, and associates not remaining neutral with hindering patients' recovery (Geller, et. al., 2001). Systemic theory has described neutrality as:

... the creation of a state of curiosity in the mind of a therapist.

Curiosity leads to exploration and invention of alternative views and moves, and different moves and views breed curiosity. In this recursive fashion, neutrality and curiosity contextualise one another in a commitment to evolving differences, with a concomitant nonattachment to any particular position. (Cecchin, 1987, p. 406)

In turn, departures from neutrality are viewed as impeding therapists' capacity to 'act therapeutically', such that they alternatively operate as a 'social controller', which limits them to moral and or legal accounts of patient behaviours. In DP, neutrality has been considered in terms of how a speaker's 'subjective stance' is managed via interactional practices (Edwards, 2007). Ways of managing disposition have been evident in detailed aspects of vocal delivery, as well as, but not separate from, the wider sequential organisation of the interaction. As noted by Edwards:

Voice modulation and vocal mirroring permit various kinds of alignment and misalignment with, or subject-side stance on, the activities being reported. (Edwards, 2007, p. 10)

This focus on such elements as intonation, has developed from, and extended previous work on subjectivity in DP regarding the management of stake and interest (Edwards, 2007). In extract 5.2, for instance, as well as working to soften her prior conduct check-up, the therapist's laughter (17) also functions as a counter-dispositional, to display the therapist as not being too invested in her previous directive, or in terms of the EDP's theoretical model of neutrality, how they are not too committed to a particular position in practice. This is similar to how laughter has been shown to manage subjectivity or stance in complaint sequences, such that it can produce the complaint as counter-dispositional (Edwards, 2005, 2007). Likewise, in the following extract the therapist's laughter (10) follows a rather perturbed and delicately produced summary formulation and question, which received only minimal acknowledgement from the patient (9):

Extract 5.3

1 **THER:** U::m (.) a:h (0.2) u::m h- how are you
2 going to balance that s- so when you go
3 home, sort of next week >how are you
4 going to balance< holding onto the u:m
5 (.) the anorexia (.) having >this
6 energy< and wanting to be strong to run
7 u::m hh (.) >but not come into
8 hospital<
9 **PAT:** °M::m°

10 **THER:** .hhh heh heh [°heh°]
 11 **PAT:** [heh] I don't kno::w
 12 (0.5) heh heh ye(h)ah

Similar to extract 5.2, the therapist's laughter works counter-dispositionally to produce the therapist as less committed to her prior directive (1-8), in that it makes light of, and downplays her level of investment. We then see immediate uptake in the patient's next turn, via the mirroring of the therapist's laughter (11), while the subsequent 'I don't know' and laughter particles (11-12) mark agreement with the notion that she cannot 'balance' opposing aspects of her conduct. Revisiting a previous extract, we can also see how vocal delivery contributes to producing the patient's account of her behaviour as normative and rational:

Extract 5.4

47 **PAT:** =It's not (.) it's hard because (.)
 48 → like (.) I don't do it in front of them
 49 a lot (.) l:ike (.) I don't drink a lot
 50 → in front of them (.) but so then
 51 therefore they say that I don't do it
 52 cause they hardly see me (.) I don't do
 53 → it deliberately (.) it just happens to
 54 be when I go to the fridge they're just
 55 not there (0.2) like they're doing
 56 things up in the bedroom or dad's away
 57 or whatever (.) so I (.) I wouldn't
 58 → deliberately not do it (0.2) so they
 59 think I don't drink cause I don't do it
 60 → in front of them (.) I've got to do it
 61 → in front of them (0.2) but otherwise I
 62 do it at work I buy myself drinks at

63 work and things (.) °so° >and I've
64 always been told at work how important
65 it is to< (.) keep your fluids up and
66 everything °so°
67 (.)
68 **THER:** U::m .hh so then related to that is
69 probably (0.2) concern around some of
70 your concerns around (.) weight (.) and
71 (.) eating has got harder for you
72 (.)

Here the patient's repeated emphasis on the term 'front' produces the activity of drinking all fluids in the presence of her parents as non-normative, falling outside the context of usual behaviour. In line with Sacks' (1992) work on membership categorisation analysis, the patient does not need to denote this behaviour as explicitly out of the ordinary, rather it is invoked as such via it not being a category bound activity of parent/teen relationships. This is also achieved via the patient's partial vocal emphasis on 'deliberately' (53, 58), which again contributes to producing her mother's claims as implausible and non-normative. The prior placement on line 58 of 'I wouldn't', also produces what Edwards (2006) terms a 'first-person generalised dispositional expression' (p. 480), whereby the patient orients to her moral character not to deceive her parents. Similar to Edwards' (2006) institutional setting of police interrogations the patient's self-assessment does not lead to a subsequent second assessment by the therapist, as regularly observed in everyday conversation (Pomerantz, 1984). In the current context, the therapist's failure to produce a second assessment may be due to the topic of the patient's fluid intake being a preliminary topic, functioning to delicately access and delay the more therapeutically relevant

matter of the patient's weight. This is evidenced by the therapist's formulation of the patient's self-assessment (68) in relation to her 'weight' and 'eating' conduct (70-71).

As noted in chapter two, some recent CA studies have examined therapeutic models or 'stocks of interactional knowledge' (SIK: Peräkylä & Vehviläinen, 2003) in therapist/patient interactions, such as concepts of empathy (Wynn & Wynn, 2006; Pudilinski, 2005), active listening (Hutchby, 2005), interpretations (Peräkylä) and reframing (Buttny, 1996). Neutrality as an institutional position though, has predominantly been studied in news interviews (Clayman, 1991; Heritage & Greatbatch, 1991) and courtroom proceedings (Atkinson, 1991; Lee, 2005). Obviously, there are major contextual differences between these settings and the current one, particularly in the judicial system where neutrality is often a legal requirement, but surprisingly many fundamental similarities as well. In news interview transcripts Heritage and Greatbatch (1991) concluded that there are generally an *absence* of affiliative responses and neutral continuers by the interviewers, as these are viewed as potentially leading the interviewees' responses and subsequently endangering their neutral 'footing' (Goffman, 1979). In contrast such interactional markers are commonplace in therapeutic talk and do not constitute an overt departure from a neutral stance on the part of the therapists. In fact, they are standard practice, reflective of the most basic of therapeutic techniques, active listening (Hutchby, 2005). In terms of contextual parallels, in both settings the case of therapist or interviewer turns that are exclusively taken up with assessments or assertions employ alternative practices

that minimise the speakers' subjectivity, as have been described in the previous and current chapter.

What Heritage and Greatbatch (1991) termed "interviewee engendered" departures from a neutral position, whereby interviewees attempt to elicit personal opinion from the interviewers are also rare in the current data and generally resisted by the therapists. The following data fragment (5.3) shows some regular features in how therapists carry out such resistance when patients try and extract subjective views from them. Previous to the extract, the therapist has been talking about the patient having been 'pretty close' to dying when she had originally been admitted as an inpatient:

Extract 5.5

1 **PAT:** I'm not as thin as some of the girls
2 that go here
3 (0.2)
4 **THER:** M::m
5 (.)
6 **PAT:** Ella's thinner (.) so is Mel.
7 (.)
8 **THER:** Mm hm::
9 (.)
10 **PAT:** Do you think they're better yet?
11 (0.2)
12 **THER:** Oh we:ll (.) u:m you know what it's
13 li:ke (.) it takes time °and°
14 (.)
15 **PAT:** Yeah heh
16 **THER:** Heh heh (.) m:m
17 (.)

18 **PAT:** Are they bigger yet?
19 (0.2)
20 **THER:** Bigger? (.)
21 **PAT:** Yeah. (.)
22 **THER:** I don't know (.) I haven't seen them
23 for a whi:le (.) but I guess (.) when
24 people leave hospital (.) they gain
25 some weight (1.2) m:m
26 **PAT:** It's like a bit pointless if they don't
27 want to gain weight (.) get out and
28 >lose it all again<
29 (0.5)
30 **THER:** M::m
31 (0.5)
32 **PAT:** Don't you think?
33 (0.7)
34 **THER:** I- It jus- just protects their bodies
35 (.) like (.) when they're adults they
36 haven't done as much ha:rm (0.2) cause
37 otherwise people end up with really (.)
38 u::m troubled bones or (0.3) a- and if
39 they don't get kind of picked up then
40 they keep on going down (.) and then
41 they do die (.) so it's about like
42 keeping people al:ive till they do want
43 to get better (.)

Although the patient's first turn is in the form of a statement regarding her bodily size in comparison to 'some of the girls' at the EDP, her subsequent turns suggest that it is a bid to elicit an opinion on this matter from the therapist. The therapist instead uses a minimal response token of 'mm' on line four that allows them to avoid making such a reply. The patient then makes another statement, remaining on-topic from her previous turn, but providing further information that

'Ella's thinner, so is Mel' (6). This again is responded to by the therapist with another minimal response token of 'mm hm' (8), after which the patient asks a specific question of 'do you think their better yet' (10). Of particular note in this extract is it is one of the rare cases in the data where a question/answer sequence is initiated by a patient, in contrast to the majority of instances where it is the therapists asking the questions. This will be examined further in chapter seven that will focus more directly on contextual issues such as the management of 'institutional identities' in the data.

Providing an explicit answer to the patient's inquiry into her personal opinion, is neatly avoided in the therapist's following turn, where she circumvents any kind of subjective response via use of generalised and idiomatic expressions, with an absence of personal pronouns. This is maximised in the therapist's turn by the combination of 'you know' (11), which denotes the preferred next action as agreement (Pomerantz, 1984), with the idiomatic phrase 'it takes time' (12). Idioms are apt to be unchallenged and be met with agreement in talk (Drew & Holt, 1988), or as Kitzinger (2000) noted they are 'hard to resist'. In specific relation to therapeutic interactions, Antaki (2007) also demonstrated that in this context idioms can work to distract from an unwanted patient's directive and move the interaction back to the therapist's alternative agenda. This is apparent in the current setting where agreement does ensue from the patient via the 'yeah' token on line 14. The therapist's previous turn also produces a subtle shift of focus onto the patient, and away from her co-patients, which is acknowledged by the patient's laughter particle (14), as well as the therapist's following laughter particles on line 15. As in extract 5.2, the laughter also works as a counter-

dispositional (Edwards, 2007), to produce a more neutral stance, or less commitment to her previous utterance (12-14).

The patient's next turn though is once more in the form of a question regarding whether 'they are bigger yet' (17). After a clarification request on line 19, the therapist again maintains her neutrality by firstly claiming ignorance, and then reverting to a statement regarding 'people' in general gaining 'some weight' when they 'leave hospital'. This again diverts focus away from the patient's prior directive, confirmed in the patient's uptake as such in lines 25 to 27, where she makes more general reference to 'they' not wanting to 'gain weight'. We see the same minimal response token of 'mm' (29) from the therapist in response to the patient's statement as earlier in the extract, with the patient's following question of 'don't you think' (31) marking her prior statement as being packaged to elicit personal opinion from the therapist. The therapist however, resists a subjective response by again producing a generalised and neutral statement, this time grounded in 'physical safety' discourse. Given the institutional requirement and treatment 'non-negotiable' that patients' physical safety be an overriding concern, even superseding therapist/patient confidentiality, it is a particularly effective resource for therapists in maintaining a neutral position, such that it is their job to keep 'people alive till they do want to get better' (41-42), rather than a subjective reflection.

This is arguably a central explanation for the deviant case in extract 5.4 below. It is deviant in respect that it is the only instant in the data where there is a therapist 'engendered' departure from neutrality, where a therapist *explicitly* delivers a

personal opinion concerning the patient's conduct. In transcript not reproduced here, the sequence has previously concerned the patient's misuse of antidepressant medication:

Extract 5.6

1 **PAT:** I know I shouldn't be taking lots of it
2 (.) >but I do<
3 (0.5)
4 **THER:** U:m .hh (.) Dr. John said I need to
5 talk with your (.) your folks about the
6 medication si:de (.) and get them to
7 look after it for you
8 (.)
9 **PAT:** Wh:y?
10 (.)
11 **THER:** So that you don't (0.2) don't do
12 anything silly that you might regret in
13 a few years time
14 (0.2)
15 **PAT:** Mm.
16 (0.3)
17 **THER:** Keep you safe.
18 (.)
19 **PAT:** How many (.) you'd like have to take
20 heaps to O.D.(.) like a whole pack
21 (0.2)
22 **THER:** We::ll (.) it's probably pretty harmful
23 taking it in combination with alcohol
24 (.)
25 **PAT:** Ye:ah (.) the last time I did it I
26 passed out and the other time I was
27 vomiting and passed out
28 (.)
29 **THER:** Yeah (.) so there you g:o=

30 **PAT:** =Heh heh heh [heh]

31 **THER:** [Heh] .hh (.) read the
32 signs (.) I don't thi- (.) not (0.2)
33 not ↓good (0.2) have you given any
34 thought to taking it like (.) on a
35 regular basis so that it does help you
36 everyday (.) rather [than]

37 **PAT:** [Not] really.
38 (0.2)

39 **THER:** H::m
40 (.)

41 **PAT:** I h- have more f(h)un with it when I'm
42 drinking heh
43 (0.9)

44 **THER:** M:m (1.5) m::m (0.5) would you be open
45 to [that]

46 **PAT:** [What?]
47 (.)

48 **THER:** Ta- taking it regularly to help with
49 your anxiety everyday (.) rather than
50 (.)

51 **PAT:** N:o (.) cause it makes my head weird
52 (.) I don't like it
53 (0.5)

54 **THER:** I I I don't think .hh (0.2) you've
55 taken it long enough and (.)
56 consis(h)tently enough to u:m heh (.)
57 know what it's actually like .hh
58 (0.3)

59 **PAT:** I- I've taken it for a few days (.)
60 °and°
61 (.)

62 **THER:** Yeah (.) but it's like anything that
63 you take for a day or two (0.2) it's
64 going to take a few days to adjust
65 (0.3) m:m

66 (2.8)
67 **PAT:** [*inaudible celebrity name*] is rea:lly
68 ugly
69 (0.3)
70 **THER:** I'm not really even sure what she looks
71 like=
72 **PAT:** =Well (.) she's ugly.

Initially in this extract the therapist makes overtly neutral responses to the patient's admissions of misusing her medication, employing the previously cited techniques of attributing her knowledge to a third party (4-7), utilising 'physical safety' discourse, such as 'keep you safe' on line 17, as well as making downgraded and generalised statements (22-24). In line 32 however the therapist's utterance of 'I don't thi-' may have been the beginning of an explicitly subjective statement regarding the patient's conduct, but is repaired to a more general remark of 'not, not good' (32-33). This is not the case in line 54, where the therapist does not repair her use of the personal pronoun 'I' in connection with a subjective assessment regarding the patient.

The prior repair in line 32, coupled with the delicate and perturbed packaging of this turn, as characterised by the expressive caution and downgrade via the laughter particle on line 56, are suggestive of the therapist's orientation to the atypical nature of her statement. It is also of interest that the patient's uptake of the statement is minimal and non-affiliated, and on her next turn, she makes a noticeably delayed and abrupt topic change. This is in contrast to other cases in the data where the therapists deliver indirect assessments or assertions, via practices outlined previously in chapter four and this chapter, such as PDS and

information-eliciting tellings. In these instances, the patient uptake was considerably greater, evidenced by no other cases of patient-initiated directive changes.

Conclusion

The analysis in this chapter has further explored some of the practices employed by therapists to carry out institutional tasks regarding the delicate items of patients' bodily states and associated conduct. In terms of the EDP's theoretical model of neutrality, the analysis demonstrated it to be an overall social achievement comprised of regular practices that were co-produced and managed in the turn-by-turn interactions. Of particular focus was the regular practice of what Bergmann (1992) termed 'information-eliciting tellings', that functioned as a way for therapists to carry out the therapeutically relevant task of 'checking-up' on patients' conduct, while managing the potential departure from a neutral footing that such a task could invoke. The practice was found to be organised in the current data such that therapists made a statement that downplayed their own knowledge on a topic regarding patients' conduct, while giving patients' unrestricted authority on the matter. This was regularly achieved via therapists attributing knowledge regarding a patient's conduct to a third party source, commonly a parent, which could subsequently be confirmed or denied by the patient. Some cases were also found where the therapist's information-eliciting statement resulted in the patient passing over the subsequent turn completion point, after which the therapist would eventually produce a question regarding the statement. This may be due to the particular patient demographic of the current setting, such that children and adolescents are often reluctant to volunteer

‘therapeutically relevant’ information without being directly asked (Hutchby, 2005; Silverman, 1997).

A distinct contextual feature of the analysis was that patients made more immediate disclosures regarding conduct relating to their *bodily* state and were more likely to confess if ‘caught out’ in a lie concerning this matter. As suggested, this may be related to a patient’s physical state being clearly accessible to the therapist via multiple sources including face-to-face, *in situ* observation, in contrast to conduct that was not so visibly apparent such as the patient’s fluid intake in extract 5.1. Other important interactional features such as laughter also functioned as counter-dispositionals in the current setting, managing the therapists’ subjectivity via displaying a reduced commitment to prior delicately marked directives that potentially incurred subject moral value and jeopardised their neutral footing. The analysis also demonstrated ways in which the therapists resisted patient engendered attempts to elicit personal opinion from them. These included the use of minimal response tokens such as ‘mm’ and generalised and idiomatic expressions. Such practices allowed therapists to conceal the subjectivity inherent in many common therapeutic tasks such as conduct check-ups or challenges.

The therapists’ utterances also oriented to, and displayed a neutral stance via the recurrent omission of personal pronouns. This was consistent throughout the data with the exception of one deviant case where a therapist explicitly used the pronoun ‘I’ in an assessment regarding the patient’s conduct (extract 5.5). This single instance may have been due to the patient’s conduct being constituted as

self-harmful, an issue that would institutionally override adherence to a neutral stance given the EDP's fundamental commitment to patients' physical safety. The therapist's utterance clearly oriented to the inclusion of the personal pronoun as uncharacteristic though, via hesitations, delays and softeners. In turn, this confirmed neutrality to be a highly relevant and stable feature of the institutional context. This deviant case also demonstrated a significant link between the EDP's theoretical models of neutrality and engagement in practice, via the lack of patient uptake to and direct topic change subsequent to the therapist's subjective statement. This suggested that the interactional practices that produce the therapist's neutral footing also constitute a way in which the therapists engage with patients *in situ*.

CHAPTER 6

On requests for accounts and the management of accountability

Introduction

In the last chapters, I have looked at some ways in which therapists carry out tasks that deal with ‘delicate’ items, which are potentially at odds with aspects of the institutional setting such as maintaining a collaborative and neutral position. As noted, it is topics and tasks concerned with patients’ bodily state and conduct that are recurrently marked and managed as delicate items in the data. This chapter shifts from a therapist focus in these matters to one that highlights how patients manage activities concerning these delicate items.

In the EDP, the state of patients’ bodies, in terms of weight, is a central factor from the first contact they have with the hospital. Body weight is the main basis for hospital admissions and readmissions and, crucially, diagnosis of AN. As mentioned in previous chapters, this is unusual in respect to most mental disorders, which generally have non-physical diagnostic criteria. It is made clear to EDP patients that the therapists have no influence in whether they are readmitted to, or released from hospital, and that the therapy setting is a ‘safe place’ that ‘accepts patients where they are at’, and is not concerned with compliance or non-compliance with overall clinic treatment goals such as weight maintenance. The EDP primarily aims to locate ‘responsibility’ or ‘agency’ for recovery with patients, which is reflected in the underlying approaches taken by

therapists, involving neutrality and low investment in regards to change.

Ultimately, though, the hospital will admit or readmit patients based on their physical state, and against their will if necessary. Such involuntary admissions are exceedingly rare, even though most patients do not favour hospitalisation.

The therapists reported that the adolescent demographic, which brings with it strong parental influence, coupled with the institutional might of a hospital, will ‘almost always’ agree to readmission if they are told it is required.

In its ten year history the EDP has endeavoured to implement a programme that can best handle the apparent ambiguity between being a powerful institution that has a mandate to keep patients physically alive, even against their will, while simultaneously facilitating an environment that maximises patients’ ‘readiness for change’. The fact that the programme has had zero mortalities to date and a high retention rate in its therapeutic services would indicate significant success in striking a balance between these competing agendas. And as mentioned, one such measure taken in this regard has been the overt exclusion of therapists from the direct case management of patients, separating them from decisions regarding hospital admissions or re-admissions. However, although these measures are in place, the fact that the therapists themselves are visibly part of the EDP, which is physically and conceptually set within the larger children’s hospital itself, arguably positions the therapeutic relationship in this institutional context. As we also saw in the last chapter, both the institutional setting and adolescent demographic of patients, also dictate that therapist/patient confidentiality is waived if clinical judgement indicates a patient’s safety is at risk. There has been significant comment in conversation analytic literature on

asymmetry in medical settings in regards to issues of power, authority and control (Pilnick, 1998; Gill, 1998; Heath, 1992; ten Have, 1991). As Maynard (1991) suggested, such asymmetry is 'interactionally achieved' by both the professional and the patient rather than solely imposed by external institutional processes. He argued that interactional reproduction of these asymmetries may be a means whereby doctors and patients handle the interactional problems created by the medical consultation and context (this is further explored in chapter seven).

As noted earlier in this thesis, there have been no studies to date that have investigated the ways in which patients' bodily states and conduct are made relevant in naturally occurring therapeutic interactions in treatment programmes for anorexia nervosa. While not directly analogous, there has been some related recent work by Pillet-Shore (2006) who examined weight accountability practices in weight measurement procedures in nurse/patient interactions. It was found that even though weight measurement in the context was merely part of a number of routine 'check-up' procedures, it posed a significant matter of 'interest' to patients who regularly produced expansive moral accounts in response to the numerical measurement of their weight.

Given the potential hindrances to a 'neutral' therapeutic context in the EDP, it is not surprising that 'cautiousness' continues to be a recurrent feature in the data. This chapter begins by focusing on a patient and therapist activity recurrently observed in the data, that centres around managing accountability, or agency, for patients' bodily states and conduct in terms of weight gain or weight loss, with

the former predicated to a recovered bodily state and the latter to a relapsed bodily state. There is also an added dimension in this context where information concerning the *physical* compliance of patients to treatment goals can be ascertained via non-verbal observation by therapists, or by a third party source such as a team doctor or parent. In this regard, literature is drawn on from DP, particularly by Wiggins and colleagues (Hepburn & Wiggins, 2005; Wiggins, 2002; Wiggins & Potter, 2003; Wiggins, Potter & Wildsmith, 2001), which has focused on embodiment in interaction, as embedded in, and constructed for interactions (as discussed in chapter two). Also in this chapter, I examine other instances in the data where the term ‘anorexia’ appears, in terms of interactional work achieved via its use.

Marked and unmarked account requests and accounts

To start with, patients regularly orient to questions from therapists relating to their state of being (e.g. ‘how are you’), as being indirect requests for them to make an account for their bodily state or conduct, as in extract one below:

Extract 6.1

1 **THER:** Um (0.8) start with a br-broad question
2 how's it going?
3 **PAT:** ↑Good.
4 (.)
5 **THER:** Yeah?
6 **PAT:** ↑Yeah.
7 **THER:** O:kay (0.6) u:m (0.9) what does good
8 mean?
9 (0.4)

10 **PAT:** U:m (1.0) I'm keeping up really well
11 with everything I've been doing like
12 (.) eating wise and stuff (0.4) which
13 is ↑good (.) s:o,
14 **THER:** That is good
15 **PAT:** :Yep.

On line three, we see the patient provide a standard receipt token of 'good' to the therapist's previous question of 'how's it going' (1-2), after which the therapist repeats the question with a 'yeah' token (5). Her next turn confirms this question as asking for elaboration from the patient, as she then makes a further specification request of 'what does good mean' on line seven. The patient then accounts for her being 'good' in terms of 'eating wise and stuff', that pertains specifically to body related conduct. We then see affiliation from the therapist in line 14 via 'that is good', with the emphasis on 'is' preceding 'good' underlining agreement with the patient's previous use of 'good' on line three. Note the prevalence of expressive caution in the therapist's question on line seven, and the patient's following turn via the lengthy pauses and hesitations, continue to mark the patient's bodily state and conduct as a delicate matters, which both the therapist and patient orient to. It is typical in the data that therapists affiliate with patient accounts, as above, that locate agency of the account with the patient. In other words patient reports of 'weight gaining' activities are credited to the *patient* themselves. This is also true of extract 6.2, where the patient is referring to having a nurse monitor her meals:

Extract 6.2

1 **PAT:** I'm hoping today that I'll get (0.2) it
2 off cause l:ike (0.5) I've done (.)
3 s- sort of well in the last couple of
4 days (1.2) so
5 **THER:** W- when you say well
6 (.)
7 **PAT:** Oh (.) like I've (.) gained
8 **THER:** Okay
9 (.)
10 **PAT:** Weight
11 **THER:** Good.

In this extract, we see the patient volunteers to the therapist that she has 'done sort of well' (2), after which the therapist makes a specification request of 'when you say well' (5). The patient again orients to this as being a request for an account regarding her bodily state or conduct, via her cautious response of 'oh like I've gained' (7) and her further qualifier of 'weight', on line 10. We see strong affiliation with this account from the therapist on line 11, with her response of 'good', again reflecting the pattern for therapists to endorse patient agency for conduct relating to a recovered bodily state. Also of note in this extract is the therapist's acknowledgement ('okay', 8), of the patient's report of 'gained' (7). It is interesting that the acknowledgement precedes the patient's following utterance of 'weight' (10), which again marks gaining weight as a highly preferred topic in the therapeutic setting.

Patient initiated agency repositioning accounts

There are also some regular ways in which patients make accounts for their conduct when it is predicated to a category of relapse or 'anorexic',

predominantly weight-loss activities. One way is that they orient to objective factors to produce themselves as being *psychologically* compliant with a recovering bodily state, when demonstrably *physically* non-compliant.

Extract 6.3 follows on from a long question/answer sequence of transcript, where the therapist has been asking general questions about how the patient has been:

Extract 6.3

1 **THER:** U:m (.) wanting to (.) exercise
2 more?
3 (.)
4 **PAT:** I haven't been doing (.) wanting to
5 do any of that (.) li- like I've been
6 wanting to go out like wan- wanting to
7 do all the normal things that a normal
8 girl my age would just want to do (.)
9 so I'm feeling really normal then (.)
10 the weight's just (.) not the:re and
11 then that's the hard thing trying to
12 like (.) think about well I've got to
13 do this and everything (.) >so that's
14 what I find really hard to< (.) it's
15 the weight bit I'm still struggling
16 with (.) s:o
17 **THER:** Yeah (.) and it sounds much more
18 normal (.) especially compared with
19 twelve months (.) twelve months ago u:m
20 (.). you know heh
21 (.)
22 **PAT:** Ye(h)ah
23 (.)
24 **THER:** Heh .hh u- u:m (.) and I guess for
25 (.). Dr. Jones in the medical reviews

26 (.) um (.) with all those other
 27 changes happening (.) they just now
 28 (.) they're in your favour of going
 29 home [again]
 30 **PAT:** [Yeah]
 31 (0.3)
 32 **THER:** U:m .hh (.) like (.) just
 33 (0.2)
 34 **PAT:** How do I get the (.) weight bit to
 35 come along now (.) now that I've got to
 36 get=
 37 **THER:** =Yeah ye:ah (.) um (.) now maybe
 38 (0.2) I was talking with Ally today and
 39 she said there's a (.) a new
 40 dietician [girl]
 41 **PAT:** [Oh] ye:ah

In line one the therapist cautiously makes an account request concerning the patient's conduct, of 'wanting to exercise more'. The patient's response beginning on line four shows the same pattern seen in extracts 6.1 and 6.2, where the patient's uptake of the question is to respond with an account for her bodily state in regards to weight. In her account, the patient goes to great lengths to categorise herself as recovered psychologically, via repeated specifications of how 'normal' she feels. She then accounts for her bodily state in terms of 'the weight's just not there' (10), and 'it's the weight bit I'm still struggling with' (15). The absence of personal pronouns prior to 'weight' and the inclusion of 'just' on line 10 works to separate the patient's bodily state from her psychological state in terms of accountability, while 'bit' on line 15 functions to downgrade her weight's significance. At the same time she continues to produce herself as compliant with treatment goals, via her 'struggling' (15) and 'trying'

(11) with something she finds 'really hard' (14). As is recurrent with similar types of patient accounts in the data, the therapist responds with affiliation on line 17, via an emphasised agreement token ('yeah'). The therapist then delivers information to the patient regarding the medical team's endorsement of her 'going home' (28).

Following affiliation from the patient (30), the therapist's next turn is markedly perturbed, with strong expressive caution via the pauses, hesitation, in-breath and downgrade of 'just' on lines 31 and 32, packaging the topic of the utterance as delicate. This topic is confirmed as 'weight' by the patient on line 34 who finishes the therapist's turn for him. The immediate affiliation from the therapist on line 37 verifies her previous turn as the beginning of an account request regarding the patient's bodily state in terms of weight. The fact that the patient could predict this from the few words of 'um, like just' is indicative of the centrality of the topic in the context, and demonstrates her orientation to 'weight' related topics as being regularly packaged with expressive caution, and may account for her recognition as such. In line with her neutral stance, and separation from physical treatment of the patient, the therapist then makes reference to a 'dietician' (40) instead of engaging in any personal advice delivery to the patient on how she might gain weight.

In summary, this extract shows an instance where both the patient and therapist's utterances constitute and account for the patient's bodily state as problematic, but locate agency for this outside her psychological state, which in contrast is co-produced as 'normal' and unproblematic. Just as the patient referenced her

bodily state via ‘the weight’ (10, 34), Parry’s (2007) study of physiotherapy treatment consultations also observed that when body parts were constituted by speakers as troublesome there was an absence of personal pronouns, producing distance between the patient and the offending body part. The analysis also showed that speakers reverted to using personal pronouns when troublesome body parts were being referenced in terms of the patients’ own ‘actions and efforts’. This is again similar to practices in the current data corpus where personal pronouns are invoked when referencing the active, psychological recovery of the patient (e.g. ‘I’m feeling really normal’, 9).

Extract 6.4 below is another example of a patient initiated agency repositioning account, though in this piece of transcript it is the therapist that calls attention to the patient’s physical non-compliance:

Extract 6.4

1 **PAT:** B- but twelve months later I’ve been
2 running the shop (.) at Mily’s↑ (0.2)
3 so I’ve been the boss (.) and u:m
4 yeah (.) j- just doing a lot mo:re
5 things than what I was (.) I’ve got
6 so much more energy (.) getting along
7 with people so much better and
8 everything↑ (.) so like totally the
9 opposite
10 (.)
11 **THER:** C- Cause u:m .hh (.) cause (.) an-
12 and I agree (.) socially (.) in
13 yourself (.) u:m (.) but (.) h- how
14 you are (.) how you’ve been the last

15 couple of times is quite different
16 (.)
17 **PAT:** M:m
18 **THER:** That doesn't seem to be translating
19 to (.) weight=
20 **PAT:** =N:o
21 (0.2)
22 **THER:** I- I guess that would be part (.) of
23 your parent's um (.) anxiety (.)
24 °m:m° .hhh
25 (0.2)
26 **PAT:** Actually it hasn't worried mum and
27 dad that much (0.2) >though like< (.)
28 c- cause they can see that I'm still
29 eating the same (0.2) like more every
30 time like everyday and trying all
31 different (.) food and stuff↑ (.) th-
32 they're pretty happy with how I'm
33 going (0.2) like they're they're not
34 as worried >as what they usually are<
35 (.) heh like you can tell when mum
36 and dad get worried (.) but they
37 haven't seemed to be like that↑
38 (0.6)
39 **THER:** U::m (0.2) ye:ah (0.4) o:kay (.)

In the patient's first turn (1-9), she produces an account for how she has been, in terms of activities that are predicated to a 'recovered' state. Notably the described conduct does not reference the patient's bodily state, instead focusing on such activities as having 'so much more energy' (6) and 'doing a lot more things' (4-5). We also see the use of an extreme case formulation (Pomerantz, 1986; Edwards, 2000) in 'so like totally the opposite' (8-9), which produces a strong contrast to a problematic or 'anorexic' category, which the patient has

been diagnostically categorised as. The fact that the patient's physical weight is central to this category, and in turn the institution may account for the patient's extreme use of phrasing here, such that she needs to produce a far stronger account of non-weight related activities in contrast. This is also confirmed by the therapist's subsequent turns that re-constitute the patient's physical state as problematic (11-19). The strong expressive caution, via the significant hesitations and pauses again produces this as a delicate task, while the summary formulation on lines 11-15 delays the topic of weight, and separates it from the patient's interior or psychological efforts at recovery. This is termed by the therapist as 'socially' (12) and 'in yourself' (12-13), which with the following utterance of 'that doesn't seem to be translating into weight' (18, 19), provides an account of the patient as disconnected from her body. The latched speech denoting the patient's immediate response on line 20 of 'no' may be due to the patient's physical state being observable by both parties *in situ*, especially as the patient had previously provided such a strong account of how 'much better' she has been doing. This is also demonstrative of the patient's affiliation with the therapist's apparent 'split' of her mind and body, and demonstrates how it is locally produced as such by both speakers.

We then see further reference by the therapist to the patient's weight on lines 22 to 24, in regards to their parents' 'anxiety'. Again the delicacy with which this utterance is packaged is apparent via the absence of the term weight, and the softener of 'I guess', while the therapist's subjectivity (as demonstrated in chapter five) is neatly managed by the matter of the patient's weight being accessed indirectly by invoking a third source, her parents. While it would seem

that the patient cannot directly disagree with assessments and accounts of her bodily state, given that it is an incontestable feature of the setting, her next turn again demonstrates the contrast with psychological matters. As well as showing preference organisation, the patient's initial use of 'actually' in her utterance (26-37) invokes greater access in regards to her parent's psychological reaction to her problematic body weight, than the therapist's. Again, there is an absence of the direct use of the term weight, which shows orientation to it as delicate. Instead, the patient uses 'it', and only in reference to producing an account of her parent's psychological state, which in her previous description she produces in extreme terms.

The centrality of patients' physical bodies to the current setting is explicitly evident in the following patient-initiated agency repositioning account, where the patient has been talking about how she has been since the previous therapy session:

Extract 6.5

1 **PAT:** But with the way I've been fee:ling
2 (0.2) I've been (.) picking up la:mbs
3 (.) for the past week↑ (.) and
4 that's something I wouldn't have
5 befo:re=
6 **THER:** =Yep↑=
7 **PAT:** =If someone had a:sked me to do that
8 (.) I wouldn't have had the energy to
9 do that (0.3) and I'm feeling >really
10 good in my head< too↑
11 (0.2)

12 **THER:** O:::k .hhh (.) w- what does (0.2) the
13 .hh y- your (.) weight say?
14 (0.4)
15 **PAT:** When I- I last went (.) u::m it was
16 (0.2) dow:n (.) one point two kilos
17 (0.2) and that's about the only thing
18 (0.2) cause my blood pressure and
19 everything's fine=
20 **THER:** =Yep
21 **PAT:** So::
22 (0.5)
23 **THER:** B- but (0.2) ah what's Doctor Jones
24 going to admit you on your blood
25 pressure (0.2) or or (0.2) your
26 weight?
27 (0.7)
28 **PAT:** Your weight (0.2) probably (.)
29 depending (0.2) if if my blood
30 pressure's bad ° >he would< ° (.)
31 ° m::m ° .

In this extract the patient's utterance constitutes her mental state as unproblematic ('feeling really good in my head', 9-10). It also produces their bodily state as differing to how it was 'before' (5), by reference to a physical activity ('picking up lambs', 3), with the inclusion of 'too' on line 10 emphasising that she is feeling both physically and psychologically well. As in the previous extract, the therapist's following turn is a delicately produced question about the patient's 'weight' (13), with only minimal acknowledgment of her prior description ('okay', 12). This failure by the therapist to produce a formulation of, or question, in regards to the patient's previous account, and her immediate shift to the matter of the patient's weight, again confirms weight as a

central institutional topic. While ‘weight’ (13) is preceded here by a personal pronoun (‘your’), the inclusion of ‘say’ (13) still separates the patients’ weight from an agentic self. There is also a perturbed repair from ‘the’ (13) to ‘your’ in the therapist’s utterance, which may be due to the normative pairing of ‘the’ with the topic of weight in the setting. The patient’s response produces a confirmation of her weight as problematic (‘it was down’, 15-16), but contrasts this to the remainder of her physical state being ‘fine’ (19). Note, the absence of personal pronouns in relation to the patient’s reference to their weight, which sequentially confirms the therapist’s use of ‘say’ (13) in her previous turn. We then see a non-affiliated response from the therapist (23-25), which produces weight as a matter that has contextual priority over other physical factors, such as ‘blood pressure’, via the therapist’s reference to hospital admission being based on ‘weight’ (25). While the patient subsequently downgrades her agreement, she does not dispute the institutional priority of weight, which is produced half-heartedly via the lower volume and increased speed of ‘he would’ (29). The delivery of the concluding ‘mm’ (29) is also quieter which packages the utterance with less conviction.

Therapist initiated agency repositioning accounts

Extract 6.6 below provides a further instance of agency for a patient’s bodily state being repositioned, but is initiated by the therapist in her account request, as opposed to in the patient’s subsequent account. However, as in the previous extracts, the overall account is locally produced by the patient and therapist. Prior to this extract (in transcript not reproduced here), the therapist has been asking the patient questions regarding her going home from hospital:

Extract 6.6

- 1 **THER:** .Hhh (0.8) and the other (0.4) thing
2 which is more s- (.) specific to
3 yourself (.) was going home and (.)
4 .hhh the idea a- or of (0.3) losing
5 weight (0.5) so to (.) lo:se (0.5) a
6 small amount of weight .hh would be
7 about (0.7) the anorexia rather (.)
8 than the (.) Natasha (0.4) so (.) so
9 where's that at (.) in terms of (.) I
10 .hh if I could .hh
11 (.)
12 **PAT:** I've lost (.) a- a small bit (.) but
13 (0.2) then (.) I- I was: (0.2) after
14 losing (0.6) those bits I've been
15 telling myself I don't really want to
16 have it down here I want to be back up
17 (.) so I've been (0.2) trying to use
18 that in my thinking um (.) to get the
19 weight back up (.) to target.
20 (.)
21 **THER:** And how's that going
22 **PAT:** ↑Good.
23 **THER:** ↑O:kay (0.2) .hhh um .hh with that
24 cause that's that motivation (.) cause
25 all of those things (0.7) cause (.)
26 the (0.6) :the (0.6) would you agree
27 that (.) the (0.2) the want to lose
28 (0.4) some wei:ght (0.4) is about the
29 anorexia.
30 (.)
31 **PAT:** Yeah.

There is underlined caution in the therapist's formulation of this question, which again highlights the delicate nature of making account requests regarding patients' bodily states. The request neatly works to locate agency for any potential weight loss outside the patient, which frames her subsequent request regarding whether the patient has lost 'weight' in a neutral context. This is achieved via losing weight being first referred to indirectly as 'the other thing' (1-2), and then upgraded to 'the idea of losing weight' (4-5). While I do not have video footage to analyse the patient's line of gaze, the frequency of such upgrades, delays and repairs in this turn suggest that the therapist is closely aware of signs of dispreference from the patient, which are arguably absent given that the therapist continues to stay on topic for the remainder of the turn. The therapist even begins to downgrade the entire question via the repair from 'in terms of' to 'I', and then the downplay to 'if I could'. The therapist's statement, of 'so to lose a small amount of weight would be about the anorexia rather than the Natasha' (5-8), explicitly shifts the agency of weight loss from the patient onto 'the anorexia', with the third person reference to the patient of 'the Natasha' excluding any use of personal pronouns. This again packages the question's item as delicate, given that the account request actually concerns the patient's bodily state, but fails to invoke any language that makes reference to this.

The patient's turn beginning on line 12, is also cautious, and while it does not delay in providing an account of a 'small bit' of weight loss, there is no actual reference to 'weight', which marks it as delicate. Note, that there are no activities directly related to physical compliance cited in this turn by the patient, such as commitments to eat more, or exercise less. Rather, we see the same production

of the patient as psychologically compliant to treatment goals (14-18) as in previous data fragments, via her 'wanting' to gain weight and 'trying' to use that in her 'thinking' to get 'the weight back up to target' (19). Note also, that when the patient does refer to 'weight' (19), she excludes the use of personal pronouns and instead preface it with 'the'. This follows the form of 'the anorexia' and 'the Natasha' in the therapist's prior turn, and again repositions agency for the patient's bodily state. This is again produced as such by the therapist on lines 27 to 29, where she explicitly states that 'the want to lose weight is about the anorexia'. In Kurri and Wahlstrom's (2007) study of psychotherapy talk, they found that 'agentless' talk was primarily used by the client to produce themselves as unaccountable for their actions, and that the therapist used reformulations to gradually increase the client's level of agency. As we have seen in the current analysis, however, agentless talk is produced by both patients and therapists, where they collaboratively reposition agency for the patients' bodily state in terms of the diagnosis of 'anorexia'.

Other uses of 'anorexia' in agentic repositioning

In this chapter the term 'anorexia' has been primarily examined in terms of the agentic repositioning involved in the co-production of accounts of patients' bodily states and conduct. Apart from the 'past tense' instances in extracts 6.10, 6.11 and 6.12 below, the term 'anorexia' does not appear in any patient utterances, being solely used by therapists. In such cases 'anorexia' or like terms are also used to do agentic repositioning work, although in terms of accounting for problematic mental states, rather than bodily conduct. For example in extract 6.6, the interaction has concerned the patient's views on gaining weight:

Extract 6.7

1 **THER:** So what's the fee:ling that goes with
2 (.) the weight?
3 (1.2)
4 **PAT:** I guess like (0.2) like do you know
5 like (.) I said (.) about my
6 [stomach]
7 **THER:** [Ye:ah]
8 **PAT:** Ye:ah (.) that (.) that's the hard
9 thing (.) a- and I look (.) and I
10 look (.) and I think (.) >oh you fat
11 as fucking person< and all that (.)
12 and I still ye:ah feel really yuk and
13 everything.
14 (0.2)
15 **THER:** U:m (0.8) i- is (.) is it u:m (0.2)
16 how do you check (.) cause it i:s the
17 anorexia
18 (.)
19 **PAT:** Ye:ah.

The patient in this extract produces a clearly negative account of her feelings associated with gaining weight, with the use of multiple personal pronouns (9, 10, 12) locating agency for the feelings with herself. As is recurrent in the data, the therapist then shifts the agency in her response of 'cause it is the anorexia', on lines 16 and 17. This was also the case in extract 4.5 in chapter 4, where 'anorexia' was repositioned to have 'wrecked', and later 'changed', the patient's family. Likewise in extract 5.2 in chapter 5, the patient *not* eating meals with her family was produced by the therapist as being 'about the anorexia being a bit stronger' (29-31) and the 'anorexia sort of creeping in'(35). As noted earlier the use of the term 'anorexia' not only functions to reposition agency, but also

manages the therapist's subjectivity, such that it allows them to challenge the patient's prior turn without compromising her neutral position. This is also evident via the emphasis on 'is' (16), which packages the statement with more conviction.

The following extract also demonstrates how therapist initiated agency repositioning accounts also function to produce problematic mental states as apart from patients' own selves and aligned with the overriding institutional diagnosis of 'anorexia':

Extract 6.8

1 **THER:** A- a- and when you're anxious (0.2)
2 what happens in terms of (0.3) the
3 progress (.) that you've ma:de (3.0)
4 what happens whe:n
5 (.)
6 **PAT:** U:m=
7 **THER:** =When you get get anxious?
8 **PAT:** I- I didn't (0.2) like (.) it makes me
9 feel like (.) I feel like (.) all those
10 feel↑ings and thoughts again
11 (.)
12 **THER:** Which (.) a::h which ones?
13 (0.2)
14 **PAT:** Like the bad ones (.) like they come
15 ba:ck a bit stronger and stuff (0.2)
16 and I fee:l (.) big and as though li:ke
17 (0.2) I'd (.) I'm not worth as much as
18 what I'd want to think↑
19 (0.5)
20 **THER:** Ye:p (0.5) what (.) and w- what impact

21 do you think that has on something like
 22 (.) the anorexia?
 23 (0.2)
 24 **PAT:** It makes it stronger again.
 25 (.)
 26 **THER:** O::k (.) so somehow putting things in
 27 place before you get=
 28 **PAT:** =Yep.

Here we see the therapist account for the patient's 'bad' (14) feelings in terms of the diagnostic category of 'anorexia' (22). The therapist's initial utterance produces the patient's mental state of being 'anxious' (2) as linked to the 'progress' (3) the patient has 'made' (3). Further on in the extract 'progress' is confirmed as referencing the patient's bodily size via the therapist's use of 'anorexia' (22). Given that 'anorexia' is recurrently used in the data to refer to, and mark patients' weight as problematic and distanced from their own self, the therapist's initial turn in this extract indirectly produces the patient's 'anxiety' as problematic and aligned with her bodily state. In other words, the agency for the patients' problematic mental state, and problematic bodily state, is attributed to 'the anorexia' (22). This is locally produced by both speakers, demonstrated by the patient's reference to 'those feelings and thoughts' (10), which results in a specification request by the therapist (12). The patient's subsequent reference to her 'feelings and thoughts' as 'bad ones' (14) is then produced as invoking the bodily state of feeling 'big'. As Potter noted (2005), the use of bad feelings can invoke a psychological state, and we see here how the patient's physical state is embedded in her troublesome mental state.

following utterance of ‘I know it wasn’t me doing it’ (10) as a stronger, more institutionally credible account. As in extract 5.1, we also see the patient use a ‘first-person generalised dispositional expression’ (Edwards 2006, p. 480), of ‘I would never have done it’ (11-12) which constitutes her moral character as separate from her past actions. The patient’s turn also invokes and marks a problematic psychological state, via ‘I sort of feel bad about it’ (12-13). While her utterance initiates the shifting of agency away from the patient, in terms of their actions, it is the therapist’s next turn that explicitly produces the location of agency for the patient’s mental state. This is produced in the therapist’s utterance in diagnostic terms, as ‘a major condition’ (16-17). The subsequent upgrade to ‘a psychological condition’ (17-18) directly includes the patient’s mental state in the repositioning of agency. Interestingly the therapist then makes reference to the patient’s name (‘Kelly’, 18), which may function to package the utterance more delicately, in that ‘Kelly’ produces more distance than pronoun ‘you’. This abstract and less personal description of the patient also provides greater contrast between the patient and the problematic state of ‘being a bad person’ (18-19), which strengthens the redeployment of agency.

Past-tense ‘bodily state’ accounts

It should be noted that in the data analysis, several sessions were identified where there were no account requests, and responding patient accounts, regarding their bodily state and conduct. What were recurrent in these sessions, however, was the phenomena of past tense accounts, whereby patients would make reference to their bodily states as being ‘anorexic’ in terms of an earlier

occasion, such as in the following extract. Prior to this extract, the therapist and patient have been discussing particular friendships of the patient:

Extract 6.10

- 1 **PAT:** I used to get really pissed off with
2 them because that was when I was
3 anorexic, and Gary used to like (.)
4 force me to eat (.) cause my parents
5 were just like ↑oh (.) my mum was
6 just like she doesn't ↑want to e:at
7 (.)
- 8 **THER:** Mm (.)ye:p (.) they really took
9 notice (.) m:m=
- 10 **PAT:** =Like Gary would sit there and go
11 just tr:y it (.) try some and I was
12 like no and he's like plea:se try it
13 and I'd just get really annoyed (.)
14 and like I'm not eating it (.) heh
- 15 **THER:** Heh m:m (0.2) ↑what did you like
16 about seeing them?
17 (.)
- 18 **PAT:** I think everyone was ni:ce, like (.)
19 instead of ye:ah (.) like arguments
20 and stuff

A regular feature of *past* tense accounts regarding patients' bodily states and conduct is that they are not oriented to, or produced as, delicate matters, in contrast to the present tense accounts provided in this chapter. This is apparent in extract 6.5, where the patient gives an unproblematic account of her bodily state at a previous point in time of 'when I was anorexic' (3-4). Unlike the present tense accounts, we see little expressive caution in the account, with the patient's

utterance being produced as unperturbed and fluid. Also of interest is the patient's use of the personal pronoun 'I' in conjunction with 'anorexic', instead of the prior absence of personal pronouns. Note as well, that the account is volitional and not a sequential result of an account request by the therapist. In all of the present tense accounts and account requests, descriptives in connection with 'anorexia' were invoked by therapists, and accomplished specific work, such as agency repositioning. In fact, the only instances in the data corpus where the term 'anorexia' or derivatives are used by patients are in past tense accounts, which are embedded in other topic sequences. In extract 6.5, for instance, the sequence is concerned with the patient's views of particular family friends, and this does not shift after the patient's invocation of 'anorexic' (3). Rather the therapist stays on topic in her two turns, with her formulation of 'they really took notice' on lines eight and nine referring directly to the family in question, with no reference to the patient's past tense account, apart from initial agreement tokens of 'mm, yep' (8). This is again the case in her next turn, where there is marked acknowledgement, via repetition of the patient's laughter token of 'heh' (15) and 'mm'. The therapist then continues to stay on topic with her question 'what did you like about seeing them' (15-16), which again demonstrates no apparent uptake by the therapist of the patient's past account of conduct. In the following extract, there is another past tense reference by the patient to anorexia, where the patient has been describing a new friendship:

non-delicate reference to 'anorexia' is produced by the patient in extract 6.12

below:

Extract 6.12

1 **THER:** U:m (0.2) how do you feel about how
2 you look no:w?
3 (0.2)
4 **PAT:** I guess very hard when I come-
5 specially when I come
6 here↓(0.2)because I see the other ED's
7 that are i:n at the moment and I then
8 think (.) my head tells me >oh you
9 should be like that< (0.2) and you
10 should .hh(.)and things and tells me
11 >oh look how much bigger you are than
12 them< and that(.) I find that very
13 ha:rd when I come back for
14 appointments (.) and things in that
15 way
 (0.4)
16 **THER:** W- What makes you think that you're
17 bigger?
18 (.)
19 **PAT:** Cause I see myself as a lot heh heh
20 bigger than what they a:re↑
21 **THER:** °Ri::ght°
22 (0.2)
23 **PAT:** And I admit that (.) I say to mum (.)
24 I fee:l (.) like I- technically I know
25 (.) I'm not as b- big as what I say I
26 am↑ and I'm not as ba:d as with
27 anorexia (.) but like I see really big
28 people out and I go >oh mum I'm that
29 big< (.) and she's like >no you're

30 not< (.) cause that's just the way I
31 feel (0.2) I know it's the way I feel
32 (.) but (.) I still see that
33 sometimes↑ .hh (.) especially at the
34 night times (.) cause that's how I see
35 it.

The use and emphasis on 'now' (2) in the therapist's initial question produces it as referencing a potential past tense account of the patient's feelings, in regards to how she looks 'now' (2). This is confirmed in the patient's subsequent turns, which distinguish her bodily state from 'other ED's' (6). The patient's description of 'look how much bigger you are than them' (10-11) indirectly produces her own self as separate from the 'ED' (6) patients, as does her description of 'bigger than what they are' (20), via the inclusion of 'them' and 'they'. There is then explicit evidence of this in the patient's past tense reference of 'I'm not as bad as with anorexia' (26-27), which as in the previous two extracts, is fluid in its delivery.

Conclusion

In part, the analysis in this chapter has shown how therapists and patients use agency as an interactional resource in several highly significant ways. It is employed by patients in accounting for their physical non-compliance in regard to treatment goals, to produce themselves as being *psychologically* compliant with a recovering bodily state when demonstrably *physically* non-compliant. Similarly, Parry's (2004) analysis of stroke physiotherapy consultations found that accounting practices produced the patients as personally competent despite their physical infirmities. Agency was also used by therapists as a resource to

make 'cautious' account requests, in terms of the delicately marked matters of patients' bodily state and conduct. As mentioned, there was nowhere in the data where therapists used personal pronouns to ask directly for an account of a patient's bodily state, in terms of weight, and would instead rely on resources such as external agency to make such requests.

Therefore, agency as an interactional resource, in the present context, offers what Schegloff called 'solution' (in Sacks, 1992) to the problem of how to make a delicate and cautious account request concerning patients' weight, while staying on neutral footing. The analysis also demonstrated how patients' physical bodies are not separate from the talk, rather they are embedded in, and locally produced for the interactions. Hence, we see the shift between bodies constituted as problematic and external from the patients' selves, and bodies produced as cohesive, with active recovering psychological states of patients. The way psychological progress, or positive attitudes are used by patients despite the presence of negative physical measures, could also be regarded in terms of more general interactional functions. For instance, it may be understandable as an endeavour by the patient to forestall any effort by the therapist to make further interventions or suggest further actions, in the face of negative physical results. This is apparent, for example, in extract 6.4 where the therapist abandons her weight related directive in light of the patient's elaborate formulation of their eating behaviours to the contrary.

As in the previous chapter, we continue to see a strong reliance on preference organisation in the data. Therapists consistently demonstrate a high level of

sensitivity to patient uptake in terms of dispreference markers, and are quick to retreat from self-initiated directives that indicate minimal uptake by patients. So notably the practices outlined in this chapter can be added to those in the previous chapter, as devices that allow for the discussion of 'delicate' topics while minimising patient failure to respond.

The repositioning of agency for conduct compliance of patients is also an interactional device that allows certain bodily states to be viewed in terms of the professional diagnosis of AN. This is similar to Hak and Boer's (1996) analysis of initial psychotherapy interactions, which suggested that formulation-decision pairs functioned as devices to convert patients' troubles into treatable psychotherapeutic problems (also see Davis, 1984).

Jefferson and Lee (1981) argued that advice reception is directly related to how the advice is organised:

acceptance or rejection may be in great part an interactional matter, produced by reference to the current talk, more or less independent of intention to use it, or actual subsequent use. (1981: 408)

Their paper suggested that if the advice is not 'sequentially appropriate', or the talk 'interactionally synchronous', then the uptake of the advice may be minimal or absent. We have seen a similar phenomenon in this chapter's analysis, whereby regularities in the sequential organisation of therapists' account requests, and patients' responding accounts, ensure the smooth co-production of

a collaborative bodily account of the patient. In summary, the analysis established two recurrent types of account producing sequences by therapists and patients. Firstly, in the form of patient initiated repositioning sequences, as in extract 6.3 above, which can be schematically represented by the following:

1. Unmarked account request by therapist (e.g. 'How are you?').
2. General affiliation token from patient (e.g. 'Good').
3. Further specification request from therapist.
4. Affiliated agency repositioning account by patient.
5. Account endorsement from therapist.

The second type can be termed as a *therapist* initiated agency repositioning sequence, as in extract 6.6 above:

1. Marked account request, including agency repositioning by therapist.
2. Affiliated agency repositioning account by patient.
3. Account endorsement from therapist.

The analysis also examined other instances in the data, apart from account requests and accounts where terms deriving from 'anorexia' were used. Predominantly such terms were invoked by therapists to again do agency repositioning work. This allowed them to accomplish tasks such as delivering information or making statements concerning patients' bodily states and conduct, with increased delicacy and caution, as well as bolstering their neutral status. The current analysis has also demonstrated that agency repositioning practices function to produce and infer certain mental states as problematic, and aligned

with the external diagnosis of anorexia. This may be due to 'anorexia' being treated as a psychosomatic condition that has physical manifestations.

Overall, the use of the term 'anorexia' also functions as a way of allowing collaboration in turn by turn interactions by the therapists and patients. In other words, it provides patients and therapists with an apparatus to discuss subject matter, in terms of a conversation, versus the therapist merely lecturing the patient with little input on their part. On a more macro level, the analysis demonstrates that rather than being simply an arbitrary or purely medical label, the term 'anorexia' functions as an available, consequential, and negotiable resource in the data. This was neatly demonstrated in past tense references to anorexia, where the term was not invoked to carry out therapeutically relevant tasks such as with agency repositioning. The past tense references can be considered as deviant cases (ten Have, 1999) that demonstrate the speakers' orientation to present tense references to anorexia, as delicately produced matters. This was demonstrated by the strong expressive caution, recurrently observed in the present tense references, being absent in the past tense references. In summary, anorexia is only packaged as delicate, and marked as a therapeutically relevant topic, when locally produced by speakers in the present tense.

In relation to previous chapters, and the overall research project, we see the analysis continues to identify important practices in the data that allow for *mutually oriented* communication in the setting, in regards to delicately marked and managed items. By mutually oriented, I mean that there is an overall absence

of failed and minimal response tokens in the analysis, while at the same time the presence of affiliated responses, such as marked acknowledgements, which indicate patient uptake, as previously identified by Heritage and Sefi (1992) in advice reception interactions. Chapter four looked at such practices, in terms of the role of PDS in relation to therapists' neutral delivery of assessments, or demonstration of challenges, and in this chapter we have seen agency repositioning in patient bodily state account sequences as another practice that produces such mutually oriented interactional sequences concerning delicate matters. In chapter seven, the analysis focuses on the therapists and patients' orientation to, and production of, institutional identities.

CHAPTER 7

Management of and orientation to contextual identities

“...as long as one is doing the questions, then in part one has control of the conversation.” Sacks, 1992:55

Introduction

Indexicality centres around the principle that words and utterances have many potential meanings and are context bound (Potter, 1996); utterances are ‘occasioned’ for particular sequences of talk and in turn in particular social settings. Indeed, as Potter (1996) noted, many common words or phrases acquire ‘precise’ meaning when analysed in context:

The ethnomethodological approach directs us to look at the methods through which factual discourse is constructed, the occasions in which it is embedded, and the uses to which it is put. (Potter, 1996: 44-45)

In this chapter I consider the issue of context in the current data primarily by examining the ways in which institutional identities are oriented to and managed in the present therapeutic setting. To conclude and contextualise the previous analysis chapters, this chapter acknowledges, and concentrates on, the current institutional setting of the EDP, in more central terms. In recent years, there has been increasing work in the areas of DP and CA specifically oriented to the institutional nature of the therapeutic context. A particular focus in terms of the current data corpus, is what makes the interactions recognisable as ‘therapy talk’,

or in other words how do therapists and patients both orient to, and constitute the interactions as ‘therapy talk’. In relation to this Button stated:

It is, rather, what those people do, and how they structure and organise their interactions with one another that achieve for some social settings its characterisability as an interview. This integrally involves the way in which the participants organise their speech with one another....

(Button, 1991:229)

While Button was referring to interviews, his statement is also applicable to other institutional settings, including therapeutic ones. The practices identified in the previous chapters demonstrate ways in which certain tasks and positions are accomplished interactionally. On another level, these practices all function in the same way in that they give the therapists and patients a way of interacting and conducting therapy. I have endeavoured to keep the context central in my analysis (Buttny, 1996; Giles, 2005) via emphasis on the local production of talk in regards to background information. For example, in terms of neutrality being a stance of therapists in line with underlying philosophies of the context, we have seen how this has been oriented to by the therapists and patients. Put another way the social interactions have reflected and constituted the context, such that, via their communication therapists and patients actually talk the context into being (Buttny, 1996). Schegloff (1991) argued that the onus is on the interaction to demonstrate structures or aspects of the context:

For that is to show how the parties are embodying for one another the relevance of the interaction and are thereby producing the social structure. (Schegloff, 1991: 51)

Context is an ongoing and controversial issue in DP and CA; perhaps best characterised by the lengthy debate between Schegloff (1997, 1998, 1999a,b) and Wetherell (1998) and Billig (1999a,b). Partly, this is because it is difficult to separate out the effect that *in situ* context has on the talk, and vice versa, how the talk constitutes the context. As McHoul, Rapley and Antaki (2007) noted, context forms an integral component of the overriding ‘reflexive equation’, putting forward a commonsensical approach to utilising contextual information in analysis, arguing for instance, that it is counterintuitive to rely on a ‘purely sequential analysis’ if information regarding the context happens to be independently and empirically obtainable. Nevertheless, they also argue that such contextual information is a ‘luxury’ rather than a necessity, and can only be available to analysts commensurate with the speakers’ orientation to context in talk itself.

There is agreement in the literature that information from outside sources should not take precedence or prejudice analysis on talk-in-interaction, but at the same time, the analyst must have understanding of the shared cultural knowledge of participants (ten Have, 1999). This is a relatively uncomplicated task in what Paul ten Have calls ‘pure CA’ studies, where little information is utilised beyond the talk. The rise of ‘applied CA’ studies though, has brought with it an increase in the amount of background observation being carried out by researchers, so as

to gain operational knowledge of the practices particular to specialised organisational settings, as noted by Christian Heath who has extensively transcribed and studied video recordings in institutions:

As studies of talk and interaction have become increasingly interested in more specialised forms of human activities, often arising within particular organisations or institutional domains, it has been recognised that it is necessary to augment recorded materials with extensive fieldwork. So, for example, our own studies of general practice involved a long period of non-participant observation before any recording took place in order to begin to assemble a sense of the organisation of certain specialised tasks such as diagnosis, treatment and using medical records. (Heath, 1997: 190)

The goal in many such institutional talk-in-interaction studies is to use ethnographic style information to the point where a researcher's knowledge of the setting matches, to some degree, that of participants. However, as ten Have (1999) points out the amount and type of background knowledge can depend on what is specifically being studied in the institutional setting. Maynard (1984), for instance, carried out three months of prior observation before making actual recordings in his study of 'plea bargaining' sessions. Many such institutional settings come with complex tools and technologies, and if these are of interest to the researcher, it is often essential for them to be understood prior to data analysis. In some cases, such as Frankel's (1989) study of calls to a 'poison centre', interactions can appear sequentially irrational without the aid of accompanying documentation. To date there are still no definitive rules in DP/CA regarding the

use of contextual information, and while some researchers argue not to go beyond the contextual knowledge of participants (McHoul et. al., 2007) others claim that this is sometimes necessary to inform a more ‘inclusive’ analytic process (Peräkylä, 1997).

In regards to the current project, I conducted a considerable amount of fieldwork at the EDP, which included carrying out team meetings, focus groups and interviews with participating therapists, as well as auditing relevant documents pertaining to the programme (as outlined in chapter 3). This was an important process on a number of levels. First, it provided me with information regarding the structure and setup of the EDP so that I could understand references made in the data to context specific practices such as ‘special nursing’. This did not go beyond the participants’ basic knowledge of the setting though, and was not used to impose categories on the data. The fieldwork also gave me information regarding the underlying therapeutic principles and approaches of the EDP clinicians, which allowed me to make links between these theoretical models and *in situ* practices found in the analysis. While I have examined contextual features in my data, in terms of the extent to which therapists and patients organise their interactions in relation to these features, this chapter, as mentioned above, will more directly focus on the interactants’ orientation to the institutional identities or categories specific to the context.

Omni-relevant devices

I examine this orientation to institutional identities, by drawing on Sacks’ (1972) understanding of contextual categorisations. Sacks (1972) identified paired

relational categories termed ‘standardised relational pairs’ (SRPs), in which interactants have standardised obligations to each other regarding the action of giving. In friendship, for example, reciprocity (be it material, emotional or otherwise) is an integral feature of the relationship. Sacks (1972) named a collection of SRPs characterised by there being symmetry in terms of such obligations, ‘collection R’. In contrast to ‘collection R’, Sacks referred to ‘collection K’ as consisting of categories of help-giving ‘experts’ who are paired up with ‘non-experts’ labelled as requiring help, such as a therapist/patient or teacher/student relationship (Silverman, 1998).

In relation to the operative nature of such category devices as collection R and collection K, Sacks (1992) referred to the concept of ‘omni-relevance’, describing an omni-relevant device as:

...one that is relevant to a setting via the fact that there are some activities that are known to get done in that setting, that have no special slot in it, i.e., do not follow any given last occurrence, but when they are appropriate, they have priority. Where further, it is the business of, say, some single person located via the ‘omni-relevant device’, to do that, and the business of others located via that device, to let it get done. (Sacks, 1992: 313-314)

Sacks (1992) utilised the example of a group therapy session for adolescents, where he identified an omni-relevant device as being that of therapist/patients, because a priority of that setting was for ‘therapy’ to be accomplished. He then suggested, that due to a number of ‘unpalatable’ aspects of this device, a ‘cover

identification' or device is used (adult/teenagers), that allows the work of the omni-relevant (or 'controlling') device to get done, but disguises its problematic nature. Sacks (1992) noted that the cover identity must have the property of 'partitioning consistency', whereby it is required to divide those concerned into the same proportions as the omni-relevant device (e.g. adult/teenagers and therapist/patients). A further property of partitioning consistency is that the cover device must be congruous with the omni-relevant device, such that the prioritised work of the latter might still get done. For instance, Sacks (1992) employed the example of spies, who need to construct cover identities that allow them to carry out their underlying task of spying.

In locating the presence of an omni-relevant device, Sacks (1992) used the case of a group consisting of teacher/students, where the interaction suggested an outwardly 'homogenous' group, until the teacher invoked his or her identity in the omni-relevant collection of teacher/students by initiating a recess. In more recent work, McHoul and Rapley (2002), proposed the operation of an omni-relevant device, psychologist/mental patient in the setting of a psychological assessment, with the alternate cover identity consisting of two 'acquaintances' having a chat (see also Antaki & Rapley, 1996).

In the current analysis, there is an overriding omni-relevant device of therapist/anorexic patient (a collection K), with evidence of orientation to an alternative cover identity of adult/teenager (a collection R). This has been apparent in the prior analytic chapters, which showed that therapists demonstrated great reluctance to depart from their neutral stance. To a certain

extent, this neutrality overtly minimises partitioning inconsistency between the omni-relevant device and cover identity, in that it diminishes some of the asymmetries integral to the context, as oriented to in the data by therapists and patients. As discussed in chapter five, such asymmetries include the therapists' duty to report 'unsafe' disclosures or conduct by the patient, the physical location of the setting within the hospital institution, as well as the therapists' position in the eating disorders team that ultimately decides the inpatient/outpatient status of patients. The power of the institution is also apparent via patients' compliance to decisions (as discussed in chapter five), with forcible hospitalisations, via the mental health act, being exceedingly rare. Orientation to this is regularly apparent in the data, as in extract 7.1 below, where the therapist and patient are discussing an upcoming appointment the patient has with an EDP gastroenterologist for medical assessment:

Extract 7.1

1 **THER:** U:m (0.5) are you worried about ↓that
2 **PAT:** O:h (.) I don't know cause I've never
3 been to an outpatient clinic with him
4 before (.) so I don't know what's (.)
5 going to happen like (.) what you'd (.)
6 what do you do?
7 (0.5)
8 **THER:** U:m (.) he's going to (.) check your
9 (.) weight and arm circumference and
10 blood pressure
11 (.)
12 **PAT:** Oh yeah. Yeah.
13 **THER:** And he's going to determine whether or
14 not (.) you're okay to go (.) ↑home

15 (0.2) o:r
 16 (.)
 17 **PAT:** They >wouldn't keep me<
 18 (0.2)
 19 **THER:** .hh well it depends on (.) how you are
 20 medically
 21 **PAT:** ↓Oh.
 22 (.)
 23 **THER:** U::m (0.2) so if if your (.) weight's
 24 dropped and your medical observa↑tions
 25 (.) suggest that (.) it's >not a good
 26 place to be< (.) then he can say=
 27 **PAT:** =↓Oh.
 28 **THER:** You'd best come into hospital (.) u:m
 29 (.) but if he thinks (.) ↑o:h you're
 30 sort of doing enough (.) then he'll say
 31 I'll see you next week.
 32 (.)
 33 **PAT:** Ye:ah.
 34 **THER:** U:m (.) and if you go away and you do
 35 okay
 36 (.)
 37 **PAT:** Ye:ah.
 38 (0.9)
 39 **THER:** U::m (1.0) so that's the tricky thing
 40 that people have to contend with

In this sequence, the therapist's initial question on line one, 'are you worried about that' implies that the patient might indeed have something to be 'worried about', as the patient has in previous transcript has merely stated that the appointment with the doctor was on that day. The therapist's question implicitly orients to compliance with the institution, as it is introducing the topic of potential hospital admission for the patient, if so judged by the doctor. If it were

merely a matter of the patient choosing freely whether she be readmitted or not, the therapist need not package the topic as possibly invoking anxiety in the patient. It is apparent in the way therapists speak about hospital admissions with patients throughout the data, that they inadvertently endorse compliance with assessments by doctors from the EDP. How they recurrently do this, is to package statements relating to hospital readmissions in an objective, matter-of-fact way, frequently drawing on the ‘physical safety’ discourse discussed in chapter five. By orienting to, and endorsing institutional compliance, they not only invoke the omni-relevant device of ‘therapist’ but also of ‘EDP team member’, that situates and constitutes the talk as being in the context of therapeutic interactions, within the wider context of the hospital institution.

On lines 13 to 15, for instance, the therapist states that the doctor is ‘going to determine whether or not’ the patient can go home, which carries with it an inbuilt assumption of compliance. The patient in line 17 orients to this, where she does not package her utterance of ‘they wouldn’t keep me’ to include reference to a personal stake in regards to her status as an inpatient or outpatient. This continues to be apparent in the patient’s ensuing turns, where her newsworthy tokens of ‘oh’ (21, 27) fail to challenge the therapist’s utterances. The downward pitch on both turns also constructs the newsworthy tokens as displaying disappointment, and in turn reluctance at the prospect of readmission to hospital. This again shows orientation by the patient to compliance with hospital assessments, which is recurrent throughout the data. Based on the fact that the EDP *have* used the Mental Health Act to involuntarily admit patients to hospital, in a small number of cases over a ten year period, it is probable that

analysis of a larger data corpus would have elicited deviant cases on this matter, but such a data corpus would far exceed the scope of the current project.

As mentioned previously in chapter five, in terms of neutrality, the ‘physical safety’ discourse drawn on by the therapist in extract 7.1 functions to minimise the hospital’s role in the prospect of involuntary hospitalisation. Note the therapist refers to the patient’s ‘medical observations’ (24), and how she is ‘medically’ (20), as grounds for potential hospital readmission, which downplays the EDP’s power as it emphasises the patient’s bodily state as dictating inpatient outpatient status, rather than the hospital itself. This type of discourse works to construct the hospital as endeavouring to keep patients ‘safe’, as opposed to alternative discourses that could focus on, for example, the negation of patients’ free will. This emphasis on the patient’s bodily state in terms of a basis for possible hospital admission is also apparent in extract 7.2 below, where the fragment of transcript falls at the beginning of a therapy session:

Extract 7.2

1 **THER:** Yes (.) so you ↑weren’t (.) going to
2 come?
3 (.)
4 **PAT:** I wasn’t going to (.) ↓no.
5 **THER:** U:m (0.3) >↑why didn’t you want to
6 ↓come<
7 (.)
8 **PAT:** Cause I was too scared that I’d have to
9 stay (0.2) and then everything I’d
10 worked hard for (0.3) so it’s like (.)
11 >well just not to be out for Christmas<

12 (.) >so everything I worked hard for<
13 (.) could be taken a↑way (.) like it
14 was last year sort ↑of
15 (.)
16 **THER:** Yep=
17 **PAT:** =Cause >I was in here last year< (.) so
18 (.)
19 **THER:** °Yeah I kn:ow° (.) .hh so u:m a::h
20 (0.3) before we get to the (.) the Dr.
21 Jo:nes >sort of part< in the (0.2) .hhh
22 what has been happening (.) that makes
23 you think that you >might have to< come
24 in?
25 (.)
26 **PAT:** >I don't ↑know< (.) I think my (.) I
27 don't know about my (.) weight (.)
28 >whether it's down or now< (.) like I'm
29 eating fine and everything ↑else is
30 fine but just like with my weight (.)
31 like I've been doing quite a bit o- of
32 work like wi- (.) like ac- actual work
33 (.) I've been working at least four
34 days a week (.) then I've been going
35 out helping Dad when I've been home so
36 I've been quite busy and ↑stuff
37 (.)
38 **THER:** Ye:p.

This extract again shows the patient orienting to the possibility of involuntary hospital admission, via her turns beginning on lines four and eight, where she confirms she had been 'too scared' to come to the EDP in case she had to 'stay'. As has been consistently observed in previous extracts, the therapist's utterances neatly construct them as separate from 'the Dr. Jones sort of part' (21-22), but at the same time endorses the authority of the hospital (collection K). Therefore,

therapists may be separate from the formal assessment process, as well as being explicitly neutral in the data in relation to it, but at the same time their utterances orient to patient compliance with the hospital having power to admit them.

Orientation to institutional identities

It is apparent in the data that orientation to the omni relevant and cover devices is collaboratively produced by both the patients' and therapists' utterances. A recurrent site in the therapy sessions that demonstrates this is at the beginning of sessions, that neatly show the partitioning consistency between the omni-relevant and cover devices, and the joint orientation to, and production of, the institutional identities of 'therapist' and 'anorexic patient'. Consider the following extract:

Extract 7.3

1 **THER:** U:m sorry I >interrupted with your
2 cards< and a:h s:o (.) >one's from your
3 aunt?<
4 **PAT:** Ye:ah and=
5 **THER:** =And one fro:[m]
6 **PAT:** [The] other one's from my
7 great aunty as well
8 **THER:** Okay ↑good. (0.2) SIXtee::n
9 (.)
10 **PAT:** Ye:ah=
11 **THER:** =My goodness (.) u:m so w- what's the
12 plan for the day?
13 (.)
14 **PAT:** Mum's going to come abou:t eleven, and
15 then we're going to go just back to the
16 motel a:nd (.) ye:ah

17 **THER:** Lovely (0.2) and have (.) you've got
18 overnight ↑leave yep=

19 **PAT:** =Ye:ah
20 (0.2)

21 **THER:** U::m .hh I'd left ↑yesterday and didn't
22 have a chance to come up to the war:ds
23 (.)so I rang Kerry and she was going to
24 chase it up (0.2) and so that's ↑good=
25

26 **PAT:** =Yeah they said (.) ye:ah.

27 **THER:** O:kay fantastic.
28 (.)

29 **PAT:** ↑Yeah.

30 **THER:** U:m ↑how's the week been otherwise (.)
31 h- how you're going?
32 (.)

33 **PAT:** U:::m (0.3) o:kay (.) some days have
34 been a (.) a bit harder than others.
35 (.)

36 **THER:** Okay (.) what are the (.) the days that
37 are u:m harder than others?
38 (.)

39 **PAT:** I (.) I was very upset on Fri:day after
40 meal support (.) because of something
41 that someone (0.2) >one of the girls<
42 did

The therapist begins the session in the guise of a friendly chat between adult and teenager, with the topic revolving around the patient's birthday cards and plans for the day. The omni-relevant device of therapist/anorexic patient becomes evident in line 30, where the therapist's emphasis on 'otherwise' invokes the overriding purpose of the institutional setting, signalling that her following question of 'how you're going' is of therapeutic relevance. The partitioning

consistency between the devices is then sequentially demonstrated and confirmed, via the patient's response that orients to a therapeutically relevant reply. The patient's initial hesitation and pauses displays her following utterance, 'some days have been a bit harder than others' (33-34), as thoughtfully produced and demonstrates her orientation to the institutional identity of patient. In the two following extracts, we continue to see orientation by the therapist and patient to the omni-relevant and cover devices:

Extract 7.4

1 **THER:** U:m (0.9) o::h (0.5) oh good to see you
2 (0.2)
3 **PAT:** °Mm.°
4 (0.2)
5 **THER:** Um (0.8) start with a br-broad question
6 how's it going?
7 **PAT:** ↑Good.
8 (.)
9 **THER:** Yeah?
10 **PAT:** ↑Yeah.
11 **THER:** O:kay (0.6) u:m (0.9) what does good
12 mean?
13 (0.4)
14 **PAT:** U:m (1.0) I'm keeping up really well
15 with everything I've been doing like
16 (.) eating wise and stuff (0.4) which
17 is ↑good (.) s:o,
18 **THER:** That is good

In this extract (which overlaps with extract 6.1) the therapist begins with a greeting of 'oh good to see you' (1-2), which invokes the cover device of an informal chat. Sequentially, we see immediate orientation by the patient to the

omni-relevant device, via her response of ‘mm’ which acknowledges the therapist’s greeting, but does not reciprocate, orienting to the institutional asymmetry in question distribution that is demonstrated consistently throughout the data corpus. This is confirmed by the therapist’s following utterance, in which the phrase ‘start with a broad question’ (5-6) foreshadows the following question of ‘how’s it going’ (6), as the first of many such turn formats. The patient’s minimal response of ‘good’ (7) is queried by the therapist’s subsequent turn, which again is met with minimal response by the patient on line 10 (‘yeah’). This query may be an attempt by the therapist to elicit a longer reply from the patient, given her following specification request of ‘what does good mean’ (11-12). We then see the patient produce what could be termed a therapeutically relevant response, in that her answer is delayed which displays a more considered utterance, and references ED related conduct (‘eating wise’ 16). This is sequentially confirmed both by the strong agreement in the therapist’s next turn, and it being the first turn of the sequence not in a question format, which suggests the patient’s previous utterance was what the therapist was ‘fishing’ for. This is also apparent in extract 7.5 below:

Extract 7.5

1	THER:	How are you?
2	PAT:	Good (0.2) °mm°
3	THER:	<u>So</u> (.) u::m (.) it’s been a little
4		whi:le (.) since we <u>caught</u> ↑up.
5	PAT:	Mm=
6	THER:	=S:o how <u>are</u> you?
7		(0.8)
8	PAT:	U::m (1.1) u:m °I guess° (1.3) things

9 have changed a lot (0.2) like u:m (0.3)
10 I've been making a lo::t of effort to
11 catch up with friends a:nd (0.2) you
12 know >get to work< on ti:me (0.2) do a
13 good [job]
14 **THER:** [M::m]
15 **PAT:** At work and [u:m]
16 **THER:** [M::m]
17 **PAT:** I got through two days without binging
18 and purging
19 **THER:** M:::M

Similar to the previous extract we see the therapist begin with a question format, which invokes the cover device of a chat between an adult and adolescent. This is maintained by the patient's response, which orients to the cover device, in that 'good' (2) is a normative conversational reply to a question of 'how are you' (1), but also to the omni-relevant device of therapist/anorexic patient via the absence in her utterance of any reciprocated question(s). The cover device is again invoked by the therapist in her next turn, where she alludes to the therapeutic setting as one might refer to an informal meeting between friends ('it's been a little while since we caught up', 3-4). The use of 'we' (4) neatly infers membership in a reciprocal paired relationship (collection R), despite the asymmetry demonstrated in the interaction invoking a collection K device. This is apparent in the therapist's next turn, where their emphasis on 'are' (6) produces the question as a request for an extended response from the patient compared with the initial 'how are you' (1) in this sequence. The patient's reply orients to this, via her delayed answer that produces an account of how 'things have changed' (8-9). As in the previous extract, the patient's answer is confirmed as such by the therapist's subsequent news worthy tokens (mm, 14, 16, 19) that

display strong affiliation with the patient's utterances. This is sequentially demonstrated by the news worthy token after the patient's reference to eating related conduct ('I got through two days without bingeing and purging', 17-18) being more strongly emphasised than the prior two instances (14, 16). Akin to extract 7.4, this emphasis in the therapist's response token marks the patient's account of her eating related conduct as therapeutically relevant.

Conclusion

The analysis in this chapter identified orientation by the therapists and patients to an omni-relevant device of therapist/anorexic patient, and a cover device of adult/adolescent. The use of, and switching between these devices has been demonstrated throughout the data, via the neutral stance of the therapists, such that they actively manage their subjectivity that could be associated with explicit categorisation as a collection K device. However, the analysis did show how the overriding collection K was evident in the data on a number of levels. Firstly, orientation was demonstrated in both the therapists' and patients' utterances to patient compliance with institutional decisions concerning hospitalisation, despite admission to hospital being on a voluntary basis. This was carried out indirectly via emphasis on the patient's bodily state as dictating hospitalisation, downplaying the EDP's involvement in admissions. While the therapists do not decide whether patients are hospitalised their utterances indirectly reference the hospital having authority to admit them. The analysis also showed how patients oriented to the omni-relevant, collection K device by responding to particular questions posed by the therapists as being requests for more detailed personal information.

Therapists' utterances further mitigate asymmetries, or collection K identities via the practices identified in the previous chapters that allow them to delicately and cautiously carry out tasks that potentially invoke the omni-relevant device, such as delivering a formulation, assessment, challenge, or checking-up on patient conduct. Such practices as agency repositioning and PDS allow the work of 'therapy' to be done within the cover guise of a 'chat' between an adolescent and adult.

The orientation by patients to the institutional identity of 'anorexic patient' is also relevant as an interactional practice that can describe the EDP's theoretical model of engagement. It shows how the patients produce therapeutically relevant answers on cue, while the cover device of a casual 'catch-up' provides an effective guise for what Sacks' (1992) termed as potentially 'unpalatable' aspects of the context, such as relational incongruencies. Rather than viewing such institutional asymmetries as being imposed on the patient by the more powerful therapist, I concur with Maynard (1991) that this demonstrates a collaborative and locally produced solution to problematic features of the context. As Antaki (2000) noted, glossing talk as a 'chat' suggests that it will be reciprocal and informal, which provides a way for therapists to keep patients talking for a thirty to fifty minute long therapy session. Given that adolescent patients diagnosed with anorexia are frequently depicted as difficult to engage in therapy, the collaborative orientation to the omni-relevant and cover devices in the interactions also has clinical relevance in terms of clearly demonstrating a way in which engagement occurs *in situ*.

CHAPTER 8

Conclusions

Chapter structure

My goal in this final chapter is to give an overall conclusion to the current thesis, predominantly in terms of the relationship between the analytic findings and the research primary aims (as outlined in chapters one, two and three). Initially, this chapter will provide a summary of the thesis as a whole, after which I integrate the analytic findings, in terms of their overarching contributions to particular academic audiences. Finally, I discuss limitations of this thesis, followed by a concluding section detailing potential future research based on the findings of this work.

Thesis summary

This section will revisit chapter one to briefly summarise the general rationale and aims of this thesis. Overall, the thesis has focused on a discursive psychological analysis of interactions between therapists and patients diagnosed with AN at a hospital based eating disorders programme. The basis of this research broadly originated from the call in the literature for more research into high dropout rates from, and resistance to, treatment services in patients diagnosed with AN. In recent years, resistance to treatment has gained greater focus in eating disorders research, particularly with the rise of motivational theories, which reconceptualise patient ambivalence to change as being the primary ‘symptom’ to target in AN patients.

The extensive range of services that encompass AN treatment, given the complex psychosomatic nature of the diagnosis, was narrowed to focus on psychotherapeutic treatment for AN, particularly in terms of engagement in therapy associated with the therapeutic relationship or alliance. This was partly due to there being a lack of studies that have analysed therapist/patient interactions in actual therapy sessions, in relation to looking at ways in which therapists engage with patients *in situ*, with most ED research being centred on patient-mediated factors associated with treatment withdrawal, such as individual attitudes and behaviours. In contrast, there has been little research examining dropout predictors associated with contextual factors, mediated by the therapist/patient relationship, particular treatment approaches or underlying principles.

The data corpus for the thesis was comprised of 24 individual therapy sessions between therapists and female adolescent patients diagnosed with AN at a hospital eating disorders programme (EDP), catering for children and adolescents on an inpatient and outpatient basis. The therapy sessions were audio recorded and then transcribed, using detailed speech notation.

The EDP was chosen as the data collection site for two reasons. Firstly, because of their particular focus on therapeutic engagement and collaboration, which correspond to the broad aims of this thesis. Secondly, because of their low rate of inpatient and outpatient withdrawal from therapeutic services and good long term patient outcomes, including a zero mortality rate.

The principal goal of this thesis has been to build on AN literature, by providing new analytic insights into how engagement with AN patients functions in *in situ* therapeutic interactions. It has also aimed to extend the DP/CA literature on institutional contexts, via investigation into how interactional practices within the data reflect the EDP's overarching therapeutic principles. A focus here has been on the sequential organisation of such practices, and how they contribute to the accomplishment of associated tasks in the institutional setting. Finally, this thesis has endeavoured to extend DP literature on the body and embodiment, particularly in regards to the diagnostic category of anorexia, in terms of its use as an interactional resource. This has not been in terms of measuring direct therapeutic outcomes, but rather via explicating the function of communicative choices in fostering therapeutic relationships.

Clinical implications of analytic findings

In this section, I integrate findings from the analytic chapters of the thesis, and review them in regards to their relevance and applicability to a clinical audience. This thesis has primarily investigated ways in which therapists engage *in situ* therapeutically with patients diagnosed with AN, with the broad aim of providing new information about the role of language in these relationships, and contribute to the ED literature pertaining to therapeutic engagement. As stated earlier, the dropout rate from treatment services for AN, including therapeutic ones is significantly high, and was identified as a major factor in poor long term outcomes for patients diagnosed with AN. Due to the literature showing that patients who continue with treatment for AN have better rates of recovery,

finding ways to reduce patient withdrawal presents as an important area of research.

By the examination of patient/therapist interactions, this thesis found a number of regularities in the data that pertain to how therapeutic engagement functions *in situ*. This was consistently seen throughout the analysis via the ‘delicacy’ of the interactions, especially concerning the topics of the patients’ bodily state and related conduct. These topics were recurrently featured in the data as delicate, via the presence of ‘pre-delicate’ markers or ‘expressive caution’ (Silverman, 1997), characterised by extended pauses, hesitations, in-breaths and the like (see chapters four, five and six). The delicacy *around* these topics was also shown to be evident in many ways, but most regularly in the therapists’ sensitivity to patient uptake of associated therapeutic directives. This was demonstrated in chapter four by the utilisation of Maynard’s (1992) PDS, which he identified as an interactional device that functions to allow professionals in medical settings to deliver potentially contentious assessments or diagnoses, in a cautious manner, that produced it as a collaboration with the recipient, which minimised the potential for conflict. The analyses found that PDS functioned in a similar way in the current data; in the way that therapists recurrently attempted to co-implicate patients in the delivery of formulations or assessments regarding the delicate topics of the patients’ bodily state or conduct.

However, unlike Maynard’s work where the central purpose of the setting was the delivery of a specific diagnosis or assessment, the current analysis found that

perspective display series regarding delicate topics were regularly incomplete, such that therapists repeatedly did *not* deliver their formulations or assessments if there was minimal uptake by the patients. This was characterised by extended and repeated attempts on the part of the therapists to elicit affiliation regarding delicately marked topics from the patients, which were eventually abandoned if unsuccessful, whereby the therapists would change direction. This not only demonstrated the sensitivity of therapists to patient responses, but also showed the priority given to their underlying principles of engagement and collaboration, in that they abandoned institutional tasks such as delivering formulations or assessments when affiliation was not gained from patients. Also, given that PDS function to allow the cautious and collaborative delivery of assessments, their regular presence in the data demonstrate a core interactional practice through which such tasks are carried out in the data.

Just as the PDS neatly functioned to allow therapists to contradict patients' perspectives, while maintaining a position of neutrality, chapter five identified further practices in the interactions in this regard. It was particularly informed by Bergmann's (1992) work on information-eliciting tellings, which was found to function in the current data as a way for therapists to cautiously 'check-up' on patients' conduct concerning delicate topics. Similar to Bergmann's study, this device was organised via therapists downplaying their own knowledge on a topic regarding patients' conduct, regularly by attribution of knowledge to a third party. This gave patients unrestricted authority on the matter to confirm or deny the external knowledge source, which was found to encourage disclosure, and

also provided therapists with a way of introducing a delicate topic or task while limiting their own subjectivity.

Chapter five examined other regular ways in which therapists maintained a position of neutrality in interactions, in particular when patients made direct attempts to elicit subjective views from them. Therapists ‘resisted’ such endeavours via recurrent use of minimal response tokens, generalised statements and idiomatic expressions. There was only one deviant case in the data where a therapist explicitly delivered a subjective assessment, as evidenced by the use of personal pronouns, presumably because the interaction concerned disclosure of patient self-harm, a topic that can potentially prevail over patient/therapist confidentiality. This deviant case was also telling, in that there was no uptake by the patient of the therapist’s ‘subjective’ view, apparent by an abrupt patient-initiated subject change. This in turn demonstrates the effectiveness of therapists’ recurrent practices functioning to uphold their position of neutrality and delicacy.

Chapter six shifted to examine how *patients* regularly dealt with topics that concerned delicate items, fundamentally those of the patients’ bodily state and conduct. The focus of the analysis primarily centered on the management of accountability in regards to these topics, and found that patients oriented strongly towards making accounts for their bodily state and conduct. This was even recurrent in response to non-direct questions from therapists such as ‘what does good mean?’ (extract 6.1), demonstrating the centrality of these topics to the context of the therapy setting. This chapter also demonstrated how the interactional practice of agentic repositioning was a regular feature in the data,

whereby patients would account for dispreferred conduct, such as weight-loss activities, in terms of the category of anorexia, while concurrently producing themselves as psychologically compliant with the antithesis of this.

Chapter six was also relevant to a clinical audience as it demonstrated that ‘anorexia’ was deployed in the interactions as a category or term available for, and extremely relevant to, the patient diagnosed as such. The ways in which ‘anorexia’ functioned as an interactional resource to accomplish such work as agentic repositioning, highlighted it as not merely an abstract or arbitrary label, but rather as a category saturated with personal meaning, constructed via many practices and consequential in the effects it invokes. Arguably, this offers therapists working in the area of AN treatment an alternative view to the traditional medical or ‘disease’ model of anorexia, in which the term ‘anorexia’ functions merely as a static diagnosis describing a cluster of symptoms.

The regularities seen in the communicative choices and practices of the therapists were also seen in those of the patients, clearly demonstrating that the talk (and thus the ‘therapy’) is co-produced by both. This has particular relevance for an applied clinical audience, in that these interactional practices highlight what Sacks (1992) called an ‘apparatus’ through which therapeutic engagement is practically achieved *in situ*, demonstrating an understanding of language not just as an inconsequential by-product of thought, but as a dynamic and effectual device in its own right. This is relevant to the training of therapists working with patients diagnosed with AN, as it highlights the some of the

consequences of communicative choices, and in turn the importance of attention to ‘micro’ details in therapeutic interaction.

The analysis throughout the thesis provides a description of interactional practices that enact the EDP’s key guiding theoretical principles. This gives therapists an improved understanding of how their overarching approaches operate *in situ*, as well as presenting analytic findings in a language that is familiar and readily accessible (Peräkylä & Vehviläinen, 2003). In particular, the delicate ways in which therapists approached the topics of patients’ bodily states and conduct, and their consistent sensitivity to patient participation, were reflective of the EDP’s principles of engagement and collaboration. This was demonstrated by the fact that the continuation of the therapeutic ‘conversation’ took priority in the institutional setting, over specific therapeutic techniques. Furthermore, the regular maintenance by therapists of a neutral or non-subjective position in the data is reflective of the EDP’s underlying guiding therapeutic principles in terms of motivational theories. Given the rise of motivational perspectives in AN treatment paradigms, the analytic findings of this thesis have also demonstrated some ways in which a neutral position, or ‘stance’ as described in motivational literature (Geller, Williams & Srikameswaran, 2001) functions in actual therapeutic interactions. This has clinical applicability for training in the area of AN treatment, as it provides greater detail about some of the core interactional activities involved in maintaining neutrality in an *in situ* therapeutic context.

To a large degree, clinical training in psychology is formally focused on facilitating a macro therapeutic skill base in terms of specific therapeutic paradigms. Less emphasis is placed on skills informed by fine-grained linguistic influences that highlight the effects of different communicative choices. Such interpersonal ‘process-based’ skills are often viewed as developing intuitively over time, and informally via on-the-job training. This may be partly due to process-based skills such as building rapport being difficult to define and operationalise in research design, culminating in there being little research that overtly contributes to therapists’ micro or process-based skills. Given the apparent difficulty with keeping patients diagnosed with AN engaged in therapeutic treatment, and their poor long term health outcomes, studying therapeutic interactions at a fine-grained level can contribute to an improved understanding of micro/process skills in terms of the core social practices underlying their application. This in turn contributes to the AN literature’s overall understanding of therapeutic treatment in the area. The current research presents a new approach to studying therapist and patient engagement in the area of AN treatment, particularly in terms of the body of ED literature concerned with explicating and reducing patient dropout rates.

The therapists’ recurrent sensitivity to non-uptake from patients (e.g. failed information-eliciting statements) arguably demonstrates an important aspect of engagement, via continuation of the turn-by-turn interaction. Moreover, an overarching analytic finding is that a primary activity of therapists is ensuring the maintenance of the interactions in terms of mutual continuation. That is, the different practices identified in the data work to facilitate a turn-by-turn

conversation. This is of relevance to a clinical audience, as it can be viewed as an interactional illustration of therapeutic engagement, which was recurrent in the present data across the different therapists, despite the utilisation of varied therapeutic modalities.

DP/CA implications of analytic findings

In this section, I address the analytic findings of this thesis in terms of implications for discursive psychology (DP) and conversation analysis (CA).

The analytic chapters of the current project were influenced by many authors in these areas, with particular emphasis on some key papers. Chapter four made analytic observations that centrally built upon work by Maynard (1992), concerning PDS, in regards to their regularity and functionality in the data. In contrast to working as a device to create, in a cautious manner, a favourable environment for a co-implicated diagnostic assessment, an overall function of PDS in the current data was as a way for therapists to confront patients and deliver assessments about the delicately marked and produced matters of patients' bodily states and conduct.

In the analyses, PDS primarily consisted of prolonged turn one and two sequences, with delayed or absent third turns. In the instances where there *was* third turn PDS completion, I found that the assessments related to patients' conduct, as opposed to their bodily state, which was observed to be a topic that more readily achieved alignment interactionally. This apparent ease of collaboration, particularly via a 'check-list' format of questioning, allowed for the subsequent delivery of associated therapist assessments. In such cases, an

observed function of the extended PDS turn one and two sequences in the current data, was to allow the therapists to *demonstrate* the conduct of the patients as excessive and abnormal on a turn-by-turn basis (see extract 4.7), such that there was agreement elicited from the patients prior to the delivery of the therapists' final assessment. Arguably, the particular organisation of Maynard's context, characterised by a primary aim to deliver a medical diagnosis to parents regarding their child, also allowed for a more structured and consistent PDS design, than in the current setting. This was evident by the practices of reformulation and clarification being more regular than the practices of confirmation and elaboration.

Chapter five drew on work by Bergmann (1992), that focused on the organisation of an interactional regularity; information-eliciting tellings. While some analogous analytic features were observed in the current data, these were accompanied by some distinct variations. In particular, there was the occurrence of what could be termed *failed* information-eliciting statements (see extract 5.2) whereby therapists' opening statements did not prompt a direct response from patients, after which the therapists followed up with a cautiously packaged question that acted to initialise a standard information-eliciting tellings sequence. Similar to Bergmann's work though, these questions still positioned the patients as having unrestricted knowledge over the accuracy of their subsequent answers. Consistent with the overall analysis, the information-eliciting tellings in the data were constructed cautiously, via frequent delicate markers such as softeners, downgrades and preference organisation delays (Silverman, 1997). This demonstrated a function of the information-eliciting tellings in the current

context, to allow the therapists to carry out institutional tasks related to checking up on patient conduct, while maintaining a neutral position and ensuring the continuation of the interaction.

Chapter five focused further on the therapists' maintenance of a neutral position, which extended work in the areas of DP/CA concerning neutrality as an institutional requirement. This work has primarily been in *non-therapeutic* contexts, such as news interviews and courtroom proceedings (Clayman, 1991; Heritage & Greatbatch, 1991; Atkinson, 1991). Unlike these settings, the current analysis found the frequent use of affiliative markers and neutral continuers did *not* function as therapist initiated departures from a neutral position, but are rather part of standard practices in therapeutic contexts (Hutchby, 2005). There were analytic similarities however, in how therapists minimised their own subjectivity when making assessments or assertions in the interactions. This focused on what Heritage and Greatbatch (1991) termed 'interviewee engendered' departures from a neutral footing, and as mentioned in section 8.3, found that therapists resisted patient attempts to solicit direct personal opinion, via use of minimal response tokens, generalisations and idiomatic phrases. The analysis also showed that the only instance where a therapist delivered an overtly subjective assessment regarding a patient's bodily state or conduct was in regards to a topic of patient self-harm, and resulted in non-uptake by the patient. As evidenced in the wider DP/CA literature (ten Have, 1999; Silverman, 1997), this deviant case demonstrated the efficacy of practices displaying the therapists' usual position of neutrality in order to encourage patient response.

The particular therapeutic opportunities and challenges following from the unusual status of AN as a *psychiatric* disorder with (some) *physical* symptoms was the main focus of chapter six. This chapter contributed to the work in DP by Wiggins and colleagues (Hepburn & Wiggins, 2005; Wiggins, 2002; Wiggins & Potter, 2003; Wiggins, Potter & Wildsmith, 2001) that has focused on embodiment, bodily conduct and accounts, specifically how they are utilised and embedded in interactions. Similarly, the current project showed bodies not merely as ‘extra discursive’ features (Wiggins, 2002), but as ‘fused’ interactional resources. The analysis found that patients and therapists regularly made agency repositioning accounts concerning bodies, and while the patients’ *physical* states and conduct were constituted as problematic in the interactions, the agency for this was located externally, to such sources as ‘the anorexia’. In contrast, patients’ *psychological* states were recurrently co-produced as unproblematic, and agency was then located within the patients.

The *external* agentic sources also functioned to allow therapists to make account requests, delicately and indirectly, regarding patients’ bodies and conduct, so that agency as an interactional resource was utilised by therapists to achieve a position of neutrality. The only instances in the data where patients made *internal* agentic accounts for their bodies as problematic, explicitly in terms of ‘anorexic’, were in past-tense accounts. This in turn, suggested the regularity of *external* agentic positioning in present -tense accounts as an embedded interactional resource.

Cumulatively, the analytic insights drawn from literature in DP/CA in this thesis extend work (e.g. Silverman, 1997) on the organisation of ‘delicate’ matters in institutional settings, illustrating some of the related core interactional practices in the current context. In particular, practices outlined in this analysis such as PDS and information-eliciting tellings, acted as an apparatus for the therapists to access delicate topics interactionally, while downplaying their own subjectivity.

Chapter seven examined the analytic findings of this thesis in regards to DP/CA literature on context. It found that while the institutional identities invoked by the setting were oriented to by therapists and patients, the previous analytic practices identified in the data worked to provide a ‘cover’ identity of an informal chat between adolescents and adults.

Thesis limitations

This thesis has looked at *some* of the functions of the interactional practices identified in the analysis. Without question, any number of theses could have potentially been written about each analytic insight produced, and infinite alternative analytic directions could have been pursued in the data. Overall, the focus of the analysis could only be very narrow, and in the end I endeavoured to take a direction that had potential for clinical relevance in terms of the EDP and AN literature, as well as building on work in discursive psychology (DP) and conversation analysis (CA). This again could have taken other forms, however I became particularly interested in the underlying guiding therapeutic principles of the EDP and current work on motivation interviewing in the AN literature, and how they are reflective in the analysis of *in situ* interactions. It is important to

note, that I did not take pre-conceived ideas regarding such principles, and in a sense ‘code’ for them in the data, a trap Paul ten Have (2001) highlights with *applied* CA. Rather, I looked at how the practices and local organisation of the interactions yielded analytic insights, that could *then* be then viewed in terms of such principles. Furthermore, my own interpretations, analytic categories and institutional identities were not *imposed* onto the data corpus; instead, the analysis relied on the speakers’ own orientations to elements and structures of the interactions.

A limitation of this thesis is that it is potentially problematic to define the concept of therapeutic engagement generally, let alone as represented by a certain set of practices in therapeutic interactions, as cautioned by Forrester and Reason (2006). The same can be said for analytic insights in this thesis that have examined how other underlying therapeutic principles of the EDP are reflected in the data, such as neutrality. To address this, I endeavoured to show in the analysis, as illustrated by Peräkylä and Vehviläinen (2003), reasonable links between certain recurrent practices in the interactions and specific theoretical principles of the therapists. For instance, the practices identified as ‘operationalising’ the motivational principles of neutrality and low investment to change, were not only recurrent throughout the data, but have also been highlighted in other institutional settings. It is also common in applied CA studies to make interpretations about functions of regular structures or activities identified in naturally occurring interactions, especially in terms of the institutional context. What associating therapeutic principles with interactional practices does is take this one-step further, and link such institutional functions

with the therapists' guiding theories. The regular interactional practices explicated in this thesis are also inevitably context-bound and locally produced, so it is problematic to make broad generalisations to other contexts.

This thesis also did not directly address the issue of high dropout rates, reported in AN populations. While it can speculate between the link between certain interactional practices being representative of therapeutic engagement, it cannot make a direct association between engagement in therapy and reduced dropout rates (as discussed in the following section).

Future research

Though it is not a basis for this study, it could be proposed that increased engagement in therapy may be correlated with improved rates on external outcome measures, such as number of hospital admissions, as well as internal measures of AN symptomatology. This would take up Heritage's (1999) challenge to extend the use of CA methods to research questions regarding the quality and distribution of outcomes. As highlighted by Woodruff and colleagues (Woodruff et. al., 2002), it can be inherently difficult in practice to apply the often highly detailed and contextually bound findings of qualitative research, such as CA. As their research that successfully utilised CA in the design process of an electronic guidebook demonstrated, it is imperative to have a close working relationship with the institution being studied. In terms of future research based on this thesis having practical effects in therapeutic treatment in the area of AN, there needs to be strong alliance and understanding between researchers and

therapists, such that findings can be integrated into clinical practice, in areas such as training, policy and practice.

Future studies that could, for instance, associate the presence or absence of certain interactional practices (Drew et. al., 2001) with specific treatment outcomes such as therapeutic withdrawal rates, would require an integrated research team and a high level of collaboration between researchers and in turn between researchers and therapists. Future research could also study certain interactional ‘circumstances’ in which therapeutic approaches in AN treatment such as individual or family based therapies are more effective, as called for in the literature (e.g. le Grange & Lock, 2005). This in turn has the potential to inform work in conjunction with larger randomised controlled trials (Heritage, 1999), which are frequently identified as a critical area of deficit in the literature. The fact that adolescents with AN who seek psychotherapeutic treatment have better health outcomes than adults (le Grange & Lock, 2005) suggests that continuing to study how *adolescents* engage in therapeutic treatment could produce findings applicable for impacting adult AN treatment.

On a broader level there needs to be scholarly acceptance in the AN literature of DP/CA research in regards to its potential for applicability to therapeutic practice. In this regard, it is essential that research papers, such as those from the current thesis, be published in clinically relevant journals, as well as in publications specifically focused on DP/CA literature. This has been the case with motivation theories in the area of AN treatment, which have been the basis

of many studies in eating disorders journals over the past decade, and has in turn had growing influence and representation in treatment programmes.

Finally, it is generally accepted in the literature that AN research into therapeutic treatment services are limited and under-funded, which is a critical and ongoing issue for the area. In this regard, relatively inexpensive qualitative research designs, such as the current one, have the potential for important contributions to theoretical and applied research.

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APPENDIX A

Transcription Notation Glossary

(.)	A micropause which is noticeable but too short to measure.
(.5)	A pause timed in tenths of a second.
=	There is no discernible pause between the end of a speaker's utterance and the start of the next utterance.
:	One or more colons indicate an extension of the preceding vowel sound.
<u>Under</u>	Underlying indicates words that were uttered with added emphasis.
CAPITAL	Words in capital are uttered louder than the surrounding talk.
°talk between°	Is quieter than surrounding talk.
.h	Inhale of breath (each .h is timed in tenths of a second).
h	Exhale of breath (each h is timed in tenths of a second).
()	Utterances in parentheses are inaudible or there is doubt of accuracy.
(guess)	Text in single brackets is a transcriber 'guess'.
?	A question mark indicates a rising inflection.
.	A period indicates a stopping fall in tone.
,	A comma marks slight fall-rise intonation
>faster<	Is quicker than surrounding talk.
<slower>	Is slower than surrounding talk.
[bracket marks	The bracket between turns indicate overlapped talk and are placed by the words overlapped.
↑	Upwards arrow marks rising pitch.
↓	Downward arrow marks falling pitch.
-	Dash marks cut-off speech.
!	An exclamation mark denote dramatic emphasis.
****	Asterisks denote 'croaky' delivery of preceding sound.
~	Tilde used to denote 'wavering' delivery.
heh	Laughter.
wha (h) t	Bracketed h's denote laughter particles in words.

APPENDIX B

Record of Therapy Sessions, Extracts and Session Times

Extract number	Therapy Session number	Extract Start Time in Session (in minutes)
Extract 4.1	6	22.29
Extract 4.2	21	0.46
Extract 4.3	1	2.15
Extract 4.4	4	32.50
Extract 4.5	2	29.33
Extract 4.6	10	8.42
Extract 4.7	15	16.17
Extract 5.1	18	11.11
Extract 5.2	1	25.34
Extract 5.3	13	18.57
Extract 5.4	18	12.38
Extract 5.5	14	35.35
Extract 5.6	23	21.49
Extract 6.1	3	0.10
Extract 6.2	7	1.28
Extract 6.3	11	17.22
Extract 6.4	11	2.35
Extract 6.5	17	4.13
Extract 6.6	1	27.10
Extract 6.7	24	38.57
Extract 6.8	7	6.12
Extract 6.9	8	15.25
Extract 6.10	19	26.49
Extract 6.11	20	40.16
Extract 6.12	16	24.38
Extract 7.1	15	9.37
Extract 7.2	6	0.29
Extract 7.3	13	0.02
Extract 7.4	3	0.01
Extract 7.5	14	0.01

APPENDIX C

Patient and Parent Consent Forms

FORM OF CONSENT (<i>PARENT</i>)
--

I
Given Names Surname

have read the information explaining the study entitled 'An analysis of therapeutic engagement in therapist/patient talk at a hospital eating disorders clinic'.

I have read and understood the information given to me. Any questions I have asked have been answered to my satisfaction. I agree to allow

.....
..
(full name of participant and relationship of participant to signatory)

to participate in the study.

I understand my child may withdraw from the study at any stage and withdrawal will not interfere with routine care.

I agree that research data gathered from the results of this study may be published, provided that names are not used.

Dated day of 20

Child's Signature
(Where appropriate)

Parent or Guardian's Signature

I, have explained the above to the
(Investigator's full name)

signatories who stated that he/she understood the same.

Signature
.....

APPENDIX D

Patient and Parent Information Sheets

PATIENT INFORMATION SHEET

Project Title: **Therapeutic Interaction in Anorexia Nervosa Treatment**

Thank you for taking the time to read this information. My name is Rachael Dunn and I am a PhD student at Murdoch University. The purpose of my study is to look at how language is used in therapy sessions between clinicians and adolescents diagnosed with an eating disorder. Results from this study will have the opportunity to provide new information on the role of language in the therapeutic process with patients in the area of eating disorders. It is hoped that this will enhance our understanding of what is helpful for the adolescent with anorexia nervosa.

You can help in this study by consenting to have your therapy session recorded using a digital MP3 recording device. Participation in this study is voluntary. You may withdraw your consent at any time during or after the therapy session at which time the recording will be destroyed. No names or other information that might identify you will be used in any publication or documentation arising from the research. If you decide to withdraw from the study or do not take part, this will not in any way affect the care you receive at the Princess Margaret Hospital for Children (PMH).

Being in this study will not involve any extra time for you. It will only mean that the therapy session you are already having will be recorded. After transcription the original recordings will be stored at the PMH in a locked filing cabinet on a MP3 recording device. The tapes will be kept through the data collection and transcription parts of the study (maximum ten months) and then they will be destroyed. Written transcripts will be made from the recording and will contain no names or details that might identify you.

A report on this study will be given to the Eating Disorders Team at PMH and will be available for you to read. If you are willing to participate in this study, could you please complete the attached consent form. If you have any questions about this study please feel free to contact me, Rachael Dunn, on 0422897119 or my supervisor Chris Harris from the PMH Eating Disorders Team, phone: 93407012 or Dr. Ngaire Donaghue from Murdoch University, ph: 9360 6450. If you would like to speak to someone not involved in the study you can contact Murdoch University's Human Research Ethics Committee, ph: 93606677 or the PMH Executive Director, Medical Services, phone: 93408221.

**Kind regards
Rachael Dunn
BA (Hons) (Psychology)**

PARENT INFORMATION SHEET

Project Title: **Therapeutic Interaction in Anorexia Nervosa Treatment**

Thank you for taking the time to read this information. My name is Rachael Dunn and I am a PhD student at Murdoch University. The purpose of my study is to look at how language is used in therapy sessions between clinicians and adolescents diagnosed with an eating disorder. Results from this study will have the opportunity to provide new information on the role of language in the therapeutic process with patients in the area of eating disorders. It is hoped that this will enhance our understanding of what is helpful for the adolescent with anorexia nervosa.

You can help in this study by consenting to have your child's therapy session recorded using a digital MP3 recording device. Participation in this study is voluntary. You or your child may withdraw your consent at any time during or after the therapy session at which time the recording will be destroyed. No names or other information that might identify your child will be used in any publication or documentation arising from the research. If your child decides to withdraw from the study or does not take part, this will not in any way affect the care your child receives at the Princess Margaret Hospital for Children (PMH).

Being in this study will not involve any extra time for your child. It will only mean that the therapy session your child is already having will be recorded. After transcription the original recordings will be stored at the PMH in a locked filing cabinet on a MP3 recording device. The tapes will be kept through the data collection and transcription parts of the study (maximum ten months) and then they will be destroyed. Written transcripts will be made from the recording and will contain no names or details that might identify your child.

A report on this study will be given to the Eating Disorders Team at PMH and will be available for you and your child to read. If you are willing for your child to participate in this study, could you please complete the attached consent form. If you have any questions about this study please feel free to contact me, Rachael Dunn, on 0422897119 or my supervisor Chris Harris from the PMH Eating Disorders Team, phone: 93407012 or Dr. Ngaire Donaghue from Murdoch University, ph: 9360 6450. If you would like to speak to someone not involved in the study you can contact Murdoch University's Human Research Ethics Committee, ph: 93606677 or the PMH Executive Director, Medical Services, phone: 93408221.

**Kind regards
Rachael Dunn
BA (Hons) (Psychology)**

APPENDIX E

Eating Disorders Program - Clinical Practice Guidelines - Princess Margaret Hospital for Children

1.0 INTRODUCTION

These guidelines will address access, assessment, treatment, and discharge of children and adolescents with Anorexia Nervosa at Princess Margaret Hospital. It will encompass acute and chronic stages of care as well as the interaction of the multiple disciplines involved during the provision of a continuum of outpatient and inpatient care.

These guidelines have been designed based on knowledge of the natural history and outcomes of eating disorders in children and adolescents. They are consistent with the evidence base for assessment and therapeutic interventions, consumer participation principles and the Australasian and international clinical practise guidelines.

This program is a statewide service operating through Psychological Medicine, Child and Adolescent Health Service at Princess Margaret Hospital. This collaborative service integrates psychological medicine, paediatric medicine, and allied health and hospital school services.

Our philosophy is to provide a collaborative, continuum of care with treatment delivered in least restrictive, community environments where possible and more intensive hospital admissions considered when appropriate for physical safety. Therefore close collaboration with families, primary and secondary health providers and education professionals (including those in rural and remote regions) is central to our approach.

1.1 Diagnosis

Anorexia Nervosa is a mental health condition that involves psychological and medical criteria. Core features of the disorder in children and adolescents include fear of weight gain, body image disturbance, weight loss or failure to gain weight (to 85% of expected weight for height) and 3 months of amenorrhea (for females). Two subtypes exist, these being a restrictive subtype where fasting and skipping meals predominate and a binge-purge subtype where binge or purge (including exercise, vomiting and exercise) behaviours occur. Many children and adolescents present with partial symptoms and develop symptoms over time.

1.2 Prevalence

International prevalence data shows that there no real increase in eating disorders in Western cultures over the past fifty years.

Similar prevalence rates are shown in Europe and North America and that it occurs at prevalence rates of between 0.3 – 2.4 per 1000 population. Peak prevalence is between 15 – 19 years of age with a decline in prevalence after the age of 24 years. International incidence data predicts 19 new cases per 100,000 females per year with 50 new cases per year in the adolescent age group. Extrapolating this data to Western Australia, given the local birth rate we would expect between 40 and 60 new cases of anorexia nervosa per year in female adolescents. One male to twenty females presents at PMH, this being less than the 1:10 ratio described in the general population.

1.3 Course and Outcome

There are problems with all longitudinal studies of anorexia nervosa in relation to duration of follow-up, quality of follow-up and outcome measures utilised. Outcomes for adolescents are generally understood to be better than for older patients. More than 60% can be expected to recover, 30% will have some improvement and less than 20% will have a chronic relapsing course. Mortality is less than 2% in long-term follow-up compared with up to 20% for adult onset anorexia nervosa. REF

Outcomes are better for children and adolescents with shorter duration of illness, who are treated in specialist, multi-disciplinary teams, and where parents and families are involved in the treatment. REF

Evidence and experience suggests that for optimal outcomes, long term, multi-disciplinary therapy needs to plan for an average length of treatment between 3 and 5 years.

1.4 Stages of Change

Children and adolescents with eating disorders often present in acute medical crisis and are reluctant for diagnosis and treatment. Motivational theory offers three stages of change to describe the types of clinical presentation and appropriate treatment approaches. Treatment planning must encompass all stages of illness from acute onset to recovery and rehabilitation.

Pre-contemplative

Contemplative

Action

1.5 Approach

Systemic and motivational theories, developmental theory and a bio-psychosocial formulation of aetiology and recovery inform our approach.

There is no single etiological pathway to the development of an eating disorder rather a unique set of contributing factors for each individual and family. Everyone involved needs to be cognisant of the contributions of physical changes, personality characteristics, family functions, and environmental stress's in both initiating and perpetuating the illness. Over the duration of a chronic course of illness it is important to remain patient, flexible and hopeful during treatment and when considering prognosis. Avoiding blame of

individuals, families and professionals is critical to maintaining a respectful, collaborative stance over the long term.

More than any other disease Anorexia Nervosa involves physical, psychological and social factors, which interact with each other to create complex symptoms and perpetuate the disease. Given this, therapy may emphasise medical, educational or psychological components at different stages. It also needs to be available until both medical and psychological symptoms abate, risks decline and the individual and family are confident in managing with minimal outside interventions.

Treatment plans should be collaborative and treatment decisions made by the individual and family in consultation with the treatment team. Some components of therapy, generally those to do with physical safety, are non-negotiable and are clearly articulated to individuals and families.

Families and professionals need to be aware that changing symptoms for other people/external reasons and premature cessation of therapy are thought to be risk factors for poor outcomes. Decisions to end therapy or transition to adult services should be carefully considered by all involved.

1.6 Access

Eating disorders in children and adolescence are typically associated with denial of symptoms and reluctance for diagnosis and treatment. Family or community members may first identify often symptoms, therefore the eating disorders program is available to assist parents; schoolteachers, general practitioners, other mental health professionals and families identify the need for, approach, and expedite assessment. It is important that access to advice, assessment and treatment is not impeded and is provided by experts who are knowledgeable about both adolescents and eating disorders.

Unlike for most adults, eating disorders in children and adolescents often present with acute medical crisis and with severe familial distress. Therefore multi-disciplinary and family sensitive assessment should take place within four weeks and when necessary emergency assessment and admission needs to be available.

In most cases parents initiate referral however in the case of a mature minor, assessment and treatment is offered with a view to involving the family where possible whilst insuring confidentiality. Further, in Western Australia eating disorders affect children and adolescents from diverse culturally and geographical circumstances and therefore we endeavour to provide an inclusive and comprehensive service and minimise barriers imposed by geography, culture and social circumstances.

2.0 ASSESSMENT

Anorexia nervosa represents a complex mental health condition compounded by the interplay of psychological and physiological symptomatology. Assessment therefore involves a comprehensive multi-dimensional process.

The PMH EDT assessment gathers information to guide a comprehensive clinical formulation taking into account both mental and physical state (see medical protocol). Content areas include presence and severity of eating disorder symptoms; impact, treatment history; understanding of illness; other co-morbid symptoms and syndromes (especially affective and anxiety disorders, substance abuse and other risk taking behaviours); personality structure; personal and family stress' s; interpersonal functioning; developmental and family history.

Individuals with eating disorders and their families have the right to prompt comprehensive assessment by an experienced multi-disciplinary team of health professionals. The assessment should be conducted by a team that include representation from medical, psychological, educational and nutritional specialities. Professionals need to possess an up to date, specialised knowledge of eating disorders and be personally comfortable with eating disorders and the issues that arise working with them.

The assessment process aims to establish collaborative relationships with the young person and family members. The assessment information guides diagnosis, clinical formulation and treatment planning. Findings are discussed with patient, family and referral agents in a clear, accurate and timely manner, inclusive of both diagnosis and treatment recommendations. Illness specific literature and program related information is provided in a written format.

Our experience suggests that the assessment of people with eating disorders should be prompt, developmentally appropriate and where possible include family members from the outset. Timely communication with referral agent is recommended both prior to and following assessment to facilitate safety during the waiting period and enhance future shared care arrangements.

2.1 Assessment process

The PMH EDP conducts approximately 60 – 80 assessments per year. Parents and the child / adolescent are asked to complete a series of self-report questionnaires prior to attending an assessment (detailed below). Both parents are encouraged to attend the assessment process conducted over two mornings (Monday and Tuesday):

Monday	Psychosocial Assessment (60 minutes) Medical Assessment (40 minutes) School Assessment (30 minutes)
Tuesday	Nutritional Assessment (45 minutes) Eating Disorder Examination for parents and young person separately (60 minutes) EDT assessment meeting (60 minutes) Feedback to family and child / adolescent (30 minutes)

2.2 Assessment Measures completed prior to assessment:

- Family Assessment Device – 13 item self report measure of family functioning
- General Health Questionnaire - self report measure of general health status (completed by parents)
- Strengths and Difficulties Questionnaire – a self report measure of general child functioning

2.3 Instruments administered at assessment:

- Psychosocial History – semi structured interview detailing developmental history, the history of the present complaint, and current presentation. Involves a 40-minute interview with parents and adolescents, 15-minute interview with adolescent alone and an optional 10-minute interview with parents.
- Adolescent Dissociative Experience Scale (ADES) – 30 item self report instrument measures completed in 5 – 10 minutes (completed by adolescent)
- Child Depression Inventory (CDI) – a item self-report instrument measuring symptoms of mood disturbance
- Multidimensional Anxiety Scale for Children (MASC) – a item self-report instrument measuring symptoms of anxiety
- Eating Disorder Examination (12th Edition) – a 62 multiple response field questionnaire of eating disorders behaviours, emotions and attitudes.
- Eating Disorder Examination (Parent version) – as above (completed by parent)
- HoNosca -
- General Assessment of Functioning (GAF) -

2.4 Emergency Assessment

The PMH EDP provides acute assessment for those patients admitted via Emergency Department generally within one week.

2.5 Diagnosis

Australian child and adolescent government mental health services currently adopt the International Classification of Disorders 10th Edition (ICD – 10) to categorize psychiatric conditions.

Consideration of severe malnutrition can compromise diagnostic accuracy. Malnutrition has the potential to: Reduce concentration, mimic depressive symptoms, increased agitation and Increase anxiety states – eg OCD

As such, differentiating psychological symptomatology from sequelae related to malnutrition is necessary.

Anorexia Nervosa
Bulimia Nervosa
Binge Eating Disorder

2.5.1 Differential Diagnosis

General psychopathology research of adult populations has mainly studied co-morbid Anorexia nervosa and Depression; although co-morbid social phobia,

Agoraphobia and Obsessive-compulsive disorder have also been reported. The co existence of a second psychiatric condition potentially complicated treatments and outcome. The need to determine psychiatric comorbidity is integral to any assessment process.

2.5.2 Mood disorders

Major Depressive Disorder (MDD) - It has been found that ED symptoms are associated with the presence of Major Depressive Disorder and Dysthymia in a community sample of adolescents. This suggests that adolescents with eating, body image, and weight concerns who have concurrent psychopathology may be at greater risk of developing an eating disorder.

Dysthymia may be more strongly associated with ED than MDD among adolescents.

2.5.3 Anxiety disorders

- Obsessive Compulsive Disorder (OCD)
- Social Phobia
- Post Traumatic Stress Disorder (PTSD)

3.0 TREATMENT

There is no uniform or agreed approach to the psychological treatment or management of anorexia nervosa in children and adolescents, either in terms of types of treatment offered their duration, intensity or the setting in which treatment is offered. Current practise is therefore informed by evidence from a combination of psychological models and research, clinical experience, developmental consideration, treatment setting.

3.1 Principles

Engagement: Effective engagement is a precondition for successful psychological treatment with this client group, who are typically ambivalent about change. Therefore a collaborative, empathic and supportive relationship needs to be established with both patient and carers, and is an ongoing process throughout treatment. Engagement is a necessary prerequisite for any process of change, which is the primary goal of psychological treatment. Clients may struggle to maintain this relationship. Consideration is given to therapist-client “match”.

Collaboration: Collaboration is an important aspect of treatment at many levels. Occurring within the multidisciplinary treatment team, between the team and the family. The aim of psychological treatment is to improve psychological well being, promote optimal functioning, promote appropriate weight gain and healthy eating, and improve quality of life. These aims are set in collaboration with the individual and their family as developmentally appropriate.

3.2 Multi-disciplinary team

Typically, the team allocates different treatment roles based around indicated treatment modalities in order to promote engagement, protection of the individual therapy relationship and structured to best meet the needs of the individual and the family. Allocated case manager coordinates these.

3.3 Care Coordination

Assigned to a member of the psychological team who is responsible for coordinating the psychological care, assisting in transitions around admissions and discharges to and from hospital, liaison between patient/family and systems involved and developing a collaborative care plan, reviewing progress and responding to current needs. The care coordinator ensures that all team members are aware and working towards shared goals

3.4 Individual psychotherapy

Current research indicates that no particular psychotherapy is superior to any other in the treatment of anorexia nervosa. The most important component to individual psychotherapy is the therapeutic relationship and the aim is to provide a safe and supportive environment in which to explore the issues impacting on the client's psychological, emotional, social, spiritual and physical functioning. Weight gain is only one of many indicators of improvement. Individual therapy is offered beyond this to address issues more comprehensively and prevent relapse. The nature of the therapy will depend on a range of both client and therapist factors. These may include:

- Interpersonal therapy,
- Play therapy
- CBT/DBT
- Schema focused therapy
- Narrative Therapies
- Creative therapies eg art therapy
- Psychodynamic
- Self psychology
- Gestalt Therapy
- Brief solution focused therapy

Parent support and psycho-education

Key issues addressed include de-mystifying some of the myths around AN, identifying helpful and unhelpful information obtained from other sources (eg. The media, Internet sources, family and friends), addressing family theories regarding the eating disorder, and the provision of supportive strategies. Explanation of the PMH model, the likely length of treatment, family impacts and the development of a collaborative relationship are further aims.

3.5 Family Therapy

There is a growing body of evidence which indicates that family based interventions are important in the treatment of adolescents with AN. Family therapy is offered with consideration of the family's initiative for exploring their relationships. Consideration is given to the role of the eating disorder within the family system and the notion of circularity, ie. The impact of the eating disorders on the family, and the impact of the family on the individual with an eating disorder. The family are viewed as experts in relation to their family processes and interactions. The developmental stage of the family is also is

important. The aim of family therapy would be to facilitate a family environment where problem eating behaviours no longer play a role.

3.6 Group Therapy

As a general principle groups can be a useful forum where issues of isolation and powerlessness can be addressed. “Comparing notes” and sharing experiences with other people in a similar situation promotes understanding that other people may have similar difficulties.

Group psychotherapy provides another context where issues relating to the eating disorder can be addressed. This different peer group experience adds to the overall treatment model to increase or intensify treatment.

3.6.1 Types of groups

- **Meal support**
 - Goal is to increase clients’ ability to manage a meal situation, which requires them to make food choices, in a peer group, in a public place.
 - The expectation for meal support outings is that clients (and staff) will all bring something to eat or money to buy something to eat eg at the food hall.
 - Clients can be prompted re the expectation to bring something, but generally not prompted to actually eat.
- **Community outing (meal support Fridays)**
- **Exercise group**
- **Discussion group**
- **Art/massage group**
- **Parent group**
- **Outpatient group**
- **Parent Information & Support Seminar Day**

Groups coordinator is usually the OT

See list of ideas for community outings

See group timetable and current staff roster

See goals and info for specific groups.

1. 3.6.2 Group Guidelines

- Staff requirement – 2 x staff + take mobile phone if community outing
- If only 1 staff member available – individual call re whether to go ahead
- Bus takes 7 people total (ie up to 5 patients + 2 staff)
- Students cannot drive hospital cars
- Consider potential hazards/dangers eg crossing roads, chemists, seat in bus
- In Summer – requirement that clients take a water bottle always
- In hospital when departing for or returning from groups – always take the lift (not the stairs)
- If clients go off from staff – they should stay in pairs and staff should have contact numbers eg mobile phone numbers of clients.
- Ward nurses’ call as to medical readiness to attend groups or not

- Inform nurses (Nursing Coordinator if possible) re clients leaving ward for group and when returning to ward.
- Write in medical (ward) file notes re group attendance with psych med sticker.
- If clients are on “continuous feeds” and they are to attend a group – they can attend group with their feed in, or disconnect if more convenient

3.7 Co-morbidities

3.8 Psycho-pharmacology

3.9 Hospital Service Agreement

2. SERVICE PROTOCOL

Hospital School Services (HSS) and Women’s and Children’s Health Service (WCHS)

PMH Psychological Medicine Clinical Care Unit Eating Disorder Program (EDP)

OUTCOMES

1. To deliver a relevant educational program to referred students
2. To collaborate with schools of referred students in devising and delivering a program in line with student need and home school curriculum
3. To work collaboratively within a multidisciplinary team and, through liaison with schools and other agencies, to support educational, medical and psychosocial needs of identified students
4. To facilitate students’ transition back to school, ongoing study or career

ROLES and RESPONSIBILITIES:

2.1 HSS

- HSS will provide a coordinating teacher for each referred EDP patient –whether inpatient or outpatient.
- EDP inpatient secondary school students will be taught on ward 7teen from 9-3:15 Monday to Thursday and 9-12 Friday. EDP inpatient primary school aged students and any secondary students confined to bed on wards other than 7teen will have assured access to teaching in the mornings only. For inpatients the coordinating teacher will provide, or arrange for, direct teaching and coordinate EDP patients’ access to other subject specialist teachers. Inpatient teaching roles are addressed in more detail in relevant ward protocols.
- HSS will also provide a teacher to support the educational needs of referred outpatients. HSS staff will do an initial school participation assessment and address school related issues arising. Time will also be allocated for school and EDP liaison, and casework to support transition and ongoing participation at the student’s own school post discharge. This will include family meetings and case conferences to support transition and ongoing participation at the student’s own school.

- If more than one HSS teacher is assigned to the team then the teachers will decide between them who is the coordinating teacher for each student and advise the relevant EDP Care Coordinator.
- Ensures HSS Parental/Student Consent to Exchange Information form has been completed before undertaking any liaison work.
- Will support and participate as appropriate in agreed EDP research.
- Will facilitate parent seminars, health professional seminars and provide other professional development relating to school issues as agreed with the EDP.

EDP:

- Refers patients to HSS teacher and provide teacher with all relevant information. Patients will be referred at EDP meetings or via ward staff. In either case the EDP care coordinator will provide a completed HSS consent form and EDP referral form.
- Provides teachers with access to clinical support and supervision
- Ensures clinical service protocols explicitly state the need for regular school attendance whether at HSS or students own school.
- Ensures all health staff involved in the care of ED patients are aware of school protocols (see attachment).
- Ensures health staff supports school attendance.
- Minimises disruptions to students' educational programs wherever possible.
- Advises the teacher in advance of a patient's discharge from hospital.
- Advises the teacher when a patient is no longer under the care of the PMH EDP.
- Will support and participate as appropriate in agreed HSS research.

COMMUNICATION PROCESSES

Collaboration

- The teacher(s) will be considered part of the multi-disciplinary EDP.
- HSS teachers will sign and respect both HSS and WCHS Confidentiality agreements. Queries will be dealt with at EDP team meetings.
- The teacher will take part in joint planning and access EDP debriefing support and relevant professional training. Much of this will take place at EDP meetings and review days. An HSS teacher will attend team meetings, assessments and other clinic appointments as agreed.**
- The HSS teacher will have access to patient records.
- HSS will be consulted in advance if any school reintegration plans are to be put into place. If it is then agreed that a patient will attend their own school from hospital, then the EDP Care Coordinator will take responsibility for arranging patient transport and supervision and ensuring parental consent for the travel. HSS will liaise with the school in advance to ensure**

necessary support is available at the school. (See attached protocol)

- EDP Care Coordinators/ Therapists will keep the HSS teachers informed of any communications with schools.
- Wherever possible the EDP Care Coordinator will accompany the teacher on a school visit.

Duty of Care

- HSS teachers will sign both HSS and WCHS Confidentiality agreements.
- HSS staff child protection/criminal record screening will be the responsibility of DET.
- WCHS offers HSS staff the same health screening and infection control measures as to other staff working in the EDP.
- HSS ensure relief teachers are given adequate handover.
- HSS staff will act in accordance with the policies and procedures of HSS and DET Regulatory Framework. Requests for exemptions to any policy or procedure are brought to the attention of the HSS line manager.
- Students remain enrolled at their own school while accessing HSS services. HSS line management must be informed of any compulsory school aged students not enrolled and act accordingly.
- WCHS will issue HSS staff with WCHS identification badges.
- Primary Duty of Care lies with the EDP and ward managers.
- The EDP teacher will raise queries or concerns at EDP meetings or directly with the patient's assigned Care Coordinator/consultant.
- If a patient has been assigned a nurse special then the nurse will stay with the patient during school hours. Nurse specials are not to delegate their duties to HSS staff at any time.

2.1.1 Forms and Reports

- Distribution of information obtained from schools and student service teams by HSS staff will be in accordance with parental consent form.
- HSS teacher will on request provide the EDP with copies of any formal reports sent to schools or parents and /or other agencies.**
- HSS staff members are responsible for ensuring completion and secure filing of student forms and reports.

LINE MANAGEMENT

- HSS employees are line managed by HSS. Performance management of HSS staff is also the responsibility of HSS. Ongoing consultation will take place with EDP Doctors and they will be invited to take part in review discussions.**
- HSS administration and the EDP Manager will be responsible for timely resolution of issues regarding service delivery.
- Identified child protection issues will be addressed according to Department of Health and Department of Education and Training policy. Both HSS and EDP staff have a duty to**

collaborate and take appropriate action in the best interest of the student.

2.1.2 PHYSICAL RESOURCES

Accommodation

2.1.3 Office

HSS will provide a teacher office but recommends that EDP provide phone and computer access for the teacher(s) within the EDP setting when needed.

Information Communication Technology

- HSS will provide students with classroom and bedside access to Internet and email facilities. This will be via DET network or alternatively WCHS will support the provision of HSS/DET network access.
- During instructional hours teachers will be responsible for students internet. HSS will provide teachers with access to DET network and computers.
- WCHS to provide phone access and dedicated line for teachers on the ward and access in EDP office. HSS to ensure ready access to telephones in teacher office is also provided.
- HSS to provide fax access in school office.
- WCHS will support agreed HSS teleconferencing needed for EDP patients.

2.2 TRAVEL

- HSS to arrange HSS staff travel except where teacher accompanies WCHS staff in hospital car.
- Any student travel is the sole responsibility of EDP and WCHS

REVIEW PROCESS

- HSS quality assurance is ongoing through line management processes, the HSS school self- assessment process and DET Director reviews.
- HSS quality assurance evaluation surveys will be sent to parents/carers, students, schools, ward manager and representatives of health team.
- There will be an opportunity to re-negotiate this agreement in response to changed needs.

3. 4.0 IN-PATIENT TREATMENT

Under certain circumstances the treatment team will recommend hospitalisation. Outpatient treatment alone is sufficient for the recovery of most individuals with eating disorders, however for some, particularly those with anorexia nervosa, hospitalisation may become necessary. This decision should be made on a case by case basis by the gastroenterologist and relates to medical criteria such as physiological instability, body mass index and degree of malnutrition. Refer to Medical Protocol for specifics – appendix X.

The goals of inpatient therapy/case management are the same as outpatient management; only the intensity increases. Individual therapy maintained. Medical and nutritional stabilisation is the first and most important goal of inpatient treatment. This is often necessary before psychological therapy can be optimally effective. Upon admission to hospital each patient is assigned a case manager and individual therapist (this may have already occurred during the assessment phase). The case manager meets with the child and parent to discuss reasons for admission and expectations during the term of hospitalisation. The gastroenterologist and dietitian assess the patient's nutritional status and determine appropriate medical nutrition therapy based on the extent of malnutrition. Most patients are given 48 hours to gain weight via oral pathway, although those who are severely malnourished begin nasogastric feeds immediately. This is also outlined in the medical protocol. The dietitian is responsible for prescribing, evaluating and monitoring dietary/enteral regimens. The dietitian also assesses the individual's attitudes, beliefs and behaviours relating to food, weight and exercise.

The advantages of treatment by a multidisciplinary team include, pooled knowledge which provides a sound base for differential diagnosis and treatment planning; team support; shared responsibility for patient care; and provision of a model of collaborative relationships for the patient.

4.1 Clinical Responsibility

In this clinical setting, patients receive a continuum of care across outpatient and inpatient settings including psychiatric and medical inpatient care. The patients admitted to medical wards are under the bed card of a physician, but the regular input of psychiatrists and mental health team is anticipated to occur in all cases.

Primary responsibility for decisions relating to malnutrition (and other medical conditions) and its management, rests with the treating physician. Primary responsibility for decisions relating to assessment and management of depression, self-harm, suicidal ideation and other co-morbid psychiatric conditions rests with the child and adolescent consultant psychiatrist or the psychiatric registrar and the EDP Care Coordinator.

The EDP Care Coordinator is central to ensuring the overall treatment plan is effective. During an inpatient episode of medical treatment, treatment of psychological issues are continued whilst medical concerns are addressed. With medical decisions being the primary responsibility of the treating physician, all major decisions regarding these patients are made in collaboration and consultation with all clinicians involved. Collaboration and consultation between the members of the team is essential at all stages of the admission and discharge process, especially so when treatment difficulties are encountered. This frequently occurs due to the intractable nature of the illness and the interaction of psychological and medical aspects.

Consultation takes place at the weekly in-patient review meeting when all medical, mental health and other treating clinicians are in attendance. Additional case review meetings may occur as necessary.

The hospital indemnifies medical practitioners for services provided to public patients, and for services provided to private and compensable patients for option A doctors or when no private account is raised, provided those services are provided in good faith. This means that there is no intention to harm, and no incapacity to provide the services of which the practitioner is reasonably aware.

4.2 Care Coordination

The care coordinator (previously case manager) is a member of the psychological medicine staff. The minimum required time for the clinician to effectively fulfill the required care coordinating roles is 0.2 FTE (1 day per week).

Aims

1. To promote a consistent and coordinated continuum of care.
2. To promote the interface between psychological medicine, gastroenterology, dietetic services, hospital school services, and nursing staff.
3. To generate informed decisions of care taking into consideration the bio - psycho - social context of the patient and their family.
4. To provide a point of contact to professionals, the individual, and family members.
5. To assist specific team members to make informed decisions. The care coordinator *is not* required to make decisions per se but to be involved in establishing an effective decision making process.

General Roles

- Information and support: be able to talk with confidence to parents and other professionals on the nature of the PMH EDP model, theories that govern care, best practice guidelines, and how the various components of care are coordinated.
- Liaison: to collaborate with other agencies on goals of care, and strategies to achieve these goals. To ensure regular contact as required with other agencies Attend meetings with outside agencies, including school meetings with HSS teacher, as required.
- Consultation: To consult to other health professionals
- Treatment planning and review: To establish a treatment plan and to make available to health professionals and / individual family via discussion and documentation. To document treatment plan in notes. To arrange case reviews with team members, other professionals, and family at 3 and / or 6 month intervals to review progress and goals of care.

Inpatient role

- To schedule an admission meeting within 5 days of admission with the patient, parent, and any other necessary persons.
- To facilitate discussions between involved professionals as specific problems arise in the provision of in patient care.

- To attend Tuesday 0830hrs medical meeting and Thursday 1100hrs clinical meeting or ensure relevant information is made available via other team member / email etc for discussion.
- To arrange a discharge meeting within 5 days of discharge with patient, parents, and any other necessary persons. Facilitate the making of medical, dietetic, and psychological follow up appointments.

4.3 Medical Protocol

The issues that need to be addressed in management of anorexia nervosa are:

- the correction of the nutritional deficit that develops
- prevention of complications that may be associated with malnutrition and its treatment and with eating disorders in particular,
- changing attitudes to body image and eating
- changing personal and family function
- maintenance of age appropriate physical, mental, social and educational development.

Care of young people with anorexia nervosa and related disorders who are more severely affected has often required prolonged hospitalisation which is expensive and may have little influence on long term outcomes. There is debate about the most appropriate approach to treatment.

We are utilising an approach based around a multidisciplinary clinic that will assess the psychological, social, medical, nutritional and dietetic aspects of eating disorders. An attempt is made to deal with medical and nutritional issues separately from psychological issues, as there is some evidence that it is not feasible to address the psychological and psychiatric problems of anorexia nervosa until nutritional deficits have been corrected. In general the clinic approach is to deal with psychological issues over a long term, preferably in an outpatient setting when the patient has contact with their family and peers.

Children and adolescents with severe nutritional deficits will be admitted to hospital for intensive nutritional therapy, psychological problems will be formally addressed in the outpatient program. Supportive counselling and an inpatient support group will be available for all patients during hospitalisation. It is anticipated that most patients will be hospitalised for two to four weeks for intensive nutritional therapy.

There are some special issues to consider in planning the management of these young people. This protocol is designed to aid in the care of young people who fulfil diagnostic criteria for an eating disorder. Thus it assumes that assessment has been completed, diagnosis established and a process of family and patient feedback and education undertaken and that the family accepts the need for treatment and our model of care. This often takes some days and patients who are admitted acutely to hospital for their first admission will often take some time to complete this process. It is important that application of the protocol await this process and transfer of the patient to the care of the Eating Disorders

Team. If they require early nutritional intervention it may be appropriate to modify the protocol until the above steps have been completed.

1. INDICATIONS FOR ADMISSION

3.1 Patients in need of cardiovascular and metabolic stabilisation

- Typically will have a weight/BMI in the normal range and fulfil diagnostic criteria for EDNOS (Atypical Anorexia Nervosa or Atypical Bulimia Nervosa)
- Utilises compensatory behaviours (laxatives, vomiting, extreme exercise) to cope with their eating and distress at their weight.
- This group will often have a long period of rapid weight loss and be symptomatic (postural hypotension, fainting), and frequently will become dehydrated and develop metabolic abnormalities, but not fulfil weight criteria for Anorexia Nervosa.

Patients in need of nutritional resuscitation.

- Patients with a Body Mass Index (BMI) in the range indicating need for intensive nutritional rehabilitation (Appendix 1).
- Patients with evidence of medical instability:
- Dizziness and fainting
- Extreme cold sensitivity
- Temperature < 35.5°C
- Postural hypotension, a drop in systolic BP > 20 mm Hg on standing.
- An increase in heart rate of >30 BPM on standing.
- Capillary return > 1.0 secs (nail compression, index finger dominant hand)

Patients in need of nutritional rehabilitation

- Patients with a BMI in the range of severe protein energy malnutrition, but not requiring resuscitative care and who are continuing to lose weight despite outpatient nutritional intervention.
- Estimated energy intake < 50% of RDI for weight at BMI 10th centile.

2. ADMISSION PROTOCOL

PATIENTS IN NEED OF CARDIOVASCULAR AND METABOLIC STABILISATION

- These patients do not fulfil weight criteria for admission, but have evidence of significant physiological compromise, evidenced by hypothermia, bradycardia, hypotension and/or marked change in pulse rate and blood pressure with postural change. They may also be admitted because of biochemical disturbance (hypokalaemia, hyponatraemia, hypocalcaemia)
- **The objective of admission for these patients is to achieve physical safety, NOT to arrest weight loss or to effect early cure.**

4. Observations

- 4 hourly observations including lying and standing heart rate and blood pressure. For the first 48 hours, thereafter to be determined according to medical status.
- Detailed fluid balance chart for all patients in need of nutritional resuscitation

- Weigh daily, at the same time each day, at 6am after emptying their bladder. Weighing should be done while patients are wearing their underwear and a gown.

5. Laboratory Investigations

- Measure serum phosphate, calcium, magnesium, electrolytes daily until stable.

Activity

- Determined on the basis of physical status

Nutritional support

- These individuals usually need correction of dehydration and electrolyte disturbance. This may be achieved with oral/NGT rehydration, or may require intravenous therapy in exceptional circumstances
- Once fluid and electrolyte status is normalised consider a liquid dietary supplement to slow down weight loss.
- Some of these patients will need some weight gain to achieve restoration of normal physiological function. It is then necessary to make a clinical judgement about the likely safe weight.
- These patients do not need to stay in hospital for a minimum of two weeks, as other groups do, but can be discharged when stable.

5.1 Review

After three such admissions, there should be a review of the team management approach to the particular individual.

PATIENTS IN NEED OF NUTRITIONAL RESUSCITATION.

Patients in need of nutritional resuscitation are severely ill and have increased risk of morbidity and mortality. They need to be managed with the same degree of acuity as other critically ill patients.

6. Observations

- 4 hourly observations including lying and standing heart rate and blood pressure. For the first 48 hours, thereafter to be determined according to medical status.
- Detailed fluid balance chart for all patients in need of nutritional resuscitation
- Weigh daily, at the same time each day, at 6am after emptying their bladder. Weighing should be done while patients are wearing their underwear and a gown.
- Patients may be told their weight at the time of weighing, if they desire to know it. Whether or not a patient is being informed of their weight is to be recorded on the weight record sheet.
- When medically stable patients may be weighed three times a week only. This is unlikely to occur before 10 days for patients admitted for nutritional resuscitation.

7. Laboratory Investigations

- Electrocardiogram to be performed on admission if patients are bradycardic.

- Measure serum phosphate, calcium, magnesium, electrolytes daily over the first 4 days then weekly.
- Weekly liver biochemistry.

8. Activity

- Strict bed rest for the first 12- 48 hours depending upon clinical status, with supervised toilet and shower access, for all patients in need of nutritional resuscitation. The reason for this is not to punish patients for being malnourished, but to protect them and the hospital from the effects of postural hypotension or energy expenditure.
- Thereafter the need for bed rest determined on an individual basis, as the medical status improves (resolution of bradycardia, postural hypotension). Patients should not have prolonged bed rest unless there is a definite medical indication.
- Graded and supervised exercise will be introduced (on medical prescription).
- Once weight gain has occurred (to Grade II malnutrition) and medical crisis resolved, individuals are allowed to go to the Adolescent Centre.

9. Nutrition

- All individuals in need of nutritional resuscitation who are critically ill are to commence continuous nasogastric tube feeding from admission (see Appendix 2).
- Feeds will be progressively graded up over 4-7 days (to avoid hypophosphataemia).
- Subsequently energy delivered to be adjusted for adequate weight gain (usually 200 – 350 gm per day). Increases will usually be equivalent to 250 calories (1000Kj) per day per oral or nasogastric.
- Phosphate supplementation to commence with initiation of nasogastric feeding, and to continue for two weeks.
- Calcium supplementation to commence at admission and to be maintained throughout the admission.
- Multivitamin supplementation to commenced at admission and to be maintained throughout the admission.
- Do not prescribe phosphate and calcium supplements at the same time (as will bind).
- Target weight range for community treatment: nutritional supplementation should be continued until the patients weight is between 10th and 25th BMI percentile (see Appendix 1) (and medically stable).
- Patients will be discharged as soon as reasonably possible after their target weight is achieved.
- Patients do not need to be eating prior to discharge, although this is desirable (see meal support).

10. Meal Support

- In order to promote normal social eating while in hospital patients will attend group meals three times a week supported by Eating Disorders Clinic and medical nursing staff.

- Meal support will provide a relaxed atmosphere conducive to eating. All patients who are not on bed rest will be expected to attend, irrespective of whether they will eat the meal provided.
- Staff will not record the portion of meals eaten, in order to avoid escalating anxiety and battles around eating.

10.1.1 Meal Times

- Meals* and snacks should be given to patients at the usual times, and removed after a reasonable length of time has elapsed (approximately 30 minutes for meals) without comment on the amount eaten. Any food not eaten at meals should be returned to the kitchen for disposal. It is expected patients will return to the ward for meals other than at meal support times as above. Snacks may be eaten up to one hour prior to meals and up to approximately 8pm in the evening (ie patients are not to eat late into the night or overnight).
- *Adolescents often find that the evening meal time is too early. It may be appropriate to change the evening meal time for adolescents to a later time if this is convenient for ward staff.
- Meals and snacks should be provided by the hospital. Any request to bring in food from outside the hospital should be directed to the team dietitian. In general this will not be appropriate.
- Food intake charts will not be routinely used. Fluid balance charts, if required, should be completed by nursing staff, **NOT** by the patient.

11. Rapid weight changes

- Rapid changes in weight (either gaining or losing) often reflect water loading or other attempts by patients at convincing staff of satisfactory progress. This can be accompanied by serious complications.
- Weight gain or loss of one kilogram or more in a day should be viewed suspiciously and serum electrolytes, Ca, Mg and Phosphate should be measured at these times.
- Bed rest may be prescribed if medical requirements necessitate this.
- Frequent weight fluctuations of this nature may require a period of weight stabilisation prior to discharge, once target weights have been achieved. This will be decided on an individual basis.

11.1 PATIENTS NEEDING PROLONGED (MAINTENANCE) ADMISSION

- A group of patients will prove unresponsive to the approaches outlined above, and will need longer periods of admission which include active psychotherapy during the period of nutritional rehabilitation.
- This group is identifiable by:
 - Multiple admissions (3 admissions in 6 months)
 - Rapid weight swings (dramatic weight loss following discharge, or rapid gains in hospital suggestive of salt and water loading)

12. Objectives

- Achievement of a period of stable weight to allow biochemical and nutritional stabilisation and repair.
- Stabilisation of psychological status, so that they can remain in the community for longer periods and participate in psychotherapeutic programs.

13. Plan of Management

- This phase of therapy will commence once the previously defined target weight for community treatment is achieved.
- It is intended that weight should remain within the target range.
- The rate of nasogastric tube feeding will be decreased to half to two-thirds the rate that has been previously utilised.
- The patient will be informed of the need for them to maintain a healthy weight by increasing their intake (i.e. the objective is not to go on increasing weight but to maintain at the target weight). If this cannot be achieved then the nasogastric tube feeding rate can be increased again.
- Patients will be maintained at the desired weight in hospital for three weeks.
- "Routine" physical observations should be made on patients.
- Weigh three times per week, at the same time each day, at 6am after emptying their bladder. Weighing should be done while patients are wearing their underwear and a gown.
- Laboratory investigations should be undertaken only as clinically indicated.
- Patients should, while they comply with the treatment program, be as free as other patients to utilise the resources and facilities of the adolescent unit and wards.

4. GENERAL COMMENTS

- It is important to avoid negotiation with patients and their families, and also to avoid compromising long term therapeutic goals. Recognition of the roles of the various team members is therefore very important.
- Avoid negotiating with patients regarding weight, energy intake or "privileges".
- Discussion regarding "food" and consumed energy should be undertaken by the dietitian, and not by other team members.
- Members of the psychological medicine CCU team members should undertake discussion of psychiatric issues and therapy.
- Ensure that patients are aware that they have some responsibility for their progression to the next stage of treatment.
- **In general it is best not to remove the naso-gastric tube prior to discharge, even if patients are eating well.**

14. Day leave

- This should **NOT BE CONSIDERED** prior to recovery from biochemical or cardiovascular instability. (This is *unlikely* to have occurred within ten days of admission.).
- Weekend leave for up to 4 hours will be available for patients who are medically stable and have met expected weight gains during the three weighing days of the week.

- During the period of weight stabilisation for patients with recurrent admissions, day leave **MAY** be considered, but is not automatically available.
- Leave should only be with immediate family members, and in particular should not be with the families of other patients.

5. DISCHARGE

- Patients admitted because of nutritional deficiency or its complications should not be discharged in less than two weeks, because weight changes over very short periods are likely to reflect changes in body water.
- Patients will generally be discharged once they achieve their target weight range and are stable, irrespective of whether they are eating or not.
- Prior to discharge the Eating Disorders Team Coordinator (Ms Julie Potts) and the team dietitian should be notified. This should be done 24 hours prior to discharge. This will enable liaison with the designated case manager, discharge planning, appointments to be made, discussion with parents and any pre-discharge assessments to take place.

General Nursing Guidelines

15. Patient management strategies

Because young people with an eating disorder often do not feel unwell and do not always agree to being admitted to hospital, they will often feel that they do not deserve a bed in a busy paediatric ward. It is important to maintain a stance of unconditional positive regard. Patients on the wards will have a therapist and often also a case manager and family therapist. Some principles to assist in maintaining empathy are:

- Be available to discuss normal adolescent issues as they arise, be available to listen and support in times of distress rather than problem solve, be aware of the potential for escalating situations. This will become evident if you begin to experience anger or frustration.
- Discussion regarding food and consumed energy should only be undertaken by the dietitian.
- Discussion of psychiatric issues should be referred to the patient's case manager or individual therapist.
- These patients are particularly sensitive to comments therefore refrain from public discussions and view target weight, daily weighing etc as very personal information.
- Avoid comments re physical appearance – looking “well” “fat”, “healthy” at a time of weight gain where they are most vulnerable. Rather ask how they slept. Do not discuss diets or body image.
- Common characteristics of eating disorder patients can include, bargaining, protest and oppositional behaviour. These individuals can actively resist and may ignore, sabotage or dispute advice in the context of severe distress (when patients are faced with their worst fears).

- In extreme cases a patient's distress may be expressed by threats or action of self-harm. In this instance, the patient's case manager should be contacted for a risk assessment and the team's psychiatrist may be involved.
- Avoid power struggles with patients and their families or within the team that limit collaborative treatment. If in this situation delay comments/ decisions until after a team review.

4.5 Treatment Refusal

It is important to remember that part of the anorexic thinking is that treatment is not needed and the aim of gaining weight is abhorrent. It is part of the nature of the illness that patients are most likely to deny the existence of a problem, and are therefore likely to be either resistant to or, at least, ambivalent about the possibility of change. The goal of engagement is to ensure the patient and family remain open to services offered. PMH would aim to maintain a therapeutic link despite ambivalence, denial or resistance.

When patients are admitted the hospital takes on a duty of care. In extreme circumstances where parents are unable to maintain their child's safety the hospital may act in locus parentis. In our experience, parents usually advocate for treatment and work collaboratively with treating team. The aim is to provide treatment within the least restrictive environment.

Psychological therapies are not enforced and therefore patients have the right to refuse psychological treatments. Medical treatment however can be enforced if there is a risk to life. A combination of medical and psychological assessment to measure risk considering developmental stage and age status will inform decisions. Make use of situation therapeutically, as a crisis may increase motivation and ability to self assess and accept treatment.

Where the family is refusing treatment on behalf on the child and the child is at risk – careful consideration of care and protection order can be made. Medical treatment at risk of harm overrides psychological risk.

4.5.1 Memo for Medical Director

Princess Margaret Hospital can only treat children (ie a person under the age of 18 years), be that treatment, medication, surgery or investigation, with the explicit consent of parents. When there is the use of physical force and other coercion for the insertion of for example a nasogastric tube, it is preferable that the parents are either present or clearly aware of the need for the procedure.

Your letter is quite correct in saying that clinical staff are at risk of being charged with assault or at risk at being found liable for “failure to warn” where there is no or inadequate consent obtained for treatment.

I therefore advise that the Gastroenterology Department needs a robust process for informing parents of the proposed interventions, the risks and benefits of those interventions, and documenting the consent of the parents to apply those interventions.

In the event that a parent is unavailable or unwilling to provide consent for a child and you believe that the child's life is at risk, then the next step is to either contact myself with a view to considering whether the hospital seeks a Court Order ordering treatment to preserve the life of a child or for the child to be put on forms so that treatment can be mandated that way.

4.5.2 Memo of Understanding

Child and Adolescent Health Service provides the only specialist state wide service for the treatment of children and adolescents with eating disorders. Psychological Medicine, Allied Health, Paediatric Medicine Clinical Care Units (CCU) and Hospital School Services work collaboratively to provide this service. In-patient treatment for medical complications associated with eating disorders is managed by the Department of Gastroenterology under the Paediatric CCU, with significant input from the other CCU's.

This memorandum of understanding is between Bentley Adolescent Unit and Child and Adolescent Health Service. It refers to involuntary treatment of adolescents who refuse to accept medical treatment for the physical complications of an eating disorder.

Most patients with eating disorders manage to adhere to medical treatment with support and containment, despite their reluctance. There are occasions when a patient suffering from medical complications, consistently refuses medical interventions and therefore to proceed with treatment may require review under the Mental Health Act. This occurs when medical status is severe and other approaches at encouraging adherence to treatment via the least restrictive methods have been exhausted.

Clinical practice guidelines suggest that a specialist, multi-disciplinary medical setting is the most appropriate place for patients with severe physiological complications, irrespective of voluntary or involuntary status. Therefore, in most cases the treatment setting of choice is at Princess Margaret Hospital.

In order to provide medical treatment when patient consent is absent, it is necessary to make the person an involuntary detained patient under the *Mental Health Act 1996 (MHA)*.

This involves:

- 1.1 A referral to an authorised hospital (Bentley Adolescent Unit) where the adolescent can be examined by a psychiatrist to determine the applicability of Involuntary Detention.
- 1.2 If the adolescent is too physically unwell to be transferred to an authorised hospital for review it is possible to treat under duty of care for 48 hours until patient can be transferred.
- 1.3 Duty of Care is not defined under the MHA and is restricted to crisis situations only.
- 1.4 If involuntary detention is required, then Under Section 59 of the MHA the adolescent can be placed on Leave of Absence from the

authorised hospital and transferred to Princess Margaret Hospital for medical treatment on a medical ward.

- 1.5 Psychiatric management remains the responsibility of the authorised unit and is delegated to the Eating Disorders Program Consultant Child and Adolescent Psychiatrist.

4.5.3 Physical Holding Policy

16. Aim

To position a child so that a medical procedure can be carried out in a safe controlled manner, wherever possible with the consent of child and parent/caregiver.

17. Key Points

- The Nurses Board of Western Australia (NBWA) defines restraint as including any action, word or deed that is used for the purpose or intent of restricting the free movement or decision making abilities of another person.
- The NBWA suggests restraint should be viewed as a temporary solution to challenging behaviour or circumstantial factors.
- By definition restraint is applied without the child's consent. The term 'restraint' is therefore abandoned in favour of 'physical holding'.
- The nurse involved in the physical holding of a child must recognise the child's developmental needs and ensure that his or her safety, both physical and psychological is taken into account.
- Equal collaboration and input from child, family and multidisciplinary team occurs prior to procedure.
- Child is held using a safe, effective, planned method causing minimal distress.
- Alternatives and preparation discussed prior to procedure negotiated with child and family.
- Child assessed and method of holding evaluated and documented.
- Age appropriate explanation given and child has full understanding of procedure and his or her rights.
- The attached framework is to be used to guide nursing staff as to whether clinical holding is appropriate in a given situation.
- All actions on the part of the nurse should be justifiable within the NBWA Nurses Code of Practice, 2000.

4.5.4 Guidelines for Special Nursing

Indications for use of special nursing are as follows:

18. Medical Special

- Ordered by medical staff for medical reasons ie: patient's compensatory behaviours (purging, siphoning, water-loading) that compromise medical progress
- May consist of "bed rest"; "ward-based"; or "hospital-based"

- “Bed rest” – NO groups generally (*note may attend art group in wheelchair)
- “Ward based” – restricted to hospital ward usually
- “Hospital based” – restricted to hospital grounds
- Patients requiring a medical nurse special are able to attend groups within the hospital grounds however patients must be escorted to and from the groups and ward staff notified of their return to the ward.

19. Psychiatric Special

- Ordered by psychiatrist or psychiatric registrar
- If client is considered “unsafe” – eg self harm, etc.

20. Arm’s length Psych Special

- Quite rare
- Staff to go with client into shower, toilet (client has only a curtain around them)
- Take the special with you if client goes on outing.

21. 4.6 Inpatient groups

As part of the inpatient program, the EDT provides therapeutic groups: meal support, discussion group, and art therapy, massage and exercise group. These groups aim to facilitate the development of a range of skills including assertiveness, body image, fitness, relaxation, problem solving techniques, managing anxiety, coping with peer relationships, development of self efficacy and resilience, anger management and other issues that relate to the nutrition management of the patient.

22. 4.7 School issues

Aiming to maintain the patient’s involvement in as many aspects of school life as possible is part of the EDT holistic approach to treatment. Patients admitted to hospital as a result of medical instability are expected to attend the Hospital School Service during the course of admission unless they are not enrolled in an educational service (that is they are not enrolled in formal study and are post compulsory school aged). All students will attend school on their own ward apart from high school students who can attend the school on ward 7teen with ward manager approval and coordination by the eating disorder team teacher. It is recommended that patients in primary school and also high school years 8 - 11 are not to attend their home school during medical admission other than during a maintenance phase. Individuals may negotiate to attend their Home School or other educational / vocational facility during the maintenance phase of a medical admission if an adequate nutritional / physical status is maintained. Individuals are not permitted to attend educational / vocational facility with nasogastric tube in situ. Nasogastric tube can be removed prior to attending and re-administered following daily attendance should this be required. The case manager and HSS teacher should act as coordinators in facilitating the process of home school attendance during maintenance. The Hospital School teacher should act as the primary liaison person between the Hospital School Service and the home school.

23. 4.8 Visitors

Visiting hours are usually restricted to outside of school hours and parents are discouraged from staying overnight. Meals and snacks should be provided by the hospital. Any request to bring in food from outside the hospital should be directed to the team dietitian. In general this will not be appropriate as during the inpatient admission it is important to challenge the range of foods accepted by that patient.