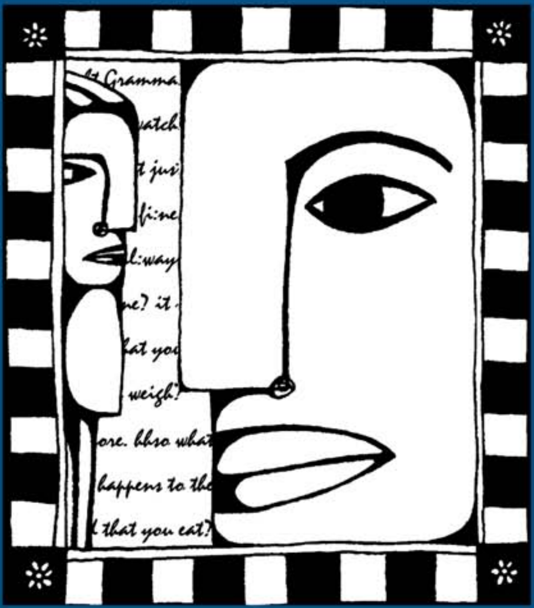
Conversations About Illness

Family Preoccupations With Bulimia



Wayne A. Beach

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Wayne A. Beach
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Publisher's Note

The publisher has gone to great lengths to ensure the quality of this reprint but points out that some imperfections in the original may be apparent.

To *Di,*
for thoughtful chats and loving support;
and to *Brandon,*
who entered our lives in the midst of this project:
though just learning the language, already our best teacher.

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Series Editors' Preface

Little is known about the ways in which family members express concern about one another's medical problems. Equally underexplored are the ways in which medical problems themselves are defined, constituted, and contextualized by family members' interactions with each other, and by their access to and invocation of various professional institutions and resources. Wayne Beach's *Conversations About Illness: Family Preoccupations With Bulimia*, the fourth volume in the "Everyday Communication" series, provides useful perspective on these issues.

Conversations About Illness examines a single conversation between a grandmother and her granddaughter using the techniques of conversation analysis. In this case study, the grandmother, who is also a registered nurse, repeatedly expresses concern for the granddaughter's health and well-being. The grandmother alleges that the granddaughter displays unwise and unhealthy actions indicative of bulimia, and questions the granddaughter's motives. In turn, the granddaughter denies and otherwise rejects ownership of the allegations, and attempts to divert the topic. The grandmother's concern is unsolicited, and the granddaughter rejects it as unnecessary and inappropriate.

Beach studies the continuous and negotiated character of a conversation about bulimia. The interaction is characterized by a sequence of initiation/pursuit/avoidance of alleged wrongdoings involving health behavior. The analysis reveals the grandmother's and granddaughter's contrasting orientations to health behaviors. In the process, readers are given a glimpse into how even expressions of concern and caring may result in conflict between family members. Moreover, the analysis reveals details of the tension between the "essential problematics of caregiving" on the one hand, and on the other the "avoidance of wrongdoing" by those denying that problematic health behaviors exist and merit the attention being given to them.

Although bulimia is the central focus of this monograph, the implications extend beyond this particular problem. In his conclusion, Beach considers how family members confront and address a variety of personal and social problems displayed by loved ones and, in turn, how those confronted routinely deny and discount alleged wrongdoings. The case study thus provides a foundation for understanding the interactional organization of previously unexamined social/family problems—bulimia and grandparent-caregiving—and for comparing such talk with related institutional discourse, such as psychiatric interviews, family therapy, and counseling related to various diseases and family predicaments.

Conversations About Illness moves beyond situating illness in physical bodies or individual perceptions; rather, it proposes as a topic of investigation the experience and discussion of illness clearly framed within existing social relationships.

Wendy Leeds-Hurwitz
Stuart J. Sigman

Introduction

The grandmother–granddaughter conversation examined in this book offers only a glimpse of interactions revealing the altogether pervasive and often troubled coexistence of family medical predicaments. Special attention is given to eating disorders in the ways these family members get caught up and thus preoccupied with an illness "problem": the solicitation and avoidance of admitting to, and seeking professional help for, bulimia. However routine such interactional involvements may be, the constituent practices and interactional consequences of initiating, confronting, avoiding, and seeking to remedy bulimic problems remain largely unspecified. Little is known, therefore, about real-time contingencies of choice and action, coauthored by individuals displaying ordinary yet contradictory concerns about health and illness. There is clearly much to learn about families as primordial institutional systems whose members must somehow deal with unanticipated yet ongoing medical problems, and the present analysis hopes to make clear that far too little is known regarding the distinctive character of how family members routinely talk through real or idealized medical concerns.

This case study involves a single audiorecorded and transcribed conversation, nearly 13 minutes in length, as a point of departure for coming to grips with a limited but revealing set of interactional moments between a grandmother (G) and her granddaughter (S/Sissy). Understanding the nature and problematic consequences of family medical talk necessitates repeated inspection of the interactional organization of such occasions, involvements best preserved by naturally occurring recordings and carefully produced transcriptions. The availability of such materials affords researchers and clinicians alike the opportunity to describe and explain family members' orientations to bulimia, and by doing so to access what members themselves come to treat as meaningful throughout illness processes. By drawing attention to G and S's moment-by-moment, occasioned solutions to evolving courses of action, it becomes possible to reveal how these solutions reflect here-and-now relevancies of what these participants, for reasons often (but not always) explicitly provided in their conversation, acted upon as meaningful and thus in meaningful ways.

In most general terms, the focus of this book addresses why and how the study of social problems such as bulimia and "grandparent caregiving," often described in terms of the "social context" of health and illness, might be practically understood through an examination of language and social interaction. Attending to how family members rely on interaction to routinely order, produce, justify, and manage their daily affairs and understandings, engaging in subtle and deceptively complex actions such as imposing and disregarding constraints regarding health behavior, reveals how families socially construct and in these ways make available their institutional orientations and priorities. More specifically, the focus rests predominantly with how G and S display contradictory preoccupations with bulimia: Just as G is persistent in her conviction that soon-to-be married S is consistently vomiting her food and therefore bulimic (e.g., as one means of losing weight to appear thinner and become more attractive), so does S consistently fail to directly admit, take ownership for, and agree to seek professional help in order to remedy alleged health problems put forth by G. It is the continuous and negotiated character of this interaction that the following analysis seeks to make clear, especially the curiously disaffiliative and at times conflicting resources G and S rely on throughout their conversation. However, certain actions can also be shown to display cooperative and even playful moments in the midst of otherwise serious matters involving an eating disorder.

Because understandings about family interactions of this sort are minimal, a detailed examination of a single case seems particularly merited.

Through an examination of how G and S socially construct their concerns with bulimia and its consequences, it will become apparent that a shift is made from inherently individualized conceptualizations of bodily disease or psychosocial illness toward an understanding of the kinds of embodied interactional activities family members bring to one another's attention as practical and significant reasons for informing actions. Here we can see, for example, just how it is that methods for expressing concern and caring by individuals may nevertheless eventuate in interactional troubles and problems between family members. With G and S, there is evidence of what might in general terms be described as the "essential problematics of caregiving": Although displays of basic concerns for others' health and well-being are routine occurrences between family members in home environments (and, of course, across friendship and various support networks), even the delicate and well-intended management of such occasions guarantees neither agreement on the nature of the alleged problems nor, consequently, a commitment to seek professional help as a predominant means of remedying a medical condition. In such cases, the very existence of an illness is itself a matter of some contention to be interactionally worked out. And it is perhaps both predictable and symptomatic that those explicitly denying (or as with S, indirectly failing to admit) that problematic health behaviors exist, also somehow let it be made known that far too much attention is being given to possibilities and consequences of illness in the first instance.

The issues raised here give rise to basic questions:

- What interactional activities are involved in getting a family member to acknowledge that he or she has a serious problem, and to seek assistance from health professionals as one means of remedying the described illness?
- How do those alleged to be ill fail to directly agree with and/or offer resistance to a family member's diagnosis, and how is such resistance responded to and possibly overcome?
- Regarding bulimia, how are preoccupations with eating, food, thinness, shape, appearance, and weight deeply embedded yet recognizable throughout the talk-interaction?

At the outset, however, it is important to clarify that these and related questions emerged gradually throughout the course of this project. It is both the allure and defining characteristic of *unmotivated*, data-driven observations that eventual recognition of the broader significance of materials examined are more retrospective than prospective in nature.

From the title of this book, *Conversations About Illness: Family Preoccupations With Bulimia*, readers might understandably assume that this investigation was conceived from a set of a priori, longstanding, even systematically explored concerns with how families deal with the illness "bulimia." But any such notions need to be dispelled in favor of far less grandiose beginnings.

The work presented herein is not a reflection of self-proclaimed expertise on eating disorders in general nor bulimia in particular, either as a researcher or resulting from direct personal or family experience with such an illness. In fact, the conversation between G and S was one of many volunteered recordings within the San Diego Conversation Library (SDCL) that, for some time, had remained unnoticed and thus gone unattended. For reasons long forgotten, several short segments of the recording were utilized in classes as evidence of what I then put forth as instances of "blaming," and a full transcription was only gradually produced and refined. It was at this point that a set of local, at times befuddling, observational problems arose: in the first few moments of the conversation, trying to figure out the rather curious fashion in which G appeared to reject S's seemingly innocent invitation to go for a walk, first by questioning S's underlying motive for walking and eventually concluding "That's stupid." Through analysis, it did become increasingly clear that G's apparent attribution of motive, and possible wrongdoing toward S's walking, was designed in consideration of S's vomiting and generally poor eating habits. However, such eventual understandings in no way minimized or dismissed the analytic, here-and-now tasks of coming to grips with a range of complex actions inherent to the moment-by-moment contingencies of this (and every) conversation. The methods or techniques recruited by G and S to coauthor this occasion, and what if anything such activities might reveal about the displayed character of family preoccupations with an eating disorder such as bulimia—not to mention the interactional organization of conversations about illness most generally—remained not only unarticulated but for a considerable period of time were simply not primary explanatory resources throughout a host of repeated listening sessions of the G–S audiorecording and inspections of the transcription.

By not bringing social problems such as bulimia to the G–S interaction a priori, but instead working first toward explicating how and just what it is that these participants are contingently orienting to in meaningful ways (i.e., in real-time situations of local choice and action), it has hopefully become possible to avoid the inherent seduction of prespecifying patterns of interaction by reference to what is known, and thus far too often taken for granted, about ways in which large-scale "macro/societal" problems are evidenced in ordinary conversation. I would like to think that discovery per se has at least been given a fair chance regarding some of the ways family members work through medical problems most generally, although especially how they deal with an eating disorder such as bulimia. Had the initial and explicit task focused on understanding bulimia as a form of illness, especially as a means of redressing and resolving bulimic problems, it is doubtful the set of findings put forth in this book would have been generated. Of course, it remains to be seen just how these findings regarding the interactionally organized nature of talk about bulimia might be informative and of value for families, practitioners, and analysts alike.

The unmotivated character of this research does have its limitations, however, and it is perhaps far too often that discussion of these potential problems get raised only as tagged-on implications within the conclusion of a book or article. By raising them at this juncture, however briefly, they can be utilized by readers as a partial lens for framing both what the analysis has become and its unmotivated inception. It also encourages readers to consistently seek grounding within the interaction that might be put forth as evidence representing "larger" claims, a task very much at the heart of what this and other inquiries must constantly be concerned with regardless of the nature and implications of the interactions being examined.

The first such limitation involves the G–S conversation not being part of a larger corpus of systematically collected materials, driven by a host of focused research questions resulting from theoretical and empirical concerns with family medical/bulimic interactions. There is, no doubt, a price to pay for this. Although diverse interactional materials are brought to contrastive bearing in order to reveal both idiosyncratic and generalizable features of the G–S conversation across numerous speakers, topics, and occasions, it remains only a single conversation. Any such snapshot of everyday affairs imposes constraints for understanding ongoing "problems" with bulimia and other forms of illness. Second, no demographic or other background data exist for G–S. It is not known, for example, whether G has been a primary caregiver for S, if S lives with G, the relationships among G, S, and S's parents (e.g., their marital status), and any social or medical history whatsoever regarding this family. And finally, the interaction was not videorecorded, which is, and increasingly so in studies of language and social interaction, useful for understanding how setting-specific features as well as non- vocal phenomena such as gaze and gesture are used, relied on, and at times actively recruited by participants in ways contributing to the ongoing development and organization of this conversation and relationship.

Many readers may conclude that these limitations cast doubt on the worthwhileness and ultimate importance of the study, and suffice it to say I have reflected on and share several of these concerns. But there are alternative considerations that aid in balancing such critical assessments. First, the single case allows for more attention to be given directly to the interaction as a practical achievement, one meaningfully produced by and for G and S and in these ways made available for subsequent analysis. This results in examinations and observations where there is minimal confounding (and potentially, clouding) with extrasituational information, and subsequently with what might be described as the inevitable "transportability problem" of constantly attempting to link up demographic and background information as explanatory devices for understanding locally organized moments in conversation. Second, audiorecordings are often sufficient data sources, even in face-to-face (rather than telephone) conversations, for discovering how participants make available their understandings of the real-time, moment-by-moment contingencies of the interaction at hand. And finally, as noted, in time it has become increasingly apparent that the emergent findings may nevertheless offer something significant by speaking to more encompassing issues of family medical talk and bulimic problems in particular. This is the case even though findings emerged, by and large, void of being driven by the need to address particular kinds of questions germane to a social problem such as bulimia, including what prior research had identified as relevant and indicative of recurrent difficulties.

Over the past few years I have, however, informally asked students, family members, and friends if they had participated in conversations about the illness bulimia. (Reportings being just that, the synopsis provided here may provoke curiosity but is less a finding than reconstructions of field notes about possible social events.) A slim majority of these individuals reported they had not; they were generally unaware of the increasingly problematic nature of eating disorders especially, although not exclusively, on college campuses. Others described such experiences as routine. The most commonly reported set of interactions involved telling stories and otherwise gossiping about people they knew, and/or experiences they had observed, involving other students', friends', and family members' abnormal methods for losing weight (i.e., vomiting, laxatives, diuretics, excessive exercise). Fewer still reported having interacted directly with others about their problems, and most often, as attempts to inform others that they were aware of, curious about, and perhaps concerned with yet bothered by their "odd" behaviors. Several individuals, however, reported that they pushed further by attempting to solicit from the alleged bulimic both admittance and commitment to seek professional help; such efforts, when they occurred, were reported as reserved almost exclusively for family members and close friends (for reasons such as "you have to really care," or "otherwise I figure it's none of my business"). In all cases, those alleged to be bulimic were described as "being secretive" or "in denial" about the "problem."

It is this latter set of actions, reported by only several individuals, that nevertheless best typifies the activities comprising the G–S conversation.

In chapter 1, "Finding Bulimia," an attempt is made to situate this study within prior research on bulimia and, relatedly, grandparent caregiving. The proposed causes, consequences, and approaches utilized to study these inherently social problems are overviewed. A necessary and considerable interest in family interactions is evident, but owing in part to overreliance on self-report methods and findings, studies focusing directly on recorded and transcribed conversational materials were not revealed. The chapter concludes with an overview of conversation analytic alternatives as suitable methods for examining interactions addressing, at least in part, concerns with and orientations to illness.

The data analysis offered in chapter 2, "From Troubles to Problems," begins at the beginning: How G (also a registered nurse) initiates and brings her "case" to S, occasioning and indirectly raising the problem of bulimia by not only refusing S's invitation to go for a walk but also questioning S's motive for walking. Attention is given to how troubles are topically generative in the ways G constructs problems out of S's stated troubles, displaying concerns with S's health and well-being by alleging S's lack of responsibility in coming to grips with her illness.

Relying on multiple resources for ensuring that S treats G as informed and takes her allegations seriously, thus laying grounds for reasonable assertion, chapter 3 addresses the interactional work of overcoming resistance:

attempts to solicit from S direct admittance via affirmation of responsibility, and commitment to seeking professional assistance for the "problems" S repeatedly fails to "own" (e.g., consistently vomiting her food as a means of becoming thinner for her upcoming wedding). In the ways G engages in a variety of actions—establishing, claiming, and imputing "knowledge," laying out consequences, citing sources, and offering evidence—the interactionally achieved character of "confrontation/insistence" is made apparent, as are routine and emergent difficulties in offering and receipting unasked for "advice."

In chapter 4, similar attention is drawn to how references to "denial" fail to adequately capture S's alternative methods for avoiding ownership of the problems G has constructed. By discounting the legitimacy of G as a viable source, accounting for the reasonableness of her actions, withholding responses through silence, seeking topic closure, and humorously downgrading (e.g., laughing-off) the seriousness of G's attributions, S can be shown to enact a series of actions amounting not only to a lack of affiliation and alignment with G's stated problems, but also the very possibility that problems exist mirroring the attention being given to such illness behaviors.

Just as conceptualizations of "confrontation" and "denial" have been shown in earlier chapters to underspecify the family medical predicaments G and S noticeably work through, so is it the case that the very circumstances they have coproduced and are caught up in are evident as preoccupations in chapter 5. Understood herein as detailed, interactionally organized phenomena rather than an upshot of individuals' mentalistic processes, S's conjoined preoccupations with bulimia and her wedding are interactionally apparent despite her failing to directly admit bulimic problems: first, as unwittingly tailored to and implicated within the very circumstances she is attempting to describe, and second, how these actions may also emerge through an easily unnoticed "speech error" produced in response to having been found in error—one version of double trouble apparent in S's attempts to characterize and thus remedy the situation she is caught up in. By examining environments of potential conflict between G and S, such as G's consistent withholding of commiseration and sympathy from S's expressed anxieties and concerns—it becomes possible to systematically address whether and how "poetics" emerge spontaneously in everyday talk, and the relevance of these understandings for unmasking such delicate involvements revealed throughout problems with bulimia.

Conclusions and implications for examining interaction and social problems are laid out in chapter 6. Discussion begins with making explicit what the study of interaction might offer toward basic understandings of bulimia and grandparent caregiving as practical, conversationally organized achievements. It is suggested that the indigenous activities of "social contexts" have not been systematically examined, resulting in "theories of social action" in their infant stages. Studies such as the one discussed here offer substantive